ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from 31 August. The Deputy Chair of Committees (Hon Stephen Pratt) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 1: Short title —

Progress was reported after the clause had been partly considered.

The DEPUTY CHAIR: Before we proceed, I will remind members to be aware of supplementary notice paper issue 1.

Hon SUE ELLERY: When we were last considering the bill, a number of members asked for further information, which I undertook to provide for them. Hon Kate Doust asked whether there was relevant research on why Western Australia has experienced a reduction in the rate of abortions. I am advised that although there is no specific research relating to Western Australia, the reduction might be attributed to a range of factors, including increased availability of contraceptives, including long-acting, reversible contraceptives; increased access to the morning-after pill; and provision of sexual health and reproductive health education and care. Hon Nick Goiran asked whether a clinical practice document I referred to during the course of our discussions could be tabled. I so table it.

[See paper 2486.]

Hon SUE ELLERY: Hon Nick Goiran also asked whether there were interstate practitioners on the ministerial panel. Members of the panel to date have all been from the Western Australian public health sector. However, the legislation does not prescribe this. The member also asked, when we are talking about abortions before 23 weeks, whether the doctor could be interstate, noting that it is not currently specified. I am advised that when a surgical abortion is performed in Western Australia, it would require the practitioner to be here. When a medical abortion up to nine weeks is performed in Western Australia, the appointment to prescribe the medication can be provided via telehealth, including by an interstate practitioner. However, a patient would still require an appointment for the ultrasound to confirm a medical abortion is appropriate. A medical abortion after nine weeks is a more complex procedure and would require the presence of a practitioner.

The honourable member also asked questions about feticide—when it was introduced and why 22 weeks is deemed appropriate. I am advised that feticide is usually performed for gestations greater than 22 weeks. It is not deemed clinically necessary prior to 22 weeks as the fetus is fragile and will not survive the labour process. King Edward Memorial Hospital for Women has routinely performed feticide for nonlethal conditions such as when an abortion is performed for maternal health reasons. Prior to 2017, King Edward Memorial Hospital did not always conduct feticide for postnatal lethal conditions for fetuses over 22 weeks' gestation, such as anencephaly or trisomy 18. In 2017, a policy on feticide for terminations after 22 weeks was introduced to avoid the situation of a live birth after termination and the potential for a coronial review, which could further increase the distress of the woman and her family. As with all medical care, it is the patient's choice to consent or not to consent to specific treatment. Feticide is offered and the majority of women opt for this process. A very small number of women may choose not to undergo this procedure, including for religious or cultural reasons. When this is the case, the medical practitioner must have regard to the relevant standards and guidelines that apply to their profession. In all circumstances, women are given advice, including of the possibility of a live birth. Comfort care or palliative care is routinely provided if clinically indicated. When a medical practitioner does not wish to proceed without a feticide procedure, they may refuse to continue the abortion. That completes the information I was asked to provide.

Hon NICK GOIRAN: At the outset, as we resume, having last considered this matter on Thursday, 31 August, the deputy chair has drawn to our attention that there is supplementary notice paper issue 1. My understanding is that issue 2 must be imminently available. I look forward to receiving a copy of that.

I thank the minister for tabling the document that she referred to as a clinical practice document. I will review it shortly. We were considering a number of matters when we were last contemplating clause 1. In particular, we were looking at the changes to what I referred to as phase 1 abortions. I intend to take us back to that particular line of inquiry.

Hon Sue Ellery: By way of interjection, to assist the chamber, let us go back to the member's definition of phase 1 abortions so we are clear what we are talking about.

Hon NICK GOIRAN: Yes. Phase 1, at the moment, includes everything prior to 20 weeks. Phase 1, moving forward, under this bill will include everything prior to 23 weeks. I am comparing and contrasting what changes will take place, other than the gestation limits. We will look at that in a moment. Before I dive back into that, a number of documents may assist us. I am going to ask questions about these documents, so I think it makes sense to get them on the record early, at the start of this week and the start of this day, in order to give the advisers the maximum

opportunity to obtain them if they are not immediately readily available. I begin with the State Coroner. I think it is a non-controversial point that the bill before us will impact upon the work of the State Coroner, and we will look at that at the relevant provisions. My question is whether the State Coroner was expressly consulted about the provisions of the bill. In particular, there has been a line of questioning during question time over the last year, or possibly the last two years, from me to respective ministers and parliamentary secretaries regarding a recommendation that was made by the coroner. In essence, the response primarily from the Attorney General in the first instance that has come back was that the recommendation could not be made immediately available because it needed to be considered by his cabinet colleagues. The indication was that it would be made available at some subsequent time. To pause at this point, has the State Coroner expressly been consulted about this bill? Secondly, can the coroner's recommendation be made available to the chamber?

Hon SUE ELLERY: Yes, the coroner was consulted. On the second part of the member's question about whether the recommendation could be made available, it is not available to the advisers who are with me. I am not sure that I would be able to provide it, based on the proposition of communication with the judiciary from government and whether we make that public. Noting the honourable member's interest in the matter, I am happy to take it up separately with the Attorney General, but I cannot take it any further today.

Hon NICK GOIRAN: I thank the Leader of the House, who perhaps cannot take it up any further at this particular point, but it may be possible that the coroner's recommendation could be made available at a later stage today, subject to necessary inquiries.

Hon SUE ELLERY: To be clear, it will not be today because I will be here, so I will not be having a discussion with the Attorney General. I will make a note and I will raise it with the Attorney General. As soon as I am able to give the member a response, if it is during the course of the debate, I will do that. I do not want to say "trust me", but I take my commitment to do these things seriously, so I will see whether I can get the honourable member an answer.

Hon NICK GOIRAN: I know that there will be other members of government and advisers who will be taking a keen interest in this afternoon's debate, so, to the extent that they can assist the minister, I would urge them to at least make those inquiries so that when the minister is available to discuss the matter with the Attorney General, that could be done in some form of an expedited fashion. The reason, which I will give briefly at this point, is that this has been a line of inquiry for not just a matter of days or weeks, but, to the best of my knowledge in fact, years. The genesis of it, interestingly enough, was a debate that the minister and I had on a piece of legislation to amend the Coroners Act. At the time, the minister was representing the Attorney General, so that goes to show how far back it has been, because, of course, Hon Matthew Swinbourn has been doing that job for a substantial period. The minister had the assistance of the principal registrar of the coroner's office sitting next to her at the time, and it was identified that none of the babies born alive after an abortion had been reported to the Coroner's Court. It was also identified at that time that it would be possible for any Western Australian to go ahead and report that. As a result of that, the very next day, I reported, as best I can recall, 26 or 27 of those deaths to the Coroner's Court. Those matters are still before the Coroner's Court and have led to a recommendation from the coroner to the government, and that is the recommendation that we are seeking to understand. What exactly is in this recommendation? As a result of that, the inquiry into those 26 Western Australian babies who survived an abortion but ultimately died has not gone any further and remains on hold with the Coroner's Court. Therefore, I would urge those people outside of the chamber who are assisting the minister to make every effort to make that recommendation available when we get to that provision.

In terms of other documents that might assist our scrutiny of the bill at this time, were any changes made to the explanatory memorandum between the versions tabled in the two houses?

Hon SUE ELLERY: The honourable member might recall that in my second reading reply, I made a correction. I did not table an explanatory memorandum to reflect that, but I made that correction to the house in my second reading reply.

Hon NICK GOIRAN: Are any blue bills available of the Children's Court of Western Australia Act 1988, the Coroners Act 1996, the Evidence Act 1906, the Freedom of Information Act 1992 and the Health (Miscellaneous Provisions) Act 1911, all of which will be amended by the bill presently before us?

Hon SUE ELLERY: I am advised that, in the process of drafting, a question was put to Parliamentary Counsel as to whether it would be appropriate to do a blue bill, and the response from Parliamentary Counsel was that when there are one or two minor—if I can describe them that way—adjustments to one of the acts that is being amended, it is not the practice to do a blue bill. Therefore, that did not happen for the acts the member listed.

Hon NICK GOIRAN: Thanks, minister. I acknowledge the response and the standard practice by Parliamentary Counsel. I make the observation at this time that what Parliamentary Counsel may consider to be a minor amendment in terms of quantum of words can make a very significant change to the state of the law—one example being the Coroners Act 1996—but I will not take it any further. My point is that in terms of documents

available to the committee as we scrutinise the bill, no blue bills are available for those acts for the reasons that the minister has identified. Would the minister have available the *Induced abortions in Western Australia* sixth and seventh reports? The sixth report provides the data from 2016 to 2018 and the seventh report, if it is available, provides the data from 2019 to 2021. Those would be the last two versions of the data extracted by the government from the abortion notification system.

Hon SUE ELLERY: We have a version of the sixth report the member requested. I advise that it is publicly available online. I am happy to table a hard copy, but it would need to be copied for the member. We do not have the seventh version.

Hon NICK GOIRAN: I ask whether the minister would, at the next available opportunity, table the sixth report, which has the data from 2016 through to 2018. My understanding is that, over the years, these have been done in three-year blocks, and the seventh report would include 2019, 2020 and 2021. What is the status of that report?

The DEPUTY CHAIR (Hon Stephen Pratt): Members, that paper is tabled.

[See paper 2487.]

Hon SUE ELLERY: Thank you, deputy chair. We do not think it has been published yet. It is certainly not available online. I will have to take on notice what the status of the report is.

Hon NICK GOIRAN: That would be great because, to the best of my recollection, this type of debate has not happened in this chamber for 25 years, so having the most recent data available—in particular, the data from 2019, 2020 and 2021—would be of assistance as we scrutinise the bill. Therefore, I appreciate that the minister has taken that on notice. At the very least, it would be great if the report is available in draft form or some data is available that would be of assistance or, alternatively, some form of explanation of when that might be available.

The last of the documents that I might ask the minister to make available, if she can, relate to the consultation summary report. The minister, I think, referred to this previously when we last sat, on 31 August. A document was prepared by the government titled *Abortion legislation reform: Community consultation summary report*. Is the minister in a position to provide a table of the list of identified key stakeholders who received a written invitation to participate in the consultation?

Hon SUE ELLERY: We do not have a list here. If there is a list, it would be held by the Office of the Chief Health Officer. I also advised that it may well be an iterative list, so there might have been a call-out and then, as more stakeholders came in, perhaps they were added to the list. We will take it on notice, honourable member. If we are able to provide that information, we will, but we just need to check what is available from the Chief Health Officer's office.

Hon KATE DOUST: When we last sat on 31 August, we had commenced dealing with clause 1. The minister might recall that I raised some issues about how technology had hopefully advanced access to information about the progress of a pregnancy. The conversation we had was about, in the minister's words, prognosis and diagnostic testing, and she made me a commitment to find some information about that. I am quite interested in the nature of the current technology for the testing procedures at various stages of a pregnancy, because that will assist in our later conversation about a couple of the amendments on the supplementary notice paper. I do not know whether the minister was successful in obtaining any of that information.

Hon SUE ELLERY: I remember the honourable member asking that. I am sorry I did not provide the answer. I do not know why that was.

