ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Brian Walker) 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 after the clause had been partly considered.

Hon KATE DOUST: I listened to the discussion between Hon Wilson Tucker and the minister prior to question time on the survey. The Leader of the House was going to try to seek some information around whether the survey would be continuous after a year. I think she was going to provide some additional information to the chamber.

Hon SUE ELLERY: I have some information on some of the issues that were raised before we broke for question time. I was asked whether the Chief Health Officer usually carries out a survey. He does carry out surveys, not infrequently. He commonly uses Citizen Space, an electronic data collection tool. Recently, in 2023, he did surveys on Genetic Services of WA clinicians and support services; the sexual health and bloodborne virus strategy; draft codes of practice—for example, the draft code of practice for onsite wastewater disposal; reporting on food and the Public Health Act; and the local government report to the CHO on data. The epidemiology directorate did a survey of client services, and on the regulation of nitric oxide supply. An abortion bill reform survey of 276 health professionals was carried out. As I indicated earlier, the Chief Health Officer also consults clinicians over strategy and policy development, quite often using roundtable discussions. For example, the Aboriginal health strategy development consultation of clinicians was by round table.

On one of the other matters about one-off or not one-off, in the first instance, the survey will give an indication of whether there is a public health problem or not. Engagement is likely to be high, as the Chief Health Officer can identify the services that undertake abortions. Abortions over 10 weeks will be done by an accredited facility. Why do it as a one-off survey? The Chief Health Officer needs to use any powers under the Public Health Act about reporting and collecting information that is relevant and important to public health with consideration and diligence. The first step is to establish whether it is a public health issue that data can be reasonably collected about. There are two issues: is it a public health issue in WA and can we collect data?

Hon MARTIN ALDRIDGE: That was quite a useful response. The Chief Health Officer does quite a lot of surveying and I think the minister just referred to 2023.

Hon Sue Ellery: Yes, it was.

Hon MARTIN ALDRIDGE: Does she have any information on the response rate that the Chief Health Officer gets, even if it is an anecdotal number? My concern is with the frequency of it. Obviously, he would not pester the same people all the time; it would be different segments of the health sector. I would be interested in any data on the response rate.

Hon SUE ELLERY: I do not have that information, which is not to be taken as meaning there is a high response or a low response. I do not have it. I do not think it would be unusual to expect a reasonable response. He is consulting about public health matters. On the honourable member's point earlier about, for example, general practitioners being busy operating in five-minute slots, despite that, they have an interest in making sure that public health policy reflects what they are seeing, because they know that the information they are collecting and providing to the Chief Health Officer will help them respond to those issues. I think a reasonable level of compliance could be expected, but I do not have an actual number.

Hon MARTIN ALDRIDGE: One of the surveys that the minister listed that the CEO has undertaken in 2023 was the abortion bill reform survey of 260 clinicians. Is this different from the community discussion paper on which community feedback was sought?

Hon SUE ELLERY: It was the same survey. It was around November or December 2022 and 276 health professionals responded.

Hon MARTIN ALDRIDGE: Were they asked the same questions? Have their responses been segmented in the consultation report that we have? I guess what I am asking is: if there is a survey of clinicians that we have not seen information on, can we have it?

Hon SUE ELLERY: I am advised that it was not segmented. Their responses were included in those that were provided in the material that honourable members already have a copy of.

Hon MARTIN ALDRIDGE: I am looking at the *Abortion legislation reform: Community consultation summary report: April 2023*. I think the minister has just said that the responses of the 276 clinicians who were surveyed form part of this report, but they are not identified separately.

Hon Sue Ellery: That is what I am advised.

Hon MARTIN ALDRIDGE: Are the responses of the clinicians available separately from the questions that were asked in the discussion paper?

Hon SUE ELLERY: No. I have no other information I can give the honourable member. Their responses were incorporated into the responses from that survey.

Hon MARTIN ALDRIDGE: I appreciate that that information is not available to the minister at the table. I assume it is available, but just not currently. Would it be possible to know whether the response of the clinicians varied in any respect from that which we saw in the broader community consultation?

Hon SUE ELLERY: As far as we are aware, no, we cannot. Their responses were not separated out.

Hon WILSON TUCKER: Before the break, the minister mentioned in response to a question I asked about whether the survey results would be made publicly available that a summary paper would be produced and, in all likelihood, would be made publicly available. I am just following up on those comments and trying to get a response one way or another on whether the summary of the survey results will be made publicly available.

Hon SUE ELLERY: I am advised that the Chief Health Officer's advice is that, yes, he could provide a public survey in the same way that the consultation one aggregated responses. He is comfortable doing that.

Hon WILSON TUCKER: That is certainly good news. With regard to the data contained in this summary, the main reason for this survey, and something that is being excluded as part of this legislation, is the reason for an abortion. Can the minister give us an indication of what that would contain? I know that we would probably be gazing into a crystal ball, but given that it will be anonymised, what can we reasonably expect by way of information on the reasons for an abortion that would be contained in that summary information?

Hon SUE ELLERY: The Chief Health Officer has been following the debate and he understands the issues that have been raised. I cannot give the honourable member a commitment about what specific questions might be asked or what specific data might be requested, but the Chief Health Officer is aware of the debate and the undertaking given by the minister, but no work has yet been done on what the questions for that survey might look like.

Hon NICK GOIRAN: Prior to the interruption to take questions without notice, the minister was seeking advice on the intersection of the commonwealth Family Law Act 1975, which is referenced under the *WA Health consent to treatment policy 2016*, and the provisions set out at proposed section 202MM and what is referred to loosely as "mature minors". Is any further information available at this time?

Hon Sue Ellery: By way of interjection, can the honourable member remind me specifically what he is looking for? I have no further information than I had before the break.

Hon NICK GOIRAN: Immediately before we were interrupted for the taking of questions without notice, I had drawn to the minister's attention the *WA Health consent to treatment policy 2016*, which is a document that has been referenced at various times during the course of the debate over the last few weeks. In particular, the document reads —

> Under the Commonwealth *Family Law Act 1975* responsibility for any children who are under 18 years of age:
>
> - rests with parents

My question is how that policy and, in particular, the federal law, intersects with this provision under proposed section 202MM.

Hon SUE ELLERY: I am still not clear in my mind what the honourable member is looking for. Where the child is a child of a marriage, an application may be brought in the Family Court of Western Australia or the Supreme Court. Under section 67ZC of the Family Law Act 1975, the applicant must be a person concerned with the care, welfare or development of the child within section 69C of the Family Law Act. For example, doctors, health professionals and hospitals are persons concerned with the care, welfare or development of the child. When the child is not a child of a marriage, the application must be brought in the Family Court of Western Australia under section 162 of the Family Court Act as that court has exclusive jurisdiction to hear applications in accordance with section 36(8) of the Family Court Act. That is probably as far as I can take it.

Hon NICK GOIRAN: I take us to proposed section 202MP because we have just finished the so-called "mature minors" clause at proposed section 202MM. Proposed section 202MN deals with unqualified persons who must not perform an abortion. That was canvassed fairly extensively, from my recollection, at clause 1, particularly the different penalty that will apply. Members might recall there was a concern on my part about whether this provision would capture the abhorrent scenario in which a person deliberately assaults a pregnant woman in the stomach and that leads to the death of the unborn child. I recall that the minister indicated it was not intended

to because there are existing provisions under the Criminal Code, from what I can recall, which would deal with that, hence why the penalty will be 20 years rather than seven years. Proposed section 202MO, in my view, speaks for itself.

Proposed section 202MP is effectively the data collection provision. During debate on clause 1 or maybe clause 4 because she took it on notice, the minister helpfully provided a list of the changes, particularly to the form 1 data collection, which is the mechanism presently available, compared with what is intended to be captured moving forward. Certain things that were collected in the form 1 will no longer be collected. This proposed section is the reason they will no longer be able to be collected. Some of the things set out here, particularly in proposed subsection (4), are of no particular concern because they still allow for the capturing of information or data by way of an age range. I particularly draw to members' attention subsection (4)(c), which deals with the age of a person on whom an abortion is to be performed. That information can still be collected by way of an age range. I think everybody agrees that is important, particularly for those under the age of 18 years. It also allows for the gestational age of the fetus to be collected, but only by way of age range. When it comes to the age of the person on whom an abortion has been performed, I can understand the argument why it might be considered that identifying the actual age of a person might lead to the identification of the person. We want to protect the privacy of the person, which is why we do not collect the actual age of the person, but we are okay with collecting the age range. Why are we concerned with obtaining the actual gestational age of what is referred to here as the fetus, for which the privacy concern would not apply?

