Parliamentary Debates

(HANSARD)

FORTY-FIRST PARLIAMENT

FIRST SESSION

2023

LEGISLATIVE COUNCIL

Tuesday, 12 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.

BILLS

Assent

Message from the Governor received and read notifying assent to the following bills —

1. Appropriation (Recurrent 2023–24) Bill 2023.
2. Appropriation (Capital 2023–24) Bill 2023.

DENTAL SERVICES — HEDLAND

Petition

HON PETER FOSTER (Mining and Pastoral) [1.02 pm]: I present a petition containing 70 signatures couched in the following terms —

> To the President and Members of the Legislative Council of the Parliament of Western Australia in Parliament assembled.
>
> We, the undersigned residents of Western Australia urgently call on the State Government to provide accessible dental services to school aged children and the wider community.
>
> The recent staff shortage at the school dental clinics in Hedland has left a gap in reliable annual check-ups and emergency care with children resorting to private care if affordable. Those that can't afford private care will be missed and this could have detrimental effects on the future care of children's teeth.
>
> The Government dental clinic is provided from a temporary caravan in the Hedland Health Campus car park has been in this location since moving from the Community Health building some 5–10 years ago is not accessible for patients with a disability/mobility issue and forced to wait under a tree in car park during Summer is unreasonable.
>
> Your petitioners therefore respectfully request the Legislative Council to investigate the shortage of Dental services in Hedland and subsequently make recommendations to the State Government to provide these regular school dental services and reduce the staff shortages experienced and plan and open a permanent space for the Government dental services that is accessible to everyone.
>
> And your petitioners as in duty bound, will ever pray.

[See paper 2484.]

ELECTORAL REFORM

Petition

HON NEIL THOMSON (Mining and Pastoral) [1.03 pm]: I present an e-petition containing 2 405 signatures couched in the following terms —

> To the President and Members of the Legislative Council of the Parliament of Western Australia in Parliament assembled. We the undersigned ...
>
> express our dismay at the proposal to abolish another regional Legislative Assembly seat in Western Australia which further erodes and silences the voices of the Regions. We note this comes on the back of attacks on regional Western Australia including: 1. the recent implementation of unworkable Aboriginal Cultural Heritage laws 2. the removal of regional representation from the Legislative Council when no mandate was given to this at the 2021 Election 3. the proposal to shut down the live sheep trade by the Federal Government 4. the abrupt decision to end sustainable native timber harvesting. We call on the Legislative Council to stand in solidarity with regional people in the face of the ongoing assault and marginalisation of regional voices and support in the strongest terms the following: 1. The retention of existing regional Legislative Assembly seats until the 2029 election cycle. 2. The establishment of a Parliamentary Select Committee to: (a) examine how to improve our democracy with fair representation from regional people. (b) ascertain whether the electoral roll has been accurately maintained to reflect the number of eligible voters in regional and remote seats in Western Australia. (c) provide recommendations to the Parliament of Western Australia and Minister for Electoral Affairs on how to ensure a balanced and robust democracy which acknowledges the challenges of isolation and remoteness in Western Australia.
>
> And your petitioners as in duty bound, will ever pray.

[See paper 2485.]

PAPERS TABLED

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

LEAVE OF ABSENCE

Motion

HON DR STEVE THOMAS (South West — Leader of the Opposition) [1.07 pm] — without notice: I move —

> That leave be granted to Hon Donna Faragher for three sitting days due to urgent personal business.

I obviously speak for everybody when we wish her the best on her loss last week.

Question put and passed.

ABORTION LEGISLATION REFORM BILL 2023

Committee

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

Clause 1: Short title —

Progress was reported after the clause had been partly considered.

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

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

[See paper 2486.]

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

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

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

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

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

Hon NICK GOIRAN: Yes. Phase 1, at the moment, includes everything prior to 20 weeks. Phase 1, moving forward, under this bill will include everything prior to 23 weeks. I am comparing and contrasting what changes will take place, other than the gestation limits. We will look at that in a moment. Before I dive back into that, a number of documents may assist us. I am going to ask questions about these documents, so I think it makes sense to get them on the record early, at the start of this week and the start of this day, in order to give the advisers the maximum opportunity to obtain them if they are not immediately readily available. I begin with the State Coroner. I think it is a non-controversial point that the bill before us will impact upon the work of the State Coroner, and we will look at that at the relevant provisions. My question is whether the State Coroner was expressly consulted about the provisions of the bill. In particular, there has been a line of questioning during question time over the last year, or possibly the last two years, from me to respective ministers and parliamentary secretaries regarding a recommendation that was made by the coroner. In essence, the response primarily from the Attorney General in the first instance that has come back was that the recommendation could not be made immediately available because it needed to be considered by his cabinet colleagues. The indication was that it would be made available at some subsequent time. To pause at this point, has the State Coroner expressly been consulted about this bill? Secondly, can the coroner's recommendation be made available to the chamber?