An example of new technology introduced into some laboratories in Australia in 2012 is non-invasive prenatal testing, or NIPT. It is also known as cell-free DNA testing and non-invasive prenatal screening. It is new technology and an important addition to the range of screening tests for fetal chromosomal abnormalities for trisomy 21 in particular. Non-invasive prenatal testing is superior to other screening modalities. That testing technology is an established option for antenatal screening for trisomy 21, trisomy 18 and trisomy 13 and other selective chromosomal abnormalities. If used appropriately, it increases the detection rate for fetal chromosomal abnormalities, while decreasing the number of invasive tests required. However, that technology has limitations and complexities that requesting clinicians and their patients need to understand. It can be carried out at any point in the pregnancy from 10 weeks' gestation onwards to increase the likelihood of sufficient fetal fraction of DNA. It is a screening test. In Australia, the most common screening modality for fetal chromosomal abnormalities is the combined first trimester screen. This is carried out between 11 and 14 weeks' gestation—so, up to 13 weeks and six days' gestation—and combines ultrasound measurements, including nuchal translucency, a maternal blood test and maternal age to produce a risk score. If the risk score is higher than a given cut-off value, it is considered a screen positive or a high-risk result, indicating that diagnostic testing should be considered. Diagnostic testing requires an invasive procedure. This can be carried out between 11 and 14 weeks' gestation by chorionic villi sampling of placental tissue.

Alternatively, after 15 weeks' gestation, fetal amniocytes can be sampled by amniocentesis. Both tests take one to two weeks to get a result.

Hon MARTIN PRITCHARD: I accept that under 23 weeks, a fetus is unlikely to survive. The minister mentioned cultural and religious reasons for not performing feticide. I cannot get any information on that. Does she have any more information so that I can understand that a bit better with regard to after 23 weeks.

Hon SUE ELLERY: We do not quite understand. Does the member want me to define religious and cultural?

Hon MARTIN PRITCHARD: As I said, I found it difficult to find information about cultural and religious reasons. I am loath to ask for examples, because that may be offensive, but I do not understand it very well. Can the minister add some information that can help me understand why a woman would choose not to do feticide after 23 weeks?

Hon SUE ELLERY: There really is no way to do it other than by example. Some of the examples I have been given include when there is a spiritual view that skin-on-skin contact is important. Equally, I am advised that there are some Aboriginal communities—perhaps some in the north west—in which the child being on country has a specific meaning and value, and that is an important reason why they would not want the feticide to happen before the baby had the opportunity to be on country. I suspect that, at its core, it goes to the need for some sort of spiritual connection, whether it is about skin on skin or being on country.

Hon NICK GOIRAN: I return to where we left things on 31 August and, in particular, the changes that are proposed to phase 1 abortions—that is, abortions that take place prior to the threshold for late-term abortions, which is 20 weeks at the moment and is proposed to be 23 weeks moving forward. At the time, the minister identified a number of changes. One of them was that at present, the approval of two doctors is needed for a phase 1 abortion. I think she used the language of a "referrer" and a "performer". The approval of those two doctors is required at the moment. That will no longer be the case under clause 58 of the bill presently before us. Moving forward, only one doctor will need to be involved. This led to the question that the minister took on notice about interstate doctors. Irrespective of the current position, moving forward when only one doctor will need to be involved, I understood her response earlier this afternoon to indicate that if a surgical abortion is needed—keeping in mind that we are talking about phase 1 abortions—it will obviously need to be done by a Western Australian practitioner just by virtue of the geographical necessity and nexus. With regard to a medical abortion in phase 1, there seemed to be a suggestion that it might be able to be done by an interstate doctor. I appreciate that the minister put a caveat on that in saying that an ultrasound might be needed for some abortions. I do not want to dive deep into the mechanics of all that. I am simply trying to ascertain at this time whether it will be possible under the bill presently before us for one doctor who is not in Western Australia to be involved in a phase 1 abortion.

Hon SUE ELLERY: That is correct—for one doctor. I will just re-read what I said earlier to make sure that the member is clear. When a medical abortion up to nine weeks is performed in WA, the appointment to prescribe the medication can be provided via telehealth, including by an interstate practitioner. There is then the caveat that there may need to be an ultrasound. A medical abortion after nine weeks is a more complex procedure and would require the presence of a practitioner. Of course, they have to be able to practise in Western Australia.

Hon NICK GOIRAN: Moving forward, a phase 1 abortion will be able to be undertaken or performed with the involvement of a single doctor, and the doctor need not be from Western Australia. That is one substantive change that the bill presently before us seeks to achieve. The second change that the minister identified when we last considered this bill was the removal of what has been referred to, by herself and others, as mandatory counselling. When we unpacked what exactly was meant by mandatory counselling, which will be removed by virtue of clause 58 of the bill, it became clear that we were actually talking about the removal of a statutory definition of informed consent.

Certainly for lawyers, and I think also for lay people, there is a significant distinction between the concept of informed consent and mandatory counselling. Informed consent is reasonably well understood; the ordinary Western Australian understands that before they agree to any particular medical procedure, they need to give their informed consent to the person proposing to perform it on them. However, mandatory counselling is quite a different thing, and because of the use of language, it almost comes with the implication that somebody is being forced to have counselling. Is it the case at the moment that a Western Australian—remember that we are just talking about phase 1 at this particular point in time—can have an abortion without counselling?

Hon SUE ELLERY: The honourable member will remember a conversation that we had, which I appreciate was more than a week ago now. The information provided to me then was that counselling was included in the definition of informed consent. The member is quite right that an ordinary person in 2023 would not necessarily take the expression of informed consent to mean that it must include counselling. However, as I recall the conversation the member and I had when we last talked about this, I think that was literally a function of the people who were trying to get the bill through and those in the respective houses of Parliament at the time. For whatever reason, they considered that that was the appropriate place to include that provision.

The member is quite right that an ordinary person looking at that might think, "Are you saying informed consent is no longer required?", but that is absolutely not the case. However, the definition that was put into the bill reflected the debate in the Parliament at the time and that is why it was done that way. I take the point that the member is making. Under the provisions in place in Western Australia now, it is a requirement to provide and meet the full conditions of informed consent set out in the current legislation.

Hon NICK GOIRAN: Can phase 1 abortions occur at the present time without counselling?

Hon SUE ELLERY: If the honourable member has the current arrangements in front of him —

Hon Nick Goiran: The Health (Miscellaneous Provisions) Act?

Hon SUE ELLERY: Yes. Sections 334 (3)(b), (c) and (d) state —

> … an abortion is justified for the purposes of section 199(1) of *The Criminal Code* if, and only if —
>
> …
>
> (b) the woman concerned will suffer serious personal, family or social consequences …
>
> (c) serious danger to the physical or mental health …
>
> (d) the pregnancy of the woman concerned is causing serious danger …

Section 334(4) then says that those things do not apply unless the woman has given informed consent—we know what informed consent means in this act—or, in the case of section 334(3)(c) and (d), it is impracticable for her to do so. I have been advised that the application of "impracticable" has not been deemed to include reasons such as it is a long way to go to get an appointment. It is for situations in which there is a serious risk to the woman herself or to her physical or mental health. It is not about a person being far away and unable to make an appointment for another two weeks. That is not enough to meet the test. I am advised that "impracticable" is taken to mean that there is a very serious reason why there should be no further hold-up in proceeding with the abortion.

Hon NICK GOIRAN: This question is in respect of obtaining informed consent. When there is an emergency in Western Australia, a medical practitioner can take a course of action on a Western Australian without their informed consent because the circumstances demand it. I am trying to ascertain whether a phase 1 abortion can occur without counselling. I acknowledge that in Western Australia at the present time, phase 1 abortions cannot occur without informed consent. However, can they occur without counselling having been provided to the person?

Hon SUE ELLERY: Yes. If the member goes to what I have just said, it is deemed impracticable. The point I was trying to make is that "impracticable", as I understand it, means that it is not enough to say, "Well, I live in X and the next appointment available to me is in three weeks' time." That is not reason enough.

Hon NICK GOIRAN: In other words, the minister is saying that unless it is impracticable to provide the counselling, it is the case in Western Australia that a phase 1 abortion can occur only if counselling has been provided. What is the nature of the counselling that must be provided under the current state of the law that will no longer need to be provided moving forward?

Hon SUE ELLERY: There are no practice guidelines, policies or procedures for what constitutes that counselling. I am advised that the general practice—if I can use that term with a small "g" and a small "p"—is that it would usually be done by the referrer. We need to bear in mind that there are two doctors: one is the referrer and one is the performer, so it would generally be done by the referrer to make sure that the person understands the nature of the procedure et cetera. But there is not a single source for: "This is how you do it; this is what you must canvass." Accordingly, the advice provided to me is that some practitioners will do it one way and others will do it another way.

Hon NICK GOIRAN: That is very significant because what the Leader of the House described as general practice with a small "g" and small "p" is the case under the existing law, for which there is a statutory definition. Moving forward, there will be no statutory definition. If people currently are doing it however they deem appropriate, we can reasonably infer that that is going to happen moving forward. People will continue to do things the way they think is reasonably appropriate, unless it is the intention of the government to issue some kind of practice guidelines, and I certainly have not heard anything to that effect. Will there be any difference between the counselling that is being provided to people at the moment in a way that the referrer or the relevant practitioner deems appropriate and the counselling that will be provided once this bill passes?

Hon SUE ELLERY: I am advised that during the course of the consultation, the feedback from practitioners—with a capital "P"—was very much that the patients are different and that some women come to them with a very clear decision and know exactly what they want: "I'm here to go through this process." There are others who genuinely want to discuss the options at the time; or, they may not want to discuss the options at the time, but when they get to actually having the procedure, they want to have a discussion and some form of counselling. There are practitioners who have information available that they routinely give to patients who indicate that they are looking for counselling support of some kind. I do not think there is a standard patient. The practitioners advised that some

women come with a very clear view of what they want and regard the proposition that they have to be counselled to be intrusive and offensive, while there are others who genuinely want to talk about what their options are.

Hon NICK GOIRAN: That may well have been the feedback, but notwithstanding that, the truth of the matter is that they are not required to be counselled; that is the point. As the Leader of the House said, at the moment there are no practice guidelines and I then said that people are doing it in a way that they deem appropriate, and that will continue to be the case moving forward. At the moment, the definition of "informed consent" in the Health (Miscellaneous Provisions) Act states, in part —

> a medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term …

That is what is required at the moment. That is what I would describe as information, rather than counselling. It is couched in the legislation as "counselling", but in actual fact it is talking about information. Counselling comes a little further along in the legislation, where it states —

> a medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term …

Perhaps if the Leader of the House and I had been involved in the debate 25 years ago, we might have been able to improve some of the language that was used. There seems to me to be, in these different limbs, a requirement to provide information as part of the informed consent and an opportunity for there to be what we could genuinely describe as counselling, but in all of this there is no real, genuine, authentic mandatory counselling taking place. There is mandatory information, if you like, that must be provided. Why? Because of the statutory definition of "informed consent". Moving forward, once this bill passes, there will be no statutory definition of "informed consent". The Leader of the House can correct me if I am wrong, but there will be a common-law requirement for a medical practitioner to obtain informed consent.