Hon SUE ELLERY: There are two reasons. It would be possible, depending on the circumstances, for somebody to match, particularly if we are talking about small communities, postcode with age range —

Hon Nick Goiran: Can I say by interjection that we cannot collect postcodes under subsection (4)(a)?

Hon SUE ELLERY: I know, that is why we are not. Let me finish what I am saying. One of the reasons we do not want to collect gestational age is that it too could be used as a factor to identify people. I am advised that the main reason for collection is for the purposes of planning health service delivery. There are different procedures—remember, we have canvassed them before—that are generally undertaken within a certain range of gestational age. That is why we do not need a precise gestational age. For the purposes of public health policy planning, we want to be able to rely on data about the range.

Hon NICK GOIRAN: I accept that the triannual report we have discussed previously has provided the information by way of a range so it is consistent with that. I am just trying to understand why we are expressly prohibiting the capturing of gestational age. What if there was to be a coronial inquiry on a matter pertaining to an abortion? I know that later on there is a clause that looks to restrict the jurisdiction of the coroner, as I understand it, but it does not completely remove the jurisdiction of the coroner. If there were a coronial inquiry, would the coroner be able to obtain the precise gestational age?

Hon SUE ELLERY: The advice to me is that the coroner would not be relying on the data collected by the Chief Health Officer for the purpose of conducting a coronial inquiry. The coroner would rely on any medical records pertinent to the person. The provisions we talk about now do not prohibit the coroner getting that information if needed.

Hon NICK GOIRAN: I thank the minister. That is helpful. The next restricted provision is proposed section 202MP(4)(f), which is the particular reason for the abortion being performed on a person. Why is it necessary to prohibit the collection of that information? Perhaps it first might help to clarify whether that information is presently able to be captured?

Hon SUE ELLERY: I am advised that what is currently collected is not useful or relied upon for the purpose of planning health services. The broader categories that we will rely on going forward are whether it is fetal or maternal, which will be more helpful for the purposes of planning. Information that is currently collected is, for example, suspected fetal abnormality or actual fetal abnormality. This language is not particularly helpful or to be relied upon for the purpose of planning health services. It might serve a purpose for some other reason, but the information that the Chief Health Officer is seeking to collect for the planning of health services is not necessarily to be relied upon. I take the member to the three-year triannual reporting, in which that level of detail is not reported. It is fetal anomaly or other.

Hon NICK GOIRAN: If the form is the problem at the moment, why not change the form rather than prohibit the collection of the information under proposed section 202MP(4)(f)?

Hon SUE ELLERY: No, it is not that the form is a problem, it is: what is the information collected for? The information is collected to assist the Chief Health Officer to determine planning for future health services. The information the Chief Health Officer has determined is required for that is, in broad terms, the reasons for the abortion: fetal or maternal. The information currently collected is not relied upon by the Chief Health Officer for the purpose of planning health services.

Hon NICK GOIRAN: Before we tear this provision down, why was it implemented in the first place?

Hon SUE ELLERY: No-one here has an accurate recollection of why it was collected in that form in the first place. The regulations were done in 1998. It may be that it reflected the debate when the bill was before the house, but that is an assumption. We do not know whether that is the case or not.

Hon NICK GOIRAN: From my research, I know that up until 2012, seven late-term abortions took place in Western Australia, with the specific condition listed as spina bifida. Two took place at 24 weeks' gestation, one at 27 weeks, one at 29 weeks and one at 30 weeks' gestation. Those seven different gestational terminations took place because of spina bifida. Moving forward, if this provision is passed unamended, would that information still be available?

Hon SUE ELLERY: Not through the method of the Chief Health Officer issuing a directive, but if there was a need to collect that information for the purpose of public health planning, it ought to be possible via medical records kept in the hospital, but not via the direction under the provisions of this bill.

Hon NICK GOIRAN: For example, I think earlier this year I asked the Minister for Health about any Trisomy 21 abortions that took place in the last calendar year. If a parliamentary question were to be asked about that, could the data be provided to Parliament?

Hon SUE ELLERY: The best answer I can give the member is it is theoretically possible, but I would not want to mislead and say yes, it is absolutely. One would anticipate the information would be recorded on medical records. If a member asks a question in here, how efficient is it to look at medical records to determine an answer along those lines to Parliament, and are we in a position to? I am not sure that would happen, so I do not want to raise expectations that we may not be able to deliver that.

Hon NICK GOIRAN: I accept that is a highly likely scenario. If proposed section 202MP, which restricts the direction or the scope of the direction by the Chief Health Officer, were to be amended to remove (4)(f), would that information then be able to be provided to Parliament more efficiently?

Hon SUE ELLERY: Yes, if the Chief Health Officer decided to collect that information it could be, but that is not a guarantee that the CHO will collect that information. I might add, just for completion, that we would not support such an amendment.

Hon NICK GOIRAN: I never thought that the minister or the government would support an amendment, with or without reference to the minister responsible. Nevertheless, I did want to understand whether this particular provision would be a stumbling block to information being provided to Parliament, not hypothetical information but information that has routinely been provided to Parliament over an extended period. I take it that the same thing would apply to any of the various conditions, whether it be spina bifida or trisomy 21, that could be described as being compatible with life. It sounds like this provision will stop that information from being provided to Parliament, albeit that it would be theoretically possible. I think we can reasonably deduce that whoever is in government is going to say, "We don't have the time to get people to trawl through various medical files to get this particular information." I want to be clear, because I am inclined to move an amendment on this particular point, that if proposed section 202MP(4)(f) were to be passed unamended, it would reduce the capacity for Parliament to receive information that it has historically received on conditions compatible with life.

Hon SUE ELLERY: Proposed section 202MP is about information that the Chief Health Officer may direct certain people to provide. It is accurate to say that the Chief Health Officer will not be able to provide that information to Parliament because the Chief Health Officer will not have the power under these provisions to collect that information. I cannot say there will be no other way that the Chief Health Officer can collect information. I cannot say there will be no other way that that information could be provided to Parliament. However, the provision in front of us right now will preclude the Chief Health Officer from collecting that information and therefore providing that information to Parliament.

Hon NICK GOIRAN: If I understand the rationale correctly, I think the minister has indicated that for planning purposes, this particular type of information does not serve a purpose. That being so, why do we expressly say to the Chief Health Officer, "You will not obtain this information." We are not even giving him or her the opportunity or the discretion from time to time to say, "Look, in due course, there could be some good planning reason why I want to get this information. I've reviewed the reasons as to why it was originally obtained et cetera." This goes beyond that. This is not saying that we do not think it is useful for planning purposes, but that under no circumstances do we want the Chief Health Officer to ever ask for this information. Why do we go so far as to do that?

Hon SUE ELLERY: There are a couple things, honourable member. As a consequence of history, it was determined that certain information that is listed in what we have referred to as form 1—the document that I tabled—was deemed 25 years ago to be of assistance. The Chief Health Officer has never, I am advised, in that 25 years relied on the information about fetal abnormalities for the purposes of health planning. If I am right—I am not sure that

I was but I think I am—in saying that it was developed as a consequence of the debate that occurred in Parliament 25 years ago, but that it actually served no purpose in health planning, the drafters considered it appropriate to say, "Actually, we don't need to do that." I think that it was a reflection of the views of the Parliament at the time. That information has not been relied upon for the purposes of health planning. It is not useful for the purposes of health planning and there is no point in collecting it.

Hon NICK GOIRAN: Yet the minister has given an indication that the Chief Health Officer will be doing a survey on sex selection, which is a reason for an abortion having been provided. How will the Chief Health Officer obtain that information when proposed subsection (4)(f) excludes him from being able to do so?

Hon SUE ELLERY: It is the method, honourable member. The provision in front of us gives the CHO the power to issue a direction about collecting certain information. In respect of the earlier discussion that I had with Hon Wilson Tucker, the CHO is proposing to do a survey. Without wanting to speak on behalf of the Chief Health Officer, because I certainly do not, at some point in the future the Chief Health Officer might decide to do a survey on anything else that is within the general realm of what we are talking about. But the provisions in front of us spell out the matters that will form part of a direction. A survey is completely different and unrelated to the things that will be captured by the direction powers. There is nothing in the direction powers that will prevent the Chief Health Officer from doing a survey about anything.

Hon NICK GOIRAN: The next provision deals with the clinical method. I think we had a discussion under clause 1 about the different methods that are used. Will this provision stop the Chief Health Officer from being able to obtain that information?

Hon SUE ELLERY: Yes, under the direction. It is important to understand that this is a list of things that he can specifically not request under a direction. He will not be able to request under a direction information on the particular clinical method that is used.

Hon NICK GOIRAN: Why is it necessary to prohibit that? I would have thought that that would be part of planning for the future. In fact, I think that the different types of methods are referred to in the triennial report.