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

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

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

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

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

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

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

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

Hon NICK GOIRAN: Thanks, minister. I acknowledge the response and the standard practice by Parliamentary Counsel. I make the observation at this time that what Parliamentary Counsel may consider to be a minor amendment in terms of quantum of words can make a very significant change to the state of the law—one example being the Coroners Act 1996—but I will not take it any further. My point is that in terms of documents available to the committee as we scrutinise the bill, no blue bills are available for those acts for the reasons that the minister has identified. Would the minister have available the *Induced abortions in Western Australia* sixth and seventh reports? The sixth report provides the data from 2016 to 2018 and the seventh report, if it is available, provides the data from 2019 to 2021. Those would be the last two versions of the data extracted by the government from the abortion notification system.

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

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

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

[See paper 2487.]

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

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

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

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

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

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

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

procedure. This can be carried out between 11 and 14 weeks' gestation by chorionic villi sampling of placental tissue. Alternatively, after 15 weeks' gestation, fetal amniocytes can be sampled by amniocentesis. Both tests take one to two weeks to get a result.

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

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

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

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

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

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

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

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

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

The member is quite right that an ordinary person looking at that might think, "Are you saying informed consent is no longer required?", but that is absolutely not the case. However, the definition that was put into the bill reflected

the debate in the Parliament at the time and that is why it was done that way. I take the point that the member is making. Under the provisions in place in Western Australia now, it is a requirement to provide and meet the full conditions of informed consent set out in the current legislation.

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

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

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

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

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

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

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

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

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

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

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

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

Hon NICK GOIRAN: That may well have been the feedback, but notwithstanding that, the truth of the matter is that they are not required to be counselled; that is the point. As the Leader of the House said, at the moment

there are no practice guidelines and I then said that people are doing it in a way that they deem appropriate, and that will continue to be the case moving forward. At the moment, the definition of "informed consent" in the Health (Miscellaneous Provisions) Act states, in part —

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

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

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

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

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

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

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

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

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

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

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

I am really surprised that, over that extended period, some thought was not given to providing a statement of information that is available across the whole of Western Australia so women can access the information and start the process of making an informed decision. Not every woman has access to King Edward. In some cases, due to language, tyranny of distance or online issues, some women would not have that access either. This arises out of the debate that we will be working through during our time here. I know that an amendment is coming up, but I do not understand why government has not given some consideration to pulling something together and making it more freely and widely available.

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

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

[Leave granted. See paper 2488.]

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

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

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

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

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

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

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

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

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: With all due respect to the stakeholder Hon Martin Aldridge heard at the briefing, when that person said that they do not think it is their job to do that—again, I am paraphrasing what that person allegedly said—it is obviously not right as a matter of law. At the moment, under the statute, they need to provide information about the medical risk of termination of pregnancy. Moving forward, whether they like it, whether they want to do it, and whether or not they think it is their role, they will have to do it because if they do not, they will breach the law of Western Australia that requires that a medical procedure cannot be undertaken without informed consent. As a result of that, I go back to my original question: what is actually changing here, other than it will not be enshrined in the statute? Are we simply changing from a statutory definition of informed consent to a common-law definition of informed consent?

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

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

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

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

Hon Sue Ellery: I do not think so.

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

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

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

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

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

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

Hon SUE ELLERY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

I know the member said that he wants to do it using the positive and not the negative, but I do not have a positive list; I have a negative list. It is useful to know where people who seek these services are in the state, but there is a very deliberate policy decision not to make that so specific that we would know their postcode, suburb or address, so it will be by region. It is also useful for health policy planning provisions to know the age category of people seeking these services. Again, so as not to potentially identify somebody, the data will be collected in age ranges such as under 15, 15 to 19 and so on. In part, honourable member, that is because if we were to combine a very specific address with a very specific age, in some of our most remote communities, it would be clear who that person was. That is not the case if we are walking around suburban Perth, but it could be the case elsewhere. The information will not include the race or nationality of the person for the same reason. Again, the gestational age of the fetus at the time at which the service is provided will be provided in an age range. The information will not include the particular reason for an abortion having been performed, the particular clinical method or the clinical outcomes. All those exclusions are so that we are not intruding to the extent that a person could be identifiable.

