Parliamentary Debates

(HANSARD)

FORTY-FIRST PARLIAMENT

FIRST SESSION

2023

LEGISLATIVE COUNCIL

Wednesday, 13 September 2023

Legislative Council

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THE PRESIDENT (Hon Alanna Clohesy) took the chair at 1.00 pm, read prayers and acknowledged country.

PAPERS TABLED

Papers were tabled and ordered to lie upon the table of the house.

VOICE TO PARLIAMENT

Notice of Motion

Hon Dr Steve Thomas gave notice that at the next sitting of the house he would move —

That this house —

(a) supports the importance of the Australian Constitution as the founding document of our nation;

(b) notes that the Australian Constitution currently treats all Australians as equals;

(c) supports strong measures to improve the outcomes for Aboriginal people across Western Australia, and

(d) opposes the federal Labor Party's proposed Voice to Parliament because —

(i) it will divide the community by creating different levels of Australian citizenship without providing the local solutions needed to achieve part (c); and

(ii) it cannot be properly explained by the federal Labor government.

COMMITTEE REPORTS — CONSIDERATION

Committee

The Chair of Committees (Hon Martin Aldridge) in the chair.

Joint Standing Committee on the Corruption and Crime Commission — Sixth Report —
The Corruption and Crime Commission's unexplained wealth function:
The review by the Honourable Peter Martino

Resumed from 22 February on the following motion moved by Hon Dr Steve Thomas —

That the report be noted.

The CHAIR: Members, we are in Committee of the Whole considering committee reports and before I call the first item, I have a statement. Before we commence with consideration of committee reports today, I advise that the chamber timers are not fully operational. The debate and motion times will be displayed on the monitors; however, the clerks will keep members' speaking times from the table and will ring a bell when a member has spoken for 10 minutes.

Hon NICK GOIRAN: It has been about six months since we last considered this report, which is effectively the report of Honourable Peter Martino. He was tasked with looking into the Corruption and Crime Commission's special function on unexplained wealth. As I say, it has been approximately six months, I believe, since we had the opportunity to consider this matter. The questions of course then arise: What has happened by the government on this matter? Has anything happened over the last six months?

Members may recall that the genesis of this matter was comments by the Attorney General, Mr Quigley, who said that the front doors of the CCC will become the "gates of hell" for criminals who will be forced to testify about their unexplained wealth. This statement, made by the Attorney General in April 2017, not long after he was sworn in as the Attorney General, sounded like a very significant and substantial aspiration on his part—one might even say it was some form of a prophecy as to what would be happening. Here we are in September 2023 and the question that arises is: have any of the so-called criminals been forced to testify about their unexplained wealth? Have the front doors of the CCC indeed become the gates of hell for these criminals?

The point that was made by Honourable Peter Martino in this review, and I note that he says as follows —

> … it cannot be assumed that the CCC will continue to be able to exercise its functions under the CPC Act effectively in the future without additional resources. The safe and effective exercise of the CCC's unexplained wealth and criminal benefits function would benefit from additional funding to resource:
>
> - accountants and financial analysts;

- investigators, including experienced financial investigators;

  …

- surveillance officers;
- digital forensic officers;
- support staff;
- further development to record management processes;
- acquisition of additional software capabilities and licences used to undertake analysis of large and complex data sets;
- acquisition of additional equipment including laptop computers, mobile telephones and surveillance equipment;
- acquisition of digital forensic analysis tools; and
- enhancements to security arrangements.

This is what Honourable Peter Martino found in his review into the CCC's function that is the investigation of unexplained wealth. This particular report that has been provided to us by the joint standing committee is more than a year and a half old. It was tabled in this place in March, not this year but last year. Since that time, the CCC has tabled its annual report, not the most recent annual report which is due by the end of this month, but last year's annual report. It was massively, massively delayed by the Corruption and Crime Commission. It is supposed to be tabled by the end of September each year; it was not even tabled in the last calendar year. It was massively delayed. In any event, we now have the CCC's *Annual report 2021–22*, and it tells us that 53 unexplained wealth matters had been identified, and that this resulted in eight initial investigations and nine more extensive investigations being conducted. Therefore, 53 were identified, but basically only 17 were actioned, so what has happened to the other matters?

We were told that there was $1.7 million in confiscation orders, and this appears to have arisen from one singular matter before the District Court. Page 42 of the annual report, titled "Significant Issues", lists funding as an issue that needs to be addressed to allow the Corruption and Crime Commission to continue to exercise its functions in the future. It noted that the 2022–23 budget provided additional funding to enable the CCC to maintain this function at the existing level of effort. It goes on to say that the CCC spent $600 000 above the 2022–23 budget to continue the delivery of its unexplained wealth function. As I say, this is not news to members. We last had the opportunity to consider this matter in February or March this year. The questions that arise are: To what extent do we expect that the annual report that is due at the end of this month will shed any light on any movement in this regard? Have any additional resources been provided? Would a government member care to inform the house whether any additional resources have been provided? After all, it was the government that appointed the Honourable Peter Martino to undertake this review. He has identified the problem. Has anyone in government done anything about this?

While we are waiting for the CCC to provide its annual report, through the government, by the end of this month, it may be instructive to look at the annual report of the CCC that was tabled in this place fairly recently and see what it says about the Surveillance Devices Act 1988. Under the Surveillance Devices Act, the commission is required to furnish to the Attorney General, as soon as practicable after 30 June, information on its execution or use of the Surveillance Devices Act. This is a very short report. Other than the covering page, it consists of a one-page introduction and then a one-page substantive report. It is three pieces of paper in total. It is hardly any wonder that it is so brief because if members take the opportunity to look at how much the Corruption and Crime Commission has utilised the Surveillance Devices Act in the reporting period—that is, for a full financial year—they will see that the results are: applications for warrants, zero; warrants issued, zero; warrant applications withdrawn, zero; applications made on behalf of another law enforcement officer, zero; applications made by means other than filing out a written application of the court, zero; applications for warrant extensions, zero; warrant extension authorisations issued, zero; warrant extension applications withdrawn, zero; applications made on behalf of another law enforcement officer, zero; applications made by means other than filing out a written application to the court, zero; applications for emergency authorisations, zero; emergency authorisations issued, zero; and applications for emergency authorisations withdrawn, zero. There has been zero performance by the Corruption and Crime Commission on the use of the Surveillance Devices Act during the reporting period. Remember, Mr Quigley said that the front doors of the CCC would become the "gates of hell" for criminals, who would be forced to testify about their unexplained wealth. Remember also that Mr Martino has indicated that the CCC needs extra funding to resource things like surveillance officers. Obviously, the CCC does not have any surveillance officers because it did not use the Surveillance Devices Act over the last financial year. Mr Martino also identified that the CCC would like to have some surveillance equipment. The CCC must not have any surveillance equipment because the CCC has had zero performance under the Surveillance Devices Act 1998.

What exactly is going on? Will we get an explanation from the government about the current state of affairs? There was little point in the Attorney General telling Western Australians in April 2017 that the front doors of the CCC

would become the gates of hell because criminals would be forced to testify about their unexplained wealth if the government then appoints a reviewer who has said that the CCC needs more resources, particularly for surveillances, and we find out there has been zero performance. Somebody in government needs to provide an explanation about what is going on here. If the Cook Labor government has completely withdrawn from the task of going after these criminals and their unexplained wealth, say so. Be honest enough to say that the CCC has not become the gates of hell and the government has completely given up on that. Be honest enough to tell us exactly what is going on.

Hon PIERRE YANG: We spoke on the sixth report of the Joint Standing Committee on the Corruption and Crime Commission for the first time on 21 September 2022 and we had another opportunity to speak on it on 22 February 2023. I think this is the third time we have had the opportunity to discuss this report. On the last occasion, I talked about the importance of the work done by the Corruption and Crime Commission and, of course, on the sixth report *The Corruption and Crime Commission's unexplained wealth function: The review by the Honourable Peter Martino*. Specifically, we talked about the importance of the potential expansion of the unexplained wealth function powers. Today I will focus my attention on one specific aspect of this review, which is under the heading "The freezing of property", on page 26 of the report. At paragraph 3.80, the report explains that the conduct of unexplained wealth matters —

> … requires authorities, including the CCC, to act quickly to ensure that assets can be identified and restrained before they are moved beyond the reach of law enforcement.

That is particularly relevant when talking about properties that could be liquidated and their value moved outside of our jurisdiction or the boundary of the commonwealth of Australia. That would require the assistance of other countries and their law enforcement agencies, which would be a lot harder than if the property remained within Australian shores. The report continues —

> The CPC Act provides for the freezing of properties freezing orders, which are issued by a court, and freezing notices, which are administrative in nature. The CCC can apply to a court for a freezing order. It is not given the power to obtain a freezing—which can be obtained by the DPP and WA Police Force …

I think it is important to distinguish between a court order that a party must apply for in a Western Australian court—for example, in the District Court or the Supreme Court—and a freezing notice, which is different in nature. That can be done differently. Paragraph 3.81 of the report states —

> The DPP has the ability to apply for both freezing orders and freezing notices. It uses freezing notices far more often than it applies for freezing orders, as can be seen from this table taken from its annual report for 2019–2020 …

As we can see in that table, for 2019 and 2020, the DPP applied for 203 freezing notices but only four freezing orders. We can see the scale and nature of the complexities involved in applying for a freezing order.

I wish to draw from my experience as a practitioner 10 years ago. On one occasion, I recall that a party applied to Landgate to have a caveat placed on a property. It took a couple of hours to draft the form, get the form signed and lodge it with Landgate, which resulted in a caveat on a person's property. If someone has a caveat placed on their property, they have the right to object. As a result of that objection, the registrar of Landgate will tell the person who applied the caveat—the caveator—that they have 21 days to apply to the Supreme Court for an extension of the functions of that caveat. I was involved in one of the processes as the instructing solicitor. I went to a barrister, prepared the caveat and prepared the writ. It took a number of days to get the form ready. Twenty-one days may sound like a long time but in situations involving a caveat, someone has to speak to a barrister to get paperwork ready to go to the Supreme Court, which can take 15 working days. Members who have worked with lawyers or who were lawyers would know that it takes some time to go through that process. Fortunately, we were able to lodge the paperwork within 21 days and obtain a hearing, so the function of the caveat was temporarily extended and that was the end of the matter. However, it just shows that a matter involving an administrative process requires less intensive work; yet when it involves a court process, it tends to be more complex and involve more resources. When we look at the end result in the table in paragraph 3.81 of the report, it shows that 203 freezing notices were obtained and only four freezing orders were obtained.

Paragraph 3.84 of the report states —

> … Mr Martin concluded that it was undesirable for there to be two different procedures for the freezing of property …Mr Martin also concluded that the undesirability of … freezing notices, being the process which involves the lowest burden on the WA Police Force and the DPP is exercised at an overwhelmingly higher rate by them, being the process which confers the least rights upon affected persons.

I want to use my remaining minute to touch on another experience I had during my time as a solicitor. In one case, a client came to me about some matters involving an investigation. Her properties were under freezing notices. Unfortunately, the value of her properties decreased significantly. She was not prosecuted after being accused of smuggling some drugs because she was found innocent by the court. Unfortunately, she lost a significant part of her wealth as a result of being set up by someone else, who was then prosecuted.

Mr Chair, I want to take this opportunity to thank you and the chamber for giving me the opportunity to make a contribution. I look forward to speaking at the next opportunity.

Hon KLARA ANDRIC: I rise today to make what I believe is possibly my fifth contribution to the sixth report of the Joint Standing Committee on the Corruption and Crime Commission, *The Corruption and Crime Commission's unexplained wealth function: The review by the Honourable Peter Martino*. Before I speak on some other areas that I have not already mentioned, I want to respond to Hon Nick Goiran, who mentioned a few things when he commented on the report. The JSCCCC's annual report is due at the end of the year, and I am sure Hon Dr Steve Thomas will agree with me when I say that we are very much looking forward to the report being tabled.

Hon Nick Goiran mentioned funding for the CCC. In the 2023–24 state budget, an additional expenditure of $12.1 million from 2023–24 to 2026–27 was approved for the CCC to further develop its unexplained wealth function, and almost $2.3 million for continuation of unexplained wealth functions for the 2023–24 budget year. I do not know whether that provides further clarification for the member; however, I thought I would mention those figures from the budget paper for the honourable member.

Hon Nick Goiran also questioned unexplained wealth outcomes, to which I thought I might refer him to a recent Corruption and Crime Commission media release. I can possibly go into it in a bit more detail if I have the time. It relates to a figure of close to $1 million that was delivered from the unexplained wealth function relating to cases involving Mr Ronald Whyte and Mr James Villa. The media release on the CCC's website is dated 25 July 2023. That is quite a significant amount of money that was obtained as a result of the CCC's unexplained wealth function. It was obtained as a result of investigations undertaken relating to those two cases.

I have spoken quite a few times on the sixth report of the JSCCCC, but I wanted to mention the legal expenses of a person whose property has been frozen. I looked at this matter a while ago. I wanted to talk about some of the issues that Honourable Peter Martino raised relating to the legal expenses of a person whose assets have been frozen, some of the commentary made by Honourable Peter Martino and also some recommendations relating to the Criminal Property Confiscation Act 2000. Currently, the CPC act does not include provisions for paying the legal expenses of a person whose property has been frozen. In some cases, the High Court will exempt some of the property under a freezing order on the condition that it is spent on legal services. As most of us can imagine, that process would be quite difficult: firstly, to determine whether the funds will go towards legal services; and, secondly, how substantial one's legal fees will be. I am sure that it would be quite tricky to figure out whether the assets were frozen as a result of unexplained wealth functions, the probabilities of legal costs and having exemptions to those funds to use for legal costs. As we all know, legal fees can be quite significant. The purpose of a limitation on exemptions is to make sure that funds are not misused. As I said, in some cases the High Court of Australia will exempt some of the property on a freezing order so that the money can be spent on those legal services. The report notes that this exemption must be taken with great care to ensure that the exempted funds are not then subsequently misused in that process. In the report, Honourable Peter Martino mentions a number of ways in which the funds can be misused such as through overservicing or overcharging, and possibly by other forms of abuse as well.

The process for exempting frozen property, as I have mentioned, is difficult and a number of factors need to be considered when deciding whether or not to grant an exemption. The sixth report outlines some of those key areas that I will take the opportunity to mention today. The decision to exempt frozen property must consider the following: whether the freezing order covers specified property only or all property that the individual owns, effectively controls, or—I thought this was interesting—has given away; whether the party has made a genuine application for legal aid assistance; and whether the individual has the capability to retain legal representation without assistance from an exemption, so is the person in question able to access legal services without having to have an exemption on the unexplained wealth properties. The sixth report outlines another consideration —

> the extent of the frozen property available to satisfy a CPC Act declaration, and the risk of depletion of frozen property by future legal fees;

As I mentioned earlier today, the legal fees can be quite extreme. I imagine that consideration given to any form of exemption would have to take those matters into consideration, after all, if it looks like the legal fees for that person will exceed or come close to exceeding the value of the unexplained wealth seized, I imagine that that would weigh heavily on the decision as to whether a person is entitled to that exemption.

The competing factors between an accused's choice of counsel and what constitutes reasonable legal expenses is another element of that consideration and something that Honourable Peter Martino noted extensively in the sixth report. In respect of the legal expenses of a person whose property is frozen he commented —

> In my view the CCC's approach to applications to a court to release frozen funds for legal expenses is appropriate and in accordance with legal authority. In my view its present practice should be followed under the legislation in its present form.
>
> However, it is also my view, having regard to the time needed to be spent by parties and courts on such applications, and the difficulties raised by the necessity to balance the consideration of the reasonableness of legal expenses and legal professional privilege, that it would be desirable for the CPC Act to be amended

> to provide that legal aid funding should be available to fund all the reasonable legal expenses, in both criminal and civil proceedings, of a person whose property has been frozen. Additionally, the Legal Aid Commission should be given a charge over the frozen property for the legal expenses that it funded …

That basically means taking ownership on to the legal service and whatever the outcome of the proceedings in which the property was frozen.

Question put and passed.

Standing Committee on Environment and Public Affairs — Fifty-ninth Report — Overview of petitions 3 December 2021 to 30 June 2022

Resumed from 15 March on the following motion moved by Hon Peter Foster —

> That the report be noted.

Hon SHELLEY PAYNE: I think I have only one minute left on this so I will be brief. I am a member of this committee along with our chair, Hon Peter Foster, Hon Tjorn Sibma, Hon Sophia Moermond and Hon Stephen Pratt. This report covers the petitions received from 3 December 2021 to 30 June 2022. The last time I spoke on this, I referred to the housing issue and how we had received petition 6 on Caravan Parks and Camping Grounds Regulations and the issue of tiny homes. I know that this is an issue that a lot of local governments have been discussing over the last couple of years, particularly the Shire of Esperance, the first shire in Western Australia to implement a tiny homes policy. I think we are still waiting for the National Construction Code to be amended to recognise tiny homes.

Hon NICK GOIRAN: It is timely that we get to consider the fifty-ninth report of the Standing Committee on Environment and Public Affairs today that looks at the petitions tabled between 3 December 2021 and 30 June 2022. I would like to specifically draw to the attention of members petition 33 found at page 11 of the report entitled "Release the Coroner's Court recommendation". This petition was tabled by me on 14 October 2021 and finalised by the committee on 18 May 2022. Given the primary order of the day that will be considered by the house today, it is worthwhile members giving some consideration to this particular petition. This petition contained more than 2 000 signatures and called for —

> … the Legislative Council to inquire into the Attorney General's refusal to release the recommendation made by the Coroner's Court in January 2020 to amend the *Health (Miscellaneous Provisions) Act 2011*. This concerned a number of cases of the live birth of children as a result of abortion procedures.

The committee faithfully reports in its report that I made a submission to this particular inquiry into the consideration of petition 33 and it quotes that I advised in my submission —

> … there has been significant concern that Western Australian babies have been born alive but then not provided the same standard of health care (or indeed any health care) that a baby of the same gestational age would ordinarily receive. This concern has been heightened in light of the non-reporting of these child deaths.

The committee report indicates that further in my submission I said —

> On 18 September 2018, it was confirmed by the Government in Parliament, that advice from the State Solicitor's Office stated that these deaths were reportable deaths but that, as at that date, they had not been reported to the State Coroner.

The committee then indicates that it wrote to the Attorney General and to the Minister for Health seeking comment on the petition. It is instructive to note that the Attorney General responded at that time by way of letter to Hon Peter Foster's committee dated 5 May 2022. The Attorney General said, in part —

> the State Coroner's recommendation to amend the *Health (Miscellaneous Provisions) Act 2011* (WA) was prepared for the ultimate deliberation of Cabinet. Because this Cabinet deliberation is yet to take place, the Government has not been in a position to make the recommendation public to date.

I do not quibble with the Attorney General and his response from 5 May last year. I simply note for the benefit of the chamber that he indicated that he and the government were not in a position to make public the recommendation of the State Coroner at that time because the deliberation had yet to take place. The deliberation has obviously now taken place because we have a bill before the house that we will consider further during orders of the day and in Committee of the Whole House. During our consideration yesterday, I urged the government to expedite the release of the coroner's recommendation. This matter has been pursued since 2018. On 18 September 2018, Hon Sue Ellery in her capacity representing the Attorney General, confirmed that the deaths of babies who were born alive after an abortion procedure had not been reported to the State Coroner. It is a matter of public record that the following day I reported those matters to the State Coroner. It is a matter of public record that since that time the Department of Health has on multiple occasions reported those deaths to the State Coroner. It is a matter of public record that those matters remain with the State Coroner in the backlog, on hold, pending the outcome of this recommendation. The problem is that we do not know what the recommendation is. Is it the recommendation

of the State Coroner that the jurisdiction of the Coroner's Court should be removed for these matters? Is it the recommendation of the State Coroner that these matters ought not be reportable deaths? Is it the recommendation of the State Coroner that there should be some capacity by the State Coroner to compel health officials to provide information to assist the State Coroner with its inquiry? We do not know. The house does not know, yet there is a bill before the house.

I again call on the government to expedite the release of that coroner's recommendation. I see no harm in doing that. If there is harm in the coroner's recommendation being released, I invite members to explain what that harm is. I invite any representative on behalf of the Attorney General to explain what that harm is. I invite someone from the government to explain why Hon Peter Foster's committee was told that it was not in a position to make the recommendation public to date because the deliberation was yet to take place, implying to Hon Peter Foster's committee that once the deliberation had taken place, it would be possible to make the recommendation public—a fair and reasonable inference of the response provided by the Attorney General. I call on the government to expedite the consideration and release of this information, which has the support of thousands of Western Australians.

Further, I make this point: we know—it is on the public record—that a coroner's inquiry was held in the Northern Territory into the death of Jessica Jane. It was a similar type of case. A young Northern Territorian was born alive after an abortion procedure but was then left to die. The coroner in the Northern Territory inquired into that matter and made some recommendations. We know that there was also a coronial inquiry in New South Wales into a similar matter at Westmead. We have had coronial inquiries in our country previously. We know of at least the Northern Territory and New South Wales cases. There has obviously not been any in Western Australia because there is this blockage. There are matters before the Coroner's Court, but there is some form of blockage, unknown to members. The blockage is known to some members who are part of cabinet because it has been brought to their attention and they have had the opportunity to deliberate on it. However, if one is not a member of cabinet, one does not know what that recommendation from the State Coroner is. I am simply asking for, preferably, the information to be released to members before we make a decision on the bill that is pending; or alternatively, if there is a good, fair and reasonable reason it cannot be provided, I call on the government to provide that explanation.