Hon SUE ELLERY: The CHO will be able to ask about broad categories—so medical versus surgical. The CHO will not be able to ask about particular clinical methods, and those are the things that are listed in proposed subsections (4)(d) and (c), for example, that we talked about previously. That information will not be collected under the direction, but broad category information can be collected that is helpful for the purposes of planning and workforce planning as well—that is, medical versus surgical.

Hon NICK GOIRAN: What about the collection of information on feticide?

Hon SUE ELLERY: The examples I have been given indicate that it is likely that broad categories of abortion will be asked for such as medical, surgical, and then, perhaps, medical/surgical, which could encompass feticide. However, there are also a range of particular ways that feticide may be carried out. The particular will not be collected, but it might be that of the broad categories—medical, surgical and medical/surgical—that medical/surgical would include feticide.

Hon NICK GOIRAN: Would the Chief Health Officer asking and directing that the number of feticides be reported back to him be prohibited or allowed?

Hon SUE ELLERY: As it has been explained to me, the Chief Health Officer could collect that information, but it would come under a broad heading of surgical and/or medical abortions. Because there are different methods of feticides, the specifics would not be able to be collected by him under these provisions. However—someone clinically will have to tell me if it is different—he might be able to determine that a combination of medical/surgical abortions could mean feticide. If that is combined with the gestational age range, that conclusion could be drawn.

Hon NICK GOIRAN: I would like to know if the Chief Health Officer could issue a direction requesting that the number of feticides performed be provided to him. I understand that at the moment there are various categories used, including in the triennial report, such as medical, surgical and a combination of the two. I accept that and that the Chief Health Officer could ask about those. That is not my question. At the moment, from time to time the government does tell a parliamentary committee or Parliament how many feticides have been performed over a period of time. Again, it is a bit like the earlier questions; I would like to know if he will be able to collect that data or if we are specifically saying that he cannot ask about feticide, because it would be a particular clinical method. Again, I hasten to add that I understand that the Leader of the House is saying that there are different types of feticide that might occur; that is not my question. Can the Chief Health Officer ask how many feticides have been performed and would he get that information?

Hon SUE ELLERY: No, honourable member.

Hon NICK GOIRAN: Well, I think that is a problem. Proposed section 202MP(4)(h) states that the particular clinical details or outcomes associated with the admission to a hospital of a person on whom an abortion has been performed are not to be provided. Does that mean the Chief Health Officer will not be able to ask in a direction how many people have died as the result of the performance of an abortion?

Hon SUE ELLERY: If I understood the honourable member's question correctly, under the Health (Miscellaneous Provisions) Act 1911, the death of a woman as the result of pregnancy or childbirth will still need to be reported to the Chief Health Officer. That is under section 336 and is not proposed to be changed.

Hon NICK GOIRAN: The outcome of death from that situation would still have to be reported, notwithstanding that it cannot be asked of by way of a direction as stated in proposed section 202MP(4)(h). What outcomes are we concerned about being reported to the Chief Health Officer? Are we talking about complications as the result of the performance of an abortion that we do not want the Chief Health Officer to know about?

Hon SUE ELLERY: For the purpose of planning health services, the view is that negative outcomes—if the member wants to describe them that way—would already be collected by the hospital for the purposes of its clinical incident reporting. Does the Chief Health Officer need to require that information for the purposes of health planning? No. However, that information does not disappear because it still forms part of the work that the particular health service provider has to collect about incidents for clinical outcomes as part of its quality assurance processes and the regulatory regime that sits over that.

Hon MARTIN ALDRIDGE: At my briefing on this bill, it was suggested that the Chief Health Officer currently collects a lot of personal information from the form 1. If that information was released, it could identify a person and equally a practitioner. As I understand it, there has not been any disclosure that has led to that, but there is potential for that to occur. I am looking at proposed section 202MP(3). It states —

> (3) The information specified in a direction under subsection (1) —
>
> (a) can only be statistical or summary information; and
>
> (b) cannot include any particulars from which it may be possible to ascertain —
>
> (i) the identity of a person on whom an abortion has been performed; or
>
> (ii) the identity of a person who has performed, or has assisted in the performance of, an abortion on a person.

I think that addresses the mischief or risk that the government sought to address. Why is it that we need proposed section 202MP(4) at all?

Hon SUE ELLERY: I sort of tried to canvass this before. As best as I can establish, the sorts of data that were being collected from form 1s and being set out in the regulations was as a function of the political debate that occurred 25 years ago. The reason that the Chief Health Officer needs to collect information about the delivery of abortion care is in respect of the planning of services. There is already a degree of sensitivity even without saying a person's name, particularly if they are in a small community, are 15 years old, have been off school and look like they have put on weight. Conclusions might be able to be drawn. That is why things like age group, postcode and other things cannot be collected. It is a combination of factors, honourable member.

Hon MARTIN ALDRIDGE: I understand. Collection of information is one thing, disclosure is another. We have a very mature approach to this. The health department probably has a whole bunch of information on all of us. However, that information is never disclosed—as it should be. That is not just relating to the health department, but the health fraternity as a whole. Whether someone is a pharmacist, GP or physiotherapist, there is a mature understanding of privacy for patients and their health matters. I am uncertain about why we are going to the extent that we are in proposed subsection (4). I think it is perhaps more specific than we need to be because in my mind, proposed subsection (3) says that the Chief Health Officer can request this stuff, but only if it does not identify a person or practitioner. I am not sure why we need to go further than that in anticipating what is in proposed subsection (4).

Sitting suspended from 6.00 to 7.00 pm

Hon MARTIN ALDRIDGE: Before the adjournment for dinner, I discussed whether it is necessary to retain subsection (4) of proposed section 202MP. I made the point that we seem very concerned about disclosure of information that could identify a patient or a practitioner, but I think there is a distinction that can be made between the collection of information and the disclosure of information. The point that I was making was that I think the medical and health community are well versed and this is well understood in terms of the requirement for patient privacy. Is it really necessary for us to place such specific instructions or limitations on the Chief Health Officer and issuing the direction beyond what is established in subsection (3), which says he or she —

> (b) cannot include any particulars from which it may be possible to ascertain —

(i) the identity of a person on whom an abortion has been performed; or

(ii) the identity of a person who has performed, or who has assisted in the performance of, an abortion on a person.

I am not convinced about the need for subsection (4), but we will come to that in time. The triennial report, which has been tabled through the course of this debate, was produced most recently in November 2019 by the Department of Health. It was produced by the maternal and child health information and system performance directorate of the Department of Health. I understand this is the sixth report, which would probably have started under a Labor government, continued under a coalition government and then this report was released under the current Labor government. The point I make, which will come to a question in a moment, is that this report will not be able to continue in the same form following the passage of this bill, because much of the information that is in here will be prohibited information. My question is: has the compilation disclosure of this report resulted in the identification of a patient or a practitioner who has performed an abortion?

Hon SUE ELLERY: Not that we are aware of, honourable member.

Hon MARTIN ALDRIDGE: I think we need to get the balance right, which is having sufficient information to make decisions and create reports such as this triennial report, balanced with the protection of personal information. We heard from the Leader of the House that, with the advice at the table, they are not aware of any practitioner or patient having been identified as a result of this report. This report will be a much simpler document once this bill passes, because the availability of information will be a narrow subset of what is currently available. That is why my preference is to allow the Chief Health Officer to make decisions around the collection of information arising from a direction that he or she issues as opposed to being overly prescriptive as I think we are in proposed subsection (4).

I have questions about proposed subsection (4). I will draw the Leader of the House's attention to proposed subsection (4)(c), which talks about —

(c) the age of a person on whom an abortion has been performed, other than as an age category including a range of not less than 5 years …

We say two things here. We say it has to be a range, and the range has to be not less than five years. I draw the Leader of the House's attention to proposed subsection (4)(e), which says —

(e) the gestational age of the foetus at the date on which an abortion was performed on a person, other than as an age range …

We say there that the Chief Health Officer can require the gestation age of the fetus so long as that age is as a range. Unlike (4)(c), we are not saying that it has to be not less than a certain period. What is the minimum time frame, as arranged, that the Chief Health Officer could require with regard to proposed subsection (4)(e)?

Hon SUE ELLERY: We have canvassed this a little bit already—not that specific question, but we have canvassed why it would be in a range at all. This is what I said to the chamber before we rose for dinner: it is because there are certain procedures that are done within a certain gestational range and that we do not do above a certain gestational range. By expressing it in this way, it gives the Chief Health Officer the power to collect information within ranges and that is linked to the particular method and the regulatory framework around the gestational age. That is why it is expressed that way. It is not expressed explicitly. It may be at some point, and this has happened over time anyway, honourable member. Medical technology and techniques change over time and we have seen that happen with the use of different methods to provide abortions since the original act was put in place.