Hon SUE ELLERY: Yes, unless—in the same way as other medical procedures apply—the person does not have decision-making capacity. I note the point the member is making about counselling. I was not in this chamber at the time of the last debate, but I was up there, watching.

Hon Nick Goiran: For the benefit of *Hansard*, that means the public gallery!

Hon SUE ELLERY: Correct, not in heaven or something like that! Not floating above, sitting on a cloud!

But it really was a case of people trying to find words that would satisfy at the time. We can look back now, but we are looking back through a completely different lens because—with absolutely no disrespect to people 25 years ago—the bill that is before us has been drafted in a very different way. I note the point the honourable member is making. I guess I would just add the caveat that it would really depend on the practice, with a capital "P", of the individual person, because some will treat it as just—to use the member's description—information; others will read that to mean, "I'm now going to have this conversation with you about a much broader range of things." We have tried, in a policy sense, to put the woman at the centre of the process, and to respect and understand the limits of practice that exist in respect of other medical procedures for which we ask clinicians and registered health practitioners to deliver a range of healthcare services, and to apply the same rules. That is the policy objective we are trying to achieve here, and that is why we have taken the steps we have taken in respect of counselling. I suspect we will have a broader debate about this; there is an amendment on the supplementary notice paper, so we can have that debate when we get to it.

Hon KATE DOUST: Just picking up on the discussion around counselling and information, I agree that the intention was always around information. Obviously the use of the word "counselling" has become quite contentious over time and I know we will be dealing with an amendment later on. My question is: does the state government, maybe through the Chief Health Officer, currently provide any uniform written generic information on access to abortion in Western Australia that is either shared with medical practitioners or distributed through medical practices?

Hon SUE ELLERY: I am advised that, centrally, no. King Edward Memorial Hospital has a lot of information that it makes publicly available on its website, but, centrally, no.

Hon KATE DOUST: I thank the minister for that; that is interesting. A set of arrangements have been in place for over 25 years. We have heard about the difficulties of access in regional areas and women allegedly having to leave the state in some circumstances. I want to talk about that a bit more later on.

I am really surprised that, over that extended period, some thought was not given to providing a statement of information that is available across the whole of Western Australia so women can access the information and start the process of making an informed decision. Not every woman has access to King Edward. In some cases, due to language, tyranny of distance or online issues, some women would not have that access either. This arises out of

the debate that we will be working through during our time here. I know that an amendment is coming up, but I do not understand why government has not given some consideration to pulling something together and making it more freely and widely available.

Hon SUE ELLERY: The answer stands. No, the government has not. The member used the word "allegedly" about some women having to travel interstate. I can assure her that that is the case. I myself know people who have, so there is no question. It is not an allegation; it is a fact. I am happy to talk about the other point about what we can do going forward when we debate the respective amendment.

Hon MARTIN PRITCHARD: I seek leave to table a document from South Australia. It is a document that is given out by doctors.

[Leave granted. See paper 2488.]

Hon MARTIN ALDRIDGE: I have been listening to the minister's interactions with Hon Kate Doust and Hon Nick Goiran, and they have brought up a couple of questions for me. I will be interested to see the tabled paper from Hon Martin Pritchard because it could also be useful if there is a conscientious objector.

If I understand correctly, this provision will change a practitioner's obligation to refer. I think something similar existed when we were dealing with the voluntary assisted dying bill, for which we had mandatory information and referral provisions. That is something we can perhaps explore. I think the minister said that we will explore it further when we get to the relevant clauses.

The issue of counselling has thoroughly confused me. Listening to the second reading contributions, I think it challenges others as well. As other members did, I went to hear the panel of clinicians the Minister for Health arranged, and somebody asked this question. I will not identify the clinician who responded, but to the best of my recollection, the response was: "If a woman comes to me wanting an abortion, I should not be required to provide that person with information—in other words, counsel them—against having the abortion." I think the minister said something similar a few moments ago. I wonder how that aligns with the common-law understanding of informed consent. My experience is that clinicians take a very standardised template form when patients agree to any sort of medical procedure: What are the risks of doing nothing? What are the risks of intervention or treatment? What are the varying treatments available? In my personal experience, it is almost, without flaw, a very standard process that practitioners follow. I am wondering why that would be any different when thinking about this concept. If a woman is going to a practitioner seeking an abortion, she will be provided information only about the risks or otherwise of the abortion as opposed to not having the abortion or having other treatment.

Hon SUE ELLERY: I think the honourable member might have been out of the chamber on urgent parliamentary business when we were last debating this. The member is quite right about the ordinary understanding of informed consent when it applies to any other medical procedure; however, at the time this bill was being debated 25 years ago, they inserted this proposition of counselling into the definition of informed consent. The law was then implemented, and practitioners interpreted that as they saw fit as a matter of practice. It does not surprise me that a practitioner might have said at the briefing, "If a patient says they want X, I do not see it is my role to do anything different." That may well have been that practitioner's point of view and practice. Maybe they looked at the words in the legislation and interpreted it this way. With due respect to the previous legislators, I think they muddied the waters by putting it into the definition of informed consent. Nevertheless, that is what they did, so that is what applied. Those words applied and were implemented as the respective practitioners saw fit, and some did more and some did less.

Going forward, we will rely on the description of informed consent that the honourable member has given. It will be the same version of informed consent that applies to other medical procedures. I suspect that the existing legislation got tangled up by the previous legislators by trying to find words that people could agree with and inserting that provision into the definition of informed consent.

The DEPUTY CHAIR (Hon Steve Martin): Members, we are having some problems with the clocks, but the clerks are keeping time on speeches.

Hon NICK GOIRAN: Still on the topic of informed consent, we have the statutory definition at the moment. The minister has just indicated to Hon Martin Aldridge that, moving forward, practitioners will still be required to obtain informed consent as they would for any other medical procedure.

In this instance, the medical procedure they will be seeking or being offered is an abortion. Will they need to be provided with information about the medical risk of termination of pregnancy?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: With all due respect to the stakeholder Hon Martin Aldridge heard at the briefing, when that person said that they do not think it is their job to do that—again, I am paraphrasing what that person allegedly said—it is obviously not right as a matter of law. At the moment, under the statute, they need to provide information

about the medical risk of termination of pregnancy. Moving forward, whether they like it, whether they want to do it, and whether or not they think it is their role, they will have to do it because if they do not, they will breach the law of Western Australia that requires that a medical procedure cannot be undertaken without informed consent. As a result of that, I go back to my original question: what is actually changing here, other than it will not be enshrined in the statute? Are we simply changing from a statutory definition of informed consent to a common-law definition of informed consent?

Hon SUE ELLERY: With due respect to Hon Martin Aldridge, I do not think it is helpful to revisit what might or might not have been said. I was not there, so I do not know that I can dig into that. I can say this: the requirements for informed consent remain in place as they apply to every other medical procedure. As a matter of law, practitioners will be required to follow whatever the requirements are to ascertain informed consent.

Hon NICK GOIRAN: I will say this, minister: I am moving on from this.

Hon SUE ELLERY: Hold on, honourable member; just give me a minute. I think I am repeating myself now. The difference is that the existing legislation refers to counselling. It appears the practice has been that counselling has depended on the practitioner's point of view, more or less, but it put a legal obligation on the practitioner, which could be tested if someone took issue with whether they had been provided with informed consent according to the language in the current legislation. Moving forward, we will treat informed consent in the same way that we treat informed consent for any other medical procedure.

Hon NICK GOIRAN: I assume that has never been tested in the last 25 years.

Hon Sue Ellery: I do not think so.

Hon NICK GOIRAN: No, I do not believe so either. I make an observation rather than ask a question before I move on to the next line of inquiry. It is most regrettable that the Minister for Health, during the course of this so-called reform, made a significant point of saying that the legislation will remove mandatory counselling, because if people scrutinise what is going on here, they will see we are simply changing the statutory definition of informed consent to a common-law definition of informed consent. As a matter of practice it will be the same, albeit that some people may have read into the statutory definition something that does not exist. It is regrettable that this purported reform refers to the removal of mandatory counselling. That is not well understood in the community. Many people have understood that to mean that in Western Australia at the present time someone cannot have an abortion unless they are forced to have counselling, and that is simply untrue. Many people have understood it in that way, when in actual fact someone cannot have an abortion in Western Australia without meeting the statutory definition of informed consent, and moving forward they will still not be able to have an abortion without providing informed consent, as it should be for any medical practice. I was pleased to hear the minister indicate that will include providing an indication of the risks involved.

I would like to move to another provision, which the minister indicated last time was a change in what we have described as phase 1 abortions—that is, the expansion of prescribers from medical practitioners to registered health practitioners. At the moment in Western Australia, a phase 1 abortion can occur by way of the prescription of a medication. As I understand it, at the present time that can be done only by a medical practitioner. Moving forward, it will be able to be done by a registered health practitioner. What types of registered health practitioners who presently cannot be involved are we trying to draw into this prescription process?

Hon SUE ELLERY: That would be captured in the regulations, honourable member. The intention right now is that it will be nurse practitioners and endorsed midwives.

Hon NICK GOIRAN: At the present time, are nurse practitioners and endorsed midwives involved in performing an abortion?

Hon SUE ELLERY: Currently, they cannot prescribe and they cannot do the abortion, but, for example, at King Edward Memorial Hospital for Women they would be part of a multidisciplinary team. It would perhaps help the honourable member to understand that "endorsed midwife" has a particular meaning. It is a midwife who has done extra training and can already prescribe certain medications. To become an endorsed midwife, a registered midwife must meet the requirements of the Nursing and Midwifery Board of Australia registration standard for "endorsement for scheduled medicines for midwives"; successfully complete a Nursing and Midwifery Board approved program of study that leads to an endorsement for schedule medicines, or a substantially equivalent program as determined by the Nursing and Midwifery Board of Australia; register as a midwife in Australia without conditions or unsatisfactory performance; and complete the equivalent of three years full-time clinical practice—that is 5 000 hours in the past six years. Completed hours can be across the full continuity of midwifery care or in a specified context of practice. Recognised context of practice must include antenatal, postnatal or antenatal and postnatal combined.

Hon NICK GOIRAN: Is it the case at the moment that nurse practitioners and endorsed midwives routinely seek informed consent?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: What has necessitated their inclusion moving forward?

Hon SUE ELLERY: Contemporary practice and access, honourable member. I have been approached by someone who I think is an endorsed midwife in remote Western Australia who is absolutely committed to providing this kind of care locally. She is absolutely convinced, and I agree with her, that people should not have to travel for this kind of procedure if it is not necessary. That is part of the reason. It is about access and it is also contemporary practice.

Hon NICK GOIRAN: These new categories of practitioners whom I would describe as "non-doctors"—nurse practitioners and endorsed midwives—and this new class of individuals who will participate will be able to be involved in phase 1 abortions only. This is not about phase 2, which requires a medical practitioner, as I understand. Can the minister confirm whether that is the case?

Hon SUE ELLERY: They may well be involved in a surgical procedure as part of a multidisciplinary team, if you like, but in terms of what they will be authorised to do in their scope of practice, it will be around prescribing, supplying and administering drugs in circumstances under nine weeks, subject to Therapeutic Goods Administration restrictions as well, within whatever parameters might be put in place.