I might add that in all the circumstances, members ought remember that section 82 of the Financial Management Act 2006 obligates the government, if it is not going to provide that information to Parliament, to issue a notice, to both the Parliament and also the Auditor General so the Auditor General can look at the recommendation from the State Coroner and give an opinion as to whether it is fair and reasonable that this information has not been provided to the people of Western Australia more broadly, but in particular to the 35 members of the Legislative Council who have a responsibility to make decisions on not only the bill but also particular clauses, some of which go to the jurisdiction of the State Coroner, all in circumstances when we are talking about the very distressing scenario of babies being born alive after an abortion procedure and there is inadequate or, in some circumstances, no health care provided to those youngest Western Australians. I hope every member of the Western Australian Legislative Council supports at least having the information available to them.

Hon LORNA HARPER: I, too, rise to talk about the fifty-ninth report of the Standing Committee on Environment and Public Affairs, *Overview of petitions 3 December 2021 to 30 June 2022*, but more broadly than Hon Nick Goiran. I do not want to dig into the details of each and every petition. Especially as I notice we have some students in the public gallery, I would like to give an overview of what the committee does and its functions. The committee considers petitions and the consideration of petitions serves to enhance transparency and inform the Parliament and public about current issues of concern to the community. A petition will not always bring about a change of policy by the government or achieve the specific objectives desired by the petitioners. That is an important point to make. The fact that a petition has been presented to Parliament does not mean it automatically becomes policy; there are a lot of other things to consider. At the submission stage the committee does not have the power to direct, amend or overturn decisions of other bodies. That is something we must be aware of because the committee has clear terms of reference and clear powers.

The committee has five members and the functions of the committee are to inquire into, and report on, any public or private policy, practice, scheme, arrangement or project whose implementation, or intended implementation, within the limits of the state is affecting, or may affect, the environment—that is a mouthful; any bill referred by the Council; and petitions. The committee, when relevant and appropriate, is to assess the merits of matters or issues arising from an inquiry in accordance with the principles of ecologically sustainable development and the minimisation of harm to the environment. The committee may refer a petition to another committee when the subject matter of the petition is within the competence of that committee. The word "may" is regularly referred to in this chamber. The committee "may"—the committee does not "have to" and it is not obliged to. That point is argued quite a lot in this chamber when some items are put forward.

I had a little look at petition 42 on Department of Communities' housing in Karawara. I used to work in Karawara. I love saying "Karawara" because of the number of r's in it. I used to work at Lady Gowrie Child Care Centre in Karawara—that was a mouthful to answer the phone to! The petition called for the Legislative Council to support a reduction in the number of Department of Communities' houses in Karawara. The tabling member, who is the

member for the area, did what we are meant to do—that is, he was asked to table a petition, so he tabled it. We do not always agree 100 per cent with petitions that we are asked to table, but when constituents ask us to do it, we do it as we represent them. I found it quite unusual that the petition was asking for a 24 per cent reduction in community housing, especially considering the lack of housing and the issues that are going on. Being a person who grew up in a council house on the west coast of Scotland, I believe in social housing and think it is very important. Well, it was social housing until Margaret Thatcher sold them all from underneath us, but that is a different matter.

The variety of petitions is very interesting. Petition 32 on an RAAF memorial in Kings Park sits next to petition 33 on the release of a Coroner's Court recommendation. Petitions are wide and varied. The committee has to deal with a lot of different petitions, and there are a lot of petitions. I do not think a week goes by when a petition is not presented to Parliament. I challenge any of you to say that three times in a row because I tripped over it! I believe the committee does an excellent and thorough job. We understand that some of the petitions before the committee at the moment are quite daunting. The committee holds hearings and people come in and ask that stuff be put in. Looking at the ongoing petitions mentioned in this report, there is one about Fiona Stanley Hospital. I could talk about Fiona Stanley Hospital quite a lot because I spent a lot of time walking around that hospital, even down below where we are not all meant to go. I spent a lot of time there. I am sure that Hon Rosie Sahanna could talk about crime and antisocial behaviour across the Kimberley—about the reality and the reasons that there might be issues in the Kimberley, such as the lack of social structure following the removal of that structure in previous years. The petition about the marine fish kills in Jurien Bay marina is a very interesting one. I do not go fishing, so I cannot really comment on that. There was even a petition opposing mandatory masks for children in years 3 to 7. I used to work with children on a regular basis. Good luck if you can keep a mask on a child aged three, four or five years old! Unless you have gaffer tape or a staple gun, it is not going to work. I do not believe that children really did it.

We could go into the depth and breadth of each of the petitions but I do not think this is the time to dig into them. The petitions have been tabled, the committee is dealing with them and it will report on them. I do not think this is the time to go into what each petition called for because they all call for something. As I said at the beginning, the committee does not have the power to change policies or to direct, amend or overturn decisions of other bodies. I think we should keep that firmly in mind when looking at these reports, and particularly this one.

Hon DAN CADDY: I rise to speak to the fifty-ninth report of the Standing Committee on Environment and Public Affairs. When petitions are read into this place, for many of us it is the first we have heard of the issue that is being described. Sometimes, a petition is read on a widespread or statewide issue and we all know the issue to some extent. Occasionally, niche issues are brought up in petitions and some individuals might have in-depth knowledge of the issue, the circumstances and sometimes, importantly, the history. The fifty-ninth report of the Standing Committee on Environment and Public Affairs includes two such petitions in terms of my knowledge of the issues they cover. I will talk about both of them if I have time, from a position of some knowledge. Petition 32 is on the RAAF memorial in Kings Park and petition 35 is on the East Subiaco A-class reserve. I will speak to the second petition first; I am sure there will be ample opportunity to speak over time. I go back to the early history of this matter in 2014, when the principal petitioner was himself a member of the council and probably could have made a difference. The redevelopment of Subi East was very much tied to both what happened with football in Subiaco and the decommissioning of Princess Margaret Hospital for Children. An ABC news article of 17 September 2014 states —

> WA Premier Colin Barnett has said he sees no future for Subiaco Oval when the new Perth stadium opens in Burswood in 2018.

Whether or not we agree with Colin Barnett, he was pretty firm on that. It continues —

> Mr Barnett said the oval, also known as Patersons Stadium, sat on prime real estate in Subiaco and could be turned into a housing development.
>
> However he stressed no decision had been made.

This was really an opportunity for those at the local government level to try to engage. He went on to say —

> … I can't see a future for Patersons Stadium as it is …

What did the council choose to do at that time? The city took out a full-page ad in the *Post* urging both the Barnett government and the state opposition at the time to make an election commitment to keep Subiaco Oval for sport. That was the sum of its efforts—to take out an ad in a local newspaper that, by state definition, nobody read as far as numbers went; it is a very local newspaper. Where was the engagement? As we know, Colin Barnett would not meet with the council at the time. This was a familiar thing. It was a very difficult council to deal with. Many developers would not bother meeting with the council at the time either. Gareth Parker probably summed it up best in an article in *The West Australian* of 31 August 2017. This article is probably the best summary of the pathos surrounding the council at the time. He referred to the old market site as well as the loss of football, which were both part of Subi East and the genesis of the petition. He referred to the pavilion site in the article as —

> … the derelict piece of real estate where Subiaco's Pavilion Market once operated: a prime location at the corner of two of Perth's most famous streets.

He then states —

> But rather than a vibrant commercial and community centre, the markets on the 5500sqm block on the corner of Rokeby and Roberts roads, a stone's throw from a railway station and a drop punt from Subiaco Oval, have been shuttered for a decade.
>
> What a dismal outcome.

It was dismal indeed; he was absolutely right. As I said, the Barnett government and developers alike avoided trying to deal with the City of Subiaco at the time, and especially the elected members. It was a council of naysayers. Gareth Parker made the point —

> The markets were shut ostensibly so the site could be redeveloped.

He said the owner —

> … had ambitious plans for a large-scale project of high-rise apartments, retail, commercial and entertainment space.

Ironically, that is exactly what is there now, but it was delivered well after the time that it could have been. The article continues —

> The concept fit neatly with bipartisan State planning policy that called for densification and housing diversity in strategically important brownfield sites.

Here is the kicker from Gareth Parker —

> Subiaco's elected members have done-in the reputation of their municipality.
>
> …
>
> Instead, an intransigent council, influenced by a tiny but vocal minority, fought the scheme rather than facilitate it—and so an entire economic cycle was wasted and an opportunity lost.

Those are Gareth Parker's words. After that important context around the history and complete lack of direction from the local government level at the time, let us get back to the specific site. I noticed in the petition it talked about 4.6 hectares, but anyone who has done research or lived through it would know that the principal petitioner and the group they were part of always talked about 1.73 hectares having to be returned to the public. The 1.73 hectares came from the size of Kitchener Park, which is now the footprint of Bob Hawke College. The Leader of the House, Hon Sue Ellery, as then Minister for Education and Training on behalf of this government, opened Bob Hawke College in 2020, but those people were not happy with the new school being built. Those people demanded the 1.73 hectares be returned as part of the Subi East development. I have an August 2019 agenda from the City of Subiaco, which says —

> Kitchener Park—was noted that it was not used as active open space and that an opportunity existed to use incorporate …

The point being, that it was simply an overflow car park for when the West Coast Eagles played. This came from people's objection to this brand new school. Ironically, it is the same school at which Premier Roger Cook, along with local member Katrina Stratton and, I think, Hon John Carey opened stage 2 on Monday.

This is when effective policy passes nimbys by. The important thing is being able to progress. The history of this is important, because it was the litany of missed opportunities and poor leadership—as outlined by Gareth Parker—that pulled Subiaco back into the dark ages, right up until a young, dynamic team was elected to council in 2017. The new council was elected, with members prepared to do the hard work for the revitalisation of Subiaco while preserving what is loved about Subiaco. The Subiaco council had money in the budget for saving footy at Subiaco Oval. Let me say that again. A new group had been elected and it looked at what was going on. The footings had gone down at the new stadium; football was gone, but there was still money in the budget for saving footy. There was not, "Let us take this money and let us see what we can build and what we can do." That is incredulous and a hangover from the time the principal petitioner himself was on council.

The revitalisation is now being realised thanks to the incoming leadership and hard work of many on council, and especially those in business in Subiaco at that time. Let us not forget that many businesses went under and were pushed to the wall by the lack of strategy from the council prior to that last game of football at Subiaco Oval in 2017—as was outlined by Gareth Parker. I go back to Gareth Parker's words. This is not the gospel according to Dan, as Hon Peter Collier will often say. Talking about the previous council, Parker writes —

> This is how Subiaco's elected members have done-in the reputation of their municipality.
>
> Over the years the council has been dragged kicking and screaming to night-time football and other events at Subiaco Oval; has opposed the $200 million hotel redevelopment at the old Ace Cinema site that proceeds only because it was approved by a development assessment panel; and has tried to snuff out the small-bar revolution that has enlivened practically every other of the city's entertainment precincts.

He then quotes Murray Gill, who was the owner—I am not sure he still is—of Juanita's bar on Rokeby Road. Gill said —

> "There's something very sad and entrenched in Subiaco … you can reinvigorate an area but you do need some co-operation."

That was in 2017, two months out from the elections. Then, as I said, the fresh council —

The CHAIR: The question is that the report be noted.

Hon DAN CADDY: A fresh council was elected and that saw the renaissance of Subiaco. Councillors like Derek Nash, Jodie Mansfield and Matt Davis—to name a few—chose to not only work with the Subiaco business community, but were also a part of it. That is critical.

I will get back to the specific history of the Subi East site from the council point of view and will talk more about that. I have another media statement about what happened next.

Consideration of report postponed, pursuant to standing orders.

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

ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from 12 September. The Deputy Chair of Committees (Hon Sandra Carr) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

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

Debate was adjourned on the following amendment moved by Hon Ben Dawkins —

> Page 8, line 6 — To delete "23" and insert —
>
> 20

Hon SUE ELLERY: Before we get to where we left off, which is the first amendment to clause 8, I will provide the chamber with information that was requested yesterday or the day before. This is not related to the matter we are debating now, but was information sought during the course of the day. Hon Nick Goiran asked a question about whether the coroner was consulted. I can confirm that the coroner was consulted, as were other heads of jurisdictions, but I am not in a position to table any of that communication. A couple of members asked about the statistical report for years 2019 to 2021. The report has not yet been completed, however data continues to be reported to the Chief Health Officer and remains available on request. One of the pieces of work was impacted by the work the Office of the Chief Health Officer needed to do in respect to the pandemic. To aid members in the debate, I am able to table the general statistical information for the past five years. The document is headed "Statistical information on abortions in WA from 2018–2022." I ask that we get copies made because it is ridiculously small.

[See paper 2494.]

Hon SUE ELLERY: I was asked about key stakeholders who received a written invitation to participate. There were 43 organisations or bodies with relevant expertise invited to make a submission. I have a list that I can table. Of course, more than 17 500 responses were received in total. I table the list as well.

[See paper 2495.]

Hon SUE ELLERY: I was also asked about the consent to treatment policy. The WA Health consent to treatment policy is available online. I can make it available in hard copy if requested. Another query, from when we sat last month, was about an outline of the changes made to data collection. I have a table headed, "Comparison of Form 1 to the new Bill" and the "Comparison of DoH Report to the new Bill." I table those two documents.

[See paper 2496.]

Hon NICK GOIRAN: At the outset, as we embark again on the scrutiny of this bill today, I thank the minister and her advisers for taking those matters on notice. At least in accordance with my notes, I think all the matters have been covered. Obviously, we will have the opportunity to peruse and consider those documents shortly. I am mindful that we are currently considering the deletion of the numeral "23". I propose, perhaps with the Leader of the House's encouragement, to park any follow-up that arises from the answers she has provided until we have dealt with this matter here.

Hon Sue Ellery: Yes, otherwise it would be very disruptive.

Hon NICK GOIRAN: It is not that they have been forgotten, particularly regarding consultation with the coroner.

To return to the present question before the house, which is whether we should delete the numeral "23" and subsequently, if that is successful, insert the numeral "20". When we left off yesterday evening, I was trying to get to the bottom of what the difference would be, particularly with a case of anencephaly. The context here is that the minister indicated to Hon Ben Dawkins that one of the reasons the government has chosen 23 weeks as the

gestational limit before the more restrictive regime of late-term abortion applies is that during the weeks leading into the twenty-third week, scans are undertaken. It is the government's view that it is important to provide a pregnant woman time to be able to make a decision following having received information as a result of those scans. Under further examination, it was revealed that the government does not intend that to mean that they would be scans of the sex of the unborn child. That is not what the government intends here. Rather, the government intends, as I understood it yesterday evening, that these are scans for what might be described as "fetal abnormalities". We started to discuss whether these might be lethal abnormalities or otherwise. We left the debate on the hypothetical case of anencephaly at 21 weeks. To the best of my recollection, before we had to adjourn proceedings, the minister was taking advice on that particular scenario and whether the difference between what I might describe as the Dawkins amendment and the proposal by government in the bill was simply the involvement of either one or two doctors.

Hon SUE ELLERY: I have re-read *Hansard* and where we left the debate. I will essentially quote from the uncorrected *Hansard*. Hon Nick Goiran sought an explanation for why the government, in his words, had chosen to extend the period from 20 weeks to 23 weeks. He said —

> … we need to understand exactly why there is a proposal to move from 20 to 23 weeks.

I want to go back and remind members how we got to the point of 23 weeks. In the second reading speech, members will recall I said —

> The bill, at part 1, division 2, will reflect a change to the current gestational age limit for additional medical oversight for the termination of a pregnancy from 20 weeks to 23 weeks.

It continues that being able to provide —

> … general abortion access up to 23 weeks will better align Western Australia with other jurisdictions and ensure fewer patients feel they have no option but to travel interstate for medical care.

It was then canvassed during the course of the second reading debate, for example, by a number of members and I responded to it in my second reading reply. It is not common for me to quote myself but I said it was about accessing abortion services. I said —

> This bill will help improve access to abortion care … The bill will remove the requirement under the Health (Miscellaneous Provisions) Act for earlier abortions to be considered by two medical practitioners. It provides that the authorisation of one medical practitioner will be required to perform an abortion on a person who is not more than 23 weeks pregnant. That change alone will significantly address some of the barriers to access …

That is, access to abortion services. It has also been made clear during the course of the debate that the requirement for late-term abortions is driven by a range of reasons. The decision to go to 23 weeks includes the government having considered the advice from clinicians about access to and the type of scans that are done in that 18-plus week period, but there is a combination of reasons. They were canvassed during the course of the second reading debate and again during the course of the clause 1 debate. It is a combination of reasons. I will come back and answer any questions the honourable member might have specifically about scans, but it would not be accurate for the house to think that that is the sole driver and the only reason abortions are sought post 23 weeks. It is not the case. It has not been claimed by me to be the case during the course of the debate. We oppose the amendment for all the reasons I outlined in my second reading reply, in the clause 1 debate and in my formal response to the amendment when it was moved. I reiterate that the parameters for the bill have been carefully considered in close consultation with health practitioners who provide abortion care and relevant health services. All relevant peak bodies and health organisations supported an increase in the gestation age at which additional requirements will apply. As I mentioned yesterday, there were a range of views on the most suitable threshold. However, none of the key stakeholders supported maintaining the status quo of 20 weeks. It is also the case that the community showed a majority support to increase the gestation age at which additional requirements will apply. I indicated that the Minister for Health hosted two clinical round tables and I attended both. Having listened to all the clinical and consumer views, the government determined that 23 weeks is the most appropriate for the Western Australian context. If we retained the status quo of 20 weeks, or even, say, amended it to 21 weeks, Western Australia would continue to have decreased access to abortions compared with other Australian jurisdictions and we would continue to find ourselves in a position whereby women from Western Australia would likely have to continue to travel interstate to seek that care.

We oppose the amendment for all the reasons that I have outlined in the various parts of the debate so far, for the reasons that I outlined yesterday and for the reasons that I have reiterated today. I will go back to the question the honourable member asked about scans and see if there is a response to that. But I want the house to understand that it would be wrong to characterise this as solely being driven by the particular scans that are conducted in the period that we have referred to, post–18 weeks. That is not the only driver.

Hon BEN DAWKINS: I will say a couple of things just because Hon Nick Goiran has covered everything that I wanted to cover in speaking to this proposed amendment. It appears to me that the minister is just not being specific enough to counter what Hon Nick Goiran has said. Hon Nick Goiran was very specific. In a nutshell, the

reasons that are being proposed by the minister for extending it to 23 weeks are reasons—including the scans—for which someone could obtain access to an abortion in phase 2, particularly if we look at the amendments concerning mandatory considerations that Hon Kate Doust referred to. The very reasoning for this extension to 23 weeks has already been countered by the fact that someone could access an abortion in phase 2 for all those reasons that the minister says that it is necessary to extend it to 23 weeks. It is not. It can stay at 20 weeks and someone can access it anyway in phase 2.

I remind the minister that—I said it before—Professor Joanna Howe's amendment that did not get through, she did not progress with initially; she proceeded with it in South Australia, attempting to keep it at 20 weeks. That did not progress in her amendments so it seems she was successful in singlehandedly getting these other amendments through. It is not as though it is coming from nowhere. It was one of Professor Joanna Howe's initial proposals for staying with 20 weeks, and I have been through the reasons recently.

I would just like to thank Hon Nick Goiran for isolating and narrowing these issues. I say that it removes the need for an extension. I just do not think the case has been made out by the minister for an extension to 23 weeks.

Hon NICK GOIRAN: I want to return to the question that I asked, which was in respect of a case of identified anencephaly at 21 weeks' gestation and whether the difference between what I have referred to as the Dawkins amendment and the proposal of the government in the bill is whether one doctor or two doctors would be involved.

Hon SUE ELLERY: To answer both the proposition put by Hon Ben Dawkins and Hon Nick Goiran, the difference between 20 weeks and 23 weeks is that under the current arrangements for a late-term abortion post–20 weeks, someone is required to get —

Hon Nick Goiran: That is not my question.

Hon SUE ELLERY: Let me answer the question, honourable member. Let us just focus on—I will respond to Hon Ben Dawkins. The difference in access, honourable member, is that if we keep it at 20 weeks, someone seeking a late-term abortion post–20 weeks would need to seek approval from the ministerial panel. Seeking that approval —

Hon Ben Dawkins interjected.

Hon SUE ELLERY: Yes; okay. I will not respond then because the member was trying to say there is no difference and I am saying the difference is the ministerial panel.

Hon Nick Goiran's question is about what the difference is in the case of a patient who has a scan and makes a decision on the basis of that scan that they want to seek a termination. That is the member's question.

Hon Nick Goiran: At 21 weeks and the scan identifies anencephaly. Is the difference that there is one doctor involved or two doctors involved?

Hon SUE ELLERY: Under the legislation as proposed at 21 weeks the difference would be one doctor.

Hon NICK GOIRAN: Right. That is what I wanted to get to, because I absolutely acknowledge that the bill deals with the removal of the panel and that is a completely different situation. That is not what I am talking about here. I am trying to understand what difference it would materially have if members were to agree to the Dawkins amendment. We are being told that at 21 weeks' gestation, in the case of anencephaly, with the Ben Dawkins amendment, two doctors would be involved. Without the Dawkins amendment, one doctor would be involved. The next question is: is a case of anencephaly considered to be a serious case?

Hon SUE ELLERY: There are a couple of things. Anencephaly is the incomplete development of the brain and/or the skull, and it is on a spectrum. There is a variety. It might be, if I can describe it, at the low end, in the middle or at the high end. The other point I want to make is that there are instances when other associated fetal anomalies may not be detected until the detailed anatomy, including cardiac ultrasound, is done around 20 to 21 weeks' gestation, which may affect outcomes and prognosis.