Hon MARTIN ALDRIDGE: I do not have access to the form 1 at the moment, but I assume—I am not sure if that is collected in range form at the moment, but certainly if we look at the triennial report, the disclosure of information on gestational age is: less than nine weeks, 10 to 13 weeks, 14 to 19 weeks and 20 weeks or more. As the Leader of the House says, it is linked to perhaps different —

Hon Sue Ellery: Methods.

Hon MARTIN ALDRIDGE: Yes, different methods that might be used in the abortion process. My question about proposed subsection (4)(e) is: what is it that we are doing? If we are restricting the Chief Health Officer from making a direction at proposed subsection (4)(e), could the Chief Health Officer issue a date range that is every two calendar days?

Hon SUE ELLERY: There would be no point in doing that, but the member can see for himself that the provision allows him to collect it as an age range. The example given there is that it is most likely to be the age range. There is nothing that precludes collecting a range of every two days, but there would be no point.

Hon MARTIN ALDRIDGE: The other issue I wanted to pick up here was proposed section 202MP(4)(d), particularly off the back of the debate last week about an amendment around abortion for sex selection purposes.

I think many of the arguments advanced for persons seeking a sex-selection abortion were associated with their cultural heritage. What is the purpose of restricting the Chief Health Officer collecting information about the race or nationality of a person on whom an abortion has been performed? I do not see how it could possibly identify a person who has had an abortion performed on them, given that the minister confirmed much earlier in the debate that the type of information we are looking at is effectively at the health region level. These are very big health regions, and postcodes and addresses are excluded information under proposed section 202MP(4)(a) and (b). We are talking about regionalised data. What is the utility in restricting the race or nationality of a person when the Department of Health sees value in reporting on it? It is one of the few things disclosed in its triannual report, the most recent one being in November 2019.

Hon SUE ELLERY: Currently, all that is collected is Aboriginal or non-Aboriginal data. For the purposes of health planning, we do not need to know that because we already know where the populations of Aboriginal people and the health services that they use are generally. The information currently collected is of no value to the Chief Health Officer for planning. It does not tell him anything other than Aboriginal, non-Aboriginal or Torres Strait Islander. We already know where those populations are and the services that they use.

Hon MARTIN ALDRIDGE: Imagine for the moment that the Tucker survey gets issued in 12 months' time and the response from clinicians is that they are not only being asked to perform sex-selective abortions, but they are performing sex-selective abortions. Keep in mind that it is lawful to do so, because there was an amendment to make it unlawful. It is lawful to have a sex-selective abortion under the current regime, and it will continue to be the case once this bill passes. I do not think the minister likes the word "lawful", but it will be permissible. It will not be unlawful. I think that the minister used a reference to New South Wales of 0.02 per cent. I am not aware of any statistical data in a Western Australian context, otherwise the government would be using it. We are reverting to a New South Wales dataset. If there is a concern, keep in mind the point made in this debate that it has been 25 years since we had the last debate, so these debates are not going to happen all that frequently. How is it that the Chief Health Officer would be able to respond, apart from issuing survey after survey, when he or she could be collecting data? I admit that sex-selective abortions are not necessarily contained within a silo of cultural heritage–associated purposes either—there could be other reasons why such an abortion is sought. If we strike out proposed section 202MP(4)(d), we will prevent the Chief Health Officer from requiring that information following the performance of an abortion at any time in the future. Apart from doing voluntary surveys with clinicians, how else would the Chief Health Officer be able over time—10, 20, 30 years perhaps before the Legislative Council considers this matter again—to ascertain whether or not this is a problem in Western Australia, keeping in mind that it is not unlawful?

Hon SUE ELLERY: We are actually talking about subclause (4) right now, about race or nationality. We can discuss sex selection if that is what the honourable member wants to talk about now. The bill in front of us now lists the things that the Chief Health Officer cannot use the powers of direction he has under this act to collect. There is no reason. In fact, we know the Chief Health Officer will survey clinicians to test to what extent requests for sex selection is a public health issue. I cannot predict what steps he might take after that, depending on the information that he gets. We have already established he has the power. He frequently uses surveys and clinical round tables to get information from clinicians about what is happening on the ground to influence decisions he might make about health planning. All of those things happen now and they will continue to happen into the future. There is nothing in the provisions of the bill in front of us now that preclude him from doing that.

Hon MARTIN ALDRIDGE: I do not think I am going to convince the minister of my concern here. I am obviously disappointed that we have not included a provision in this bill prohibiting sex selection, because that would have given me greater confidence to move past this a bit more quickly. We heard from Hon Dr Brian Walker, and when he responds to the Tucker survey, he will probably tell the Chief Health Officer exactly what he told the Legislative Council. There may be other doctors who have been asked to perform sex-selective abortions. If the Chief Health Officer—now or in 10 years' time—wants to collect more fulsome data around whether this is happening and whether it is linked to a person's race or nationality, amongst other things, he or she and their office will be prohibited from collecting that information. As I said before, a distinction should be made between information that is collected and the information that is disclosed. I think the Department of Health and the medical fraternity have a very good track record of managing very sensitive information. Due to that and where we are today, I am not satisfied that a one-off survey in 12 months' time is sufficient. For those reasons, I move without notice —

Page 22, lines 19 and 20, to delete the lines.

Hon SUE ELLERY: I just indicate for completion, in case there is any doubt, that the government will not be supporting this amendment. We have already had a fairly wideranging discussion. I can characterise the honourable member's reasons for moving the amendment as being linked to his concerns about sex selection. Without wanting to verbal him, he has expressed some concern that if the Chief Health Officer were to find that there is demand

for abortion services for reasons of sex selection, he would not be able to determine whether that was linked to a particular race.

We have already established that the first thing that will happen is the Chief Health Officer will undertake a survey to determine to what extent there actually is an issue. The Chief Health Officer has all sorts of powers and capacity to collect information, including other surveys, clinical round tables and the like, if he decides that there is an issue that warrants further investigation. The list in front of us lists the specific powers that he must not exercise when he is exercising his right to issue a direction under this part of the legislation. As we know from the events of the past three years, the Chief Health Officer has wideranging powers and can use those, as well as things like surveys and clinical round tables, to establish anything he needs to for the purposes of public health planning.

Amendment put and negatived.

Hon NICK GOIRAN: We are still dealing with this difficult proposed section 202MP(4), which is the provision that will authorise the Chief Health Officer to give directions to obtain particular information. As Hon Martin Aldridge has pointed out very well, proposed subsection (3) makes it very clear that whatever information the Chief Health Officer specifies in the direction, it cannot include any particulars from which it may be possible to identify a person. From what I can gather, that provision has unanimous support. I have not yet heard anyone make an argument that information that could identify the person should be available. Notwithstanding that, the government has gone out of its way to list eight specific things that under no circumstances the Chief Health Officer can ever ask for by way of a direction. One thing that cannot be asked for, at proposed subsection (4)(f), is the reason for an abortion.

This essentially goes to the same point that Hon Martin Aldridge was making on sex selection. If that is the reason given, it will not be possible for the Chief Health Officer to ask for that information by way of a direction. If it is because of Down syndrome, it will not be possible for the Chief Health Officer to ask for that reason. If it is for anything else, such as spina bifida, it will not be possible for the Chief Health Officer to ask. Interestingly, the research I conducted some years ago found that the top two most frequent reasons for late-term abortions were spina bifida and trisomy 21. We know that there were seven for spina bifida. There were two at 23 weeks' gestation, two at 24 weeks, one at 27 weeks, one at 29 weeks and one at 30 weeks. For trisomy 21, otherwise known as Down syndrome, there were six—one at 23 weeks' gestation, three at 24 weeks, one at 31 weeks and one at 34 weeks. Again, I do not know why we would prohibit the Chief Health Officer from being able to obtain this information. It is not possible for us to identify these people. We do not need to know, and I do not suspect that anyone wants to know. But I think that there is a public policy benefit in knowing exactly how many times an abortion takes place in Western Australia because of spina bifida, trisomy 21 or some other condition that is compatible with life, including the sex of the unborn child. Now that it has been established that this will definitely prohibit that from occurring, I move —

Page 22, lines 25 to 30 — To delete the lines.

Hon SUE ELLERY: As I think I indicated in part of the earlier conversation that we had, we will not be supporting the amendment. This is a list of matters that, for the purposes of planning abortion care services into the future, the Chief Health Officer is not required to collect information about. Having that information does not help the Chief Health Officer to do the planning for future abortion care services. It might be of interest, and I am sure it is, to certain members to have that information, but the Chief Health Officer does not require that information to do the job he needs to do, so we will not accept the amendment.