Hon NICK GOIRAN: In a situation in which they will be prescribing and no medical practitioner is involved, they will be responsible. If they do not obtain informed consent, they could be subject to litigation and there could be some form of malpractice, just as there could be for a medical practitioner. The point is that they will now be primarily responsible for this particular procedure, but it will be restricted to medical abortions and will not open it up to surgical abortions.

Hon SUE ELLERY: That is absolutely correct; it is not within the scope of their practice. Nurse practitioners in particular have been around for a very long time. About a thousand years ago, I worked for the Australian Nursing Federation. Nurse practitioners often operate as sole health practitioners in remote parts of Western Australia and have to undertake a range of care, but always within a prescribed scope of practice.

Hon KATE DOUST: I have a question following on from that. I understand that there are a range of other health practitioners—I suppose that is the word—or professionals, including pharmacists. Just so that I am clear in my own head, will a pharmacist's role in the early stage be simply to supply the drug and nothing else? I am thinking of perhaps remote, regional areas in which there may not be a nurse practitioner or any other differently qualified individual.

Hon SUE ELLERY: There will be no change to their role. They can dispense now; they may dispense under the new legislation.

Hon KATE DOUST: There will be no change to their role, so going back to the discussion about informed consent, will informed consent have to be obtained by the pharmacist in that circumstance, or will it still be obtained by the originating doctor?

Hon SUE ELLERY: It will be the prescriber who will obtain informed consent, not the dispenser.

Hon WILSON TUCKER: I want to spend some time focusing on the data and the information that the Chief Health Officer will be able to collect about an abortion. The bill contains a number of exclusions regarding the type of information that the CHO will be able to request from a clinician. Given the number of exclusions, it is hard to determine what will be the value of the remainder of the information that could be requested by the CHO. Rather than focusing on what cannot be provided, I thought it might be helpful to focus on what can be provided. Is the minister able to give an example of the type of information that the CHO will be able to request from a clinician about an abortion?

Hon SUE ELLERY: They are set out in the bill at clause 8, and I will go through them with the honourable member in a minute. I make the point at the outset that it is yet to be determined by the Chief Health Officer exactly what data he, in this case, will be collecting.

I know the member said that he wants to do it using the positive and not the negative, but I do not have a positive list; I have a negative list. It is useful to know where people who seek these services are in the state, but there is a very deliberate policy decision not to make that so specific that we would know their postcode, suburb or address, so it will be by region. It is also useful for health policy planning provisions to know the age category of people seeking these services. Again, so as not to potentially identify somebody, the data will be collected in age ranges such as under 15, 15 to 19 and so on. In part, honourable member, that is because if we were to combine a very specific address with a very specific age, in some of our most remote communities, it would be clear who that person was.

That is not the case if we are walking around suburban Perth, but it could be the case elsewhere. The information will not include the race or nationality of the person for the same reason. Again, the gestational age of the fetus at the time at which the service is provided will be provided in an age range. The information will not include the particular reason for an abortion having been performed, the particular clinical method or the clinical outcomes. All those exclusions are so that we are not intruding to the extent that a person could be identifiable.

Hon WILSON TUCKER: I thank the minister. I understand and acknowledge that it is a balancing act between trying to preserve the privacy of someone who is seeking an abortion and collecting that information. The minister mentioned the address components that are specifically listed as exclusions, and I think the bill refers to postcode and suburb. How general are we talking for the geographic information that the CHO will be able to collect from someone seeking an abortion?

Hon SUE ELLERY: Although the actual decision is yet to be made by the CHO, I am advised that WA Health has its own list of regions. As a sidebar, that may be different from the list of regions and the borders of those regions maintained by the Department of Education, for example. It is likely to be the way that Health generally describes its regions, so Kimberley, Pilbara et cetera, but that is to be determined by the CHO himself.

Hon WILSON TUCKER: The minister mentioned that the sum of the parts could be collected together and could identify someone; in the case of regional WA, I think that is true. I will wait until we are debating that specific clause to get into some of the rationale, because it does seem like a very broad generalisation around data collection. I think some cases could present in the future whereby this generalisation approach and these exclusions could work against the Department of Health, but I will leave that for a later discussion.

The minister mentioned that the reason for an abortion will be one of the exclusions from the information that the CHO will be able to request from a clinician. I believe that a number of different types of reasons are listed within the bill. Is sex selection included as one of the reasons? If a clinician suspects that someone is approaching them to perform an abortion based on gender selection, will that be excluded from the information being collected by the CHO?

Hon SUE ELLERY: No, honourable member; it is not listed specifically.

Hon WILSON TUCKER: It is not listed specifically, so will the CHO be able to request that information? Will gender determination or gender selection be a reason that will be able to be provided back to the CHO from a clinician?

Hon SUE ELLERY: It could.

Hon NICK GOIRAN: Is the minister sure? I turn to page 22 of the bill, line 25, proposed section 202MP(4)(f). It appears that that might not be the case.

Hon SUE ELLERY: I take the point made by the honourable member. I am advised that the examples given in proposed section 202MP(4)(f) go to the reason why that proposed paragraph was added. It is about the diagnosis of a particular abnormality or condition in the fetus or in the person on whom the abortion was performed.

Hon NICK GOIRAN: We will dive into that clause when we get there, minister. I hope that Hon Wilson Tucker understands that the answer that was provided—that, yes, that data could be collected—is clearly, no, it cannot be provided. I do not support proposed section 202MP(4)(f) for reasons we will get to at the relevant time, but I do not want anyone to be misled. The honourable member's line of questioning was excellent. Significant restrictions are being proposed in terms of data collection, for reasons that are not immediately apparent. The minister has made good points about suburbs and the like. I think what might be helpful, minister, and may assist the member, is the document the minister tabled earlier, being the sixth report of the Western Australian abortion notification system, and the work that is happening behind the scenes. Let us see if we can get the seventh report, which was due in November last year. The data collected is statistical in summary and nature and includes things such as abortion rates and the abortion proportion. It looks at abortion by age group, place of residence and the like. Will that information continue to be provided in light of the restrictions set out in proposed section 202MP?

Hon SUE ELLERY: The report will be different as a consequence of the provisions of proposed section 202MP.

Hon NICK GOIRAN: It will be different. I do not know whether the minister has the document readily available. I note that at page 6 it includes abortion rate by age group, and so includes the age range of 15 —

Hon Sue Ellery: Sorry, can the member take us to where he is?

Hon NICK GOIRAN: Page 6 of the sixth report of the Western Australian abortion notification system. Under the heading "Abortion rate by age group", it provides statistical, de-identified data about age ranges. For example, it includes how many abortions were performed for people aged 15 years through to 19, 20 to 24, 25 to 29 and so on and so forth. That seems to be an example of data that could continue to be obtained under proposed section 202MP(4)(c), about the inability to obtain —

> 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);

That is an example of something that ought to be able to be collected, but the minister indicated —

Hon Sue Ellery: By way of interjection, correct.

Hon NICK GOIRAN: Thank you. The minister indicated that there would be changes. Is she in a position to identify what those changes would be?

Hon SUE ELLERY: I do not want to hold up the debate while we go through page by page and make sure I give the member the correct answer, so I give the member an undertaking that I will provide him with an answer later on in the debate.

Hon NICK GOIRAN: That is fair enough. Thanks, minister. In terms of the changes to phase 1 abortions, we have discussed that at the moment there needs to be two doctors. Moving forward, there will be one. At the moment there is a statutory definition of informed consent that needs to be complied with. Moving forward, it will be a common law definition of informed consent, as it is with any other medical procedure. We have discussed that, at the present time, only medical practitioners can prescribe a medical abortion. Moving forward, two other classes of registered health practitioners will also be able to prescribe, being nurse practitioners and endorsed midwives. Will there be any change in the way abortion is to be recorded? I do not want to dive back into the debate we have just had about data collection, but at the present time there must be some form of process. If an abortion is conducted in Western Australia, something needs to be recorded. Is that recording process going to change for phase 1 abortions?

Hon SUE ELLERY: I am advised that the answer is no in respect of how information is recorded on the patient's medical record, for example, and how the clinic or hospital currently records procedures that it undertakes. There will be a difference with proposed sections 202MO and 202MQ. The Chief Health Officer will issue directions about how information is reported. The difference is that, currently, that is prescribed in the regulations. It is proposed in the bill that that will be subject to a CHO direction. He will issue a direction as to how he wants the reports to be provided. If the member's question was about what will be recorded about the actual performance of the medical procedure, it will not be any different from the way it is recorded now.

Hon NICK GOIRAN: We are still talking about phase 1 abortions, although I imagine when we are talking about recording, it covers the field. At the moment, the obligation to record is through the regulations, and moving forward the obligation will be through the —

Hon Sue Ellery: To report. Perhaps if I describe it again.

The CHAIR: Leader of the House.

Hon SUE ELLERY: In terms of what will be recorded by the clinician or the hospital on the patient's medical record or in the records that are kept by the clinic or hospital, nothing will change. In respect of the instrument by which information will be reported, the instrument will change from the regulations to a CHO direction.

Hon NICK GOIRAN: I think what has been referred to as a form 1 will not be a regulation anymore; it will be a direction. Will the information that is currently recorded and reported via a form 1 continue to be recorded and reported via the directions?

Hon SUE ELLERY: I do not want to hold up the committee, but we do not have a form 1 here and I want to double-check what information is on a form 1. Perhaps when there is a break later, we will get information and come back to it if that is helpful, honourable member.

Hon KATE DOUST: I am following up on that, minister, because I was intrigued to hear that there will be a shift from regulations to directions from the Chief Health Officer. Why is the government enabling that change to happen? Why will we move from having a regulation, which is accessible to the public and open to disallowance, to a direction for which it is very difficult to know what is happening, who is making the decision or what is guiding that decision? To the best of my knowledge, there is no accessible public mechanism available to know what is happening with a CHO direction; we saw that a little bit during COVID when some directions were put out. I must admit that having to track down one of those was an extremely difficult process; therefore, what has prompted the government to move from the current method of having a regulation in place, which is fully accessible, transparent and disallowable, to having a mechanism that is not?

Hon SUE ELLERY: The government's view is that it is not necessary for data collection to be managed via regulations. It is more appropriate for datasets to be set at a more local level by the CHO, with the exclusions provided for by legislation to protect identifying particulars. The purpose of data collection on abortions has always been to enable improvements to the provision of healthcare services, which enables healthcare improvements and public service planning, including for neonatal, mothers' and midwife services et cetera. That is best managed by the CHO via the mechanisms of the Department of Health. In any event, it is intended that any direction made by the

CHO will be published on the department's website so that it is clear to all relevant persons as to their reporting requirements. The direction will be publicly available, but will not be a disallowable instrument.