Another point I want to make to the house—it is important to understand this—is that we could take an example and say that the clinical presentation of this example at 21 weeks showed X. In another example, the presentation, or the combination of factors, could be completely different and the mother's health could be completely different. I do not think it is necessarily helpful to hang our hat on one particular case of an anomaly and consider that one presentation of it equals X and therefore we should change the limit for the number of weeks' gestation from X to Y. The point of the way it has been drafted is to take into account the fact that there are a variety of reasons—all of them awful—for why a person finds themselves needing a late-term abortion. The thinking into how we landed on the number is reliant, in part, on a particular time frame within which a certain set of scans can be undertaken. That is a helpful tool for us to use to decide where we should land on the gestational period. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists provided the government with a consensus statement titled *Prenatal assessment of fetal structural conditions*, which states —

> Fetal structural conditions affect 2–3.5% of all pregnancies. Routine screening for FSA by ultrasound has become a part of standard prenatal care throughout the world.
>
> …

> Approximately 25% of fetal conditions manifest only in the second and third trimesters and therefore cannot be identified at 11–14 weeks. These include microcephaly, subtle midline brain conditions, echogenic lung lesions and renal structural anomalies and tumours.
>
> …
>
> The second trimester fetal anomaly ultrasound has been the mainstay for diagnosis of structural conditions over the past 30 years. The examination is generally performed between 18–22 weeks.
>
> …
>
> It is recommended that all consenting patients be offered ultrasound assessment for fetal structural conditions in the mid trimester (generally between 18-22 weeks).

I am just trying to make the point that we can pick any range and any potential fetal anomaly and explore it and land on a particular position, but this has been crafted in the bill to take advantage of the information that is provided by the scans. We also need to acknowledge that that is one factor that is taken into account and that all the factors to be taken into account by the relevant clinicians will be different from patient to patient.

Hon Dr BRIAN WALKER: I get the sense from the questions that have been asked that there is an incomplete understanding of how we go about the process of assessing what is wrong. The first question is the one doctor, two doctor thing. That is wrong. It is actually a team effort. We have the sonographers, the assistants, the radiographer who assesses the sonographer's report and maybe the gynaecologist or obstetrician, who is certainly very capable of looking at the ultrasound and making a determination. That is something to be checked again. The fact that we are talking about one doctor or two doctors does not reflect the actual practice.

Secondly, we have to recognise that when we come to a decision about what to do, we are not taking into account one single factor; we are looking at a wide variety of factors, including personal decisions. The mother might be entirely happy to take to term a child who would have a miserable quality of life. It is entirely her right. It is also entirely a mother's right to be informed about what would happen to the child should it progress to full-term delivery. Does she want that? Is that going to be something she cannot bear? Would it be such a difficult task that her life would be ruined? To try to simplify things to yes or no or a tick-box resolution is simply not appropriate. I think the debate so far indicates that there is a great lack of understanding about what actually goes on in the clinical services surrounding this very difficult type of situation. To be clear, this is a complex decision and no single factor will make a determination. Were members to see an anencephalic child born, they would realise how distressing it is for all concerned—the doctors, nurses and parents. Members might say that perhaps the child could have quality of life with a partial anencephaly, which is true. I personally—this is background information—went into medicine hoping to become a paediatrician. I realised very quickly, seeing the suffering that the children go through, that my heart would break and I could not do that job. I chose not to go into paediatrics because the pain of seeing what the children have to go through was too much to bear. That was just from walking around the ward and seeing what could be done and walking on. I did that in my training and it was more than I could bear, and I think that it would be for most people.

We have to bear in mind that we are not dealing just with a diagnosis, but with a whole spectrum of issues, and trying to reduce it to a common factor that we can then legislate for is entirely inappropriate. Yesterday, I mentioned that the more regulations we put in place, the more the doctors hate it because we need to make decisions based on clinical conditions in consultation with the people who are directly involved, not with the outsiders and bystanders or people with a moral view, whatever their moral view may be. It is entirely up to the caring clinicians and the grieving parents to make a decision about this. It is not at all simple. A process must be gone through, allowing a bit more time for people to process this. Supposing at 21 weeks a decision has to be made, the mum and dad will be talking about it constantly, worrying about it and praying over it. At 22 or 23 weeks they make the decision that they cannot go on. In that very moment, we are not going to make the decision: we have discovered this and now you must do this. That is not the way it happens and that is not the way it should happen. That is placing an intolerable burden on the parents. The idea of limiting it to 20 weeks and specifying what can and cannot happen is entirely inappropriate, clinically. I am speaking from the point of view of a doctor with some experience in this area. It is a terrible situation. The non-clinicians have to get into that mindset of what is actually going on and not deal with this at a distance and speculate on what would happen if this or that occurred and make points about it. That is just not the way things work in medicine.

Hon NICK GOIRAN: The minister explained to the house what anencephaly is. The description the minister provided was that it was either the absence of a brain or, shall I say, a deficient development. That is what I would describe as a serious condition. Under the proposed legislation, if anencephaly has been identified during the scans and a woman seeks an abortion at 24 weeks' gestation, which would be her right under this legislation, there would be no panel and two doctors would be involved in that serious condition. If the bill is not amended, and this was done at 21 weeks for the exact same condition, which is the serious condition anencephaly, it would require a single doctor. As I understand it, that is the only difference here. We need to understand, in practice, what the difference is between accepting Hon Ben Dawkins' amendment or not accepting it. Does the anencephaly case warrant

two doctors being involved or not? As I understand it, anencephaly does not apply at 13 weeks' gestation because it cannot be identified at that time. By the government's own logic and reasoning, it has said it would like people to have the opportunity to consider the scans. It follows that the scans must be of serious matters. In fact, to use the words of the Leader of the House, all the reasons are awful. If all the reasons are awful, and if it is all about the scans and we want to give people the opportunity and time to consider them, it follows that it would be preferable to have two doctors involved.

I take the point Hon Dr Brian Walker made and the objection, if you like, to the regime and the regulation. If he has a grievance with that, I would say that he should take it up with the government because it is not my legislation. Whether we like it or not, moving forward, doctors will be subject to some kind of regulation. The question is whether one doctor or two doctors will be involved, and the government is drawing the line at 23 weeks. I am putting the government to the test about why 23 weeks is the determining factor. If the reason provided by the government is that it needs people to have time to access the scans, I would not quibble with that; that is fine, but what is the purpose of the scans? We have already identified that it is not about sex selection—at least that is not the intention of the government. It is about what have been described as "awful decisions". I interpret awful decisions to mean that there has been a very significant diagnosis. In earlier debate, the minister drew to our attention that there are conditions such as trisomy 18. We have already discussed the anencephaly situation. I know that there are also cases of hydrocephalus; in fact, there were two cases in Western Australia—one was at 27 weeks and the other 28 weeks. A number of other conditions will be of consideration to members, and particularly to the practitioners at the time.

I am just asking for some further elaboration or clarification on why, having received a scan showing a serious condition, the government says, quite genuinely and with good intent on its part, it wants people to have more time to consider the decision they are making. I understand all of that. Whether I agree with it or not is irrelevant. The point is that if a scan shows a serious condition, would we not want two doctors involved rather than one? If not, why is it a case of anencephaly at 24 weeks warrants the involvement of two doctors? By the government's own logic, we should just dispense with having two doctors involved at any particular point in time, and it should always be one doctor.

Hon SUE ELLERY: We are going back to a matter that has been canvassed a number of times. There are differences in clinical practice over the spectrum of time. The honourable member has asked the question of whether it is one doctor or two doctors a couple of times. In the circumstances that he describes, at 21 weeks it would be one doctor, and at 24 weeks it would be two doctors. That is because clinical judgements have been made that say that the requirement is that two doctors be involved when it is past point X. It is based on the best clinical judgements that are available to be made.

However, I think we have to go back to make sure that we are not—I say this with the most generous heart—being verballed. I just scribbled down that the member made a comment along the lines of, "The minister says it is all in respect of the scans." I am trying to make the point that the scans are an important tool and piece of information and advice that may be relied upon, but they are not the only tool nor piece of advice that will be relied upon. I think that is one of the points that Hon Dr Brian Walker made. It is the case that each patient will present with a different combination of reasons for why the decision is being made.

When trying to determine the best way to set the policy of the bill about the regulatory framework around these clinical decisions, the government relied upon advice provided by clinicians. They stated that one of the things we should take into account, depending on the presentation of the woman, was the period between 18 and 22 weeks when a range of scans are done. That was seen to be a useful factor to build into how we developed the policy about the point at which we put in extra regulatory framework around the provisions of that kind of health care. I do not think I can explain it in any other way, honourable member. We listened with great intent to the clinicians at the two round tables to get the best advice. I think the honourable member has already made the point that the discussion paper that went out floated 24 weeks. Based on the consultations we undertook, we landed on 23 weeks. I do not think I can explain it in any other way. We acted on the best advice available to us. We put the patient at the centre, with the principle of seeking to improve access to abortion care. We sought to make sure that for circumstances requiring a late-term abortion, we would have the appropriate regulatory framework in place. Generally, we are trying to make abortion care as accessible as possible. I am not sure that I can describe it in any other way.

Hon NICK GOIRAN: Can I get some advice from the chair? The question before the house is to delete "23". The foreshadowed question that would follow in the event of that question being successful would be to insert "20". I think I flagged this in my contribution to the second reading debate. I have given some consideration of whether I will move an amendment myself regarding whether the limit be 23 weeks or 22 weeks. Again, the minister has not provided any other information to the ordinary person. They would say, "What would be the difference between 23 and 22?" The simple response I have to that is that we are drawing a line here as members of Parliament, whether we like it or not. The line at the moment is 20 weeks in Western Australia and has been for 25 years. The government is proposing to draw the line at 23 weeks. We need to have a rational and substantive reason to draw the line if we are going to change it. The government has provided some explanation in that respect.

The reason that I suggested we might consider 22 weeks is because the Australian Medical Association advocated for that during the consultation process. In and of itself, it is not sufficient for me to make a case to members to say that we should do this just because the AMA says so. However, I simply make the observation that the government does rely on third-party endorsement from time to time. The more substantive point that I would make with regard to 22 weeks is that from answers to parliamentary questions we know that Western Australian babies have survived at 22 weeks. They have not survived at 21 weeks or 20 weeks—at least according to the answers to parliamentary questions. They have survived at 25, 24, 23 and 22 weeks, but not at 21 and 20 weeks. On that basis, if the government is going to draw an arbitrary line, it follows in my mind that it would be at 22 weeks. Why? Because from there on, a very significant change occurs in terms of what might be described as viability.

I am asking some advice from the deputy chair at this particular point. If the question to delete "23" is successful and then the question to insert "20" is unsuccessful, is it open for a member to move to insert "22"?

The DEPUTY CHAIR (Hon Sandra Carr): Honourable member, yes it is.

Hon NICK GOIRAN: In the same way then, if the question to delete "23" is unsuccessful, would there then be no opportunity to move to replace "23" with "22" because the primary question was defeated?

The DEPUTY CHAIR: That is correct, honourable member. It cannot be replaced with anything else.

Hon NICK GOIRAN: I thank you for the clarification. I presume that puts all members in some form of a dilemma. They will have to make a decision about what they are going to do about the question before the chamber. At the present time, I am inclined to support the amendment to delete "23" for the reasons I have already outlined, not the least of which is that there is an objective and rationale basis for there being viability at 22 weeks' gestation and that answers provided in question time state that Western Australian babies can survive from 22 weeks' gestation. If viability is a factor, if viability matters and if viability changes people's view—what some people might regard as a fetus suddenly becomes an unborn child because at that point they are considered to be "viable"—then to me it follows that that would be the threshold. But that is not the option available to us because the proposal by Hon Ben Dawkins is that it be 20 weeks. That is why I have spent some extra time, more than I perhaps planned when we first looked at debating this bill, trying to fully understand the government's rationale with regard to why it had decided to shift from 20 to 23 weeks. I accept that the Leader of the House has not on one occasion, but on more than one occasion, endeavoured to explain that it is not only about the scans. I accept that that is what has been said.

The point I make is that despite that, it is not apparent what it is other than the scans. It is one thing to say that it is more than the scans, but it is not apparent what else is different. Why are we changing from 20 to 23 weeks other than because we have this extra information provided by clinicians to say that between 18 weeks and 22 weeks' gestation, it is quite common that scans are taken to identify any fetal anomaly. I accept that. My point is that if we identify a fetal anomaly and that is the key driver behind this change, because what other driver can there really be—it cannot be about access because presumably the whole point of this bill by the government is to stop the scenario in which people are allegedly going interstate. There is already significant access in Western Australia. There will be even more access moving forward because the panel has been removed. The panel is no longer a barrier. All that is left in the case of a serious fetal anomaly being identified is a decision as to whether one or two doctors are involved. As I said earlier, it may be the case that that causes offence to doctors in the house, but I would just put to members that if that same fetal anomaly is identified and a decision is made a few short weeks later, two doctors have to be involved.

I have not been provided a response by the minister for why a 24-week case of anencephaly warrants the involvement of two doctors. Do not get me wrong, deputy chair and members, I support the involvement of two doctors. I am not making a case for there to be one doctor involved in the case of anencephaly at 24 weeks' gestation. I am not making that case. Others may want to, but that is not the proposal before the house. We have a system under the government's bill that will mandate that two doctors are involved from 23 weeks onwards. The question that members should ask themselves is why. What is so special that it would warrant the involvement of two doctors? One of the reasons that I might offer is viability. That makes sense. As members of Parliament, we are saying that we know that if these unborn humans are born from 22 weeks onwards, they are viable and can survive, so we want to take a different approach. We want to give special consideration and have extra circumstances considered and we would like the benefit of having two doctors involved. I assume that is why the government and members support a different regime from 23 weeks onwards. If there is another reason why we want two doctors to be involved after 23 weeks, I am open to be persuaded by members, but during the course of this debate I have not heard of any other explanations as to why two doctors are involved from 23 weeks onwards. I am left with the information provided by the honourable minister that significant weight has been put towards the existence of scans between 18 and 22 weeks. The scans are not for sex selection but for determining the existence of fetal anomalies. It follows that if this "awful" decision has to be made any time after 18 weeks actually and a scan has been provided, that the family would benefit from two doctors being involved just as they are from 23 weeks onwards.

Hon MARTIN PRITCHARD: This is not a question but just a quick statement. Reflecting on the advice of the Chair of Committees and taking the opportunity to read the uncorrected *Hansard* from last night, I would like to

say that I made a mistake about one aspect of Hon Ben Dawkins' contribution on his amendment. I was wrong to suggest that he implied that there would no longer be abortions after 20 weeks and I apologise for that part. However, I will still not be supporting his amendment.

Division

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

Ayes (4)

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

Noes (27)

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

Amendment thus negatived.

Hon NICK GOIRAN: We have dealt with the first of the amendments on the supplementary notice paper and the following two now fall away. The next amendment on the supplementary notice paper, at 18/8, stands in my name. Before I move that amendment, I note that it pertains to page 9, line 13 of the bill and proposed section 202ME, "Performance of abortion by medical practitioner at more than 23 weeks". Before we get to proposed section 202ME, I will continue to ask a few questions on the two preceding proposed sections—that is, proposed sections 202MC and 202MD, just to assist the deputy chair with the management of the bill.

I take the Leader of the House back to where we were prior to the amendment being moved, when we were considering the information she kindly provided to the chamber earlier this afternoon. One document was on the impact of data collection changes on the triennial report. The Leader of the House kindly tabled a document that set out the changes to form 1 under the bill—the reporting information—and also the triennial report. I indicate that I am yet to receive a copy of that tabled paper; I think it was the last of the ones provided by the Leader of the House. I have been provided with a copy of the statistical information on abortions in WA from 2018 to 2022—that is, the last five years—and the list of organisations and bodies invited by the Department of Health to make a submission to the abortion consultation in 2022. I thank the Leader of the House for providing that information, and I thank the deputy chair for arranging such an efficient way for that other tabled document to now be provided to me! I want to conclude the consideration of the issue of the triennial report. As I said, I thank the Leader of the House for providing five years' worth of data. Is it intended that the triennial report for 2019 to 2021 will still be prepared?

Hon SUE ELLERY: I am not able to give the honourable member a precise answer. The decision is still with the Chief Health Officer on whether he will do that. No decision has been made just yet.

Hon NICK GOIRAN: I am happy to take this by interjection. If a report is to be provided and these arrangements have not yet commenced, it is reasonable for us to expect that the report will be similar to the previous triennial reports. If it is prepared after these new arrangements are in place, it will be in a modified form, as that was the explanation provided in the tabled paper.

Hon Sue Ellery: I expect that to be the case, but I have no further information than what I have already given the honourable member.

Hon NICK GOIRAN: The final outstanding matter that was taken on notice concerns the State Coroner. There may have been some misunderstanding. I asked whether the coroner was consulted. The Leader of the House indicated yesterday that that was the case and she reaffirmed that point today. The Leader of the House indicated today that the coroner was not the only person consulted, but the communication on that consultation cannot be tabled. My question still remains about the coroner's recommendations, not the consultation on this bill.

Hon Sue Ellery: I know what you are referring to.

Hon NICK GOIRAN: Can that be provided?

Hon SUE ELLERY: I am advised that the advice from the Attorney General is that, no, we are not in a position to provide the honourable member with that information.

Hon NICK GOIRAN: I will take it up at another time. I do not understand why the Attorney General has said that to the Leader of the House or the advisers, given that he told Hon Peter Foster's committee—a point we discussed a little earlier this afternoon during consideration of committee reports—that the reason it could not be provided

at that time was that it had yet to be deliberated by cabinet. The implication was that once it had been deliberated by cabinet, it could then be publicly released. Having pursued this issue for some three years, including by way of a parliamentary petition, and now at the pressing point of needing to decide about the coroner's jurisdiction in these matters, I do not understand why that matter is not going to be released to us. We will take that up at the relevant clause.

Going back to proposed section 202MC, during the consideration in detail stage in the other place on 15 August, the member for Vasse asked the health minister questions about whether any pain relief is given at the 13-week gestational level and above. The response by the health minister was —

> There is no indication that birth in itself is a painful process …

I refer to a 2020 study in the *Journal of Medical Ethics* titled "Reconsidering fetal pain". The researchers recommended —

> Fetal analgesia and anaesthesia should thus be standard for abortions in the second trimester, especially after 18 weeks when there is good evidence for a functional connection from the periphery and into the brain.

In light of that study, is it the case that pain relief is given in Western Australia after 13 weeks? The context, of course, is that proposed section 202MC will allow a medical practitioner to perform an abortion at no more than 23 weeks.

Hon SUE ELLERY: The first point, of course, is that I do not have a copy of the study that the honourable member referred to. I believe him when he said that he was quoting from its findings, but we do not have a copy of it, so I take it on face value. I can tell the honourable member that the position in Western Australia is based on the advice of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which is that by studying the neural pathways and brain development of the fetus, the scientific community has determined that the fetus cannot perceive pain as a noxious stimulus before 23 to 24 weeks' gestation. Prior to this time, the nervous system is not developed enough to perceive noxious stimulus as pain. Guidelines for abortion procedures take this into account. It should be noted that sedation and pain relief given to the mother will cross the placenta and also act to sedate and anaesthetise the fetus. It is for this reason that maternal morphine and midazolam is used at King Edward Memorial Hospital for Women. That ensures that the fetus is always treated with due care and respect. The American Society for Maternal–Fetal Medicine stated in its 2021 paper that the use of analgesia and anaesthesia for maternal–fetal procedures makes it clear that the experience of pain is dependent on specific development of the nervous system, which is not present prior to the late second or early third trimester at 23 to 24 weeks. As I said, this position is supported by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Hon NICK GOIRAN: All of which is to say that under proposed section 202MC, which authorises a medical practitioner to perform an abortion on a person who is not more than 23 weeks, pain relief is not given to the unborn baby. I heard what was said about pain relief being provided to the mother. Does it follow that for abortions performed by a medical practitioner at more than 23 weeks under proposed section 202ME pain relief is provided?

Hon SUE ELLERY: I am advised that the practice in Western Australia at King Eddy's is based on the fact it is feticide. If the mother decides otherwise, for reasons that we canvassed before, a decision is made based on the circumstances of what is happening in the theatre at that time. It may be the case that if the mother has not chosen feticide and the birth occurs, a clinical judgement will be made on what is the best way to provide immediate care to that child. That may include pain relief or some of analgesia. It will depend entirely on the clinical circumstances.

Hon NICK GOIRAN: That seems to exclude pain relief being provided when feticide occurs.

Hon SUE ELLERY: Yes. In feticide, the fetus is dead. There is no need to provide pain relief. If I anticipate the member's next line of questioning, the answer is no. There is no pain relief when feticide applies.

Hon NICK GOIRAN: I accept that that is the outcome with feticide, but the performance of feticide on the unborn baby may, I take it, involve pain, depending on the gestational age of the unborn baby.

Hon SUE ELLERY: To be clear, when the feticide practice is used, it is normal practice to provide the mother with some form of analgesia or sedation, and that goes through the placenta to the unborn child.

Hon NICK GOIRAN: For the benefit of members, I indicate that I have no further questions about proposed section 202MC, and I move to proposed section 202MD. I note that this does not prevent members from going back to that proposed section to ask further questions if they wish. Proposed section 202MD looks at incorporating a group of registered health practitioners to be involved in phase 1 abortions or those done prior to 23 weeks. The definition of a prescribing practitioner is a person who —

> (a) is authorised under the *Medicines and Poisons Act 2014* to prescribe an abortion drug …

It also goes on to state —

> (b) is prescribed by the regulations for the purposes of this definition.

Who are the registered health practitioners it is intended will be able to prescribe other than those captured under proposed section 202MD(1)(a)?

Hon SUE ELLERY: It is anticipated that we would include only nurse practitioners or endorsed midwives in those regulations, but their scope of practice is such that they could only be included in that list for terminations that are performed up to nine weeks. There is no intention to add anyone else. For those that the proposed section intends to add, it is within their scope of practice, which is up to nine weeks. If that is helpful, that is the Therapeutic Goods Association guidelines.

Hon KATE DOUST: With the addition of two categories of practitioners, and that earlier provision about the restricted period of time, are they mainly being added to perhaps provide better access in remote or regional areas or will they also be able to perform that function in the metropolitan area as well?

Hon SUE ELLERY: It is not just about rural or remote. It is also important to note that these practitioners are already authorised under schedule 4. However, it is generally about improving access. It will include rural and remote, but it is not limited to that.