Division

Amendment put and a division taken, the Deputy Chair (Hon Steve Martin) casting his vote with the ayes, with the following result —

Ayes (8)

Hon Martin Aldridge	Hon Kate Doust	Hon Martin Pritchard	Hon Wilson Tucker
Hon Colin de Grussa	Hon Steve Martin	Hon Neil Thomson	Hon Nick Goiran *(Teller)*

Noes (21)

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

Amendment thus negatived.

Hon KATE DOUST: The next two amendments listed on the supplementary notice paper are in my name. I indicate to the house that I will not be moving either of those amendments.

Hon NICK GOIRAN: The next amendment that sits on the supplementary notice paper stands in my name. It looks to insert a new provision, proposed section 202MS, at page 24 after line 26.

Before we move to that proposal, with regard to the data on an abortion that the Chief Health Officer may direct certain persons to give him, apart from the Chief Health Officer, were other people consulted on what can and cannot be included in the direction?

Hon SUE ELLERY: I am advised it was the Chief Health Officer; he has a range of people within his office. I am advised that it occurred in broad terms, but not in the specifics, as in the precise wording of the provisions in proposed section 202MP(4). In broad terms, at the clinical round tables, the types of information that the Chief Health Officer may no longer collect was canvassed, but, as I said, not the precise wording of the clause before us.

Hon NICK GOIRAN: Was there representation at the round tables from the Royal Australian New Zealand College of Obstetricians and Gynaecologists?

Hon SUE ELLERY: Yes, there was.

Hon NICK GOIRAN: According to the college's recommendations in its current statement, on the issue of monitoring and research, it says —

> In order to better understand the individual and public health impacts of abortion, the College supports the monitoring and collection of statistics relating to abortion —

That is a pretty uncontroversial point because it is indeed what I understand the government is seeking to achieve by the use of this direction.

Hon Sue Ellery: It is in proposed subsection (3).

Hon NICK GOIRAN: Yes. But the statement continues —

> including the occurrence of complications of these procedures.

At this point in time there will be no opportunity for the complications to be obtained because of proposed section 202MP(4)(h). Why has proposed subsection (4)(h) been included in contradiction of the position of the college on monitoring research?

Hon SUE ELLERY: We have talked about proposed paragraph (h) before and the conversation was around it being common practice for hospitals and health service providers to collect information on adverse outcomes, if I could describe them as that, as part of their normal clinical governance arrangements irrespective of the royal college's point of view. It may well hold the point of view that it should be part of the Chief Health Officer's directions. In the bit that the member read out to me, I did not hear it say "and that needs to be in the Chief Health Officer's directions".

Hon Nick Goiran: That is true. They did not say that.

Hon SUE ELLERY: So, it is still possible for information to be collected by health service providers. It is possible for the CHO to talk to health service providers about that information. In front of us is a list of things that the CHO will not use his directive powers to collect. It does not mean that he cannot have those discussions with health service providers and clinicians in other ways. He does that frequently. I gave the member the list earlier of the sorts of things about which he regularly consults with clinicians.

Hon NICK GOIRAN: I move —

> Page 24, after line 26 — To insert —
>
> **202MS. Annual Report**
>
> (1) The Chief Health Officer must, by 30 June each year, provide the Minister with a report about abortions performed in the preceding calendar year.
>
> (2) A report under subsection (1) —
>
> (a) can only be statistical or summary information; and
>
> (b) cannot include any particulars from which it may be possible to ascertain —
>
> (i) the identity of a person on whom an abortion has been performed; or
>
> (ii) the identity of a person who has performed, or has assisted in the performance of, an abortion on a person.

(3) A report under subsection (1) must include the following information about an abortion —

(a) the age category of the person on whom the abortion was performed (for example, under 16 years of age);

(b) a clinical estimate of the gestational age range of the unborn baby, at the date on which the abortion was performed (for example, up to 9 weeks, between 10 and 13 weeks, between 14 and 19 weeks, between 20 and 22 weeks, from 23 weeks);

(c) the type of place at which the abortion was performed (for example, a public or private hospital or a private health facility);

(d) if the abortion was performed on a person who was more than 23 weeks pregnant — the class of reason for the abortion having been performed (for example, an emergency to save the person's life, an emergency to save another unborn baby, unborn baby with a lethal abnormality, unborn baby with a non-lethal abnormality);

(e) the health profession of each registered health practitioner who performed, or assisted in the performance of, the abortion, including whether the practitioner holds specialist registration under the *Health Practitioner Regulation National Law (WA) Act 2010* and, if so, the practitioner's specialty;

(f) the method used to perform the abortion (for example, vacuum, vacuum and medication, medication only, dilatation and curettage, dilatation and evacuation);

(g) whether there were complications arising from or following upon the performance of the abortion on the person, including whether the person died as a result of the performance of the abortion or the complications;

(h) whether the performance of the abortion resulted in a live birth;

(i) other information (including data and statistics) of a kind prescribed by the regulations or determined by the Minister.

(4) The Minister must cause a copy of the report provided to the Minister under this section to be laid before each House of Parliament within 12 sitting days of the House after the day on which the report is provided to the Minister.

Hon MARTIN PRITCHARD: I have been trying to follow the discussion between the minister and Hon Nick Goiran. If we pass this amendment, would it be compatible with proposed section 202MP(4)? Would it be possible for both to operate simultaneously? Will they be compatible if we pass this amendment?

Hon SUE ELLERY: They appear on face value to contradict each other.

Hon NICK GOIRAN: It is interesting that the member asked the question and the minister would respond in that fashion. If I can draw the member's attention to proposed new section 202MS(3)(a) —

(3) A report under subsection (1) must include the following information about an abortion —

(a) the age category of the person on whom the abortion was performed (for example, under 16 years of age);

I am not sure why the minister says it is in contradiction given that at —

Hon Sue Ellery: Will you take an interjection?

Hon NICK GOIRAN: I will finish what I am going to say first. Proposed subsection (4)(c) states —

> the age of a person on whom an abortion has been performed, other than as an age category including a range of not less than 5 years (for example, under 15 years of age, 15 to 19 years of age, and so on);

Members can see that proposed new subsection (3)(b) states —

> a clinical estimate of the gestational age range of the unborn baby, at the date on which the abortion was performed (for example, up to 9 weeks, between 10 and 13 weeks, between 14 and 19 weeks, between 20 and 22 weeks, from 23 weeks);

Of course, this would be entirely consistent with proposed subsection (4)(e), which states —

> the gestational age of the foetus at the date on which an abortion was performed on a person, other than as an age range (for example, 9 weeks or less, 10 to 13 weeks, and so on);

I draw member's attention to proposed new subsection (3)(c), which refers to the type of place, not the address, in which the abortion was performed—for example, a public or private hospital or a private health facility. Regarding a late-term abortion under the existing scheme, proposed new subsection (3)(d) states —

> if the abortion was performed on a person who was more than 23 weeks pregnant—the class of reason for the abortion having been performed (for example, an emergency to save the person's life, an emergency to save another unborn baby, unborn baby with a lethal abnormality, unborn baby with a non-lethal abnormality);

Members will see that this is different from proposed subsection (4)(f), which states that it needs to inhibit the particular reason for an abortion as distinct from the class of reason. Further in the amendment, it refers to the health profession of each registered health practitioner who performed, or assisted in the performance of, the abortion. That is obviously talking about the health profession by way of a group or title. Proposed new subsection (3)(f) refers to the method used to perform the abortion—for example, vacuum, vacuum and medication —

Hon Martin Pritchard: Is the member taking interjections?

Hon NICK GOIRAN: I will just finish this. It continues to refer to methods such as medication only, dilatation and curettage, and dilatation and evacuation. Proposed subsection (4)(g) refers to the particular clinical method. I spent some time asking the Leader of the House about things like feticide. An explanation was given that different types of feticide could be performed. Proposed new subsection (3)(g) states —

> whether there were complications arising from or following upon the performance of the abortion on the person, including whether the person died as a result of the performance of the abortion or the complications;

We heard earlier from the Leader of the House that there is nothing in the existing law and that, in fact, there will be an obligation to report if deaths occur as the result of an abortion. Proposed new subsection (3)(h) states —

> whether the performance of the abortion resulted in a live birth;

Proposed subsection (4)(h) of the bill refers to the particular clinical details or outcomes associated with the admission to a hospital of a person on whom an abortion has been performed. If an abortion performed on a particular person at a hospital results in a live birth, would that be in contravention of proposed subsection (4)(h) in the bill? That is something that will need to be considered by members when considering this amendment. Do we want to know whether babies continue to be born alive after an abortion? We know that the health minister is on the record as saying that no such thing occurs. We know that it can occur.

Lastly, proposed new subsection (3)(i) states —

> other information (including data and statistics) of a kind prescribed by the regulations or determined by the Minister.