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

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

Hon WILSON TUCKER: The minister mentioned that the sum of the parts could be collected together and could identify someone; in the case of regional WA, I think that is true. I will wait until we are debating that specific clause

to get into some of the rationale, because it does seem like a very broad generalisation around data collection. I think some cases could present in the future whereby this generalisation approach and these exclusions could work against the Department of Health, but I will leave that for a later discussion.

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

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

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

Hon SUE ELLERY: It could.

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

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

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

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

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

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

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

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

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

Hon Sue Ellery: By way of interjection, correct.

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

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

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

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

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

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

The CHAIR: Leader of the House.

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

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

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

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

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

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

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

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

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

> Hon Martin Aldridge noted the removal of the ministerial panel for late-term abortions and queried why information held by the panel was not available. The Department of Health holds information on the number of induced abortions performed in WA through the reporting mechanism established under the Health (Miscellaneous Provisions) Act. When the medical practitioners on the panel do not approve an abortion to proceed, it is noted on the individual person's medical record but not on a database. There is

> no statutory requirement to collect information about the decisions of the panel other than whether an abortion was performed. For this reason, information of this nature cannot be provided to third parties. In any case, the provision of this information would not provide an accurate picture, as patients report they may seek an abortion interstate rather than approach the panel.

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

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

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

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

Hon SUE ELLERY: I am somewhat limited by the information available to me. All I am able to report to the honourable member is that an individual's medical record remains the medical record. That is held wherever that medical record is held, whether that is with the referring practitioner or the hospital that the patient attended. The medical record remains. On the advice available to me, it appears there is no, and has been no, collation of that information about the noes. I am not in a position to assist further.

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

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

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

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

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

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

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

Hon SUE ELLERY: It is the case that the principle I read out would apply. It would go both ways. The honourable member can appreciate that, as I said, when there are conflicting views about whether consent should be granted by a parent or a child, the medical practitioners involved will go to great lengths to make sure that they both understand what that means and might even, as a matter of practice, bring in other practitioners or members of their healthcare team to help the family resolve that situation, because they would still have a familial parent–child relationship. However, if consensus is not able to be achieved, by law, Gillick competence says that it is the patient who makes the decision.

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

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

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

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

Hon Martin Aldridge: Until something goes wrong.

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

The Gillick competency is in place. It prevails, but I am advised that the practice of practitioners would be to make sure as much as possible that everybody understands the consequences and what is being considered. Ultimately,

the point of Gillick competency is to draw a line when a mature minor is saying that they do or do not want X and a parent is saying that they do or do not want X. How is a decision made when one has to be made? They rely on Gillick competency.

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

Hon SUE ELLERY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hon NICK GOIRAN: Is the minister saying that the provision in proposed section 202MM, which would allow a substitute decision-maker to make the decision on behalf of the young person moving forward, does not apply under the current state of the law? I think data has been collected that has suggested that abortions have occurred from

as young as 12 years old, for example. I seem to recall having read something about that. I will use a 13-year-old for this particular example. As I understand the minister's answer, at the present time if a young person at the age of 13 seeks an abortion, there is no capacity for a substitute decision-maker to make the decision on their behalf. If a medical practitioner says, "No, look, this 13-year-old doesn't have capacity and doesn't meet the test", what would happen in that situation?

Hon Sue Ellery: Now?

Hon NICK GOIRAN: Yes.

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

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

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

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

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

Hon NICK GOIRAN: Under the current law, irrespective of the age of the person, they must provide informed consent, as set out in the statute, but is it not the case that in order to provide that informed consent in accordance with the statute, the person must have capacity? It is a fundamental principle of informed consent that the starting point is that they have to have capacity. If the person does not have capacity, there can be no informed consent; that is why we talk about things like substitute decision-makers. In a situation in which a medical practitioner says, "Look, I cannot get the statutory informed consent of this 13-year-old because I have determined that the person does not have capacity, either as a matter of law or as a matter of my own assessment, Gillick or otherwise", what would happen at the present time?