Hon MARTIN ALDRIDGE: This is an area I talked about at length in my speech at the second reading stage, and I highlighted that it was an area of interest. Subsequent to that, the health minister's office reached out to me and arranged a meeting with Dr Zoe Bradfield, a nurse, midwife and academic at King Edward. She is also the vice-president of the Australian College of Midwives. She addressed a lot of the practical questions that I wanted to understand about the application, scope of practice, the ability to order diagnostics and a range of other things. I was also interested in the interaction between a midwife and the abortion process. That relationship would probably happen later in a pregnancy, although I appreciate that there are circumstances in which people are on their second, third or other pregnancies and may have an established relationship with a midwife at that point. My question is about proposed section 202MD, which states —

(1) In this section —

prescribing practitioner means a person who is a member of a class of registered health practitioners that —

(a) is authorised under the *Medicines and Poisons Act 2014* to prescribe an abortion drug; and

(b) is prescribed by the regulations for the purposes of this definition.

Is my understanding correct that a prescribing practitioner needs to meet both limbs, in that they need to be authorised under the Medicines and Poisons Act and be prescribed by the regulations?

Hon Sue Ellery: By interjection, yes, honourable member.

Hon MARTIN ALDRIDGE: Okay. Why is an authorisation under the Medicines and Poisons Act 2014 not sufficient?

Hon SUE ELLERY: Essentially, there are two reasons. Firstly, medicines can be used for a variety of purposes so a person may be authorised under the Medicines and Poisons Act to prescribe an abortion drug but that particular drug may not be just for the purposes of abortion. It is adding an additional layer of accountability so that we are specifically saying, for abortion care, that is the test they have to meet. The formal explanation is that the Medicines and Poisons Act provides the class of registered practitioners who can prescribe a scheduled drug. Any authority to prescribe what is confirmed under the Medicines and Poisons Act is done so by broad schedule classification only—not a specific drug, but the entire schedule. For example, currently, the act provides that a medical practitioner, nurse practitioner or endorsed midwife can prescribe a schedule 4 medicine. This includes any medicine in schedule 4 and so would not exclude one that may or may not be used for abortion. A drug can be included in more than one schedule and can be prescribed for any number of medical uses. For example, this is the case for MS-2 Step, which, prior to 2012, was approved in Australia only for the treatment of gastric and duodenal ulcers. It is about adding an extra level to the provision of this particular form of care.

Hon MARTIN ALDRIDGE: Thanks, minister. That makes sense. I mentioned the Therapeutic Goods Administration approval in my contribution to the second reading debate. The TGA amended its previous decisions and approval of MS-2 Step, which I understand is the common abortion drug that is used. It extended it to nurse practitioners and endorsed midwives and therefore the relevance of this section before us. Is my understanding correct that jurisdictions beyond Australia authorise the use of MS-2 Step after nine weeks of pregnancy? I ask that because we are talking about nine weeks now but obviously if a TGA decision occurs in the future that it is safe to use at 10, 11 or 12 weeks, will that automatically flow through to our regime as a decision of the TGA?

Hon SUE ELLERY: There were two questions. On whether other jurisdictions allow the use of MS-2 Step beyond nine weeks, the best advice is that we think, yes, in the USA, but do not take that as gospel because it is not tested. The second question was whether, if the TGA makes a decision to extend the period, it would automatically flow. It would not automatically. If such a decision was made, our regulation-making power in Western Australia gives us the capacity not to change the gestation period within which that drug could be applied by people who practice here. I am advised that common practice is that we follow the TGA rules, but we are not obliged to.

Hon MARTIN ALDRIDGE: That is interesting because my natural assumption was that if I am a prescribing practitioner, I am authorised under the Medicines and Poisons Act 2014 to prescribe an abortion drug and I am

prescribed by the regulations for the purpose of this definition. As long as I comply with the other clinical guidelines and policies, including those of the TGA and probably many other bodies, it is within my scope of practice to do so. The minister is saying that we are able to limit that by regulations. Where in the bill is the ability to provide that regulatory limitation?

Hon SUE ELLERY: It is the regulation-making power we are looking at now in proposed section 202MD(1)(b). I put the caveat again that it is anticipated we would have no reason to deviate from the TGA's position, but paragraph (b) gives us the capacity to say in our regulations that, for the purposes of this definition, a "prescribing practitioner" who is an endorsed midwife or a nurse practitioner, can dispense and administer the drug up to nine weeks. We can put a limit around it. I do not want to go down a rabbit hole because the overall caveat is that there is no reason to think we would not follow TGA advice.

Hon MARTIN ALDRIDGE: Yes, I understand that. I wanted to understand whether we have effectively outsourced the decision to make it nine weeks because I cannot find nine weeks mentioned anywhere in the bill. Whether we simply outsource it to the TGA to make a decision or retain some decision-making power, the minister is saying that this proposed section, through the regulations, can qualify it. I assume the only provision is in proposed section 202MD (1)(b) —

> is prescribed by the regulations for the purposes of this definition.

The minister is saying that the government can qualify, for the purposes of proposed subsection (1)(b), the practitioner and also circumstances such as gestational limits on whether someone is a prescribing practitioner. That is not obvious from my reading of the bill but if the minister is saying the government has the ability to say "only these practitioners have the ability to prescribe up to certain gestational limits", then I accept that.

Hon NICK GOIRAN: Further to this line of questioning by Hon Martin Aldridge, I picked up an article in *The Australian* of 17 July. It is entitled, "Peak obstetricians' body warns women at risk after abortion pill access expanded". I will briefly quote from it —

> National Association of Specialist Obstetricians and Gynaecologists president Gino Pecoraro said allowing nurses to prescribe the abortion pill would see "lesser trained practitioners" handing out the medication.
>
> "You can't just start something like this, you have to have all the infrastructure in place to deal with all of the complications and it may simply be that it's just not safe to do this everywhere," he said.

The article goes on to say —

> Dr Pecoraro said he had been called in to help save the life of a 40-year-old woman earlier this year who was flown in from regional New South Wales after being prescribed …

The medicine—I apologise, minister. My notes are cut off at this point, so I will stop there in terms of quotes. My staff will be thrilled that the quote was cut off when they read this in *Hansard*. The point is, have any of those concerns about bringing in what is being described here by the specialist as "lesser-trained practitioners" been raised with the government in regard to proposed section 202MD?

Hon SUE ELLERY: While the advisers are considering advice, I will advise the member, and perhaps ask Hon Dr Brian Walker to close his ears. This is an old chestnut about what nurse practitioners, in particular, can do. I say that from the perspective of someone who worked for the Australian Nursing Federation. I was involved in debates about scope of practice for nurse practitioners and how there was a view amongst some in the medical profession that the sky would fall down and the end of the world was nigh. It has long been the case that nurse practitioners, like a whole range of other clinicians, operate within the scope of their practice. They are required to be registered. They are required to be highly trained. They are required to do ongoing professional development. They are required to meet any number of standards. I can formally advise that nurse practitioners already demonstrate strength in clinical assessment and health history taking and are authorised to prescribe schedule 4 drugs. Sound sexual health and contraception knowledge are essential, as is the ability to undertake women-centred counselling around these topics. They have a good understanding of the medications used in abortion and provide clear education on their use, effects and side effects.

Additionally, nurses who care for women undergoing surgical abortions must have knowledge of the perioperative patient journey. Nurses from other clinical areas often facilitate women's access to abortions. It is worth noting that the idea of midwives being involved in the abortion process was brought up by the Senate Community Affairs Reference Committee of the Australian Senate at recommendation 20, that midwives should be allowed to prescribe MS-2 Step.

The member's actual question was whether it was raised by anybody. I am advised that it was raised by the AMA during the course of the consultations. I met with the AMA specifically and I do not recall them raising that with me. I invited the AMA to listen to the debate and I would like them to close their ears at this moment. This is an old chestnut. I do not mean to diminish or belittle the proposition put, but nurse practitioners have long been providing complicated and complex care within the scope of practice.

Hon NICK GOIRAN: The point is that the government is aware of the debate, the concern or views, and has considered it and has landed where it has. Later in that article, where I do have the further quote, the president of the National Association of Specialist Obstetricians and Gynaecologists said —

> Of all medical abortions, he estimated about 5 per cent resulted in complications.

The article goes on to say —

> "Someone could die because of this," he said.

Is there any data that has been collected in Western Australia? The context here is that he said he was called to save the life of a 40-year-old woman from regional New South Wales. Is there any Western Australian data with regard to the complication rate as a result of medical abortions? If so, I am particularly interested in any rates for the fewer than nine weeks' gestation period, in which we will be empowering this new cohort to be prescribers.

Hon SUE ELLERY: The answer to the question is no. We do not have any data, nor are we aware of any data on complications for medical abortions performed up to that gestation point. It is not that we do not have it and it is somewhere else, we are not aware of it being collected anywhere.

Hon NICK GOIRAN: Moving forward under this proposed regime, will data be obtained about complication rates and death rates in particular? I know there is going to be a different level of data provided to the Chief Health Officer based on their direction.

Hon SUE ELLERY: It is not intended for the information to be collected through the process of the directions—that we have already touched on—that the Chief Health Officer will issue. Information about deaths, for example, is collected elsewhere for other purposes, regardless of the procedure being performed. In respect of complications, it may well be, depending on the clinical setting that there are requirements around critical incidents. A critical incident or complication is not of itself a critical incident, but it depends on the circumstances. The immediate answer to the member's question is no. It is not the intention of the CHO to gather that material through the mechanism of the directions. Depending on the circumstances, it may be that that information is collected elsewhere as part of routine data collection around negative outcomes in respect of a whole range of medical procedures.

Hon NICK GOIRAN: Noting that the Chief Health Officer is yet to make a decision about what type of data will be collected, strong consideration should be given to this data being collected. We want to know if there will be serious complications that will arise. If this expert from New South Wales is saying that the complication rate is five per cent, that is not insignificant when we consider how many medical abortions are taking place. We have already ascertained that under the existing regime over the last 25 years that the significant majority of abortions take place in the earlier stages. By definition that means that the majority of them are taking place by way of a medical abortion. If five per cent have complications, I would have thought that it would be in the best interest of the Chief Health Officer and Western Australia to continue to monitor that. I make the case that that data ought to be collected. Given that some data will be collected, it should not to be too difficult to record any complications that arise—and it is even more important if a death were to occur. I make that case and I hope the Chief Health Officer in due course will give that due consideration.

My final question on proposed section 202MD, found at page 8 of the bill, is on the 23-week limit imposed on prescribing practitioners, who are registered health practitioners. What is expected to be the practice for them to be informed of the gestational age?

Hon SUE ELLERY: They will establish that by way of an ultrasound, honourable member. For them to prescribe, they need to have seen the ultrasound.

Hon Dr BRIAN WALKER: Just for clarification for the benefit of members, for every woman who presents to a medical practice and says "I have missed my period", the first thing we do is determine the date of their last period, which gives us an approximate date of confinement. That date is further qualified by the first scan. By the second scan, once we have a clearer view of the organ development, we can give a better idea. The age of gestation is found, but it is always plus or minus a few days. Every woman who has conceived will have a date attached to her name in her medical records. That is without exception.

Secondly, on a point of clarification, the honourable member mentioned that five per cent of the terminations might have a complication. One in 10 pregnancies ends in a miscarriage. They have rates of complication as well. These are things such as retaining products of conception. This is a normal process. When the implantation of the placenta separates with the loss of the pregnancy, the patient may retain products that can cause infection, inflammation and certainly bleeding. That would certainly be interpreted as a complication. When we say "complication", it is not something bad. It is simply one of those things that happens. For example, if someone gets a boil after a simple injection, it is a complication of the injection. It can be life threatening but it is something we would expect. Every single procedure in medicine has a potential for complication. That is a normal aspect of medical life, which is why we are so heavily regulated. Things can go wrong.

We even have a measure of development within society of maternal mortality. The greater the maternal mortality, the less developed are the health services. Even in well-regulated and well-developed health services, we have

a significant rate of maternal mortality. This is a normal part of pregnancy. This is why we need to be careful about this. Questions about abortion and death rates—this happens throughout normal pregnancy as well. The member makes a big deal of it, but it is a normal part of life. We need clinical considerations at all times regarding what we are doing with a woman at this time under these conditions. The complication rate may be a red herring. It is not something to be worried about but members should take note that these things can happen.

The member mentioned nurse practitioners, who do a fantastic job and I am very much in support of that. I must tell members that very often the nurses put out their hand and stop the doctor from doing something they should not do, because we can get some pretty stupid actions. By the grace of God go most doctors, and nurses hold them back from doing something stupid.

Hon Kate Doust: Just as well as there are some regulations in place.

Hon Dr BRIAN WALKER: Indeed, that is so. This is why we need qualifications and people maintaining standards and working as a team. People need to respect each other as part of a team all doing different jobs but working together. The concept here around abortion is not of one person making decisions; it is the whole team. Bearing in mind the natural progress of a pregnancy against the method here of abortion, each one would have particular problems that might be associated with a particular approach used. For example, with progestin to be given intravaginally to stimulate delivery, we get a normal delivery of a very underdeveloped foetus, but things can still go wrong. It needs to be regulated and that is why we have such strict controls.

Hon KATE DOUST: Minister, I am just going to start to ask a few questions leading up to moving a couple of the amendments I have on the supplementary notice paper. I am not planning on moving them right now, but I refer in particular to division 2 and proposed sections 202MC and 202ME. One of the amendments I have on the supplementary notice paper is in relation to sex selection. I made reference to that in my second reading debate contribution. There is a range of reports around sex selection as an issue in the world. I was looking at a report today from the United Nations Population Fund, Asia and Pacific region, 2012. It referred to the increase in sex selection being used and creating an imbalance in gender throughout the world in quite significant numbers. It references that globally there are about 117 million missing girls because of sex selection abortion and a preference for male children.

I know that sex selection has been banned in Australia, since, I think, the early 2000s. I am not sure whether it is just anecdotal information from doctors or whether formal data has come out of other states. I am wondering whether there is any type of information or data in the Western Australian health system. Have doctors reported formally or provided anecdotal information that women have sought an abortion for gender selection at the earlier stage, phase 1, which is currently up to 20 weeks? I want to be very clear, minister, that it is not for sex selection purposes when there may be an inherited family disease, because that is a different issue. Even the amendment that I have put on the supplementary notice paper includes that but not in a negative way. Really, it is about the question of whether people have requested an abortion for the purpose of gender selection—whether they have a preference for males or females. I am interested to know whether there has been any reporting in Western Australia.

Hon SUE ELLERY: The short answer is no. Clinicians who provide abortion care, including those who provide it at later gestations, advise there is no evidence of that. The short answer is no.

Hon Dr BRIAN WALKER: Here I can give the member an answer directly because I have been approached by women who wanted sex selection.

Hon Martin Aldridge: Hmm.

Hon Dr BRIAN WALKER: “Hmm” indeed. We find that those who choose to do that come from a certain social grouping in which the birth of a boy child is far preferable to the birth of a girl child. I have refused to take this further, as I hope every single other doctor in this country also has. It is entirely unacceptable, but it points out an area of concern. I will refer, if I may, to another horror in our nation, which is female genital mutilation. I cannot think of a single doctor who would actually go through with that. However, there are doctors who come from a country where female genital mutilation is accepted and, in fact, demanded and supported, who, behind closed doors, might secretly perform that procedure, but when they are reported and found, they are disbarred from practice, as they should be, because that is entirely unacceptable. The same thing, I believe, is also true for anyone who would consider doing a secular abortion based on the choice of the sex of the unborn child. It is true that in places like India and China that has taken place, and it is to be condemned entirely; it is not part of Australian culture at all. As far as I am aware, our law is such that a request for such a selection would be refused by any gynaecologists that I know of.

Hon KATE DOUST: Thank you for that, member. That was very helpful.

I do not think a single person in this place would support gender selection simply for that preference model, if you like, in any way, shape or form. I pick up on the member’s point that, sadly, it has been based upon particular ethnic groups. That, in fact, was the focus of the report that I looked at. I note that friends of mine who have come from some of those countries have talked about their own experience of having been taken to an ultrasound and pressure was applied to them if they were not carrying the right gender. The nature of technology has changed and advances

have been made in both accessing scans and the imagery of the scans that assist in identifying the gender of a child earlier. It used to be roughly around 16 weeks when someone who asked could expect to be told what the gender was. I do not know whether that time has been brought forward because of the changing technology. I have raised that a couple of times over the last couple of days. The report that I looked at talked about the fact that because technology has advanced and is much cheaper to put into not only hospitals, but also smaller clinics and other places, that has enabled better access and it has become more affordable for individuals to get that information. My concern about changing the goalpost from 20 to 23 weeks when a woman can seek an abortion without having to provide a different justification when it is life threatening to the child or themselves—I will keep it in those simple terms—perhaps gender selection either will or is happening and we just do not know it and perhaps doctors are not reporting it. I have a series of questions around that. Is there a guideline in Western Australia, or a document from the Chief Health Officer or the department, that provides guidance to doctors or medical practitioners about how to deal with the question that is put to them by a pregnant woman who wants gender selection as a reason for an abortion? Is there information about how to manage that?

Hon SUE ELLERY: No, honourable member.

Hon KATE DOUST: I only ask that because I am pretty sure that Queensland and New South Wales have quite detailed guidance notes around a whole variety of termination issues. The gender selection issue was quite interesting to see, particularly in New South Wales. I might just find the document because it goes into a whole range of detail. It is titled *Prevention of termination pregnancy for the sole purpose of sex selection*. It is from the New South Wales government and was published in June 2021. It is a fairly straightforward document. It is only a couple of pages. It talks about the key principles in New South Wales pertaining to this particular issue. I will quote select parts of it. It says —

> The NSW Parliament has opposed the performance of termination of pregnancy for the sole purpose of sex selection.

The Parliament has been very clear, not just the government. I think we have seen that also in South Australia, which is one of the reasons I have put my amendment on the notice paper. The document goes on to say —

> This Guideline relates to when a termination of pregnancy is sought for the sole purpose of sex selection. This Guideline does not apply to a termination due to the possibility of a sex-linked medical condition in the fetus.

I have already said in my earlier comments that that is an entirely separate issue, in my view. The guideline goes on to say —

> Before performing a termination of pregnancy, it may be disclosed to the medical practitioner that the reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the practitioner **must not** perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety.

Towards the end of the document, it says —

> When a termination for the sole purpose of sex selection is refused, the medical practitioner must offer additional support and referral to counselling or other relevant services.

We are told that those situations have not been formally reported in Western Australia. If the New South Wales Parliament, and obviously the New South Wales government, has taken the hard decision on this aspect—I think there is a reference of a similar nature to it in Queensland—will the Western Australian government, given the shift in the time line to 23 weeks, clarify for medical practitioners what to do in that circumstance? It may be that our good friend Hon Dr Brian Walker is not alone in his experience, and for some reason it is just not something that doctors think they should report or can report or know how to report or seek guidance on. I imagine it would be a pretty tough position for a doctor to be put in when that question is put to them. I will wait for the answer to my question about whether the government will contemplate putting some sort of guideline in place in a similar vein to that which exists in New South Wales currently.

Hon SUE ELLERY: I am advised that there is no intention to issue a guideline along the lines the member referred to. There is an amendment on the notice paper, and we will be able to debate that when we get there, but there is no intention or plan to do that, which is not to say it will never happen.

Hon KATE DOUST: I know that the amendment has been proposed. The minister has already indicated that the government will not support any of those amendments. In light of that anticipated outcome, will the government give consideration, in the absence of a requirement in the legislation, to provide a guideline?

Hon SUE ELLERY: There is no intention to do that, honourable member. That does not mean it will not happen at some point in the future. The advice available to me here at the table right now is that there is no intention to provide that specific guideline. The advice available to me is that in the clinical advice sought on the bill, clinicians did not report that being an issue. That does not take away from Hon Dr Brian Walker's experience. I believe him when he said that is what a patient presented to him. However, the best available advice to me is that clinicians

did not indicate that that was an issue for them and there is no intention from the Chief Health Officer at this point to issue any guidelines. That might change at some point in the future, I do not know, but there is no intention at this point.

Hon KATE DOUST: I understand the minister saying that clinicians did not indicate that this was an issue. Were clinicians actually asked the question? Was the question about this situation posed to clinicians?

Hon SUE ELLERY: Yes, honourable member.

Hon NICK GOIRAN: I will move the amendment standing in my name. Before I do, I will respond to the worthwhile dialogue that was just taking place there. I will say to Hon Kate Doust that as a point of hope, we need to remember that there has already been a principle established earlier in this bill that it is important to include things for the sake of clarity and safety, including things like defining the term “person”. One would hope that when we get to the relevant amendment about sex selection, most members will support it as a matter of safety and clarity. It would do no harm because, apparently, this is not a practice that we need to be concerned about and it is a practice that nobody supports. There could not possibly be any harm in including the amendment for the sake of clarity and safety, given that we have gone to the extent of even defining what a person is. I move —

> Page 9, line 13 — To delete “circumstances.” and insert —
>
> circumstances; and
>
> (c) the primary practitioner, or a medical practitioner consulted under paragraph (b), holds specialist registration in obstetrics and gynaecology under the *Health Practitioner Regulation National Law (WA) Act 2010*.

By way of explanation to members, proposed section 202ME deals with what can be described as late-term abortions. Members will be well aware that under this proposed regime, any two doctors will be able to, and will need to, be involved. My brief submission in support of the amendment that is currently before members is simply to quote from the AMA’s position statement regarding this particular clause. It states —

> Clause 202ME—Specialist skills required to perform post-23 week abortions, should be prescribed in the Bill.
>
> Abortion after 23 weeks gestation is a highly specialised procedure which if performed without adequate expertise, can be dangerous and traumatic.
>
> **It should always involve at least one specialist obstetrician and gynaecologist and the Bill should be amended to expressly refer to this.**

Hon SUE ELLERY: I will indicate that the government will not be supporting the amendment. I think it is important to note at the outset that it is not common practice to stipulate specific specialties in any health-related legislation. We do not see abortion as being any different. All medical practitioners are required to act within the scope of practice at all times. In addition, medical practitioners are well versed in referring a patient to another practitioner if they are not able to provide the appropriate level of care. The current WA act does not stipulate a particular specialty. The majority of other Australian jurisdictions do not stipulate a specialty in their respective legislation. There is no evidence to suggest that non-specification has led to unqualified practitioners providing abortion procedures.