That would allow the Chief Health Officer and the minister to determine whether they would like any other information on the matter. I encourage members to give strong consideration to this amendment. The reason I put it on the supplementary notice paper is that this type of information is collected in South Australia. I see no reason why information that is collected in South Australia cannot also be collected in Western Australia. That said, I note that both the Leader of the House and the honourable member wanted to pose a question by way of interjection. I am happy to take further questions.

Hon MARTIN PRITCHARD: I was just reading proposed new subsection (3)(f) of the amendment and proposed subsection (4)(g) of the bill. I have not got into the other parts, but they seem to be contradictory.

Hon NICK GOIRAN: It will depend on how the particular clinical method is defined or whether the examples listed at proposed subsection (4)(f) are by way of category. The theme that has emerged from the government is that it does not want particulars to be disclosed, but it seems to be happy with the Chief Health Officer being able to collect ranges of data, classes of information and the like. If we are told in due course that there were 500 medication-only abortions, I would suggest to members that that would not be of any concern with regard to identifying a person on whom an abortion has been performed, which is, of course, the ultimate concern.

Hon SUE ELLERY: We will not be supporting the amendment. The amendment seeks to include an annual reporting requirement that does not currently exist, and we do not seek to have it exist under the new arrangements. The Chief Health Officer is best placed to determine the frequency of reports, and trend data is better analysed over longer periods of time rather than just annually. The Department of Health regularly produces a statistical report, and members have referred to the triennial report on a number of occasions during the course of the debate thus far. I am advised that it is intended that a similar report could continue to be published using the new data that is acquired under the new Public Health Act abortion provisions, and the parameters for the collection of that data set out under proposed sections 202MP and 202MQ were carefully considered in consultation with the Chief Health Officer. We need to go to the purpose of the data collection: why is it that we are collecting the data? The purpose

of the data is to enable the planning and delivery of abortion health services and to monitor trends over time. Privacy is one element, but it is not the only element. It is also about what information is required to be used for the purposes of public health planning. For those reasons, and noting that we have had several conversations about this already, we will not be supporting the amendment.

Hon KATE DOUST: I rise to indicate that I will be supporting the amendment moved by Hon Nick Goiran. As I have already mentioned, I had an amendment in a similar vein, but not to the same level of detail. I looked at the South Australian model, which Hon Nick Goiran is supporting through this amendment, and thought that I would put a simpler version that was narrower in its scope and in the nature of the detail that was provided, but I am persuaded that in these circumstances, the South Australian model is perhaps a better proposition in respect of the long-term attention to detail that could provide guidance for future decision-making.

Hon NICK GOIRAN: We will in due course consider clause 15, which deals with a five-year anniversary—a statutory review, if you like—to be conducted on one occasion in five years' time. How many triennial reports will be available for the purposes of that statutory review?

Hon SUE ELLERY: Assuming they continue as triennial reports, we would expect them to collect information that becomes operational in the first half of 2024. They will be collecting information in 2024, 2025 and 2026, and we would expect the report to be available some time in 2027.

Hon NICK GOIRAN: That would mean that one triennial report would be available for the statutory review.

Hon SUE ELLERY: That is what I just said; yes, assuming that is how the counting is done.

Hon NICK GOIRAN: If my amendment to the annual report is successful, how many reports will be available for the statutory review?

Hon SUE ELLERY: Four.

Division

Amendment put and a division taken, the Deputy Chair (Hon Steve Martin) casting his vote with the ayes, with the following result —

Ayes (8)

Hon Martin Aldridge	Hon Kate Doust	Hon Tjorn Sibma	Hon Wilson Tucker
Hon Colin de Grussa	Hon Steve Martin	Hon Neil Thomson	Hon Nick Goiran *(Teller)*

Noes (24)

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

Amendment thus negatived.

Clause put and passed.

Clauses 9 to 11 put and passed.

Clause 12: Section 280 amended —

Hon NICK GOIRAN: Clause 12 is looking to delete in section 280 "Proceedings for an offence under this Act", and insert, amongst other things —

> (1) Proceedings for an offence under this Act (other than an offence under section 202MN(1)) …

What has given rise to the necessity for this clause?

Hon SUE ELLERY: This bill will amend section 280 of the Public Health Act to enable proceedings for an offence under proposed section 202MN(1), which pertains to the performance of an abortion by an unqualified person, to be commenced only by certain persons. Generally, offences under the Public Health Act are commenced by the Chief Health Officer, local government or an enforcement agency, as defined under the Public Health Act. However, proposed section 202MN(1) is an indictable offence, and as such, the new section 280(3) will ensure that only persons under section 20(3)(a)(ii) or (iii) or section 20(3)(b) of the Criminal Procedure Act may commence and prosecute the offence. Thus, the bill will amend section 280(1) to exclude the Chief Health Officer, local government or an enforcement agency from commencing proceedings for the abortion offence at proposed section 202MN.

Clause put and passed.

Clauses 13 to 15 put and passed.

Clause 16: Part 21 inserted —

Hon NICK GOIRAN: This is dealing with the transitional provisions. Will live births still need to be reported to the coroner during the transitional period?

Hon SUE ELLERY: Perhaps if I answer the honourable member this way: the current arrangements will apply up to the point at which the Abortion Legislation Reform Bill 2023 comes into operation; that is, a report will be made to the coroner. It is anticipated that that period will be about six months. Once it comes into operation, the whole of the new provisions will apply and those reports will no longer be required.

Hon NICK GOIRAN: Will those reports no longer be required because of clause 20?

Hon SUE ELLERY: Correct, honourable member.

Hon NICK GOIRAN: There are 28 cases currently before the coroner. Will those cases still be able to be considered by the coroner during the transitional period?

Hon SUE ELLERY: Up until the act commences, the coroner can conduct an inquiry. I take the member to proposed section 3B(2) at clause 20. It starts on the bottom of page 29 and goes to page 30. Proposed subsection (2) states —

> Subsection (1) applies whether the death occurs before, on or after the day on which the *Abortion Legislation Reform Act 2023* … comes into operation.

Once it comes into operation, despite the fact that they have occurred previously, they will no longer meet the definition of "reportable death" and will no longer be eligible to be investigated by the coroner.

Hon KATE DOUST: I just asked a question about the proposed subsection that the minister referred to. Why has the government taken the decision to make this a retrospective change in this circumstance?

Hon SUE ELLERY: It is deemed that it is not in the public interest. If those deaths were to remain reportable deaths and the process of the Coroners Act was followed, parents would need to be contacted. This would likely cause great distress to women who, in many cases, have already been through that process, dealt with that process and moved on with their lives. It is considered to be—I understand the sensitivities of the debate—not in the public interest to revisit that for the purposes of the women involved.

Clause put and passed.

Clauses 17 to 19 put and passed.

Clause 20: Section 3B inserted —

Hon NICK GOIRAN: As we just discussed when considering the transition provisions set out at clause 16, this is a very significant clause. It will very substantially change the law of Western Australia. At the moment, if a child is born alive and subsequently dies following the performance of an abortion, it is a reportable death. As a result of this provision, that will no longer be the case. Are these types of deaths reportable deaths in other jurisdictions?

Hon SUE ELLERY: Yes, they are.

Hon NICK GOIRAN: Did the coroner request this?

Hon SUE ELLERY: I am not in a position to provide the member with an answer to that question. I referenced this earlier—it might have been in clause 1; I cannot recall—when we were talking about heads of jurisdictions being consulted. Our practice is generally not to share their particular views but to incorporate their views into the work that is done in the drafting process. I am not able to give the member a precise answer.

Hon NICK GOIRAN: Is the provision before us at clause 20 inconsistent with the coroner's recommendation?

Hon SUE ELLERY: The member is asking me the same thing in a different way. It is not my first rodeo! I am not able to provide the member with the answer he is seeking.

Hon NICK GOIRAN: I understand that. One might say that this is perhaps not too different from when Hon Martin Aldridge asked the Leader of the House whether it will be lawful to have an abortion for sex selection moving forward. She responded by saying that it will not be unlawful. Yes, the Leader of the House is right; it is another way of asking the same question. At this point, members have to decide whether they will support clause 20. It is the case that the Western Australian coroner made a recommendation to government several years ago on this matter in general. We do not know whether the coroner asked the government to remove the jurisdiction of the coroner to consider these reportable deaths or whether the coroner asked for greater power to be able to investigate these reportable deaths. The public record demonstrates that, systemically, the Department of Health was breaking the law. For years and years, the Department of Health did not report these deaths. In 2018, when the Coroners Amendment

Bill 2017 was before the house and the Leader of the House was representing the Attorney General at the time, it was finally disclosed in Parliament that they were reportable deaths and any Western Australian could report them. Those matters were reported to the coroner the following day. Since that time, the number has increased slightly, in accordance with the chronology set out by the Leader of the House earlier today. In none of those cases has the coroner's investigation been completed. There is a backlog before the coroner. Perhaps she can confirm that. Something may have changed during the last few weeks. Are all those 28 cases still before the Coroner's Court of Western Australia?