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

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

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

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

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

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

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

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

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

I am trying to find the bit in my notes that is relevant. Maybe I will just read the whole thing. If the child is a child of marriage—that is, the child of the husband and wife in the marriage—the application may be brought in the Family Court of WA or the Supreme Court of WA under section 67ZC of the Family Law Act 1975. The applicant must be a person concerned with the care, welfare or development of the child within section 69C of the Family Law Act. For example, doctors, health professionals and hospital staff are persons concerned with the care, welfare or development of the child. If the child is not the child of a marriage, the application must be brought in the Family Court of WA under section 162 of the Family Court Act, as that court has exclusive jurisdiction to hear such applications under section 36(8) of the Family Court Act. The application may be brought by a person concerned with the care, welfare or development of the child within section 185 of the Family Court Act. If an application cannot be brought under the Family Court Act or the Family Law Act, because, for example, the proposed applicant would not have standing or another prerequisite to the exercise of the jurisdiction of the Family Court cannot be met, then an application would need to be made to the Supreme Court seeking orders in the exercise of the Supreme Court of WA's parens patriae jurisdiction. However, that jurisdiction of the Supreme Court should not be seen as a residual jurisdiction. In deciding whether to make an order about a child, the court must regard the best interests of the child as the paramount consideration.

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

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

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

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

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

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

Hon NICK GOIRAN: As I was saying, we have reasonably comprehensively scrutinised the distinction between phase 1 abortions at the present time and moving forward. The definition of a phase 1 abortion for the purposes of the debate has been those abortions that take place prior to 20 weeks' gestation; under the new legislation, it is proposed to be prior to 23 weeks' gestation. Four key changes have been identified as a result of that scrutiny. Firstly, two doctors—a referrer and a performer—are presently involved. Moving forward, only one doctor will be involved. At the present time, those two doctors need to obtain informed consent as defined under the statute. Secondly, moving forward, the singular doctor will still need to obtain informed consent as per common law. Thirdly, in situations in which a medical abortion takes place, it will now be possible for two further types of practitioners—nurse practitioners and endorsed midwives—to prescribe the medical abortion. As with any medical practitioner, they will still need to make an assessment of capacity, albeit there will be some changes in the court of jurisdiction that may be invoked in presumably rare cases. Fourthly, there will be some changes to the reporting regime. In particular, the reporting at the present time is prescribed by the regulations; moving forward, it will be done by way of directions. The minister has taken on notice that in due course she will inform the house about some of those differences when comparing the current form of reporting process with what the process will be under the directions. This is particularly important when we consider it is triennial reporting, and the minister identified that there will be some differences in what can be included in the triennial report.

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

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

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

Hon SUE ELLERY: Yes.

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

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

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

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

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

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

patient, under the current arrangements, it is an adult and a minor via the version of informed consent that we have been talking about. Under the provisions before us, it will be all adults and minors. Then we have discussed the changes in reporting.

Does the member want me to go to clause 23?

Hon Nick Goiran: In a moment, yes.

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

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

Hon SUE ELLERY: Honourable member, perhaps that was my shorthand. I was trying to describe the parameters within which a practitioner will perform an abortion and deem that the patient presenting is justified, if you like, in seeking that abortion. The practitioner has to operate within their own scope of practice, and then a range of other factors will come into account. Please do not read anything more or less into it other than me giving the member a shorthand list of the factors that an individual practitioner will apply.

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

Hon Sue Ellery: Yes.

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

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

Hon NICK GOIRAN: Yes.

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

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

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

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

Hon KATE DOUST: We have done a swap to give a bit of variety to the cause. I have been interested to listen to this part of the debate. Minister, I looked at page 11 of that document titled *Induced abortions in Western Australia 2016–2018*, where it talks about the health service category and breaks it down into the provision by different public or private entities, and I listened to the discussion around ethics and who provides that. Just based on this information from 2016 to 2018, the absolute bulk of abortions conducted in this state were conducted via the private sector, not the public sector. One question there is why is that the case? We are having this discussion about what we do with staff development, using data to provide updates and all those sorts of things, but the reality is that if

almost 89-plus per cent of abortions at that point in time—I do not know whether that has gone up or down because we have not had the opportunity to see the updated statistics. If a woman is crossing the threshold into one of those premises, she is there for a very deliberate reason, and for the people who work there, that is a service that they deliver. It is a different discussion in some ways to the one around going to a private practice when we start to talk about this "refuses versus unwilling" type of situation. It is an interesting discussion that we are having when the reality is that the vast bulk of these services are provided by the private sector. I find that quite interesting when we have this discussion around access and provision of services and how we change things.