We are relying on the established mechanisms as we do for the provision of any other of any other health care to ensure that safe clinical practice is maintained. If there are concerns about a particular practitioner, they can be investigated by the relevant bodies such as the Australian Health Practitioner Regulation Agency and Health and Disability Services Complaints Office or, if it relates to criminal conduct, by the Western Australia Police Force.

The medical practitioner best placed to advise on a particular case may vary. It could include a whole range of practitioners such as oncologists, geneticists, psychiatrists or a person’s known practitioner in another field. It may be useful to receive advice on a particular condition or on the relevant medical history of the patient. Rather than technical medical advice, detailed knowledge of the particular patient and their circumstances, medical history, responses to particular drugs and behaviours may be required. For these reasons, we will not be supporting the amendment.

Hon MARTIN PRITCHARD: I have seen some comments regarding the advice of the AMA. If this amendment went through, it would not necessarily require the person performing the abortion to have that. It could be the consulting practitioner. It will not actually address the concerns of the AMA, or am I looking at that wrong?

Hon NICK GOIRAN: I am happy to assist the member. In its submission talking about late-term abortions after 23 weeks, the AMA stated that they should always involve at least one specialist obstetrician and gynaecologist and that the bill should be amended to expressly refer to that. In its submission, it did not say whether it should be the primary practitioner or the consulting practitioner. Accordingly, when I briefed parliamentary counsel, the member will see that the words proposed to be inserted are that the primary practitioner or a medical practitioner consulted under paragraph (b) hold the relevant specialist registration.

Division

Amendment put and a division taken, the Chair of Committees casting his vote with the noes, with the following result —

Ayes (8)

Hon Peter Collier	Hon Kate Doust	Hon Martin Pritchard	Hon Neil Thomson
Hon Ben Dawkins	Hon Steve Martin	Hon Tjorn Sibma	Hon Nick Goiran *(Teller)*

Noes (24)

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

Amendment thus negatived.

Hon KATE DOUST: I will just pick up one of the other points raised by the Australian Medical Association (WA) in the emails that I think most members received, as well as in its position statement. The link back to the bill is proposed section 202ME(4)(a), which states —

> the principal place of practice (as defined in the *Health Practitioner Regulation National Law (Western Australia)* section 5) of a medical practitioner with whom the primary practitioner consults need not be in Western Australia …

The AMA was quite clear in its email and document, stating —

> There is no sound clinical justification for permitting the medical practitioner with whom the primary practitioner consults for the purposes of Clause 202ME (1)(b), to have a principal place of practice outside Western Australia.

Can the Leader of the House explain whether it is a new arrangement to enable that person to consult outside Western Australia?

Hon SUE ELLERY: No, it is not, honourable member; it is just that the existing legislation does not refer to it at all. From time to time, a practitioner might need to consult somebody from a different jurisdiction. It has been inserted into the bill before us to make it clear that that is not prohibited. That does not mean that it has to be done; it just means that it is not prohibited. For example, I referred earlier to the need to understand a patient's history, so consultation might need to occur with somebody who used to provide care in another jurisdiction or who used to provide care here but is now in another jurisdiction. It could be for a range of reasons. It might be that the best person to consult in a particular area of speciality is in another jurisdiction. We would not want to limit getting the best advice based on the jurisdiction. I am advised that it is not new in the sense that it is precluded now and will be allowed in the future; the current legislation is silent on it.

Hon KATE DOUST: I know that the Leader of the House will correct me if I am wrong, but am I correct in thinking that situations in which a primary practitioner might seek advice from a different type of practitioner elsewhere will apply only for post–23 weeks abortions or will it also apply to pre–23 weeks abortions?

Hon SUE ELLERY: Under the bill before us, people will not need to consult two practitioners for abortions up to 23 weeks. That does not mean that a single practitioner might not seek advice from a colleague—they might, and they might be interstate. The provisions that we are talking about sit within proposed section 202ME, "Performance of abortion by medical practitioner at more than 23 weeks". Proposed subsection (4) at the bottom of page 9 is in reference to abortions performed at more than 23 weeks, because that is when two practitioners will be required. Proposed subsection (4)(a) specifies that the second medical practitioner will not need to reside in Western Australia. Nothing will prohibit a practitioner who is going to perform an abortion prior to 23 weeks from picking the brains of a colleague who resides elsewhere if they think they need assistance or clinical advice. Nothing will stop them from doing that.

Hon KATE DOUST: Proposed section 202ME(4)(b) states —

> if a medical practitioner … does not believe that performing the abortion is appropriate in all the circumstances, this does not prevent the primary practitioner from consulting …

In what circumstances beyond 23 weeks will they not believe it to be appropriate? Is there any guidance? Is there a list of circumstances in which that might be the case?

Hon SUE ELLERY: No, there is not. It will be a clinical decision. It could be any number of things, as the honourable member can imagine. All kinds of reasons could lead to late-term abortions. It could be a situation with the health of the mother or the fetus, or it could be the two combined. We do not have a prescriptive list and we would not want to do that. It is about the best care for the patient in the circumstances in which the patient presents at that time.

Hon NICK GOIRAN: Further to this line of questioning, the Leader of the House has indicated on a few occasions that access is important. That has been part of the thrust behind this bill. Part of that has been the anecdotal evidence provided to the Leader of the House and others that some people go interstate. Under this regime, there will be no reason for anyone to go interstate for a phase 1 abortion, but there may be a reason for someone to go interstate for a late-term abortion if they cannot get two practitioners to agree that they reasonably believe that performing the abortion is appropriate in all the circumstances. That could be a possibility. I know that is a concern for the Leader of the House and the government; that is part of the reason the government brought this bill forward. Hon Kate Doust asked for examples of why a medical practitioner might consider that it is not appropriate. I would have thought that the government would have contemplated that. If that circumstance arises, the government will fear that people will go interstate. The Leader of the House can correct me if I am wrong, but she might say that one circumstance that the government feels passionate about is sex selection. She might say that the government's view is that neither the primary practitioner nor the consulting practitioner could or should reasonably believe that it is appropriate to perform an abortion for sex selection reasons. The Leader of the House and the government might hold that view, but that will mean nothing if no guidance is provided to practitioners. It will mean something if the amendment that will be moved in due course gets up. I would like to know what other scenarios the government is concerned might still lead to Western Australians purportedly needing to go interstate.

Hon SUE ELLERY: As I indicated to Hon Kate Doust, I do not have a list. We have not prepared a list. If the honourable member wants to put it in some context, we already know that only a very small number of abortions are carried out post–23 weeks in any event.

The prospect that within that small number there is a sufficient number of people who will not be able to find the two practitioners, including one who might be practising in another jurisdiction, is very small. Nevertheless, it might exist. We have not contemplated the list because we have determined that this is about putting the patient at the centre. What are the circumstances that the patient presents with? That is what we need to consider, and a clinical judgement needs to be made about that every single time. I appreciate the line of questioning, but I am not in a position to come up with a list of examples. It would depend entirely on the clinical circumstances that the woman presents with.

Hon Dr BRIAN WALKER: Can I verify for the benefit of all members here that the current mood in the medical profession is that selecting sex as a reason for an abortion simply does not come into the equation. It is not something that we would contemplate or permit, or that would even come into our consciousness, because it is utterly irrelevant for the purposes of an abortion. It is not part of our social circumstances. It might have been said earlier that doctors have not raised this as a problem, but that is because it is actually not a problem. If a woman comes to us and says that their 16-week ultrasound showed that they are having have a girl and they want to have a boy so they want to have an abortion, not one of my colleagues would say, "Yes, we'll refer this woman for an abortion." It does not come into the equation. It is not something we would ever take into account. It does not feature within the medical profession because it is irrelevant, as far as I am aware. I am happy to stand corrected if anyone has another experience, but this is my experience within medical practice in not just Western Australia, but all the countries that I have worked in. It is just not the case. We do not refer mothers to have an abortion simply for the purposes of sex selection. That just does not happen.

Hon MARTIN PRITCHARD: In contemplating this, I am aware of the isolation that we have in this state and the reliance on telehealth. In the debate on clause 1, the minister touched on that issue. I am inclined not to support this amendment based on that. Can the minister expand on that at all?

Hon SUE ELLERY: If I understand the honourable member correctly, his question is: to what extent does this impinge on the question of access? Every time we add another layer of regulation, we add to the complexity of the process for people living outside metropolitan Perth. That is one of the factors that would impact on access. One of the main drivers of the government's opposition to this particular amendment is that if we do not require this for other forms of health care, why would we require it for this particular kind of health care? But the member is right to raise it as an issue. Every time we add another layer of something that someone has to do, we know that it is harder to do the further a person is from the metropolitan base.

The CHAIR: Just so that everyone is aware, we are dealing with clause 8 of the bill. I will allow some latitude for debate to occur around foreshadowing amendments, but if we are going to get into detail on an amendment, my preference is that we move to debate the amendment. The question is that clause 8 do stand as printed.

Hon KATE DOUST: We will not have much time as something else is coming along shortly, but the first tranche of amendments that I have on the supplementary notice paper—have I missed something?

The CHAIR: You have the floor, Hon Kate Doust.

Hon KATE DOUST: Sorry; I was just being distracted by hands waving and people talking.

Hon Sue Ellery: Ignore them.

Hon KATE DOUST: Thank you. As I was saying, the first formal amendments that I have on the supplementary notice paper are very much linked together, so I was hoping, minister, to seek the chamber's indulgence to move them en bloc and to talk to them. The first amendment is a linking amendment to enable the second one to be moved,

and the third one is the substantive change that is being proposed. I refer to amendments 3/8, 4/8 and 5/8. I am happy to move them and read them out if people are happy to deal with them en bloc. I will do that to deal with them perhaps more expeditiously and because it makes more sense to manage them in that way.

The CHAIR: The first step of the process, Hon Kate Doust, is to seek leave of the committee to move the three amendments together and if leave is granted, you can move the three amendments.

Hon KATE DOUST — by leave: I move —

Page 9, line 23 — To delete "abortion." and insert —

abortion; and

Page 9, after line 23 — To insert —

(d) without limiting paragraphs (a) to (c), the matters referred to in section 202MEA.

Page 10, after line 12 — To insert —

202MEA. Mandatory considerations for performance of abortion by medical practitioner at more than 23 weeks

For the purposes of section 202ME(2)(d), the matters to which a medical practitioner must have regard are as follows —

(a) whether it is essential to perform an abortion of an affected foetus in a multiple pregnancy at a gestation that does not risk severe prematurity and its attendant consequences for the surviving foetus;

(b) whether there are serious foetal abnormalities that were not identifiable, diagnosed or fully evaluated before the pregnancy reached 23 weeks, including but not limited to abnormalities involving the brain, heart, renal and skeletal systems, or whether the foetus has been exposed to infective agents which may damage or limit the gestation and development of the foetus;

(c) whether the person on whom the abortion is to be performed (the ***patient***) has had difficulty accessing timely and necessary specialist services before the pregnancy reached 23 weeks, including but not limited to patients experiencing significant socio-economic disadvantage, cultural or language barriers and those who reside in remote locations;

(d) whether the patient has been denied agency over the decision to continue a pregnancy or not, including (but not limited to) the abuse of minors and vulnerable adults to sexual and physical violence including rape, incest and sexual slavery;

(e) whether the abuse outlined in paragraph (d) includes circumstances in which such abuse is not apparent, or the pregnancy is not diagnosed until an advanced gestational age;

(f) whether medical or psychiatric conditions of the patient may become apparent or deteriorate during the pregnancy to the point where they are a threat to the patient's life;

(g) whether the patient has a deteriorating maternal medical condition, or late diagnosis of a disease requiring treatment incompatible with an ongoing pregnancy (such as malignancies).

The CHAIR: Hon Kate Doust has moved amendments 3/8, 4/8 and 5/8 standing in her name en bloc. The question is that the words to be deleted be deleted. Noting the time, I am going to leave the chair for the taking of questions.

Committee interrupted, pursuant to standing orders.

[Continued on page 4512.]

QUESTIONS WITHOUT NOTICE

GRIFFIN COAL — LIQUIDATOR

1017. Hon Dr STEVE THOMAS to the minister representing the Minister for State and Industry Development, Jobs and Trade:

I refer to the answer to question without notice 992, asked yesterday, on the appointment of administrators and receivers to the insolvent Griffin Coal in September 2022 in which the government acknowledged that Treasury officials had met with Sternship Advisers about Griffin Coal.

(1) What contract or contracts, if any, did Treasury or the government have with Sternship Advisers when the assistant Under Treasurer for agency budgeting and governance met with it in February and April 2023?

(2) What was the value of any contracts the government had with Sternship Advisers in relation to Griffin Coal and what payments have been made to it in 2023 in relation to Griffin Coal?

(3) Has Sternship Advisers had any previous contracts with the McGowan or Cook governments in relation to the coal industry; and, if so, what were the conditions and value of the contracts?

(4) Has Sternship Advisers advised the government how to remedy the crisis at Griffin Coal; and; if so, what was that advice?

Hon STEPHEN DAWSON replied:

Thanks, President. It is not even Thursday! I thank the Leader of the Opposition for some notice of the question.

(1) Sternship Advisers was engaged from October 2022 to July 2023 to provide a commercial facilitation service between commercial parties related to Griffin Coal and strategic advice to government. That advice is confidential and commercially sensitive.

(2) The total value of contracts in relation to the coal industry, including Griffin Coal, is $626 143.96, excluding GST. In the calendar year 2023, Sternship Advisers was paid $195 295, excluding GST.

(3) Sternship Advisers was engaged from July 2019 to July 2022 to provide advice on the coal industry to government. Sternship was paid $176 500 for this contract.

(4) See the answer to (1).

GRIFFIN COAL — LIQUIDATOR

1018. Hon Dr STEVE THOMAS to the minister representing the Minister for State and Industry Development, Jobs and Trade:

I refer to the answer to question without notice 991, asked yesterday, on the appointment of administrators and receivers to the insolvent Griffin Coal in September 2022 in which the government advised that the new "process agreement" contained additional terms to the previous financial assistance agreement.

(1) Will the government please provide a list of the additional terms in the process agreement?

(2) If no to (1), why not?

(3) What additional reporting requirements have been added to the process agreement?

(4) Does the process agreement require any repayment of the grants?

(5) Why were the original financial assistance agreements not process agreements with additional, and possibly adequate, terms and conditions?

Hon STEPHEN DAWSON replied:

I thank the Leader of the Opposition for some notice of the question.

(1)–(3) The process agreement between the state and Griffin's receivers is confidential and commercially sensitive.

(4) It is the government's intention to recover the funds provided to Griffin's managers and receivers as part of any longer term commercial arrangements. It is intended that the payments will be recovered from additional revenue as a result of increased prices. Treasury has appointed Ad Astra Corporate Advisory to assist the government with discussions with commercial parties. The discussions remain ongoing.

(5) The original financial assistance agreements were short-term agreements to maintain coal supply. The new financial assistance agreement, termed the process agreement, was drafted to align with the 12-month extension of the state agreement with Griffin Coal, with the possibility of a further 12-month extension.

MINERVA FOODS

1019. Hon COLIN de GRUSSA to the Minister for Agriculture and Food:

I refer to reports of the closure of the meat processing plant operated at Shark Lake near Esperance by Minerva Foods.

(1) Has the minister received a briefing on the status of the plant from either the Department of Primary Industries and Regional Development or Minerva Foods?

(2) If so, when was the minister briefed?

(3) What actions is DPIRD undertaking to —

(a) assess the impacts on the livestock producers that utilised the facility; and

(b) identify alternative processing options, given current processing capacity constraints and prevailing market conditions?

Hon JACKIE JARVIS replied:

I thank the member for some notice of the question.

(1) Yes.

(2) DPIRD provided a briefing to me this week. I have requested a meeting with the operators of the Shark Lake abattoir.

(3) (a)–(b) It is disappointing that Minerva Foods has made a commercial decision to suspend operations at the Shark Lake facility. I am aware that other processors have increased operations to reduce the impact on WA sheep producers. Although the closure of the Shark Lake facility will have an impact on the Esperance community, it is not expected to have a significant impact on the state's red meat processing capacity as the Shark Lake operation was relatively small.

FREMANTLE RAIL LINE — LEVEL CROSSINGS

1020. Hon TJORN SIBMA to the minister representing the Minister for Transport:

I refer to railway level crossings on the Fremantle line.

(1) For each level crossing, on how many occasions daily are the boom gates activated during the working week?

(2) For each level crossing, how many cumulative minutes a day are the boom gates closed during the working week?

Hon STEPHEN DAWSON replied:

The honourable member did not even have a smile on his face!

This information cannot be provided in the required time frame. I ask the honourable member to place this question on notice.

BANKSIA HILL DETENTION CENTRE AND UNIT 18, CASUARINA PRISON — STAFF

1021. Hon PETER COLLIER to the minister representing the Minister for Corrective Services:

(1) What is the current staffing profile of Banksia Hill Detention Centre?

(2) How many staff have resigned from BHDC in 2023?

(3) What is the current staffing profile of unit 18, Casuarina Prison?

(4) How many staff have resigned from unit 18, Casuarina Prison in 2023?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. The following information has been provided to me by the Acting Minister for Corrective Services.

It is not possible to provide an answer within the required time frames, and an answer will be provided to the honourable member tomorrow.

ELECTORAL EDUCATION — REGIONS

1022. Hon NEIL THOMSON to the parliamentary secretary representing the Minister for Electoral Affairs:

I refer to page 7 of the Western Australian Electoral Commission's *Annual report 2021–2022*.

(1) How many of the 39 780 school students involved in the electoral education awareness came from the electoral district of North West Central?

(2) How many of the 17 702 participating electoral education centre interactions in term 4 came from the electoral district of North West Central?

(3) What percentage of the 108 school elections were based in the Perth metropolitan area or what percentage of students accessing online material during the reporting period were based in any electoral district in the Mining and Pastoral Region?

Hon MATTHEW SWINBOURN replied:

The member has provided no notice of this question. It was submitted after the cut-off time. His office was told that. I believe he was told that. There is no answer to that question.

ENVIRONMENTAL PROTECTION AUTHORITY — PREMIER McGOWAN

1023. Hon BEN DAWKINS to the parliamentary secretary representing the Minister for Environment:

I refer the minister to the news article dated 10 September 2023 by Kathryn Diss at the ABC.

(1) Is there a written record or file note relating to the phone call referred to in the article between former Premier Mark McGowan and the head of the Environmental Protection Authority, Dr Tom Hatton?

(2) If there is, can the minister table the record; and, if not, why not?

(3) Is the Environmental Protection Authority still an independent authority?

Hon DARREN WEST replied:

I thank the member for some notice of the question. On behalf of the Minister for Environment, I provide the following answer.

(1)–(3) The Environmental Protection Authority maintains its own independent records. The legislative framework of section 8 of the Environmental Protection Act 1986 outlines the independence of the EPA and the EPA chair.

BANKSIA HILL DETENTION CENTRE AND UNIT 18 DETAINEES — SUICIDE ATTEMPTS AND SELF-HARM AND OUT-OF-CELL HOURS

1024. Hon Dr BRAD PETTITT to the minister representing the Minister for Corrective Services:

I refer to youth justice. Will the minister please provide the following information on Banksia Hill Detention Centre and unit 18, respectively, for August 2023 —

(a) the number of suicide and self-harm attempts;

(b) the monthly average out-of-cell hours; and

(c) the number of occasions on which a young person spent 20 or more hours in their cell?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. The following information has been provided to me by the Acting Minister for Corrective Services.

The Department of Justice advises the following.

(a) This information is in tabular form. I seek leave to have the response incorporated into *Hansard*.

[Leave granted for the following material to be incorporated.]

	Attempted Suicide	**Self-Harm—Serious**	**Self-Harm—Minor**
Banksia Hill Detention Centre	0	0	21
Unit 18 Juvenile Security	0	4	30

President, there are a number of definitions, also in tabular form. I seek leave to have the response incorporated into *Hansard*.

[Leave granted for the following material to be incorporated.]

Minor Self-Harm	An act of self-harm that does not overnight hospitalisation, overnight care at a prison medical centre/infirmary or ongoing medical treatment or any other act of self-harm that does not result in injury.
Serious Self-Harm	An act of self-harm that requires either overnight hospitalisation in a medical facility (including prison clinic/infirmary), or ongoing medical treatment.

(b) In August 2023, at Banksia Hill, it was eight hours and 33 minutes; at unit 18, it was two hours and seven minutes.

(c) In August 2023, at Banksia Hill, there were 331; at unit 18, it was 410.

VARANUS ISLAND GAS PLANT — ALLEGED INCIDENT

1025. Hon WILSON TUCKER to the parliamentary secretary representing the Minister for Mines and Petroleum:

I refer the minister to the answer to my question without notice dated yesterday in which the minister advised the house that, on 22 March 2023, the government was informed of the findings of an internal investigation by oil and gas company Santos into a potential oil spill that occurred near the Varanus Island gas plant off the coast of Karratha.

Will the minister table the advice and/or report that the government received from Santos?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. As the matter is still under investigation, it is not appropriate for the report to be tabled.

CANNABIS — LEGALISATION

1026. Hon Dr BRIAN WALKER to the parliamentary secretary representing the Minister for Racing and Gaming:

I refer the minister to a recent academic paper, published in the journal *Health Policy*, which shows that for every dollar spent on legalised recreational cannabis across seven Canadian regions, a drop of between 74¢ and 84¢ was seen in alcohol sales.