Hon MARTIN ALDRIDGE: The minister correctly pointed out earlier that I was away from the chamber on urgent parliamentary business; nevertheless, I read *Hansard* from Thursday and the minister's second reading reply when she addressed a number of the issues that I raised during the course of my contribution to the second reading debate. One issue was about data. Through the briefing process, we have been provided statistical information that shows that on a five-year average from 2018 to 2022, some 7 500 induced abortions at not more than 12 weeks' gestation were performed, which accounted for 93 per cent of all abortions in Western Australia. Fewer than one per cent of induced abortions were beyond 20 weeks' gestation—in number, that is about 80 a year.

One of the things I was trying to understand was why the current ministerial panel process, which we will be significantly modifying, has been very conservative in its approvals. I get a sense that under the current process, very few abortions get approved by the panel and many get rejected. Following the briefing, I was told —

> When the medical practitioners on the panel do not approve an abortion to proceed, it is noted on the individual person's medical record … For this reason, information of this nature cannot be provided to third parties.

In the second reading reply on Thursday last week, the minister said —

> Hon Martin Aldridge noted the removal of the ministerial panel for late-term abortions and queried why information held by the panel was not available. The Department of Health holds information on the number of induced abortions performed in WA through the reporting mechanism established under the Health (Miscellaneous Provisions) Act. When the medical practitioners on the panel do not approve an abortion to proceed, it is noted on the individual person's medical record but not on a database. There is no statutory requirement to collect information about the decisions of the panel other than whether an abortion was performed. For this reason, information of this nature cannot be provided to third parties. In any case, the provision of this information would not provide an accurate picture, as patients report they may seek an abortion interstate rather than approach the panel.

We have a ministerial panel. Earlier today, the minister said that the panellists—for good reasons, we do not know who they are—are all WA public health sector workers, and, as far as I am aware, they are all doctors. I find it challenging that there is no record-keeping process of the applications at a high level; for example, in 2022, the panel received 1 000 applications for a post-20-week gestation abortion and approved 25 of them. I would have thought that this panel and the public servants on it would have obligations under the State Records Act or perhaps other acts, and I find it quite remarkable that we do not know. The reason for me asking this is that although we say fewer than one per cent of all abortions are post–20 weeks' gestation, I want to understand what the unmet demand for them is. The information I am trying to access is: how many women who apply for late-term abortions and not approved?

Hon SUE ELLERY: I appreciate that the member finds it challenging, but that is the case. The practice, as has been described to me, is that a medical practitioner will contact the chair of the panel and provide all the information to them. The chair of the panel will then find two members who are available to make a decision on that application, and the decision is made. The decision is not reported.

It is the case that we cannot precisely define the number of women who find that process so daunting that they go interstate. I can tell the member anecdotally, as a 61-year-old woman in Western Australia, that in the course of my lifetime I have known women who have travelled interstate because this process is just too difficult. Although I appreciate the point the member is making—that it is difficult to believe—that is the case.

Hon MARTIN ALDRIDGE: I am not challenging or arguing against the reformed ministerial panel, I just find it difficult to believe that it is not a good record keeper. I have already gone to the question about what the referral pathway is. The chair identifies two panel members who are able to participate at that time. As I understand it, the panel reviews the file that has been referred to it. It is not a patient examination or consultation or anything like that. It results in either an approval or a rejection. If it is approved, we record and disclose it. That information is available, because I have a table here. It tells me, for each of the last five years, precisely how many have been approved, but we do not know how many have not been approved. I could probably accept that the information is available, but gathering it together is so cumbersome it would take a public servant many hours, weeks and months to do it. Surely that patient file does not go through the shredder in the Department of Health once the panellists have made their decision; surely there is some reasoning. I do not know whether it is subject to external review, whether the Ombudsman or Auditor General has jurisdiction, or whether some sort of judicial review of the system could take place, but surely there is some documentation about decisions that are not approve.

Hon SUE ELLERY: I am somewhat limited by the information available to me. All I am able to report to the honourable member is that an individual's medical record remains the medical record. That is held wherever that

medical record is held, whether that is with the referring practitioner or the hospital that the patient attended. The medical record remains. On the advice available to me, it appears there is no, and has been no, collation of that information about the noes. I am not in a position to assist further.

Hon MARTIN ALDRIDGE: I understand the minister is trying to be helpful, but it is interesting that this information is not available. From what I have just heard from the minister, the chair of the six-member panel is the gatekeeper. We know that just shy of two are approved every week—one and a half are approved every calendar week of the year. Do we have an anecdotal understanding of how often the panel or chair gets a call to say, "We have got a referral"? Is it 10 times a week, 20 times a week or three times a week?

Hon SUE ELLERY: I do not have any more information about the operation of the ministerial panel other than what I have already said. I appreciate the member's interest in the matter. I can ask if anybody else in the team has that information, but I am not sure that I would get an answer. I certainly am not in a position to give an answer from the table now.

Hon MARTIN ALDRIDGE: I understand there is a provision in the bill about freedom of information, or maybe I am mistaken. Can I ask about the jurisdiction of the Ombudsman over decisions made by the panel? If a woman has made an application and it has not been successful, what are the current options available for a review of that decision? Does she have the ability to seek judicial review or a review by some other quasi-judicial body?

Hon SUE ELLERY: The Ombudsman is a bloke. We do not have a copy of the act here. The member understands the Ombudsman's office has been given, over time, specific roles around child-death and family and domestic violence reviews. Unless there is a specified role, I understand that the general function of the Ombudsman's office is to deal with individuals who believe they have a grievance against the state. I do not have any advice that says that that general function does or does not apply to decisions of the ministerial panel. The general way that the Ombudsman's office works is that an individual says, "The government has made a decision and I am not happy about that decision, and I seek assistance to review it." I do not have any more information here. I can ask if there is further information, but it is not an act amended by this bill, so I do not even have a copy of it available to me.

Hon MARTIN ALDRIDGE: Another area I want to ask about is informed consent. There has been discussion about it today, but this is on a different aspect. In my contribution to the second reading debate, I said it was taking me a while to understand the concept of how the health system deals with mature minors generally. Some of that was quite an enlightening experience for me as a parent. I am trying to understand the application of it. If a practitioner deems a person who is a minor to be Gillick competent, then that person can make medical decisions for themselves. That is not age-restricted; it is based on the assessment of the practitioner following consultation with their patient. My previous misunderstanding comes from when, as is quite often the case, parental consent is granted for a medical procedure on a minor. In circumstances in which parental consent is granted but the patient is a competent mature minor, does parental consent still have relevance and apply, or does it not? I guess this is a broader healthcare question, but we are trying to normalise and treat abortion care like general healthcare. If I, as a parent, consent to a medical procedure for one of my children, but the reality is my child is 16 and can make the decision for herself, would my decision be valid if it came to the crunch and somebody examined whether informed consent was given?

Hon SUE ELLERY: The member would appreciate that this matter has been considered and debated in the medical profession and by those involved in the health system for some time. It is a subject quite separate from abortion care. The term "Gillick competence" comes from a landmark English case, in which the courts first recognised that a minor might be competent to make decisions without parental consent. The case held that parental right yields to the child's right to make their own decisions when they reach a sufficient understanding and intelligence to be capable of making up their own mind. In the case that the member is referring to, if the parent says, "I want this medical care to be provided", and the child says, "I do not want it", and an assessment is made that the child is Gillick competent, it is the child's decision that will prevail. The member can appreciate that these are difficult decisions, so practitioners will do their best to try to make sure that, whatever the provision of care is, a decision is made that everybody can live with. However, ultimately, if the child is deemed Gillick competent, it is their decision that will rule the day.

Hon MARTIN ALDRIDGE: I understand the example that the minister gave. A parent says that they do not consent to the procedure, but it is deemed that the minor is sufficiently mature or competent to make the decision for himself or herself and therefore that is the decision that is the important one. My question was about the opposite of that. As a parent, I provide consent to a medical procedure for my dependent child, who is mature and competent and capable of making his or her own decisions. Would informed consent have been given in that circumstance?

Hon SUE ELLERY: It is the case that the principle I read out would apply. It would go both ways. The honourable member can appreciate that, as I said, when there are conflicting views about whether consent should be granted by a parent or a child, the medical practitioners involved will go to great lengths to make sure that they both understand what that means and might even, as a matter of practice, bring in other practitioners or members of their healthcare

team to help the family resolve that situation, because they would still have a familial parent–child relationship. However, if consensus is not able to be achieved, by law, Gillick competence says that it is the patient who makes the decision.

Hon MARTIN ALDRIDGE: I think I am building my understanding of this test in a very preliminary, nonscientific way, but I was trying to reverse it. My experience of the medical profession is that if an adult and a dependent child are present and the adult signs the form and the child's appendix or kidney is taken out or a fracture is fixed—whatever the medical procedure is —

Hon Sue Ellery: You're not at the tricky point yet.

Hon MARTIN ALDRIDGE: No, and I am not looking forward to it either! When it all goes pear-shaped after the medical procedure has occurred and the kidney has been removed, there would be some sort of examination of what happened and who made the decision. If Dad signed the consent paperwork, but the child was 16 or 17 years of age and was able to make the decision for themselves, would consent have been given? In the circumstance in which a mature minor, competent to make their own decision, did not make the decision but the parent exercised their decision, would informed consent have been given? I am trying to explain it in a few different ways. That is the nub of what I am trying to establish.

Hon SUE ELLERY: It is going to depend entirely on the circumstances. It may well be that there is no issue between the child and parent and the practitioner.

Hon Martin Aldridge: Until something goes wrong.

Hon SUE ELLERY: Yes. The medical practitioner will make a judgement: do they need to ensure that the child knows that they have the right to make a decision according to the rules of Gillick competency? It will depend a bit on the circumstances. The member can imagine that this does not happen very often, but it is really challenging when it does. It is up there with the challenges faced by practitioners when, for example, somebody does not want a blood transfusion for religious reasons. It is a life-and-death decision and it is about making sure that the patient knows the circumstances and understands their rights.

The Gillick competency is in place. It prevails, but I am advised that the practice of practitioners would be to make sure as much as possible that everybody understands the consequences and what is being considered. Ultimately, the point of Gillick competency is to draw a line when a mature minor is saying that they do or do not want X and a parent is saying that they do or do not want X. How is a decision made when one has to be made? They rely on Gillick competency.

Hon NICK GOIRAN: Earlier we identified that under the current law only a medical practitioner can prescribe a medical abortion. However, moving forward, nurse practitioners and endorsed midwives will be able to do so. Will they be able to prescribe a medical abortion to a minor?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: At the moment, a medical practitioner can prescribe a medical abortion for a person under the age of 18 years. Must they always obtain parental consent or a court order for a person under 18?

Hon SUE ELLERY: Under the Health (Miscellaneous Provisions) Act, a dependent minor is someone who is under the age of 16 years and is being supported by a custodial parent—so, it is not 18 years; it is 16 years. The next part of the member's question has just gone out of my head.

Hon NICK GOIRAN: At present, a medical practitioner can prescribe a medical abortion to a person aged from 16 to 18 years without the involvement of the parent. That will be expanded to include nurse practitioners and endorsed midwives. At present, only medical practitioners can prescribe a medical abortion for someone under the age of 16 years. Must they have either parental consent or a court order?