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

Hon SUE ELLERY: I think it is probably due to a combination of reasons and I do not know that we can be particularly precise about it. One of the reasons is that there is increasingly a trend to medical abortions that can be performed by a general practitioner at the lower gestation level. Therefore, more of those are being done at the lower gestation level because more can be done and because GPs can do that. The ones that are performed at the higher level are, as we talked about a lot during the course of the debate, inevitably complex and need to be performed in a hospital setting. That is why that happens. I do not know that we can be more precise than that, honourable member. Historically, it is probably a function of the laws in Western Australia. I cannot give the member the stats, but I think we have probably had a disproportionately high number of people who have gone interstate for an abortion, if they can afford to go interstate, because it is easier. But over time, this trend of GPs being able to prescribe and give access to the respective drugs has changed as well. I do not think I can be more precise than that, honourable member.

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

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

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

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

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

Hon Sue Ellery: To take what path?

Hon KATE DOUST: The feticide, at that point.

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

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

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

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

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

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

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

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

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

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

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

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

be from the ministerial panel. One of the doctors is referred to as the primary practitioner and the other one could be called, for lack of a better description, the consulting practitioner. Could either the primary or the consulting practitioner be a person who is not a medical practitioner?

Hon SUE ELLERY: No.

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

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

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

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

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

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

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

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

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

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

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

Hon SUE ELLERY: I sort of answered that before in response to Hon Kate Doust. I cannot be precise, honourable member, but what we know right now is that for the particular method of feticide, there is a specific set of qualifications for the methods used in Western Australia. I think that of itself will limit where it can be done for the foreseeable future. These laws might mean that the profession will change and that more people will choose

that particular specialty pathway. I am not sure. I do not know whether I can be more precise. My personal expectation is that making access to abortion care itself, not just late term, but across the spectrum, may well see more Western Australian women seeking abortion care here rather than choosing to go interstate, but I think that will perhaps mean a higher number of procedures at the lower level. I do not see anything in these laws that will change the clinical drivers for the reasons women have late-term abortions.

Committee interrupted, pursuant to standing orders.

[Continued on page 4372.]

QUESTIONS WITHOUT NOTICE

GRIFFIN COAL — LIQUIDATOR

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

I refer to my questions without notice in the last week of August 2023 pertaining to the execution of financial assistance agreements between the state and Griffin Coal in which the minister said that two FAAs had been executed between the state and Griffin Coal—the first on 11 January 2023, but amended on 19 May 2023; and a further FAA of 14 August 2023, which the minister termed the "process agreement".

(1) What is the difference between a financial assistance agreement and a process agreement?

(2) What variance in compliance regimes or obligations between both parties exist in an FAA versus a process agreement?

(3) Who or whom determined that a process agreement between the state and Griffin Coal for the third tranche of taxpayer bailout money was the appropriate mechanism; and on what advice, basis or rationale was the decision taken?

Hon STEPHEN DAWSON replied:

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

(1)–(2) The process agreement is similar to the previous financial assistance agreements but contains additional terms that apply to Griffin's receivers and managers, such as additional reporting requirements.

(3) Senior public servants recommended the process agreement as an appropriate mechanism, based on commercial and legal advice.

Hon Dr Steve Thomas: I hope they tell us what the changes are.

GRIFFIN COAL — LIQUIDATOR

992. Hon Dr STEVE THOMAS to the minister representing the Treasurer:

I refer to the appointment of administrators and receivers to the insolvent Griffin Coal in September 2022 and the months leading up to and since those appointments.

(1) In relation to Griffin Coal, since 1 July 2022 has any Treasury representative or officer, including departmental or ministerial staff, met with representatives, employees or officeholders of —

(a) Cor Cordis;

(b) KPMG;

(c) the ICICI Bank;

(d) Sternship Advisers;

(e) Oceania Resources;

(f) Lanco Pty Ltd; or

(g) Lanco Resources Australia?