(1) Is the Cook government committed to tackling the health and economic impacts of excessive alcohol use in Western Australia, and regional Western Australia in particular?

(2) If yes to (1), what is being done to further that goal?

(3) Will the government consider a regional trial here in Western Australia, allowing cannabis to be consumed legally, so as to monitor the impacts of such a move on problematic alcohol consumption and associated antisocial behaviour; and, if not, why not?

Hon DARREN WEST replied:

I thank the member for some notice of the question. On behalf of the Minister for Racing and Gaming, I provide the following answer.

(1) Yes.

(2) A number of policy interventions are underway to reduce the impacts of excessive alcohol use in Western Australia. This includes the provision in section 175 of the Liquor Control Act 1988 for dry communities. There are 26 communities across Western Australia that have elected to be dry communities, with no sale or consumption of alcohol. Under section 64 of the act, liquor restrictions are implemented across multiple towns. The banned drinkers register and takeaway alcohol management systems are implemented in towns with daily alcohol limits. The banned drinkers register is currently in place in the Kimberley, Pilbara, goldfields, Carnarvon and Gascoyne Junction, following the passage of new legislation through Parliament—the Liquor Control Amendment (Banned Drinker Register) Bill 2023. There is also the implementation of carriage limits in the Kimberley region and the Shire of Carnarvon to support liquor restrictions and combat sly grogging.

(3) No. It is not a priority of the Cook Labor government to modify the existing laws and penalties in place regarding cannabis possession and use.

INDUSTRIAL HEMP PRODUCTION TRIALS

1027. Hon SOPHIA MOERMOND to the Minister for Agriculture and Food:

I refer to the industrial hemp production trials in the south west, funded by the Department of Primary Industries and Regional Development and AgriFutures Australia, which aims to develop a thriving industrial hemp industry through research and industry development.

(1) Given that this was a three-year project from 2021 to 2023, does the government intend to continue its partnership with AgriFutures to work with industrial hemp in 2024?

(2) Will the position currently funded by DPIRD to work with AgriFutures to investigate industrial hemp continue in 2024?

(3) If the position will no longer be funded, why not?

Hon JACKIE JARVIS replied:

I thank the honourable member for some notice of the question.

(1)–(2) Yes.

(3) Not applicable.

FIRE DANGER RATING SYSTEM

1028. Hon MARTIN ALDRIDGE to the Minister for Emergency Services:

I refer to the national review into the Australian Fire Danger Rating System, and Legislative Council question without notice 690, asked on 20 June 2023.

(1) What is the status of the national AFDRS review, and what improvements, if any, will be implemented ahead of the southern high-threat period?

(2) Did the Department of Fire and Emergency Services provide a submission to the national AFDRS review; and, if so, will the minister please table this submission?

(3) Has DFES completed the state-level review as referenced in the minister's media statement on 31 May 2023; and, if so, will the minister please table this review?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question.

(1) The Australian Fire Authorities Council has completed the national review of the AFDRS identifying a number of recommendations and key findings relating to program governance, community-facing elements, operational and industry capability development, and fire science and technology. A draft national implementation plan has been developed and will be circulated to all jurisdictions by AFAC for review and comment.

(2) DFES contributed to the national review process through its involvement in a series of facilitated review workshops and provided input at the AFDRS board, implementation coordination group, and predictive services group meetings. There is no formal or single submission that can be tabled.

(3) Concurrent to the national review, DFES has an ongoing continuous improvement process to support the implementation of the AFDRS. Issues identified are being addressed locally or referred through the national processes as appropriate. There is no single state-level review document that can be tabled.

DISTRICT COURT — APPEAL DECISION — CRIMINAL INJURIES COMPENSATION

1029. Hon NICK GOIRAN to the parliamentary secretary representing the Attorney General:

I refer to the appeal decision by District Court Judge Staude in Re AB [2023] WADC 28 in which he said —

> Without being asked to provide written reasons pursuant to s27, but no doubt aware of the notice to produce, Ms Hafford published reasons on 3 October 2022.

On what date was Assessor Hafford first made aware of the notice to produce ordered by Registrar Kubacz on 31 August 2022?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. The following answer has been provided to me by the Attorney General.

It is inappropriate to answer the question on the grounds that it relates to the performance by the assessor of her functions as an assessor of criminal injuries compensation in respect of a particular application and, in performing those functions, the assessor acts independently from government.

PUBLIC HOUSING WAITLIST

1030. Hon STEVE MARTIN to the minister representing the Minister for Housing:

I refer to the public housing waitlist.

(1) How many applications for the following have indicated domestic violence concerns —

(a) public housing waitlist; and

(b) the priority housing waitlist?

(2) For each of the above, how many individuals does this represent?

Hon JACKIE JARVIS replied:

I thank the honourable member for some notice of the question. The following response has been provided by the Minister for Housing.

An answer is unable to be provided in the time available. Should the member wish to place this question on notice, the minister will endeavour to provide a response.

COMMUNITY RESOURCE CENTRES

1031. Hon Dr STEVE THOMAS to the parliamentary secretary representing the Minister for Regional Development:

I refer to the community resource centre network and each financial year from 2016–17 to 2022–23 inclusive.

(1) How many CRCs were operable in Western Australia?

(2) How many full-time, part-time and casual employees were employed by operable CRCs?

(3) What was the total core funding and regional traineeship funding allocated to Western Australian CRCs?

Hon KYLE McGINN replied:

I thank the member for some notice of the question. The following answer has been provided by the Minister for Regional Development. It was accurate as of 29 August, when the question was asked.

(1) There were 101 state-funded CRCs in Western Australia, and two commonwealth-funded CRCs in the Indian Ocean Territories—Christmas Island and the Cocos (Keeling) Islands.

(2) The Department of Primary Industries and Regional Development funds CRCs through the royalties for regions program. However, it does not own or operate CRCs. This information is not available.

(3) The answer is in tabular form so I seek leave to have it incorporated into *Hansard*.

[Leave granted for the following material to be incorporated.]

Financial Year	Total CRC budget (including Regional Traineeship Program)	Regional Traineeship Program budget
2016–17	$14.0 million	$2.0 million
2017–18	$13.0 million	$2.0 million

2018–19	$13.0 million	$2.0 million
2019–20	$13.0 million	$2.0 million
2020–21	$13.0 million	$2.0 million
2021–22	$13.0 million	$2.0 million
2022–23	$13.2 million	$2.0 million

SOUTH COAST MARINE PARK — INDICATIVE MANAGEMENT PLANS

1032. Hon COLIN de GRUSSA to the parliamentary secretary representing the Minister for Environment:

I refer to the proposed south coast marine park.

(1) Has the state government engaged a consultant to undertake a socio-economic impact assessment based on the draft indicative management plans for the proposed marine park?

(2) If yes to (1) —

(a) when will the assessment be completed;

(b) will the assessment be released with the draft IMPs during the public comment process; and, if not, why not; and

(c) will the assessment rely on existing data or information, or utilise bespoke analysis data commissioned as part of the assessment?

Hon DARREN WEST replied:

I thank the honourable member for some notice of the question. On behalf of the Minister for Environment, I provide the following answer.

(1)–(2) The Department of Biodiversity, Conservation and Attractions has engaged a consultant to undertake a socio-economic evaluation to provide a high level socio-economic profile of the south coast region and draw on previous studies to outline the socio-economic impacts of the establishment of marine parks in Australia. A final version of the report is being finalised and will then be provided to government.

NAZI SYMBOLS — LEGISLATION

1033. Hon TJORN SIBMA to the parliamentary secretary representing the Attorney General:

I refer to the Attorney General's media statement of 18 January this year, "Government to ban display and possession of Nazi symbols".

Will a bill to this effect be introduced to Parliament this year?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question.

The timing for the introduction of bills is a matter for cabinet. The government remains committed to banning the public display and possession of Nazi symbols in certain circumstances.

WANDOO REHABILITATION PRISON — BUNBURY REGIONAL PRISON — SEXUAL HARASSMENT

1034. Hon PETER COLLIER to the minister representing the Minister for Corrective Services:

I refer the minister to his response to question without notice 979 on Thursday, 31 August 2023.

In which particular court is matter 1 being considered?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. The following information has been provided to me by the Acting Minister for Corrective Services.

The Department of Justice advises that the matter is being heard before the Bunbury Magistrates Court.

BUILDING FOR TOMORROW CAMPAIGN

1035. Hon NEIL THOMSON to the minister representing the Minister for Transport:

I refer to the high intensity social media and general media advertising on the theme Building for Tomorrow.

How much was spent across government on the Building for Tomorrow campaign —

(a) in 2022–23;

(b) in 2021–22; and

(c) in 2020–21?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. The following answer has been provided on behalf of the Minister for Transport.

Building for Tomorrow is an awareness and education campaign that launched in 2020, informing the community about the unprecedented level of transport infrastructure in planning, under construction or nearing completion across the state. State government infrastructure awareness campaigns are common practice.

(a) It was $2.17 million, excluding GST.

(b) It was $2.94 million, excluding GST.

(c) It was $3.68 million, excluding GST.

ENVIRONMENTAL PROTECTION AUTHORITY — PREMIER McGOWAN

1036. Hon BEN DAWKINS to the Leader of the House representing the Premier:

I refer the Premier to the news article dated 10 September 2023 from Ms Kathryn Diss of the ABC and the phone call between former Premier Mark McGowan and the head of the Environmental Protection Authority, Dr Tom Hatton, referred to in the article.

(1) Was there any correspondence or conversation between the former Premier and any industry group or companies such as Woodside prior to the phone call?

(2) If so, can the Premier table the correspondence and any file note; and, if not, why not?

(3) Will the Premier refer this matter to the Corruption and Crime Commission and the parliamentary inspector for investigation?

Hon SUE ELLERY replied:

(1)–(3) The matter raised by the member was detailed comprehensively in media reports in 2019.

For the record, I refer the member to public comments made by the former chair of the Environmental Protection Agency, Dr Tom Hatton, to an article published by ABC Online on 14 March 2019. He said —

> "My conversation with the Premier today was respectful, it was measured, it was informative, I didn't feel pressured.
>
> "He was giving me feedback from industry that I was already getting from industry, so there were no surprises there.
>
> …
>
> "We remain independent in terms of what we do with that information and nothing has changed there.

PUBLIC HOUSING — WAITLIST

1037. Hon Dr BRAD PETTITT to the minister representing the Minister for Housing:

I refer to the wait-turn and priority public housing waitlists.

(1) How many applicants and individuals were on each list at the end of August 2023?

(2) How many of those applicants and individuals receive a disability support payment?

(3) On what date did the applicant who has been waiting the longest on each waitlist initially join the waitlist?

(4) As the inquiry into the financial administration of homelessness services in Western Australia recommended, will the minister commit to recommencing the publication of a housing dashboard of key public housing statistics like these monthly, without the need for non-government members of Parliament to use up questions during question time, as is done in other Australian jurisdictions?

Hon JACKIE JARVIS replied:

I thank the honourable member for some notice of this question. The following response has been provided by the Minister for Housing.

(1) As at 31 July 2023, the public waitlist fell to 18 984 applications statewide, representing 33 943 people. This includef 4 768 priority applications, representing 9 447 people.

(2) As advised in the response to Legislative Council questions without notice 632 and 864, data recorded on applications containing a disability support payment is unable to be provided to this level of specificity as not all people on an application may be in receipt of a disability support payment and data is recorded on a tenancy level.

(3) This data is unavailable to be provided within the time period specified. Should the member place this question on notice, the minister will endeavour to provide a response.

(4) As the honourable member has previously been advised, waitlist data is regularly made publicly available. As was noted in the response to the inquiry into the financial administration of homelessness services in Western Australia, no other jurisdiction routinely makes data available to the level recommended by the committee and it would require a significant diversion of resources from core functions.

BUILDING BONUS GRANTS

1038. Hon WILSON TUCKER to the Minister for Finance:

I refer the minister to the building bonus scheme announced on 7 June 2020, which provided eligible applicants with a grant of $20 000 towards the cost of either building a new house or purchasing a property in a single-tier development already under construction.

(1) How many grants were issued under this scheme during the period of its existence?

(2) How many of these grants were used toward the construction of a new house or purchase of a property with a sale price or property value of —

(a) less than $500 000;

(b) more than $500 000 but less than $1 million;

(c) more than $1 million but less than $2 million; and

(d) more than $2 million?

(3) What was the highest sale price or property value for which a grant was used?

(4) Under this scheme, could an applicant receive a grant on multiple occasions via separate transactions?

(5) If yes to (4), how many applicants received a grant on —

(a) more than one occasion;

(b) more than three occasions; and

(c) more than five occasions?

(6) If yes to (4), what was the highest number of grants issued to one applicant?

(7) How many grants were issued to an applicant without Australian citizenship?

The PRESIDENT: Minister, can you attempt to answer that rather long question seeking a lot of data?

Hon SUE ELLERY replied:

Thanks for your advice, President, because there are 12 parts to the question that was asked. We have a four-hour turnaround to provide answers, so while I thank the member for some notice of the question, the information requested cannot be provided in the time frame available. I undertake to provide a response to the question tomorrow, 14 September.

MEDICAL CANNABIS — MELANOMA

1039. Hon Dr BRIAN WALKER to the Leader of the House representing the Minister for Health:

I refer the minister to a recent study published by researchers at RMIT University in Victoria, with input from colleagues at the University of Western Australia, looking at constituents and derivatives of cannabis sativa as an effective treatment for patients suffering from melanoma.

(1) How common is melanoma in Western Australia?

(2) What is the Cook government doing to reduce and better treat melanoma cases in our community?

(3) Will the Department of Health consider this latest research and its recommendation that cannabis sativa constituents and derivatives are strong candidates for ongoing evaluation as a potential treatment for the disease?

Hon SUE ELLERY replied:

I thank the honourable member for some notice of the question.

(1) In 2019, melanoma was the second most common cancer for both males and females in Western Australia, with 953 cases for males, representing 12 per cent of cancer cases for men, and 681 cases for women, representing 10.9 per cent of cancer cases for women.

(2) The Western Australian government continues to fund the ongoing management of melanoma cases through its support of the statewide multidisciplinary WA Kirkbride Melanoma Advisory Service—WAKMAS. In addition, each major teaching hospital in Perth has its own skin cancer multidisciplinary team clinic that manages referrals within these hospitals.

The Future Health Research and Innovation Fund is the state government's primary vehicle for the provision of health and medical research and innovation funding. To date, $1.84 million has been awarded to research in which melanoma is the primary focus. This includes support for two new clinician researchers in the area of melanoma research: one at South Metropolitan Health Service and another at the University of Western Australia. The WA government is assisting the Cancer Council with ongoing SunSmart campaigns to prevent melanoma.

(3) The Department of Health supports and facilitates the use of safe, high-quality and sustainable medicines and health technologies for Western Australian patients. Consideration of relevant research is part of this function.

FAMILY AND DOMESTIC VIOLENCE — SPECIAL TASKFORCE

1040. Hon SOPHIA MOERMOND to the minister representing the Minister for Prevention of Family and Domestic Violence:

I refer to the announcement yesterday, 12 September 2023, by the Premier of a special taskforce to help guide the next phase of the state's efforts to address family and domestic violence with a time limit, initially for six months, to focus on delivering results.

(1) How did the government measure the effectiveness of the $200 million that has been spent on addressing family and domestic violence since 2017?

(2) How will the government measure the effectiveness of the taskforce?

(3) Do the government's programs address the role of alcohol in family and domestic violence?

(4) Is the government aware of studies that have shown a link between the legalisation of cannabis and a drop in family and domestic violence?

Hon JACKIE JARVIS replied:

I thank the honourable member for some notice of this question. The following response has been provided by the Minister for the Prevention of Family and Domestic Violence.

(1) Our government takes our response to family and domestic violence very seriously. The measures the WA government has invested in include, but are not limited to, building new refuges for women and children to escape family and domestic violence; setting up one-stop family and domestic violence hubs; supporting more community-based programs, including those focused on behaviour change for perpetrators; and primary prevention programs such as the respectful relationships program. These are well-established ways of supporting a system-wide response organised around victim safety and perpetrator accountability. The government will continue to monitor these measures and how they work for women, children and families experiencing family and domestic violence.

(2) The taskforce was a key request from the recent family and domestic violence forum attended by the Premier, the Minister for Prevention of Family and Domestic Violence and several other ministers on 31 August 2023. The taskforce, to be co-chaired by Professor Colleen Hayward, AM, and director general Emily Roper, is a priority. The taskforce will be time limited and will regularly feed back to the Minister for Prevention of Family and Domestic Violence to ensure actions continue to advance work in the community and government.

(3) It is well established that alcohol use, particularly by perpetrators, is a contributing factor to the severity and impact of family and domestic violence. Specialist family and domestic violence services that support victim–survivors and work with perpetrators, as well as mainstream services—for example, health services—would understand the impacts of alcohol use when working with clients. The government established the state's first-ever therapeutic refuge, which works with victim–survivors with comorbidities of mental health and/or drug and alcohol use. The government has also funded the development of an intersection capability framework between the Western Australian Network of Alcohol and other Drug Agencies and the Centre for Women's Safety and Wellbeing. Other initiatives, led in other portfolios, also address the relationship between alcohol and family and domestic violence. Liquor restrictions, such as those introduced in Carnarvon, and the reforms to the banned drinkers register are examples.

(4) It is not a priority of the Cook Labor government to modify the existing laws and penalties in place regarding cannabis possession and use.

The PRESIDENT: That was a very long answer in response to a question that was seeking a lot of information. I call Hon Martin Aldridge.

Hon MARTIN ALDRIDGE: Thank you, President. I agree.

The PRESIDENT: Thank you for your endorsement, honourable member!

KIMBERLEY FLOODS — AFTER-ACTION REVIEW

1041. Hon MARTIN ALDRIDGE to the Minister for Emergency Services:

I refer to the Kimberley floods, which have been described as "the worst flooding event our state has ever seen", and the Kimberley major flood incident review.

(1) Noting it has now been over nine months since this event occurred, have the terms of reference for this review been finalised?

(2) What is the status and expected completion date of this review?

(3) Given the scale and magnitude of the destruction caused by this flooding event, will the state government commission an independent and public inquiry into the event?

(4) If no to (3), why not?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. This was a significant event, as the honourable member would appreciate, and indeed the focus remains on the recovery of those communities and getting them back on track as quickly as possible.

(1)–(4) The terms of reference are being finalised and the after-action review will commence once the terms of reference are agreed.

CHILDREN IN CARE — WHEREABOUTS UNKNOWN

1042. Hon NICK GOIRAN to the minister representing the Minister for Child Protection:

I refer to the inconsistent answers to my questions without notice 623 and 824 on 14 June and 10 August 2023.

(1) Does the minister recall that on 10 August she informed the house that as at 14 June 2023, one child was recorded as missing for three days?

(2) Does the minister recall that on 14 June she informed the house that no child was recorded as missing?

(3) Which answer is inaccurate?

(4) How many children who are in the care of the CEO have their whereabouts currently recorded as —

(a) unaccounted for—in contact;

(b) unaccounted for—not in contact; and

(c) missing?

Hon JACKIE JARVIS replied:

I thank the honourable member for some notice of the question. The following response has been provided by the Minister for Child Protection.

The Department of Communities advises the following.

(1)–(3) At the time the answers were provided, both answers were accurate. Question without notice 623 was answered on 14 June 2023 using information as at 13 June 2023. The response to question without notice 824 was answered on 10 August 2023 using information as at 14 June 2023.

(4) Children and young people may move between living arrangements, which are recorded by case management in the child's or young person's placement type. Many of the children are teenagers. Every child still has access to the same supports that would be made available to them if they were residing in their approved placement. Communities and the WA Police Force work to contact and locate the young person to ensure their safety. Communities and the WA Police Force have aligned nomenclature regarding missing children that includes updating the previous placement type of "unknown—in contact" and "missing" children with the following placement types: unaccounted for—in contact; unaccounted for—not in contact; and missing.

Communities advises as at 12 September 2023 —

(a) three children were unaccounted for—in contact;

(b) four children were unaccounted for—not in contact; and

(c) no children were missing.

HOME INDEMNITY INSURANCE SCHEME

1043. Hon STEVE MARTIN to the Minister for Commerce:

I refer to the minister's correspondence dated 12 September 2023 regarding the home indemnity insurance scheme, and her specific comment that she was advised that extending the retrospectivity conditions of the increased payout amounts would have a significant impact on the scheme's sustainability.

(1) Since the announcement of the increased payouts, retrospectively applied to 1 June 2020 —

(a) how many applications have been received;

(b) how many were approved at the enhanced payment provisions; and

(c) at what cost?

(2) How many applications have been received since the announcement of the increased payouts —

(a) that were not eligible for the enhanced payout provisions;

(b) and were approved; and

(c) at what cost?

(3) Had all these applications been approved under the revised scheme provisions, what would the balance of the fund be now?

The PRESIDENT: Leader of the House, give it go!

Hon SUE ELLERY replied:

I thank the honourable member for some notice of the question. The honourable member would know that the HIIS is run by QBE Insurance Group, so providing the information that he is seeking requires consultation with QBE Insurance and I cannot provide it in the time frame available. I ask the member to put the question on notice.

QUESTION ON NOTICE 1513

Paper Tabled

A paper relating to an answer to question on notice 1513 was tabled by **Hon Darren West (Parliamentary Secretary)**.

ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Sally Talbot) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

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

Committee was interrupted after the amendments moved by Hon Kate Doust had been partly considered.

The DEPUTY CHAIR (Hon Dr Sally Talbot): Members, we are considering the Abortion Legislation Reform Bill 2023. We are in committee, we are on clause 8, and we are considering three amendments, 3/8, 4/8 and 5/8, moved by Hon Kate Doust.