Hon SUE ELLERY: Under the current arrangements—again, something has been inserted in the use of the term "informed consent"—section 334(8) states —

> … a woman who is a dependant minor shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed …

That is not the parent giving consent; the consent needs to be given by the dependent minor. In order for the dependent minor to give that informed consent, the custodial parent needs to have been informed that an abortion is being considered and given the opportunity to participate in a counselling process, and the provision goes on. If the member's question is whether the parent gives informed consent in that case, the answer is no, but for these purposes, informed consent under this legislation—not anywhere else—means that a parent must be informed and given the opportunity to participate in the discussions and counselling around that.

Hon NICK GOIRAN: At the present time, is there any involvement from the courts regarding these dependent minors?

Hon SUE ELLERY: Down from section 334, which I just referred to, is section 334(9). It states —

> A woman who is a dependant minor may apply to the Children's Court for an order that a person specified in the application, being a custodial parent of the woman, should not be given the information and opportunity referred to in subsection (8)(a) …

Hon NICK GOIRAN: There is no change to the test that applies to determine the capacity of the young person seeking an abortion. By default, a person under the age of 18 does not have capacity, but they may have capacity and so a test must be applied. That is the case at the moment and will continue to be the case moving forward. Going back to our earlier discussion about the changes to phase 1 abortions, there will be a change here in that there will no longer be a mandatory requirement for information to be provided to what is described as the custodial parent. Will the need for the Children's Court be eliminated moving forward because there will be no need for that information to be provided to the custodial parent?

Hon SUE ELLERY: The need for the Children's Court will be removed, but there will remain a role for the Supreme Court and the Family Court when the child cannot be deemed to have Gillick competence.

Hon NICK GOIRAN: The minister has pre-empted where I was going next. At the present time, if the medical practitioner determines that the young person does not have capacity, can a substitute decision-maker make the decision on behalf of the young person?

Hon SUE ELLERY: Currently no, but under the bill before us, yes.

Hon NICK GOIRAN: What provision in the bill will allow for a substitute decision-maker to make a decision on behalf of a young person?

Hon SUE ELLERY: Proposed section 202MM refers to a guardian as a person who at law has parental responsibility as defined in the Family Court Act. That will apply if an abortion is being proposed and the registered health practitioner considers that the patient does not have capacity to consent on their own behalf or that it is not possible to ascertain whether the patient has capacity to consent and the patient agrees to a parental guardian participating in the decision-making et cetera.

Hon NICK GOIRAN: Is the minister saying that the provision in proposed section 202MM, which would allow a substitute decision-maker to make the decision on behalf of the young person moving forward, does not apply under the current state of the law? I think data has been collected that has suggested that abortions have occurred from as young as 12 years old, for example. I seem to recall having read something about that. I will use a 13-year-old for this particular example. As I understand the minister's answer, at the present time if a young person at the age of 13 seeks an abortion, there is no capacity for a substitute decision-maker to make the decision on their behalf. If a medical practitioner says, "No, look, this 13-year-old doesn't have capacity and doesn't meet the test", what would happen in that situation?

Hon Sue Ellery: Now?

Hon NICK GOIRAN: Yes.

Hon SUE ELLERY: Gillick competence does not apply under the current arrangements; that is a difference between what is in place now and what will be in place in the future. Currently, section 334(8)(a) of the Health (Miscellaneous Provisions) Act states —

> subject to subsection (11), a woman who is a dependant minor —

That is, under the age of 16 years and supported by a custodial parent or guardian —

> shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed that the performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed …

One of the critical differences in the new legislation is the recognition and application of the Gillick competence protocol to minors. The clinician will make a judgement on whether a minor is able to make their own decisions, and that will determine the path that is taken. I have mentioned this before: the legislators, at the time, inserted into the definition of informed consent for a minor provisions on informing the parent, and the parent being given the opportunity to participate in the counselling process.

Hon NICK GOIRAN: Under the current law, irrespective of the age of the person, they must provide informed consent, as set out in the statute, but is it not the case that in order to provide that informed consent in accordance with the statute, the person must have capacity? It is a fundamental principle of informed consent that the starting

point is that they have to have capacity. If the person does not have capacity, there can be no informed consent; that is why we talk about things like substitute decision-makers. In a situation in which a medical practitioner says, "Look, I cannot get the statutory informed consent of this 13-year-old because I have determined that the person does not have capacity, either as a matter of law or as a matter of my own assessment, Gillick or otherwise", what would happen at the present time?

Hon SUE ELLERY: Perhaps if I use an example. In the case of a 14-year-old with an intellectual disability, can consent be given if the intellectual disability is such that the child cannot make decisions about themselves? Is it possible, under the current law, for an abortion to be performed and for informed consent to be deemed to have been given? Yes, it is, following the steps that I read out under section 334(8)(a). If the parent is informed and has been given the opportunity to participate in the counselling process and in consultations on whether or not the abortion should be performed, it can be performed. I am also advised that if there is disagreement between the practitioner and the parent, under the current provisions —

Hon Nick Goiran: The parent doesn't make the decision. All they're entitled to is getting some information.

Hon SUE ELLERY: Yes, I know, but the point I am trying to make is that in that example, which does happen, informed consent is deemed to have been given if the parent participates in the ways that are set out under section 334(8)(a). But there are discussions happening here, so I am going to double-check.

Hon NICK GOIRAN: We have to get this right. At the moment, we are using the example of a 13 or 14-year-old. They still have to comply with the existing law, which is that informed consent means consent freely given by the woman, and a set of circumstances apply to the medical practitioner; the medical practitioner has to provide information. In the case of a dependent minor, extra information must be provided to the person called the custodial parent. The point remains that, whether there is a custodial parent or not, the dependent minor must still consent freely, in the words used in the statute. What happens if the medical practitioner is of the view that this young person does not have the capacity to consent freely?

Hon SUE ELLERY: My advice is that either the parent or the practitioner can take the matter to the Children's Court for the purpose of making a decision.

Hon NICK GOIRAN: A substitute decision can be made pursuant to a court order; will that still be the case, moving forward? Again, I understand that the Leader of the House has said that we are going to introduce the test and so forth, but what if the medical practitioner has said that this 13-year-old person does not meet the test and that they need someone to make a decision? I understand that the Leader of the House has indicated that there is a provision that allows for parents to make a decision, but maybe there are no parents, or maybe the parent does not want to agree. Will the same opportunity remain for a court order to make a substitute decision on behalf of the young person?

Hon SUE ELLERY: The answer is yes. An application may be made to the Supreme Court or the Family Court for a decision to be made in the child's best interests.

Hon NICK GOIRAN: A question arises from that. I think the Leader of the House indicated that, under the current law, that type of application for a substitute decision by way of court order is made to the Children's Court. She then indicated, as she did earlier, that a decision will be made by the Supreme Court or the Family Court. Why are we removing the Children Court's jurisdiction in this matter?

Hon SUE ELLERY: There are two things. One is that, in the first instance, the policy change is around Gillick competence. That being the case, we will no longer need the current arrangements' provisions for how to make decisions. In the case we are talking about now, Gillick competence is not applicable because the child is not able and does not have capacity to make decisions, and the view is that the more appropriate courts are the Supreme Court or the Family Court. The Family Court of Western Australia already has jurisdiction to make orders relating to the welfare of children. I am advised that parens patriae is within the purview of the Supreme Court. The member might be more familiar with that term than I am.

I am trying to find the bit in my notes that is relevant. Maybe I will just read the whole thing. If the child is a child of marriage—that is, the child of the husband and wife in the marriage—the application may be brought in the Family Court of WA or the Supreme Court of WA 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 hospital staff are persons concerned with the care, welfare or development of the child. If the child is not the child of a marriage, the application must be brought in the Family Court of WA under section 162 of the Family Court Act, as that court has exclusive jurisdiction to hear such applications under section 36(8) of the Family Court Act. The application may be brought by a person concerned with the care, welfare or development of the child within section 185 of the Family Court Act. If an application cannot be brought under the Family Court Act or the Family Law Act, because, for example, the proposed applicant

would not have standing or another prerequisite to the exercise of the jurisdiction of the Family Court cannot be met, then an application would need to be made to the Supreme Court seeking orders in the exercise of the Supreme Court of WA's parens patriae jurisdiction. However, that jurisdiction of the Supreme Court should not be seen as a residual jurisdiction. In deciding whether to make an order about a child, the court must regard the best interests of the child as the paramount consideration.

Hon KATE DOUST: I thank the minister for that very useful information. It got me thinking. Part of the discussion about the reasons for this bill's changes that will extend the time period from 20 to 24 weeks has been about getting information, perhaps about a deformity or other issue with the child or a challenge to the life of the woman, at a later point. In this example, we are talking about the child. I wonder about the shift from the Children's Court to these other court arrangements—to the Family Court or the Supreme Court. I do not know how to frame this right. Given the earlier discussions about the degree of urgency about getting a decision made, how does that translate into the real world when applying to these courts, which traditionally have a much longer wait period to get into the process? Will an arrangement be put in place to fast-track, for want of a better set of words, these situations into either of those courts and get an expedited decision, rather than having to wait weeks or months in some cases, which would be unacceptable? I am curious about how dealing with these situations will be managed for the changes proposed in this bill.

Hon SUE ELLERY: I thank the honourable member for the question. Those courts already make decisions about what is in the best interest of the child in all sorts of circumstances, including other medical procedures. They are already in a position to know that certain decisions, particularly about the provision of medical care, need to be made quickly. They already have procedures in place to do that. The Chief Justice of the Supreme Court was consulted, and he advised that matters such as abortion decisions can be dealt with on an urgent basis when necessary. Policies and procedures are already in place for urgent matters, and those policies and procedures would be utilised if a decision were sought about an abortion for a minor.

Hon KATE DOUST: I want to follow up on that. There is a definition of a guardian who, I suppose, in normal circumstances would be or could be appointed by the courts to represent that young person, young adult or young child. Would that occur only if no parent was involved at all—not on the scene—or if there was an ongoing debate and an outcome could not be reached or be perceived to be reached between the parties? Could the court then intervene and impose a guardian and remove the parent? I will let the minister answer that half first.

Hon SUE ELLERY: That is not related to this bill at all. I think the decisions about how a guardian is appointed are under child protection provisions. There may well be other provisions. This bill does not go to a decision about appointing a guardian. A court would be asked to make the decisions we are talking about here, about whether a procedure should go ahead or not, and courts already make those decisions about medical care from time to time. I am sure it does not happen every day, but it does happen from time to time. Decisions need to be made, and practitioners are unable to determine whether they have consent or there is a dispute between the guardian, family members or whoever is responsible for the child. There is nothing in the bill before us today that goes to how guardianship is determined. That is covered by separate laws.

Hon NICK GOIRAN: I would like to move to late-term abortions. I think we have reasonably and comprehensively scrutinised the changes about phase 1 abortions, which are abortions that presently take place prior to 20 weeks of gestation and that it is proposed will take place prior to 23 weeks of gestation. Together, we have identified four key changes. Firstly, at the present time, two doctors are involved: a referrer and a performer. Moving forward, only one doctor will need to be involved. Secondly, at the present time, the doctors must obtain informed consent as defined under the statute. Moving forward, the single doctor will still need to obtain informed consent but as a common-law principle consistent with any other medical procedure.