(2) If yes to (1), on what dates did these meetings occur; and who was in attendance and in what representative capacity?

(3) What records, minutes, documentation, recordings or notations of these meetings were compiled, and will the minister table them in the house?

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

Hon STEPHEN DAWSON replied:

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

(1)–(4) The Assistant Under Treasurer of Agency Budgeting and Governance, who is responsible for energy matters within Treasury, met with Sternship Advisers on two occasions—28 February 2023 and 14 April 2023.

SOUTH COAST MARINE PARK — INDICATIVE MANAGEMENT PLANS

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

I refer to the proposed south coast marine park.

(1) Have the draft indicative management plans for the Wagyl Kaip, Wudjari, Ngadju and Mirning been endorsed by the respective governing bodies?

(2) If no, can the minister provide an indicative time frame within which endorsement of the IMPs will be obtained?

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) The Wagyl Kaip Southern Noongar Aboriginal Corporation and the Esperance Tjaltjraak Native Title Aboriginal Corporation have endorsed their respective indicative joint management plans. The Ngadju Native Title Aboriginal Corporation has advised that it does not currently have capacity to engage in the process. The indicative management plan seeks to enable opportunities for joint management with the Ngadju Native Title Aboriginal Corporation in the future.

(2) Endorsement from the Mirning Traditional Lands Aboriginal Corporation on the indicative joint management plans is expected imminently.

MINISTERIAL STAFF — TERM-OF-GOVERNMENT

994. Hon TJORN SIBMA to the Leader of the House representing the Premier:

I refer to the transition from the McGowan government to the Cook government in early June this year, and the consequential financial impact of departed or departing term-of-government ministerial staff. Who among these staff have ceased employment and what is the value of each individual payout?

Hon SUE ELLERY replied:

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

I wish to table the paper attached to the answer.

[See paper 2489.]

Hon SUE ELLERY: Ministerial staff are employed by way of term-of-government contracts under section 68 of the Public Sector Management Act 1994. On termination of employment, term-of-government employees are entitled to a termination payment and any accrued leave entitlements. Following the 2017 election, termination payments to ministerial staff of the previous Liberal–National government totalled more than $5.6 million.

POLICE — STAFF

995. Hon PETER COLLIER to the minister representing the Minister for Police:

(1) How many police resigned in August 2023?

(2) How many police retired in August 2023?

(3) What is the current total number of police officers in Western Australia?

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 Police.

The Western Australia Police Force advise as follows —

(1) a total of 29 police resigned;

(2) six police retired; and

(3) as at 31 August 2023, there were 6 902 police officers.

COMO SECONDARY COLLEGE

996. Hon NEIL THOMSON to the minister representing the Minister for Education:

I note that the South Perth/Como high school community has raised concerns for several years regarding the rundown facilities at Como Secondary College, which has seen a third of eligible students from the area go to alternative public schools outside the catchment area.

(1) Will the minister commit to visiting Como Secondary College?

(2) What is this government's commitment to pay more than lip service to that school's needs?

Hon SUE ELLERY replied:

I thank the honourable member for some notice of the question. The Minister for Education has provided the following answer.

(1) I visited Como Secondary College on Thursday, 7 September 2023, accompanied by Geoff Baker, MLA, the member for South Perth.

(2) The Cook Labor government is delivering significant upgrades to our schools as part of our $1.5 billion investment in public education capital works. This program of works is the largest investment in public education capital works in our state's history.

It builds upon our September 2019 announcement of our $200 million school maintenance blitz program. A total of $2.079 million of this funding was spent at Como Secondary College to address air conditioning systems, resurface playing surfaces, undertake toilet upgrades, roof replacements, structural upgrades and other minor works, and refresh classrooms.

All up, since 2017, the McGowan and Cook governments have invested $4.57 million at Como Secondary College.

The member should note that the Department of Education's asset investment program for 2023–24 is also the largest of its kind in over a decade, at $626.8 million.

"TREE STREETS" LOCAL HERITAGE AREA — BUNBURY

997. Hon BEN DAWKINS to the parliamentary secretary representing the Minister for Heritage:

I refer the minister to the City of Bunbury's proposed "tree streets" local heritage area.

(1) How many local heritage areas in WA include 200 or more homes, and where are they?

(2) Can the minister table the feedback or advice the department provided to the City of Bunbury relating to the proposed "tree streets" local heritage area; and, if not, why not?