Hon KATE DOUST: Members, I know that we have had a brief discussion, on another occasion, about the language in the series of amendments that I have just moved, and I remind members that one of these amendments was moved and passed in the South Australian Parliament in 2021 for the legislation that it was dealing with at that time. I am, basically, moving this because I have been asked to do so by a number of people in our community who have picked up on a couple of changes that were made in South Australia. I think I said the other day that this amendment is not about taking away from the bill that is before us; it is, hopefully, about providing some clarity and further guidance for the stakeholders involved in this bill.

When we look at the bill and some of the language under proposed section 202MEA, adding this amendment will expand upon the language that is already there. The amendment we are dealing with is the post–23 weeks phase. It is not the lead-up to; it is the after time frame. The set of words that are repeated throughout this clause are "in all the circumstances". The bill says that a practitioner can make the decision to perform the abortion "in all the circumstances" and they can take into account whether the woman is able to have an abortion "in all the circumstances". Subclause (2) provides a couple of examples of this, but they are very generic, if you like. I know that sometimes the intent of the legislation is to have very broad terms so that we have capacity to move, but I like the language that is in the South Australian proposal and its version of the amendment because I think it steps out and reinforces some of the discussions that we have had. We have all talked about how a woman gets to the point of making the decision to have a termination post–23 weeks, and the minister has referred to how horrific it would be for someone in that situation to make the decision about a child who was wanted, anticipated and loved—I may have modified her words, but I think that was the gist of it. I do not think any of us would want to be in the awful position of having to make that call. All the proposed new section will do is provide a range of scenarios and examples. It outlines lots of different types of real-life situations for the practitioner to work through to make the decision in all the circumstances, not just the couple that are listed there. It just steps them out. It would add clarity to the legislation.

I think I also made the point that in other bills in the past, there was not a lot of detail—the language I used was skeletal. The detail was found in other documents that were not necessarily open to parliamentary oversight or public access. I have always taken the view, particularly on issues like this, that it is much better to put as much detail as

possible into legislation so that everyone knows where they stand. I know that my good friend sitting across from me Hon Dr Brian Walker will disagree. We have had the discussion a couple of times about feeling as though people are imposing additional layers on doctors, but I do not think we would be.

I also want to make the comment—I think I have made it in the past—that it is our job, as members of Parliament, to make these decisions on behalf of the community. We may not always be skilled in that particular set, but we certainly try to adapt and act in the best interests of everyone involved. Although members might think it is a constraint, I think that putting in place this level of detail would provide guidance on the way forward. Obviously, when members of the South Australian Parliament contemplated their legislation, they decided that this was a very good approach to take in providing guidance to practitioners as a mechanism to assist them in the decision-making about post–23 weeks abortions that they would be involved in with their patients.

I may very well have more to say on this as we work through it, and I am happy to go through each part. I just wanted to put it on the record again. I thank the chamber for enabling me to deal with all three amendments together. It makes more sense to manage them in that way. I look forward to the government response, and I might have a few words to say about that when I have heard it.

Hon BEN DAWKINS: I think that the way that Hon Kate Doust has drafted proposed new section 202MEA is perfectly suitable. I would have thought that these sorts of mandatory considerations would have been in the Labor bill from the outset. They seem to me to be very sensible. There are plenty of things in there that, once the medical practitioner has considered them, would allow access to a phase 2 post–23 weeks abortion for some people in the disadvantaged situations that we and the government have been speaking about. I see it as very sensible and I commend Hon Kate Doust for it. I stand to be corrected, but I cannot see why there would be any difficulty in adding this level of sophistication to what otherwise, as Hon Kate Doust said, is not a particularly helpful set of provisions as they stand. I think this would be a very commendable addition.

Hon Dr BRIAN WALKER: Let me first of all acknowledge the words of my esteemed colleague Hon Kate Doust. Every word she said is quite correct, but I would like to reference what my colleague Hon Ben Dawkins has just said. He missed out a few things that should be said. For example, what is the current liver function status of the patient? What is her haemoglobin level like? Do we have a reasonable check on her calcium and potassium levels? Members might ask what is the point of that. That is what doctors do. We might then ask: what is the psychiatric status of the patient? What else has gone on? What about her history of sexual abuse, the PTSD she is suffering from, the side effects she has had from the medication to treat her PTSD and how will that impact on the risks of pregnancy in the future?

What members have just said is trying to teach doctors to suck eggs. Everything that is written down on the supplementary notice paper is very sensible and I have personally taught it to medical students. This is the kind of conversation that all medical students go through at the very beginning when they are considering how to deal with this. As a supervisor of young doctors who would come to me with a problem that they had to deal with, I would talk them through the very same points that are listed here, because this is the essence of good medical practice. Do we want to put on top of this bill a thick medical text with all the details of how doctors have to behave? This is our profession. This is how we think. This is how we act. If members want to codify that into law, as my colleague has rightly said, I will oppose it. This is what we do already as a matter of course. This is what doctors do. This is our life.

Frankly, it is quite difficult for those of us in the medical profession to be lectured by people who have not once held a scalpel in their hands and taken a cut in a patient. Not once has anyone here had to switch off a patient's life support—not once. I remember the first time I was asked to switch off life support. It was for a man who had fallen from a roof and we were treating him on the ward. He was brain dead to all intents and purposes. This was a long time ago and we have made further advancements. I vividly recall standing there and thinking that I saw a spark of life in the person, knowing that I was going to switch off his machine and that once he stopped getting ventilated, he would no longer be alive—he would be buriable. I also vividly recall being called to an emergency. I was working in organ transplant at the time and an 11-year-old boy had been hit by a car. There was a bit of brain hanging from his right ear. I had been called from a shopping expedition with my family and my youngest son was there. There I was, at the operating table, and in was wheeled an 11-year-old who looked exactly like my youngest son. I was about to assist in taking out the heart, the lungs and the liver—every single organ. The last part was when he was exsanguinated, and what had been a living, breathing dead boy became an empty corpse. Is anyone here prepared to talk me through the ethics and the emotions of how to do that? This is our profession. This is what we do. It is probably difficult for people who are not in that position to understand what doctors actually do in their daily life, when they come home from work exhausted and want nothing to do with anybody else because of what they had done that day.

When dealing with a late-term abortion, it is not a case of "Next patient, please". We have a process to go through; we help people understand what they will go through. Why will they go through it? If I take an unborn life from them, for whatever reason, I have a person who will be grieving and I want to make it as smooth as possible. While they will grieve, they will feel pain, they will be distraught and it may take them a long time to recover. I need to

ensure that I treat them in the most respectable, helpful, healing, loving and kind way. We do not rip life out of people willy-nilly and say, "Next patient, please" and carry on. This is what we always do; this is natural for us. The fact that the member wants to codify it tells me that she does not understand what doctors do. Although I appreciate what the member is saying, it is very respectfully meant and I fully respect where she is coming from, it is not necessary.

Hon NICK GOIRAN: The three-part amendment moved by Hon Kate Doust en bloc seeks to insert seven mandatory considerations that a medical practitioner must take into account before determining whether they think it is reasonably appropriate to perform an abortion. Proposed section 202ME(2) on page 9 of the bill lists three matters that should be taken into account. Are these three matters at (2)(a), (b) and (c) also mandatory considerations for performance of abortions by medical practitioners at more than 23 weeks?

Hon SUE ELLERY: Yes. "Must have" is the language that is used.

Hon NICK GOIRAN: The government has already decided as a matter of policy that it wants to mandate considerations for medical practitioners for late-term abortions. That is an uncontroversial point. The government has highlighted three of those mandatory considerations. Hon Kate Doust seeks to insert seven. I ask the minister to look at the amendment to proposed section 202MEA and the seven itemised mandatory considerations. Are any of those seven mandatory considerations listed by Hon Kate Doust captured by the three mandatory considerations in proposed section 202MEA(2)?

Hon SUE ELLERY: They might be. I have not responded to the amendment yet, but I will in due course. The drafting of (a), (b) and (c) in proposed subsection (2) is sufficient to capture all that is necessary for clinicians to make a decision. If I can rely on the contribution of Hon Dr Brian Walker, to be any more specific or any more prescriptive is to be stepping into the shoes of the clinician. Clinicians are already trained to take these things into account. The existing provisions in the bill before us are sufficient. That is not my full answer in response to the amendment but that is my answer to the member.

Hon NICK GOIRAN: For example, one of the mandatory considerations that the government seeks to impose can be found in proposed subsection (2)(c), which states —

> the professional standards and guidelines commonly accepted …

Those things are not in the ether; they are commonly accepted by members. Are they documented in any way?

Hon SUE ELLERY: Yes. We have talked about scope of practice, for example, a number of times during the debate. That is defined. It operates within certain parameters. Those things are set out.

Hon NICK GOIRAN: In other words, someone would not be involved in something that they are not qualified to do. Is that what is meant by 2(c)? Presumably, it is something more than that.

Hon Sue Ellery: It could capture that; it could capture a range of things.

Hon NICK GOIRAN: I am not asking whether it could be. Is it captured or is it not captured?

Hon Sue Ellery: It could be, honourable member.

Hon NICK GOIRAN: So scope of practice is not necessarily captured as a mandatory consideration. It is definitely captured.

Hon Sue Ellery: It is.

Hon NICK GOIRAN: It is okay to say it is definitely captured. It is not a controversial point. If scope of practice is definitely captured, are any of the seven things that Hon Kate Doust included not incorporated in the professional standards and guidelines that are commonly accepted?

Hon SUE ELLERY: We think we can mount an argument that they are all covered.

Hon NICK GOIRAN: I appreciate that the minister flagged that she has not yet responded on behalf of the government to the amendment moved by Hon Kate Doust. I simply make the point that if the seven considerations are already covered—that certainly seems to be consistent with what Hon Dr Brian Walker is saying—Hon Kate Doust's amendment is unnecessary because this is already a matter of practice; this is what doctors do. My submission to the minister and other members is that there would be no harm whatsoever in accepting the amendment. We could include it as a matter of clarity, as we did earlier in the bill by defining the word "person". We could use it as a matter of not only clarity, but also safety as we did earlier in the bill, when we inserted the catch-all provision. These are things that were argued to be unnecessary but which the government said it would like to have in the bill anyway. Yes, there is an argument that it is unnecessary but as a matter of clarity and safety, the government has decided to include these things, like the definition of "person".

My respectful submission to members is that at the very least it does no harm to support Hon Kate Doust's amendment because, as Hon Dr Brian Walker said, this is what will happen anyway. As the minister said, it is part of the professional standards and guidelines commonly accepted by members of the medical profession.

Hon MARTIN PRITCHARD: First of all, I would like to congratulate Hon Kate Doust. I think her amendment comes from a very good place. Listening to Hon Dr Brian Walker, I am more inclined to accept that under proposed subsection (2)(a) "all relevant medical circumstances", a doctor would take these things into consideration. My contention is that if we put more words into the bill, we may create anomalies. I do not wish to pick the amendment apart but, for instance, section 202ME(2)(b) states —

> whether there are serious foetal abnormalities that were not identifiable, diagnosed or fully evaluated before the pregnancy reached 23 weeks …

It is possible and quite likely that if scans done between 18 and 22 weeks identify these things, people in remote areas in particular may get a diagnosis at 21 or 22 weeks and may not be able to receive an abortion until after 23 weeks. I understand that they only have to take note of this and that would probably not preclude them from going forward with the abortion. As I said, the more words we put in the bill, the more difficult it could be for a doctor to move forward. I am more inclined to accept proposed subsection (2)(a) of the bill, in which all medical circumstances are taken into account.

Hon BEN DAWKINS: There may be a fundamental misunderstanding of what this amendment will do. I do not see this amendment as limiting access to abortion. We might even call it an enabling amendment; it will actually open up new avenues for women who are in hardship to access what we are calling late-term abortions. There is nothing wrong with being more specific in this instance, because it helps the individual patient. The doctor only considers this. We are not telling him what to do; we are asking him to consider things, so there is no impingement upon his professional freedoms. All we are asking him to do is consider the things that the minister referred to, such as abuse, socio-economic disadvantage and remote locations. By inserting these specific words, we would open up access for these women; we would not be narrowing it down. It may be that other amendments on the supplementary notice paper will have a narrowing effect, but to paint this amendment as something that will detract from the government's objectives of the Abortion Legislation Reform Bill 2023 is simply wrong. It will empower people and provide more criteria for people to be assessed on and therefore access a late-term abortion, in an overall sense. I do not think the chamber should look at this amendment as something that will detract from the overall objectives of the legislation; I think they will improve it. Sometimes it is good to be prescriptive, because this is prescriptive in an expansive way, if that makes sense, not in a narrowing way. I am just not sure that all members can see the good intent behind this amendment, because they are completely consistent with what the government has told us this legislation is all about.

Hon SUE ELLERY: The government will not accept the amendment. Amendment 5/8 on the supplementary notice paper seeks to insert proposed section 202MEA, which will require additional mandatory considerations that a medical practitioner must consider prior to the performance of an abortion at more than 23 weeks. These considerations are prescriptive, clinical, physical, social, economic and psychiatric criteria that we say are better and more generally encompassed under the existing proposed section 202ME(2) of the bill.

The bill sets out what medical practitioners must take into account when considering an abortion after 23 weeks. That includes all relevant medical circumstances; we do not need to list them, because we could not. It also includes the person's current and future physical, psychological and social circumstances; and the professional standards and guidelines that apply to the medical practitioner in relation to the performance of an abortion.

The amendment inserted into the South Australian bill provides, if you like, granular-level detail. It requires medical practitioners to take into account whether the patient had difficulty accessing timely and necessary specialist services before the pregnancy reached 22 weeks and six days, including, but not limited to, patients experiencing significant socio-economic disadvantage, cultural or language barriers; and those who reside in remote locations. We say that these things are already captured in the bill by requiring medical practitioners to have regard to the person's current and future physical, psychological and social circumstances. The level of detail captured in the South Australian version, which is what amendment 5/8 is, is inconsistent with our ordinary legislative practices. The suggested considerations are also invasive of both the patient and the practitioner, and would cause the practitioner to have to make a speculative judgement call as to whether the patient could have accessed an abortion service earlier, or whether they would have wanted to continue the pregnancy if they were in a better financial position. That places on the practitioner responsibility for subjective and unwarranted judgement calls about the patient. For those reasons, the government will not support the amendments.

Hon KATE DOUST: First of all, I want to say to Hon Dr Brian Walker that I take these issues extremely seriously. I always have and always will. It does not matter whether we are dealing with abortion, end of life or anything in between, we have to give our fullest consideration to any legislation that is going to terminate a life at any point, and in some circumstances we need to apply a rigid set of rules to be followed for those processes.

The idea of this amendment is not about implying that doctors do not know or do not understand what they are doing; it is about providing a much broader range of information and options. It is not the be-all and end-all, because I appreciate that there probably are other things, but it struck me that it was good enough for the South Australian Parliament to give serious consideration to adding value to its legislation and enhancing it. As I said earlier, this will not take away from the bill in front of us. When I was dealing with Parliamentary Counsel, some of my original

amendments would have sought deletions and insertions. My thinking was that there was no value in that. The idea of adding value and an explanation was, I thought, a much better proposal. It is disappointing that the government will not give any consideration to this amendment. I say to members that, on the basis that this amendment will not take away from the bill before them, they will not reduce any of the proposals the government has put before members for their consideration. They are simply about putting in a range of options to provide the clarity we would ask a doctor to provide before that decision was made. As I have said before, the doctor would consider this for a very narrow—possibly less than one per cent—number of all abortions that occur in this state. It is for the very narrow group of the most diabolical, dreadful situations. I know my colleague does not like the use of the word "dreadful" or whatever; there is probably a range of other adjectives I could use. I think "heartbreaking" is probably the way to go. It is a heartbreaking decision for that woman to make. This amendment will just step that out and provide clarity. It is not just for the doctors; this is about the whole community understanding the circumstances in which this could play out. In what circumstances do we, as a society, think it is appropriate for this type of abortion to occur? I do not see this as being detrimental to the bill in front of us; I see it as an enhancement so that anyone who opens up this legislation can find out what is going on, be they a doctor, a person on the street who is curious about the process, or the woman at the heart of the situation who wants to know where she stands and the options available to her, rather than just waiting before she goes to a doctor. I acknowledge that the member has said that this is the meat and bones for doctors and is at the core of their work in respect of how they conduct themselves. We do this with lots of different types of legislation. We put in place regimes to tighten up the legislation, provide clarity and transparency and offer a much clearer pathway to a decision. I do not see this as being any different. It is not there to cause insult or injury to the practitioner at all. It is there to provide some straightforward guidelines and options when it comes to decision-making. I say to members that this amendment will not be detrimental to the bill before us; it is simply about opening up information and providing guidance. I hope people give appropriate consideration to supporting the amendments before us.

Hon WILSON TUCKER: I felt myself being swayed, really, on both sides of the fence and supporting the amendments from listening to the passionate contributions of members. I take Hon Dr Brian Walker's point about telling doctors how to suck eggs—I think his words were—and being too prescriptive in codifying a set of rules for something doctors already do and that we trust them to perform. I imagine that in the vast majority of cases—if we want to put a percentage to it, it is probably 99.9 per cent—doctors do the right thing and follow the ethical and moral guidelines that we expect them to follow every day as part of their practice. As legislators, we should not necessarily take the happy path, which I think is easier, and put in a set of rules that we expect people to follow, but rather flesh out cases on the edge and cater for some of the bad actors in the system. There are always bad actors who look to undermine the rules in place. That is the tricky point, and as legislators in this chamber we should really think about it and try to tease it out. It is important that we attempt to codify some of those rules and set some guardrails for those cases on the edge.

I take the view that if these provisions do not impose any friction on women seeking an abortion or add any additional friction to something doctors already do and that we expect them to do, there is no harm in including them. Given that provisions in these amendments are included in the South Australian legislation and the Parliament there thought it appropriate to include them, I am curious to understand whether the government has looked at the South Australian Parliament's rationale for including these provisions in its legislation, as well as the rationale that preceded the debate that culminated in them being included. It is curious that we all live in Australia and one Parliament has thought it fit to include these rules, but we are having this debate and the government's position is to not support them because it feels they are too prohibitive. I am curious to hear any response from the government on that point.

Hon SUE ELLERY: I am happy to provide the member with one. During the course of the debate earlier, we had an exchange, I think during the debate on clause 1. We talked about how there were particular curiosities, if I can describe them in that way, in the existing legislation that were put in place 25 years ago because they reflected the position of the Parliament of the day. For example, there was the extraordinary circumstance of the definition of "informed consent" meaning one thing for every other medical procedure, but in respect of abortion it had two—if members remember—very bespoke, very specific definitions, because that reflected what I referred to earlier as politics being the art of what you can achieve. That reflected the views and the make-up of the Parliament at that time. I have no doubt that that is the case in South Australia; that is, the provisions that were adopted reflected the debate and circumstances of what it would take to get that legislation through.

Before my adviser provides me with more information, I want to make this point as well: it is important to understand what the bill would look like if we passed these amendments. The page of the bill I am referring to will be a bit messy if members have marked it up themselves, as I have, to note where the amendments on the supplementary notice paper would fit. There are four amendments proposed on the bottom half of page 9 of the bill, so it is a little bit messy. To follow through the three amendments that Hon Kate Doust proposes, go in the first instance to line 23, at the bottom of proposed section 202ME(2). Proposed subsection (2) is the provision that refers to the matters that must be had regard to. It states —

(a) all relevant medical circumstances; and

(b) the person's current and future physical, psychological and social circumstances; and

(c) the professional standards and guidelines commonly accepted by members of the medical profession that apply to the medical practitioner in relation to the performance of the abortion.

The amendments before us would have us delete the word "abortion" there and put in its place "abortion and", so something is about to be added. Let us say that that amendment gets up. The end of proposed subsection (2)(c) would read "in relation to the performance of the abortion and". Without limiting what has just been referred to in proposed paragraph (c), which are the broad general descriptors that have been set out, mandatory considerations, there is also the requirement to consider all seven matters listed in Hon Kate Doust's amendment. A doctor or a clinician will be required in the first instance to consider all of the relevant medical circumstances; the person's current and future physical, psychological and social circumstances; the professional standards and guidelines commonly accepted; and, if we accept the amendment, the seven things listed in it. I have great faith in clinicians but that is quite a confusing regime to expect them to operate under. Which step takes primacy?

Medical practitioners are already required by law to consider all relevant medical circumstances; that is already established. Therefore, they would have to second-guess themselves. They will wonder whether they have covered the list of seven things when they consider all relevant medical circumstances. I do not question for a minute Hon Kate Doust's intent in moving the amendment, but the upshot of it is a very confusing regime for those practising and a very confusing regime for the woman who is 23 weeks pregnant or more and needs to access an abortion. She will have to understand all of the things that the clinicians will ask about, and she will need to look at this legislation and say, "There is that list and there is this list." It is confusing for the consumer and the clinician. For those reasons, we say that the language drafted for proposed section 202ME(2)(a), (b) and (c) will provide clinicians with the required set of measures, arrangements, facts and information that they need to satisfy themselves with, and that is the better proposal before the chamber now.

Hon Dr BRIAN WALKER: I want to give an example of what happens when detail is put into legislation and decisions are left in the hands of clinicians. This is a true story. I was working at a hospital, and in the geriatric department was a geriatrician who was terrified of getting sued by relatives of someone who died. For example, if someone has had a stroke or has some other major disability and they are lying in bed unable to feed themselves, we should technically let them pass away because their time of life has ended. I am cutting the story a bit short, but in the end, we should let things go naturally. The doctor was terrified. Every single geriatric patient was lying there, non–compos mentis—lying in bed, unable to move or blink or do anything. They had a tube put down the gastroscope and shone light in there, and a needle was put into their stomachs and a percutaneous endoscopic gastrostomy tube was inserted. Those patients were then given PEG feeding. They may have lasted two years, being turned for their ulcers and being cared for. Relatives visited the patients. There was no response but they came to visit. These patients were lying in bed. They could not do anything. They could not demand the tube be taken out because the doctor said he could be sued for killing a patient. It was terrible. The natural course of things at the end of life is that you die. We can artificially prolong life quite a lot. If you are frightened of being sued by patients' relatives, you are going to do what you can. There is the classic example of when someone aged 86 years has been hit by a car and is in the ICU. They are very frail, but they are kept alive for as long as they can, because they can be.