Hon SUE ELLERY: Yes, to the best of our knowledge.

Hon NICK GOIRAN: Members should remember that these deaths are reportable in other jurisdictions. In Western Australia, there has been a systemic problem because the Department of Health failed to report these matters to the coroner. They are now before the coroner. They have been before the coroner since 2018, so for five years. This clause says that from now on, these matters will not be reported to the coroner. In fact, the 28 files that are currently before the coroner should be shredded and not considered by the coroner once this bill is passed, despite the fact that these are reportable deaths in other jurisdictions. Is it the case that these are reportable deaths in every other Australian jurisdiction?

Hon SUE ELLERY: I thought I answered that earlier. Yes, that is the case.

Hon NICK GOIRAN: To clarify, I just asked whether one of the other jurisdictions did; I did not ask whether they all did. We would be the only ones that would be removing this provision for them being reportable deaths. From what I can gather, the minister indicated in response to Hon Kate Doust that part of the reason would be that it could be traumatic for the family to be involved in such an inquiry. The Chief Coroner in the United Kingdom has guidance notes on this matter. The document is entitled *Chief Coroner's guidance no.45 stillbirth, and live birth following termination of pregnancy*. It reads as follows —

> **INTRODUCTION**
>
> … The purpose of this guidance is to help coroners understand and apply the current law relating to stillbirth, and live birth following termination of pregnancy, to promote consistency in the scrutiny of unnatural neonatal deaths.
>
> … Because the guidance is primarily intended for a professional readership, it is necessarily expressed in legal and medical terminology which the Chief Coroner acknowledges, with sincere regret, may strike some readers as insensitive.
>
> **THE CORONER'S JURISDICTION**
>
> … For the purposes of death registration, a stillborn child is one which has issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life.
>
> … Coroners do not have jurisdiction to conduct an investigation concerning a foetus or a stillborn child, as where there has not been an independent life, there has not legally been a death.
>
> … However, a child who is born showing signs of life, whether that is prior to the 24th week of pregnancy or after it, has had an independent life and that child's death must be investigated if section 1 Coroners and Justice Act 2009 is engaged. This is so even where the mother's pregnancy was intentionally terminated.
>
> … Where there is doubt over whether a child was born alive, that is a matter for the coroner to determine (see 'Establishing whether there has been a live birth' below).
>
> **NOTIFICATION OF DEATH**
>
> … Medical Practitioners and registrars of births and deaths have a legal obligation to report certain types of death to the coroner.
>
> **Reporting by Medical Practitioners**
>
> … The Notification of Death Regulations 2019 set out the circumstances in which registered medical practitioners must notify the coroner. The Regulations do not specifically reference neonatal deaths. However, some of the prescribed circumstances might apply to them, including where a medical practitioner suspects:
>
> i) the death was caused by the person undergoing a treatment or procedure of a medical or similar nature;
>
> ii) the death was unnatural, but does not fall within any of the circumstances specifically listed in the Regulations; or

iii) the cause of death is unknown.

… Accordingly, if a child was born alive (or may have been) and there are questions about the medical care that was provided, the reason for the child's death is unknown, or the mother's pregnancy was terminated (and the child's death was therefore caused or contributed to by a medical procedure), the coroner should be notified.

…

… Regulation 41 of The Registration of Births and Deaths Regulations 1987 sets out the circumstances in which registrars must notify the coroner. The Regulations may lead to the referral of neonatal deaths, as the circumstances include where the cause of death appears to be unknown, and where the registrar has reason to believe the death was suspicious, unnatural, caused by violence, caused by neglect, or caused by abortion.

… Regulation 33 of the 1987 Regulations also requires the registrar to report any alleged stillbirth where there is reason to believe that the child was born alive.

ESTABLISHING WHETHER THERE HAS BEEN A LIVE BIRTH

… To be considered to have been born alive, a child must:

i) have issued completely from its mother's body. It does not matter whether the birth was natural or by caesarean section, and it is not necessary for the placenta to have been delivered, or for the umbilical cord to have been cut.

ii) have shown signs of life. There is no formal definition as to what constitutes a sign of life and coroners may need to obtain a medical opinion. Signs that are generally accepted as being signs of life include (but are not limited to): breathing, crying, or sustained gasps; a heartbeart; a pulsing umbilical cord; or making definite movement of voluntary muscles.

… If a child has been born alive (no matter how brief that child's life is, and whatever the extent of any physical defects the child might have), the coroner will have a duty to investigate the child's death if section 1 Coroners and Justice Act 2009 applies. However, it can be difficult to establish whether a child showed signs of life after birth, as medical opinion suggests there may be fleeting reflex activity in babies that have died shortly before birth. Parents and medical professionals might also have opposing views as to whether signs of life were observed.

… Where there is doubt about whether a child was born alive or was stillborn, a coroner can either make preliminary inquiries to try to establish the position, or can begin an investigation. A coroner does not have to be satisfied on the balance of probabilities that the child was born alive before an investigation can be commenced.

… A post-mortem examination can be requested under s14 Coroners and Justice Act 2009, either as part of a coroner's preliminary inquiries, or as part of an investigation. Other evidence can also be obtained where appropriate.

… Where there is any dispute over whether a child was born alive, and s1 Coroners and Justice Act 2009 would be engaged if there had been a live birth, it is the Chief Coroner's view that there should always be an investigation, and this issue should be determined at inquest.

… If it transpires before an inquest that a child was stillborn, the coroner should notify the registrar using Form 99, and should set out the facts as far as they are known.

… Where it has been found at an inquest that a child was stillborn, the short-form conclusion of 'Stillbirth', which is listed in Note (i) in the Schedule to The Coroners (Inquests) Rules 2013, should usually be used.

LIVE BIRTH AFTER TERMINATION

… The subject of termination of pregnancy is a sensitive one. However, the law as it applies to coronial investigations is clear and must be applied consistently.

… A lawful termination of pregnancy under the Abortion Act 1967 can trigger the coroner's duty to investigate. This is because a child who is born alive and whose death is caused by prematurity following a termination of pregnancy, will have died an unnatural death.

… Investigations of a child's death following termination of pregnancy are likely to be highly emotive, but however the coroner or Interested Persons may feel, there is a statutory requirement that an investigation takes place.

… Any investigation must be sensitive, empathetic and sufficient to make the findings and determinations required by sections 5 and 10 Coroners and Justice Act 2009.

… Coroners should consider whether it would be appropriate to conduct any inquest in writing, or admit written evidence under rule 23, to avoid the family going through the stress of an in-person hearing.

… An example of a sensitive narrative conclusion where there has been a live birth following termination is: 'X died from extreme prematurity after being born alive following a termination of pregnancy under section 1 of the Abortion Act 1967'.

… Coroners should bear in mind that a child who is born alive following a termination of pregnancy has the same rights as any other person in this jurisdiction, including the Article 2 Right to Life. This means the child should receive the same life-saving treatment, or palliative care, as would be appropriate for a child in the same condition whose birth occurred naturally.

NOTIFICATION REQUIREMENTS

Live births

… For live births ending in neonatal death, both the child's birth and death must be registered. The coroner should supply to the registrar the same forms as with all death investigations.

… In England, child deaths must be reported to the local Child Death Overview Panel. In Wales, all child deaths must be reported to the relevant Regional Safeguarding Children Board.

Stillbirths

… Where a potential neonatal death is reported to the coroner, but the coroner decides without an inquest that the child was stillborn, the coroner should notify the registrar using either Form 100A or Form 100B, as appropriate. The coroner should complete as much of the information on the form as possible (e.g. recording the date of the stillbirth, as opposed to the date of death), and should clearly state on the form that the child was stillborn.

… Similarly, the child's body should be released by the coroner as soon as is reasonably practicable using the usual Order for Burial Form 101 or Form Cremation 6, but the coroner should clearly state on the form that the child was stillborn.

… Following an inquest into a potential neonatal death where the conclusion is that the child was stillborn, coroners should notify the registrar using Form Rev 99A …

… CHIEF CORONER

2 February 2023

I have taken some time to read out that guidance note from the United Kingdom as to how it sensitively deals with this issue of inquest after babies are born alive. Is there a similar guidance note in Western Australia?

Hon SUE ELLERY: Not to our knowledge.

Division

Clause put and a division taken, the Deputy Chair (Hon Sandra Carr) casting her vote with the ayes, with the following result —

Ayes (26)

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

Noes (4)

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

Clause thus passed.

Clauses 21 and 22 put and passed.