Hon SUE ELLERY: Honourable member, I need a second to bring the chair's attention to something. I am sorry about stopping the member midstream. I need to swap out an adviser, so I want to do that. I did not want the member to put his whole question and then not be in a position to answer it. If we allow that swap to happen, I will get the member to ask his question again.

Hon NICK GOIRAN: As I was saying, we have reasonably comprehensively scrutinised the distinction between phase 1 abortions at the present time and moving forward. The definition of a phase 1 abortion for the purposes of the debate has been those abortions that take place prior to 20 weeks' gestation; under the new legislation, it is proposed to be prior to 23 weeks' gestation. Four key changes have been identified as a result of that scrutiny. Firstly, two doctors—a referrer and a performer—are presently involved. Moving forward, only one doctor will be involved. At the present time, those two doctors need to obtain informed consent as defined under the statute. Secondly, moving forward, the singular doctor will still need to obtain informed consent as per common law. Thirdly, in situations in which a medical abortion takes place, it will now be possible for two further types of practitioners—nurse practitioners and endorsed midwives—to prescribe the medical abortion. As with any medical practitioner,

they will still need to make an assessment of capacity, albeit there will be some changes in the court of jurisdiction that may be invoked in presumably rare cases. Fourthly, there will be some changes to the reporting regime. In particular, the reporting at the present time is prescribed by the regulations; moving forward, it will be done by way of directions. The minister has taken on notice that in due course she will inform the house about some of those differences when comparing the current form of reporting process with what the process will be under the directions. This is particularly important when we consider it is triennial reporting, and the minister identified that there will be some differences in what can be included in the triennial report.

On that point, I want to move to the changes relating to late-term abortions. One of the obvious differences is the threshold. At the present time, the threshold is 20 weeks' gestation; it is proposed that it will be 23 weeks' gestation. I note that on the supplementary notice paper, Hon Ben Dawkins, who is away on urgent parliamentary business, has foreshadowed an amendment to bring it back to 20 weeks. Other than the threshold changing from 20 to 23 weeks and the pretty well-documented and previously deliberated change of removing the ministerial panel and making it that any two medical practitioners can be involved rather than two practitioners from the ministerial panel, will this bill implement any other changes for late-term abortions?

Hon SUE ELLERY: Honourable member, yes, it will. Under the current arrangements, obviously there has to be agreement by two panel members. Under the bill before us, it will be one medical practitioner. That is at proposed section 202MC. Under the current act, there are no arrangements for one registered health practitioner to be able to prescribe, supply and administer. Under the proposed bill, one registered health practitioner will be able to prescribe, supply and administer on their own accord, or supply and administer upon direction.

Hon Nick Goiran: Sorry, minister; we are just talking about late-term abortions at this point.

Hon SUE ELLERY: Yes.

Hon Nick Goiran: But they would not be prescribing an abortion at late term.

Hon SUE ELLERY: No. Sorry, honourable member. I am talking about what we describe as "phase 1B", at 20 to 23 weeks' gestation. If the member wants to go to —

Hon Nick Goiran: The minister is dealing with, if you like, that new cohort?

Hon SUE ELLERY: Yes. If that is not helpful to the member —

Hon Nick Goiran: No, that is helpful. Please continue, yes.

Hon SUE ELLERY: Under the current arrangements, a medical practitioner can refuse with no obligation to refer. Under the bill before us, they will be able to refuse, but there is an obligation to refer. In regard to what might be described as justification for an abortion, under the current arrangements, it is situations in which the mother or the unborn child has a severe medical condition that in the clinical judgement of the panel justifies a procedure. Under the bill before us, there is no statutory provision, but medical practitioners generally will be bound by the existing oversight mechanism. At an individual level, that is their scope of practice—what they are legally allowed to do—their registration requirements, their code of ethics, their personal ethics and their continuing professional development. At a hospital level, hospitals will have committees and procedures for clinical incident events, licensing and accreditation and others, so there might be external complaints procedures and the like. The mandatory counselling that is currently required will not be required under the bill that is now before us. With regard to the patient, under the current arrangements, it is an adult and a minor via the version of informed consent that we have been talking about. Under the provisions before us, it will be all adults and minors. Then we have discussed the changes in reporting.

Does the member want me to go to clause 23?

Hon Nick Goiran: In a moment, yes.

The DEPUTY CHAIR (Hon Dr Sally Talbot): Just a moment. Minister, I have been advised that your advisers need to be swapped again.

Hon NICK GOIRAN: I thank the minister for drawing my attention to perhaps the benefits of scrutinising this new cohort—that is, the cohort of between 20 and 23 weeks' gestation who, under the current law, are subject to the late-term abortion provisions, but will now be captured by the phase 1 provisions. Interestingly, the minister introduced this notion of personal ethics. I want to pause to explore this for a moment. Why would the personal ethics of the medical practitioner come into play for an abortion between 20 and 23 weeks' gestation?

Hon SUE ELLERY: Honourable member, perhaps that was my shorthand. I was trying to describe the parameters within which a practitioner will perform an abortion and deem that the patient presenting is justified, if you like, in seeking that abortion. The practitioner has to operate within their own scope of practice, and then a range of

other factors will come into account. Please do not read anything more or less into it other than me giving the member a shorthand list of the factors that an individual practitioner will apply.

Hon NICK GOIRAN: It is possible that I could be mistaken here, but my recollection is that the minister was reading from a prepared document that included the phrase "personal ethics".

Hon Sue Ellery: Yes.

Hon NICK GOIRAN: It was not just shorthand from Hon Sue Ellery to try to assist the house; it was actually —

Hon Sue Ellery: No, but will you take an interjection?

Hon NICK GOIRAN: Yes.

Hon Sue Ellery: It got it into that document because I asked for a range of factors. That is literally my list of what I asked to go into the document, honourable member.

Hon NICK GOIRAN: I want to be able to understand the scope of practice, personal ethics and role of the medical practitioner for 20 to 23-week abortions. My understanding is that under the proposed law a person presenting and requesting an abortion at, let us say, 22 weeks' gestation only needs to get the agreement of one medical practitioner to perform the abortion. I cannot see anything in here that suggests that it is subject to the scope of practice of the medical practitioner or their personal ethics or anything like that. Where has that concept been introduced? Do not get me wrong, minister; I am not arguing against this. I think it is good if there are medical practitioners who say, "Hang on a second. I am incredibly uncomfortable being asked to perform this abortion at 22 weeks' gestation, when I, the same medical practitioner, have successfully delivered a Western Australian child at 22 weeks' gestation." I want to get a better understanding of whether there is any role whatsoever for the medical practitioner's personal ethics in determining whether an abortion will take place at 22 weeks' gestation?

Hon SUE ELLERY: Far be it for me to complicate matters but I think I have. I asked the advisers to give me the list of parameters within which a person performing an abortion operates. From my understanding through interaction with the health bureaucracy over the years, hospitals need accreditation and individual practitioners need registration. I wanted to understand the full range of parameters within which practitioners would perform an abortion. I asked my advisers to make a list. It is not a clinical list. It is the "Sue Ellery list of parameters".

However, a provision in the bill before us says that a practitioner does have the right to refuse based on their own ethical reasons, but we have inserted certain obligations to be placed on them. That is the where the ethics bit comes in. In terms of scope of practice, we go back to that. Each practitioner must act within their scope of practice. That means a doctor can only do the things that doctors are allowed to do and a nurse practitioner can only do the things that they are allowed to do, and scope of practice is clearly defined by the respective bodies for each profession. Each practitioner has registration requirements that require certain accreditations to be maintained and conduct to be adhered to, and then there is an individual's code of ethics that might apply if a practitioner wanted to trigger the "I am going to refuse" bit, and they can but under certain obligations. Of course practitioners are also required to receive continuing professional development and specific training that they must have as a starting point.

Hon KATE DOUST: We have done a swap to give a bit of variety to the cause. I have been interested to listen to this part of the debate. Minister, I looked at page 11 of that document titled *Induced abortions in Western Australia 2016–2018*, where it talks about the health service category and breaks it down into the provision by different public or private entities, and I listened to the discussion around ethics and who provides that. Just based on this information from 2016 to 2018, the absolute bulk of abortions conducted in this state were conducted via the private sector, not the public sector. One question there is why is that the case? We are having this discussion about what we do with staff development, using data to provide updates and all those sorts of things, but the reality is that if almost 89-plus per cent of abortions at that point in time—I do not know whether that has gone up or down because we have not had the opportunity to see the updated statistics. If a woman is crossing the threshold into one of those premises, she is there for a very deliberate reason, and for the people who work there, that is a service that they deliver. It is a different discussion in some ways to the one around going to a private practice when we start to talk about this "refuses versus unwilling" type of situation. It is an interesting discussion that we are having when the reality is that the vast bulk of these services are provided by the private sector. I find that quite interesting when we have this discussion around access and provision of services and how we change things.

I think that shift has been gradually happening since 2002 based on the other figures here. Is there a reason why these services have predominantly been conducted in the private sector?

Hon SUE ELLERY: I think it is probably due to a combination of reasons and I do not know that we can be particularly precise about it. One of the reasons is that there is increasingly a trend to medical abortions that can be performed by a general practitioner at the lower gestation level. Therefore, more of those are being done at the lower gestation level because more can be done and because GPs can do that. The ones that are performed at the

higher level are, as we talked about a lot during the course of the debate, inevitably complex and need to be performed in a hospital setting. That is why that happens. I do not know that we can be more precise than that, honourable member. Historically, it is probably a function of the laws in Western Australia. I cannot give the member the stats, but I think we have probably had a disproportionately high number of people who have gone interstate for an abortion, if they can afford to go interstate, because it is easier. But over time, this trend of GPs being able to prescribe and give access to the respective drugs has changed as well. I do not think I can be more precise than that, honourable member.

Hon NICK GOIRAN: Minister, we have just touched on this period of between 20 weeks' gestation and 23 weeks' gestation. Pursuant to the discussion we had when we were last sitting on 31 August 2023, my understanding is that the method known as feticide is typically or commonly or regularly used for abortions that take place at 22 weeks. This is particularly significant given this bill has a threshold of 23 weeks onwards; we will get to the analysis of that in due course. But for an abortion under this new regime, the use of feticide at 22 weeks' gestation would involve only one practitioner, whereas if feticide were used at 23 weeks' gestation, two practitioners would need to be involved.

Hon SUE ELLERY: I just want to make sure that we understood the question correctly. If the question, as I heard it, was "How many doctors would perform the abortion?", it is one. If the member is asking whether there is a difference in the number of doctors involved in performing the abortion if feticide is the method, the answer is still one.