I will tell members another story. A patient of mine was taken to surgery. It was a simple thing. It was to take out his spleen. There was a massive problem with the spleen. I assisted with the surgery and all was going well. The spleen was taken out and the sutures went in and off I went. That night, about 2.30 in the morning, I got a call. As the assistant to the surgeon, I raced up to the hospital with the surgeon and opened him up again. He had a bleed. One of the sutures had got loose. He had an arterial bleed after the operation, which had seemed fine but these things happen. As a result, he was hypovolaemic and he suffered brain death. He was resuscitated and ended up in ICU. There he was, non-responsive and clearly brain dead but the bureaucratic requirements—this was in Hong Kong—stated that as he had recently had surgery with anaesthetic, the test for brain death was no longer valid and therefore they had to wait seven days. After seven days in the ICU it could be declared that the anaesthetic was gone and any effects on the brain from the EEG were now valid. They could then say he was definitely brain dead. When he went to post-mortem, of course his brain had already begun to dissolve because for seven days we had kept him alive in the ICU at great cost. It was because they were frightened of being sued for having murdered a patient by switching off his machine too early.

These are the consequences when we put words into legislation, thinking we are doing good, but there are unintended consequences at the end. I would caution against putting too many words in legislation regarding how doctors should behave, if they are behaving ethically, morally and humanely, because it could end up with a false outcome. It could mean bad outcomes. The intent is to do good, but the unintended consequences may result in people suffering—not just the patients who are dying, but also their families who are watching. I caution against too many unnecessary words.

Having said that, I thoroughly appreciate all the words that Hon Kate Doust mentioned. I support them all. She is quite right: every single word is true but it is not necessary to mention them in this legislation.

Hon NICK GOIRAN: The argument from the government in opposing the amendments moved by Hon Kate Doust is that it would be confusing for medical practitioners to have the list set out here at proposed section 202ME(2) and then to have the seven considerations offered by Hon Kate Doust. I have said all along in this debate: test everything you hear. I remember saying it first in the Liberal Party room when this bill came in. If members hear me say something, test it. If they hear something said by the Minister for Health, test it, especially if she says that there is no such thing as a baby born alive after an abortion. If Hon Sue Ellery says something, test it. If Hon Sue Ellery says that, on behalf of the government, she is opposing the amendments because they are going to be confusing for practitioners, consider this. Hon Dr Brian Walker said that the seven considerations are already done by medical practitioners. That is what they do all the time. I respectfully suggest that there is nothing confusing for a medical practitioner at all because they are doing it all the time. Hon Sue Ellery said that the seven considerations are part of the professional standards and guidelines commonly accepted by practitioners, so there is nothing confusing for a medical practitioner in fulfilling the seven requirements that Hon Kate Doust has put forward. Why? It is in the South Australian legislation. If these are good enough mandatory considerations for the South Australians, they should be good enough for Western Australians.

Hon PETER COLLIER: I had no intention of speaking on these amendments at all. I know where I stand. I am going to support this bill. I want to make that perfectly clear. That is not the issue here. Being a doctor would not mean I am an expert. I am not a doctor. I am not an expert. All I know is that I have been in this place for 18 years and I find that as we work through these things, sometimes we can enhance and improve legislation. It takes me back to the Voluntary Assisted Dying Bill, which people will remember. In a lot of instances, it was an extraordinarily long bill. My honourable colleague Dr Brian Walker suggested putting in too many words can sometimes make it too complex, prescriptive and difficult. I take members back to the VAD bill. I worked personally over time with the Australian Medical Association and a number of my colleagues with that bill to ensure we enhanced a number of areas to make it a better bill. It passed this Parliament. It did not pass in the format in which it entered. When it came out the other end, I think it was a significantly enhanced piece of legislation, even though I did not support it. It was as a direct result of communication that went on during the duration of consideration of that bill. The minister, Hon Stephen Dawson, handled the bill with aplomb. He was really receptive to input from various members of the chamber. There was a concern at that time about palliative care. As a direct result of what happened in this chamber, that bill was an enhanced piece of legislation at the end, even though some people did not support it. I still think it was a better bill when it came out the other end than when it went in.

On these amendments, I have to be honest. At this stage, I can say to Hon Kate Doust that I am still not sure how I am going to vote. I think there is some real merit in them. I do not think there is an issue with being too prescriptive, to be perfectly honest. That is the only reason I stood. I think it is important that in such legislation we are not fearful of making amendments if they will enhance the legislation. As we have heard already, if it is already happening and will not in any way or circumstance diminish the legislation, and if it will provide some clarity and certainty, I would be prepared to support the amendments. That is how I honestly feel. I come in here with eyes wide open on these amendments. I have listened intently to debates on both sides. Yes, I am not a medical practitioner, but I am an experienced legislator and I know there is nothing wrong with accepting an amendment, particularly something like this, which to me seems quite frankly eminently sensible. The Leader of the House said it is already happening. Hon Dr Brian Walker said it is already happening. I am sorry about this, Leader of the House, because I know she has already covered it, but can she confirm this with me to help me make up my mind: will the amendments in any way diminish the legislation or in any way alter the intent of the legislation? If not, why will the government not accept them?

Hon SUE ELLERY: I appreciate the honourable member's contribution. I do not think anybody is saying that people should not move amendments. People are entitled to. The government's position is that the particular set of circumstances are bespoke to South Australia. No other jurisdiction in Australia adopts them. The other jurisdictions are Queensland, New South Wales and Victoria, which adopted the provisions we put in this bill—that is, the three bits captured at the bottom of proposed section 202ME(2). The other jurisdictions do not. I genuinely believe that what happened in the South Australian Parliament is what was required to get the bill through. That does not necessarily make it best practice or easy to work with.

No clinicians, clinician peak bodies or clinician leaders have asked for more prescription on what matters they should take into account when they make a decision about a 23-week termination. They have not asked us for more prescription or for another list. As I said before, I believe that more prescription would make it harder for clinicians to understand what weight they should place on one element or another, and I think it would confuse consumers about what they need to satisfy in order to get the termination, bearing in mind where they are in the gestation. They are at the 23-week mark. They do not have a hell of a lot of time to make what is an awful decision for them. Bearing in mind all those things, honourable member, we say it is a detriment to the bill before us; it would make it harder to make it work, and it would make it harder at a point at which women do not have a hell of a lot of time to make that decision.

Hon MARTIN PRITCHARD: I thought of this very same issue that the minister has just identified towards the end there. I think that any educational program that is put out for people in this situation will basically reprint that

clause. If a layperson at 23 weeks' gestation were to read that clause, I think that they would read through all the relevant medical circumstances and then see a list of specifics, and I believe that they would try to fit within those specifics. If they did not fit within those specifics, they may feel that they cannot raise that with a doctor or they cannot have an abortion. We either try to be prescriptive, and that is very difficult, because the list would be endless, or we try to be a bit more generic so that the person they ask and who provides the advice is the person they go to—the health provider, the health professional, the doctor. The more I think about it, the more I think it is better that it is generic so that they get the actual information from the doctor.

Hon NICK GOIRAN: In Western Australia at the moment, how many medical practitioners make a determination on a late-term abortion?

Hon SUE ELLERY: It is the ministerial panel that is made up of six members, and the chair will contact two to make a decision. We have covered that many times.

Hon NICK GOIRAN: How many medical practitioners will be eligible to make a decision on a late-term abortion after this legislation passes?

Hon SUE ELLERY: It will be two.

Hon NICK GOIRAN: Only two Western Australian medical practitioners will be able to make a decision?

Hon SUE ELLERY: No, honourable member; there are more in the profession than two. I thought that the member was asking me how many were required.

Hon NICK GOIRAN: No, I want to compare apples with apples. To be clear, under the current law, six Western Australian doctors are eligible to make a decision, of whom two need to make a decision in order for a late-term abortion to be performed. Moving forward, two will still be needed, but how many will be eligible to make that decision?

Hon SUE ELLERY: We do not have that information available here. It would depend entirely on who was registered at the time in Western Australia. The number might be this today but that tomorrow. I am not in a position to give the member an actual number.

Hon NICK GOIRAN: The government does not know how many medical practitioners are registered in Western Australia?

Hon SUE ELLERY: I am still not in a position in which I can give the honourable member a number. I am sure the member is aware—we will probably get to debate it at some point later in the debate—that there is a right to refuse provision.

Hon Nick Goiran: I am saying eligible.

Hon SUE ELLERY: Yes; I cannot give the honourable member that number. There may be some who are eligible but who may refuse. Maybe they will refuse today; maybe they will not refuse tomorrow. I cannot give the member a precise number.

Hon NICK GOIRAN: The government does not know how many medical practitioners are registered in Western Australia, because that is the actual answer to the question I have asked, but I put it to the minister that we are talking about hundreds. In Western Australia, hundreds of medical practitioners will be eligible to make a decision on late-term abortions once this bill passes. At the present time, there are six. In other words, in Western Australia, we have six experts making these decisions on late-term abortions, but as soon as this bill passes and comes into force, every medical practitioner in Western Australia will be eligible to do so, irrespective of whether they have any experience in this area at all. I could absolutely understand the objection by members to the so-called prescriptive list proposed by Hon Kate Doust if we were leaving it as the six experts, because there would be no need to provide them with any guidance. But we are opening the door here to every single medical practitioner, some of whom may not have the level of experience of Hon Dr Brian Walker. They might have been a medical practitioner for five seconds. What would possibly be the harm in making sure that we include this prescriptive list that we have heard from one expert is normal medical practice and we have heard from the honourable Leader of the House is part of the commonly accepted professional standards and guidelines?

Hon KATE DOUST: Hon Nick Goiran raises a very interesting issue, to which I must admit I had not given a lot of thought. Given that we anticipate that with the change in this legislation there will be a shift from the six specialists who are currently able to make those calls, and we will be opening the doors up to a significant number of practitioners who, as Hon Nick Goiran said, may not have the experience or expertise, what arrangements have been put in place or will be put in place to skill up or train up those medical practitioners who will then be able to make decisions about whether a post–23 weeks abortion could occur or participate in a post–23 weeks abortion, and to ensure that they fully understand the requirements that are set out in those three points already articulated in this bill on how they manage the medical and other circumstances before they make that decision?

Hon SUE ELLERY: I thank the honourable member for the question. The member will recall—I think it may have even been in answer to a question from her—that we dealt with the proclamation date and why we would

need I think six months before certain parts of the bill come into effect. I set out in my answer then the things that need to be put in place around training, our policies and procedures, changing clinical guidelines et cetera. What I said then and I rely on now is that we will be developing processes and training within a number of internal and external bodies; for example, the Women and Newborn Health Service will need to review and modify current care for women considering abortions and their aftercare.

When I gave the answer in the debate earlier, I think I was talking about a range of education and training that will need to be provided to clinicians and health service providers. The six-month period is there to ensure that that work can be done.

Hon MARTIN ALDRIDGE: It has been an interesting discussion on this amendment, and I think it has been quite helpful. Certainly, from my perspective, when trying to weigh up the advantages and disadvantages of supporting the three amendments, this was probably one that, when considering the supplementary notice paper, I did not have a starting position. It certainly has been good to hear the discussion that has occurred. Some of it has been more useful than others. I am probably not convinced at this point about the merits of the value that will be created by inserting these additional seven provisions. My position at the moment favours the status quo over the amendments. Although I do not necessarily accept all of the government's reasons for opposing the amendments, due to the complexity and risks presented by supporting them, it is a difficult decision and I agree with Hon Peter Collier in that regard.

One thing I also say on this amendment is in response to Hon Dr Brian Walker. We have heard this a few times through the course of the debate and I think his clinical experience and background has been quite useful. I am challenged by some of what is said by the honourable member when there is an insinuation that his view is worth more than others because of that experience. By all means, I encourage the member to impart his knowledge and experience and try to convince others, in the course of a respectful debate, why something should be supported or not. It is illogical to suggest that only doctors or healthcare providers deserve, or ought to have, a view one way or another on these issues. I am not sure how many medical doctors there are in the cabinet who approved the drafting of this bill. As I understand it, there are two doctors in the Parliament, one in this house, one in the other. They could meet in a very small room and discuss the desirable outcome and come back and tell us what the result is. We could apply the same logic to many other topics that the Parliament has to consider. We are all one of 36, we are all equal members. We all get one vote. Not one of us gets any more than another. I encourage members when considering this bill that their experience is different from mine and my experience is different from theirs. Members should use the power of their voice to convince others how they should vote. However, please do not suggest that somehow one individual's experience or background is more important than someone else's.

The ACTING PRESIDENT (Hon Dr Sally Talbot): Members, we are considering three amendments, 3/8, 4/8, 5/8. I will put the first of those amendments in the form of the question that in regards to 3/8, that the words to be deleted be deleted.

Division

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

Ayes (7)

Hon Ben Dawkins	Hon Steve Martin	Hon Neil Thomson	Hon Kate Doust *(Teller)*
Hon Nick Goiran	Hon Tjorn Sibma	Hon Wilson Tucker	

Noes (25)

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

Amendment thus negatived.

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

NIRRUMBUK ABORIGINAL CORPORATION

Statement

HON ROSIE SAHANNA (Mining and Pastoral) [6.18 pm]: I take this opportunity to speak about an incredible organisation based in Broome. The Nirrumbuk Aboriginal Corporation celebrated its thirtieth anniversary last week on Friday, 8 September. It was a momentous occasion for an organisation that continues to do so much for the community. Community members, stakeholders, and past and current staff of Nirrumbuk came together last week to celebrate the remarkable 30-year journey of the corporation.

The milestone is a testament to the strength, resilience and enduring spirit of Nirrumbuk. The organisation has grown from the robust leadership and direction set by the Nirrumbuk board of directors, who set the course from the onset, making early decisions that determined that welfare dependency was not the future. As a result, the organisation quickly pivoted and focused on developing economic opportunities that would help create employment and also address social needs of members and users of Nirrumbuk's services.

The key pillars that the board instilled throughout the organisation include working together and respecting each other, adapting to change and striving for sustainable growth, and never losing sight of where they came from. Throughout the last 30 years, Nirrumbuk has achieved remarkable milestones. It has set up several standalone entities including Nirrumbuk Environmental Health and Services, Kullarri Building Pty Ltd, Djaringo Pty Ltd, Broome Electrical Services Ltd and Kullarri Employment Services Pty Ltd. All of these entities are well managed and create employment and deliver effective services throughout the Kimberley.

Nirrumbuk has also established several joint ventures and partnerships with many other Aboriginal community–controlled organisations, entities and stakeholders and has supported a number of Aboriginal entrepreneurs to establish their own businesses. Nirrumbuk is focused on supporting disengaged young people to re-engage with the community and work towards positive career pathways. It has assisted many young people through the advancement of education and training, leading them into sustainable employment opportunities and also creating opportunities for many to participate in employment through the delivery of programs and services that empower Aboriginal people to lead healthier and happier lives.

A key indicator of Nirrumbuk's success is the growth in employment the corporation has experienced, especially in the last five years. In 2018, it employed 122 people; it currently employs over 215 with more than 75 per cent identifying as Aboriginal or Torres Strait Islander. Nirrumbuk's involvement in the local economy and Aboriginal employment cannot be denied. The 30-year journey has not been without its challenges but Nirrumbuk has faced adversity head-on, overcoming obstacles and working hard to create a brighter future for generations to come. I am confident that Nirrumbuk will continue to be a beacon of strength and progress.

To give a bit of background on Nirrumbuk, it started off as a community development program organisation back in 1993. Full credit to the board of directors and members—they decided that they needed to sustain themselves because CDP was not going to cut it and the money was not always going to be there. They put a lot of work into starting up a few businesses that did not make it, but that did not stop Nirrumbuk from establishing businesses and keeping the organisation going. There are many people who play a big part in the organisation. The membership consists of 10 member groups to whom the organisation provides financial support to build their capacity and their little communities up on the peninsula.

It is the only organisation in Broome that is sustainable. It supports and provides help for everyone. It is not only for Aboriginal people either. That is one thing about Nirrumbuk: it is not attached to any native title group. That makes it such a better organisation to be in. There are no political obstacles in the way for it to move forward. It is just a bunch of 10 people who decided to take ownership of the organisation and build it to where it is today.

I take this opportunity to congratulate everyone who has been a part of Nirrumbuk's incredible journey: their board, their elders, their members, their staff and their partners and supporters. People have been dedicated to ensuring Nirrumbuk thrives. May its journey continue to provide help and opportunity to Broome and the surrounding communities. I want to mention the CEO, Joe Grande; the chairperson, Louie Bin Maarus; and Raymond Christophers. Gee, I could go on and on, but I will not; I will name only three people.

For me, my personal thing with Nirrumbuk is that I have been involved with the organisation since the day it started. That is 30 years of my life with Nirrumbuk. Prior to becoming a member of Parliament I was the chairperson for 10 years. I had to give that up to become a member, which was really a big stepping stone for me on my personal journey. The board are the people who make the organisation work and there is no other organisation in Broome that is as sustainable. They are visionary people who just want to keep on making Nirrumbuk a bigger organisation. Thank you, guys.

Members: Hear, hear!

COOPER DAVID WEST — STILLBIRTH RESEARCH AND EDUCATION

Statement

HON DARREN WEST (Agricultural — Parliamentary Secretary) [6.26 pm]: It is always difficult to follow Hon Rosie Sahanna and I acknowledge the wonderful work done by Nirrumbuk in Broome. For anyone who goes to Broome, do what I did and take the time to make contact with Hon Rosie Sahanna and have a look. It will inspire you and you will never forget the experience of the wonderful work. I am pleased that the honourable member acknowledged her contribution because she has certainly been a driving force behind Nirrumbuk over many years.

Today is 13 September and it is just another day for many people, but for our family it is a very significant day. On 13 September 2000, our third child, Cooper David West, died and was born, and our family has never been the same since. It is literally heartbreaking when this happens. Tomorrow is someone else's day and the day after that

is another family's day, and every day there is a family that has been torn apart by infant loss and stillbirth. I wanted to take the opportunity to speak about it. As a member of Parliament, we are very privileged to be here and we have a platform to campaign for these issues.

I want to take the time to acknowledge those who work in services within the health system and other things such as Red Nose Australia for the amazing work they do in areas of prevention and support for families. I know for us that support was so important. It is such a difficult time when people expect to be bringing home a healthy bouncing baby and have the ultimate heartbreak. Those organisations who pick those people up and dust them off and help them manage that are certainly very special, and have been to us and to many families. If members can support those organisations financially or with their time, please do so because they make a significant difference.

I want to touch on what is probably the elephant in the room when it comes to this. I am referring to a report on the Department of Health website, which is titled *The 16th report of the Perinatal and Infant Mortality Committee of Western Australia, for births between 2014 and 2018*, which provides an overview of the —I will need Hon Dr Brian Walker to help me with this!

The PRESIDENT: Epidemiology.

Hon DARREN WEST: The report provides an overview of the epidemiology of stillbirths, neonatal deaths and post-neonatal deaths between 2014 and 2018 in Western Australia and a summary of the findings of the committee and its recommendations. The key findings are about the incidence and the trends. The report states —

- Between 2014 and 2018, there were a total of 174,050 births, 1,164 stillbirths, 290 neonatal deaths and 158 post-neonatal deaths.
- Overall, the rates of perinatal and infant mortality were low. Since 1990–92, there has been a significant decrease in the neonatal mortality rate (from 3.9 to 1.7 per 1,000 live births) and post-neonatal mortality rate (from 2.9 to 0.9 per 1,000 live births) in 2014–18.

That is a significant reduction in neonatal mortality. The report continues —

- The rate of stillbirths has remained unchanged for nearly three decades.
- The rates of stillbirth, neonatal and post-neonatal mortality for babies born to Aboriginal mothers continue to be higher than the comparable rates for babies born to non-Aboriginal mothers.

I now refer to the risk factors —

- The following factors were associated with increased odds of stillbirth in a multivariate model: Maternal age ≥35 years, maternal smoking during pregnancy, maternal ethnicity … nulliparity, multiple pregnancy, absence of antenatal care, complications during pregnancy, region of residence in Western Australia … lower socio-economic status and male sex of the baby.

Some other significant risk factors are listed. I will skip to the recommendations of the committee, which I think are significant and would like to place on the public record —

1. That the Department of Health, the Women and Newborn Health Service, and public and private maternity care providers across the State be made aware that the rate of stillbirth remains largely unchanged, and that new strategies are required and will need support.
2. That the ongoing high rates of perinatal loss in Aboriginal people need all health services to provide evidence-based and culturally sensitive services with appropriate support.
3. Congenital anomalies (birth defects), including rare diseases, remain a major cause of perinatal loss. Some of these anomalies are preventable. The WA Birth Defects Registry … should be encouraged and supported to provide the health services with timely state-wide data enabling appropriate decision making in regard to preventative strategies.
4. Preterm birth remains one of the major causes of perinatal loss. Effective strategies are now available to prevent many cases of early preterm birth and health care practitioners and services are directed to the guidelines of the Australian Preterm Birth Prevention Alliance … to remain updated on the National program now underway to safely lower the rate of early birth across Australia …

The recommendations go on. Members who are interested can refer to that document and look at the great work of the committee. There is plenty of information and data online that will back this up. In 30 years, essentially, the number of stillbirths remains too high. We have not been able to understand and prevent stillbirths like we have with early neonatal births.

As I said, whilst I am an MP, and the Parliament sits on 13 September, I will continue to remember and honour our little man and do what I can to prevent what we went through from happening to others.

House adjourned at 6.32 pm