Clause 23: Act amended —

Hon NICK GOIRAN: If the minister is happy to, we will deal with clauses 23 and 24 en bloc in division 4, part 4, of the bill that is presently before us. This division deals with amendments to the Freedom of Information Act. Why has it been deemed necessary to change the Freedom of Information Act with respect to these matters? To what extent does this differ from what is happening in other jurisdictions?

Hon SUE ELLERY: There is currently a requirement under section 32(2) of the Freedom of Information Act that if an agency intends to give access to a document that contains personal information about a third party, after deeming such a course of action to be in the public interest, the agency is not to give access unless it has taken such steps as are reasonably practicable to obtain the views of the third party as to whether the document contains information that is exempt under clause 3. This could result in a situation in which a person who has access to abortion care is contacted with regard to an access application, which could cause distress or concern regarding the potential release of their personal information, and a standalone exemption will preclude this from happening.

In addition, when considering whether personal information is exempt, a decision-maker must consider whether the release of that personal information would be in the public interest. The government has taken the view that information pertaining to a person's access to abortion care should be exempt and should not be subject to any assessment of public interest that could have variable results, depending on the views of the agency decision-maker who could have varying levels of experience and skill in decision-making.

The second part of the honourable member's question was about other jurisdictions. The answer is no; it does not apply in other jurisdictions.

Hon NICK GOIRAN: To be clear, is this a new provision that will be distinct along the lines of the earlier provision in which we removed the coroner's jurisdiction? Are we also changing the regime with regard to the freedom of information?

Hon Sue Ellery: Correct, by way of interjection, honourable member.

Clause put and passed.

Clauses 24 to 28 put and passed.

Clause 29: Section 18A inserted —

Hon NICK GOIRAN: I have chosen clause 29 for convenience because the next few clauses deal with the State Administrative Tribunal. To what extent does the State Administrative Tribunal currently play a role?

Hon SUE ELLERY: It does not currently play a role, honourable member.

Hon NICK GOIRAN: So moving forward, unlike with the coroner whereby we will remove their jurisdiction, here we will empower the State Administrative Tribunal to be involved. To what extent will the State Administrative Tribunal be involved in decisions on the performance of an abortion?

Hon SUE ELLERY: The short answer is that the role of the State Administrative Tribunal and the extent to which it will be involved will be in respect of adult patients who are deemed unable to make a reasonable judgement about an abortion, and, in that case, application must be made to SAT. The new framework for adults who lack capacity is set out at proposed section 110ZND of the Guardianship and Administration Act and will apply to adults who are unable to make reasonable judgements about whether they should undergo an abortion procedure. The framework is closely modelled on the frameworks that apply in other states and territories in Australia that require a decision of their equivalent of the State Administrative Tribunal to make abortion decisions for adults who lack capacity.

Hon NICK GOIRAN: I know that we touched on this in debate on an earlier clause. We were trying to get to the bottom of what happens at present, because, as the minister has just indicated, the State Administrative Tribunal does not have a role. I know that we spent some time on minors, but which court of jurisdiction currently makes the decision on behalf of adults who do not have capacity?

Hon SUE ELLERY: We have canvassed this a little bit. In a 2015 decision, SAT found that informed consent to an abortion can be given only under section 334 of the Health (Miscellaneous Provisions) Act by the pregnant woman concerned and cannot be given by a guardian appointed under the Guardianship and Administration Act to make treatment decisions for her. The question of whether there could be recourse to the Supreme Court has never been tested in Western Australia. It has been thought highly doubtful that the Supreme Court would authorise an abortion that would otherwise be unlawful under the clear provisions of the Health (Miscellaneous Provisions) Act. It is acknowledged that this is a highly problematic current state of affairs and that is one of the reasons we are making the reforms that are before us now.

Hon NICK GOIRAN: The minister mentioned the 2015 SAT decision, which was that there was no jurisdiction. Moving forward, there clearly will be. Where will appeals lie?

Hon SUE ELLERY: Appeals will be made directly to the Court of Appeal.

Clause put and passed.

Clauses 30 to 35 put and passed.

Clause 36: Section 30 amended —

Hon NICK GOIRAN: This is a curious provision that will insert a definition of the word "determination". It specifically says that it will include a decision about consent or the refusal to consent to the performance of an abortion. What has necessitated this clause?

Hon SUE ELLERY: I am advised that it will make it clear that it applies to both consent and refusal. The clause will insert proposed subsection (1A) to make it clear that the section that sets out the powers of a court upon appeal will apply to decisions made under proposed section 110ZND to consent or refuse consent to the performance of an abortion on a person. The definition of the word "determination" includes such a decision.

Hon NICK GOIRAN: To be clear, is the consent or refusal envisaged here the consent or refusal of the tribunal?

Hon Sue Ellery: By injection, that is correct, honourable member.

Clause put and passed.

Clauses 37 to 41 put and passed.

Clause 42: Section 110U replaced —

Hon NICK GOIRAN: There is an existing section 110U of the Guardianship and Administration Act 1990. The clause before us seeks to delete that provision and insert a substituted section 110U. We are dealing with circumstances of an advance health directive. Can the minister provide further information to the house how advance health directives are currently used with the performance of abortions and how they will be used, moving forward, by virtue of this and other clauses in the bill?

Hon SUE ELLERY: If we go back to the Health (Miscellaneous Provisions) Act 1911, section 334(3) provides the current arrangement that an abortion is justified if —

> serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed;

Moving forward, if there is an advance directive, the clinician must take into account the provisions that are laid out in that directive. Proposed section 110ZLA(2) provides —

> If the person has made an advance health directive containing a treatment decision in respect of the performance of the abortion … whether or not the abortion is performed … must be decided in accordance with the treatment decision.

That is, as set out in the advance health directive.

Hon NICK GOIRAN: Is the minister saying that, at the moment, if an advance health directive said a person wanted to have an abortion, a medical practitioner would not be able to rely on that?

Hon Sue Ellery: By interjection, yes, that is correct.

Hon NICK GOIRAN: However, moving forward, if there is an advance health directive that says a person would like to have an abortion, would the medical practitioner be obligated to proceed?

Hon Sue Ellery: By interjection, that is correct, honourable member.

Hon NICK GOIRAN: Would there be any circumstances in which a medical practitioner, having read the advance health directive saying that an abortion is requested, would not be able to proceed?

Hon SUE ELLERY: The member might not be referring to this but the advice to me is that there are provisions around the right to refuse or to make a conscientious objection that might prevent a medical practitioner from performing an abortion. I do not think that is what the member is talking about. I think he is talking about if an advance health directive says, "This is my wish" then the practitioner must follow the advance health directive. That is the advice to me, as long as the advance health directive is valid. It is all the circumstances that apply to an advance health directive—that is, the person is 18 years or older, has full legal capacity at the time of making the advance health directive, they sign it in the presence of two witnesses aged 18 or older, including one person who is authorised to witness stat decs in WA, and they make at least one treatment decision in "Part 4: My Advance Health Directive treatment decisions".

Hon NICK GOIRAN: If there is an advance health directive for a person who does not have capacity because they are not conscious, and their spouse says to the medical practitioner, "Yes, but I know that she was about to

change that advance health directive. She's changed her views on that matter, but didn't get around to it. She's just been involved in a car accident", are those views taken into account?

Hon SUE ELLERY: The Guardianship and Administration Act does not contemplate that circumstance. To be valid, an advance health directive must comply with the formal requirements that are set out in section 110Q of the Guardianship and Administration Act. Further provisions at section 110S govern the operation. Section 110S states, in part —

> … a treatment decision in an advance health directive operates only in the circumstances specified in the directive.
>
> (3) Subject to subsection (4), a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that —
>
> (a) the maker of that directive would not have reasonably anticipated at the time of making the directive; and
>
> (b) would have caused a reasonable person in the maker's position to have changed his or her mind about the treatment decision.

In determining whether that is the case, section 110S(4) gives a number of matters that must be taken into account, including the maker's age at the time the directive was made, whether the maker reviewed the decision at any time and the nature of the condition. A number of people may be consulted to determine those questions: the guardian or enduring guardian, spouse or partner, nearest relative, primary carer or a person with a close personal relationship to the maker.

Hon NICK GOIRAN: Are abortions being performed in other Australian jurisdictions on the basis of advance health directives?

Hon SUE ELLERY: Yes is the short answer. In Queensland, that is the case. In Victoria, under section 148, that is the case. In South Australia, under its Guardianship and Administration Act, that is the case. In the Northern Territory, that is the case. In New South Wales, there are no statutory advanced care directives, only common law. The ACT does not specify anything about advance health directives, and in Tasmania advanced care directives apply.

Progress reported and leave granted to sit again, pursuant to standing orders.