Hon NICK GOIRAN: What I am trying to get to the bottom of here, minister, is the distinction between an abortion that takes place at 22 weeks and one that takes place at 23 weeks. There are a number of reasons for why that is significant, but one of them is the use of this method called feticide. It is not a particularly pleasant term to use, but that is the term that has been used in Western Australia and implemented since 2017. It is not relevant with regard to earlier gestational limits even at the upper end, like 20 weeks and 21 weeks, because we know that feticide is not used at those gestational limits. There is something unique about the 22-week mark because feticide is introduced and it is the only gestational week when a phase 1 abortion could take place moving forward and feticide could be involved. My question relates to the number of practitioners involved because from 23 weeks onwards, for a late-term abortion to take place, it is common that feticide will be involved, acknowledging the earlier responses that it is possible for it not to be involved. We can expect reasonably that at 22 weeks feticide will be involved and at 23 weeks feticide will be involved, yet at 22 weeks one practitioner will need to be involved but at 23 weeks two practitioners will need to be involved, at very least in a consultation capacity. Why is that the case given how significant feticide is?

Hon SUE ELLERY: I am not sure that this is the information that the honourable member is seeking, but if he is operating on the basis that the trigger for 23 weeks is solely linked to feticide, that is incorrect. It is the case that late anatomy scans are generally performed between 18 and 22 weeks and may identify an anomaly. The 23 weeks is about giving enough time for the results of those scans to be considered and the mother to make whatever decision she needs to make. Feticide may or may not be used post–23 weeks because there are other methods, which we have talked about. The trigger for feticide is a clinical decision and the wishes of the mother. It is not a case of "It is 23 weeks so it must be feticide", if that makes it clear to the honourable member.

Hon KATE DOUST: Can the request to take that path come from only the mother at that point?

Hon Sue Ellery: To take what path?

Hon KATE DOUST: The feticide, at that point.

Hon SUE ELLERY: The decision is made between the mother and the clinician. King Edward Memorial Hospital for Women's preferred practice post–22 weeks is to recommend feticide, but if the mother, for the reasons that I outlined in a much earlier conversation, wants to take the other path, that will be taken into consideration and the decision is made between the clinicians and the mother, depending on the particular circumstances.

Hon KATE DOUST: I want to go back to our earlier discussion around the fact that 86 per cent of abortions in Western Australia between 2016 and 2018 occurred in private clinics. Let us just imagine that that is still the same figure; and the minister has referenced King Edward Memorial Hospital for Women. Would the same apply to an abortion that is conducted at 22 or 23 weeks in a private arrangement, in a private clinic or private hospital?

Hon SUE ELLERY: They do not do them now. They are only done at King Eddy's.

Hon KATE DOUST: That is the next question. With the change in this legislation pushing that boundary of 20 weeks out to 23, will those private clinics or those private hospitals then have the capacity to conduct that type of abortion at that point in time or will that woman have to go back into a venue like King Edward?

Hon SUE ELLERY: The practice in Western Australia is that a person who performs feticide needs to be a fetal medicine specialist. They need to be an obstetrician–gynaecologist. There are very few of them. As I understand it, they are not carried out at private clinics, and I think that is a function of the fact that there are so few of them. That is not to say that there might not be more of them in the future, but with the current arrangements and what we anticipate certainly in the short term going forward, because there are so few of them, they will continue to be conducted at King Edward Memorial Hospital for Women. That is where those particular clinicians are.

Hon KATE DOUST: Thanks for that information. Let us imagine that a woman who is moving into the 20 to 23–week zone has perhaps already sought advice or is contemplating going through a private clinic. Under the changes that are going to be made, will the private clinic be obligated to send her to King Edward?

Hon SUE ELLERY: It is going to depend on the particular circumstances. There are other ways of doing a late-term abortion that do not involve feticide, and we talked about some of those before. The particular medical specialist who is required to do what I was describing before is to perform feticide in a particular way, which is the only way that it is carried out in Western Australia. In other jurisdictions, there may be other ways, but those are not the ways it is carried out in Western Australia.

On the question of whether a private hospital or private clinic could perform late-term abortions at 22 weeks, the answer is yes. The practice in Western Australia has generally been that they cannot because they are not allowed to, but even going forward, because such a specialist group of clinicians do the work, I am not sure that we will see any significant shift. That might happen over time; I do not know. It will depend on what happens with the profession, but I cannot see it happening in the short term.

Hon NICK GOIRAN: We are dealing with this cohort of 20 to 23 weeks. As I indicated, I am particularly concerned about the 22-week gestational limit, because we know from answers that have been provided in Parliament that babies survive at 22 weeks. We know from answers that have been provided in Parliament that they do not survive at 21 weeks. They have survived at 25, 24, 23 and 22 weeks, but they have not survived at 21 or 20 weeks. At least, that is the information that we have been told over the last month or so. I am hearing from the minister's exchange with Hon Kate Doust that there is, as a matter of practice, an importance about having a certain level of specialty at this stage of the gestational journey.

The question I have for the minister is about the threshold of 23 weeks. Whoever drafted the consultation paper proposed 24 weeks. I know that the Australian Medical Association suggested 22 weeks and I see that this bill has landed at 23 weeks. The minister provided some form of explanation earlier and said that scans typically happen between 19 and 22 weeks and therefore it is, at least in the government's view, useful or appropriate to provide some time for a decision to be made. That said, at the 22-week mark, special considerations come into play. If that were not the case, we would not introduce feticide. If it was just the same as at 21 weeks, we would proceed accordingly. This is really a segue into a round of questions about the differences for late-term abortions—that is, those from 23 weeks onwards. Apart from no longer requiring the involvement of two doctors from the ministerial panel, although two doctors will still be required to be involved in abortions from 23 weeks onwards, are there any other changes?

Hon SUE ELLERY: Reading from the Sue Ellery note sheet, yes. In addition to the medical practitioner change, one registered health practitioner will, upon direction, be able to prescribe, supply or administer. The requirement for mandatory counselling is being removed. The other elements about the patient are the same as those we canvassed before. There is a particular variation of informed consent and reporting. There are changes to do with assisting and who can be in the team that performs it. Currently, other health practitioners can be involved in assisting and they are part of a multidisciplinary team. That has happened as a matter of practice, but it is not referred to in the legislation, so, for the avoidance of any doubt, proposed section 202MG includes that. Otherwise, the changes are the same as those we canvassed before.

Hon NICK GOIRAN: I accept that a number of changes that will occur for phase 1 abortions will flow through to phase 2 abortions. The minister has identified things like the removal of the statutory definition of "informed consent" and the reporting regime, which is part of the questions that have been taken on notice. With regard to the involvement of other health practitioners—that is, the prescribers—is it the case that an abortion after 23 weeks could involve a health practitioner? I will not say "involve" because, as the minister has said, there can be a multidisciplinary team. Moving forward, two doctors will still need to be involved in late-term abortions; they just will not have to be from the ministerial panel. One of the doctors is referred to as the primary practitioner and the other one could be called, for lack of a better description, the consulting practitioner. Could either the primary or the consulting practitioner be a person who is not a medical practitioner?

Hon SUE ELLERY: No.

Hon NICK GOIRAN: Why then, in the minister's explanation of the differences after 23 weeks, is reference made to the health practitioners and to prescribing and administering?

Hon SUE ELLERY: It is limited to supplying or administering upon direction. The doctor may well write up the script but it might be the registered health practitioner who goes into the room and administers it. That is within their scope of practice now. There is nothing new about that, but it is for these particular procedures.

Hon NICK GOIRAN: Again, we are talking about after 23 weeks' gestation. Is the prescribing of a medication to the person in and of itself sufficient to procure an abortion at 23 weeks?

Hon SUE ELLERY: The procedure will be performed in a hospital and will require two doctors to be part of the total process. The doctor will write up the prescription for the drug that will induce labour, for example, and that will start the process.

Hon NICK GOIRAN: Thanks, minister. Going back to the question about the consultation paper suggesting that the gestational threshold be 24 weeks and the Australian Medical Association suggesting that 22 weeks be the gestational threshold, why has the government proceeded with 23 weeks?

Hon SUE ELLERY: I think I canvassed some of the factors around 22 weeks and 23 weeks when we met last time, but different stakeholder groups expressed slightly different views. The government needed to make a decision based on the best clinical advice. Looking at the best clinical advice available, it seemed that 23 weeks was the appropriate number. I think it could have been argued that it could have been 23 weeks or 24 weeks, but, based on the best clinical advice, it seemed that we could probably reach a consensus, clinically, around 23 weeks. There are reasons around 22 weeks and 23 weeks, which I canvassed previously and do not intend to repeat now because we are going to have this debate again when we get to the amendments, so I will not say it three times. It was around trying to achieve clinical consensus with the Western Australian clinicians.

Hon NICK GOIRAN: Why, under this regime, is it considered necessary for two practitioners to be involved from 23 weeks onwards, whereas there is a need for only one practitioner prior to that?

Hon SUE ELLERY: It is primarily driven by the view that these are often complex cases. If we go back to the previous conversations we have had about the small number of cases, they are often complex cases. Clinically, the view was that we want to have two medical practitioners involved to provide the best decision-making capacity around some of those complexities. The complexities would differ with each patient. The best clinical advice was that given the complex nature of this small number of cases, the best decision-making would be done with two medical practitioners.

Hon NICK GOIRAN: Minister, I accept that they are small in number. I think that the data certainly reflects that. If these are complex cases, why does the bill allow for any two medical practitioners to be involved when the current regime permits only two doctors but with ministerial approval?

Hon SUE ELLERY: It is driven by the principle of patient-centred care. Rather than appointing a ministerial panel of technical experts, it recognises that we need to take into account the particular circumstances of the patient. It might be that a particular doctor knows the patient's history really well and understands the particular issues with the pregnancy, and she wants that doctor involved because that is the person who knows about her history and about her health care. It is about what is in the best interests of that patient and what is the best combination of doctors. It might be that it will require a particular combination of technical skills, but it might also be a combination of technical skills and someone the patient knows and who is familiar with the patient's history, the patient's responses to certain drugs and all those sorts of things. It is about best clinical practice for the patient. It is well within the medical practitioner's current scope of practice to make a referral when they think there is a need to do so, and they may well consult with relevant specialists for the particular patient, depending on the particular circumstances.

Hon NICK GOIRAN: This goes to the minister's answer to an earlier question from Hon Kate Doust. At the moment, late-term abortions can take place only in King Edward Memorial Hospital for Women and Broome Health Campus. They are the only two authorised places where that occurs. As the minister said, these are complex cases. The minister has also said that they are small in number. That being so, is it the expectation of the government that notwithstanding that they will be able to occur geographically anywhere in Western Australia, including in a private facility, other than in perhaps rare circumstances, whether that be an emergency or however we want to describe "rare", a significant majority of these procedures will continue to take place in those two places?

Hon SUE ELLERY: I sort of answered that before in response to Hon Kate Doust. I cannot be precise, honourable member, but what we know right now is that for the particular method of feticide, there is a specific set of qualifications for the methods used in Western Australia. I think that of itself will limit where it can be done for the foreseeable future. These laws might mean that the profession will change and that more people will choose that particular specialty pathway. I am not sure. I do not know whether I can be more precise. My personal expectation is that making access to abortion care itself, not just late term, but across the spectrum, may well see more Western Australian women seeking abortion care here rather than choosing to go interstate, but I think that will

perhaps mean a higher number of procedures at the lower level. I do not see anything in these laws that will change the clinical drivers for the reasons women have late-term abortions.

Committee interrupted, pursuant to standing orders.

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