(3) Can the minister table the local heritage assessment relating to the proposed "tree streets" local heritage area from 2004; and, if not, why not?

Hon SAMANTHA ROWE replied:

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

(1) Data on local heritage areas is maintained by local governments.

(2) Yes. I table the paper attached to the answer.

[See paper 2490.]

(3) No. The 2004 investigation into the cultural heritage significance of the "tree streets" area was commissioned by the City of Bunbury.

SMART ENERGY FOR SOCIAL HOUSING

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

I refer to the Smart Energy for Social Housing trial announced in July 2020.

(1) Has the Smart Energy for Social Housing trial now finished?

(2) If yes to (1), will the minister please table the results?

(3) If no to (1), to what extent is the trial still being funded?

(4) How many houses have had solar panels installed as part of the trial to date?

(5) If known, what were the average savings per household participating in the trial?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. I am answering this question on behalf of the Minister for Agriculture and Food, who is out of the chamber on urgent parliamentary business. The following information has been provided by the Minister for Housing.

(1)–(5) The Smart Energy for Social Housing trial announced in July 2020 is a joint partnership with the Department of Communities and Synergy and is scheduled to be completed by 30 June 2024. The trial is investing $6 million to install 3.6 kilowatt solar panel systems on 500 social housing dwellings. As at 6 September 2023, a total of 281 social housing dwellings have had solar panel systems installed. On completion of the trial, the Department of Communities will work with Synergy to evaluate the trial.

MINES, INDUSTRY REGULATION AND SAFETY — COMPLIANCE PROGRAM

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

I refer the minister to the compliance program of the Department of Mines, Industry Regulation and Safety.

According to month and for the period August 2022 to August 2023 —

(a) How many reports of an incident or noncompliance were received by the department in relation to —

(i) minerals; and

(ii) petroleum?

(b) Of the incident reports, how many were and how many were not received within the required reporting period of —

(i) 24 hours within detection, in relation to minerals; and

(ii) two hours within detection, in relation to petroleum?

(c) In relation to minerals, how many recordable incident reports were received that stated —

(i) a recordable incident took place; and

(ii) no recordable incidents took place?

(d) In relation to minerals, how many reports of an incident or of noncompliance were investigated and found to be in breach of tenement conditions?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. Probably not surprisingly, due to the amount of information required, it will not be available today. I therefore ask the honourable member to put his question on notice.

MEDICAL CANNABIS

1000. Hon Dr BRIAN WALKER to the Leader of the House representing the Minister for Road Safety:

I refer the minister to research undertaken in Italy and published earlier this year in the journal *Current Pharmaceutical Biotechnology* under the article title "Cannabis and Driving: Developing Guidelines for Safety Policies", which concludes that the regulation of cannabis users behind the wheel is necessary but also achievable.

(1) Will the minister ensure that this research is considered by the recently announced medicinal cannabis and safe driving working group, not least because it concludes that a THC cut-off between 3.5 and 5 nanograms a millilitre is a more balanced way to approach this than the current zero-tolerance model we have in place?

(2) Can the minister inform the house when the working group is likely to hold its first meeting, and what time frame, if any, it has been given for a reporting deadline?

Hon SUE ELLERY replied:

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

(1) Any specific research considered by the medicinal cannabis and safe driving working group will be a matter for the working group.

(2) It is anticipated that the working group will commence this year.

HEALTH — PATIENTS — DRUG TESTING

1001. Hon SOPHIA MOERMOND to the Leader of the House representing the Minister for Health:

I refer to the Medicines and Poisons Act 2014, which makes stipulations regarding reporting of drug dependence among patients by authorised health personnel.

(1) What guidelines and regulations does the Department of Health provide for psychiatrists and paediatricians regarding drug-testing regimes among patients?

(2) What data is retained by the Department of Health regarding the presence of drugs, including cannabis, among psychiatric patients?

(3) Does the Department of Health have data on how many people diagnosed with ADHD are being refused treatment due to the presence of cannabis in their system?

Hon SUE ELLERY replied:

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

(1) The schedule 8 prescribing code suggests urine drug screening may be included as part of a clinical assessment of risk prior to commencing treatment with stimulant medicines in patients over 13 years of age.

(2) If a patient meets the defined high-risk criteria under the schedule 8 prescribing code, stimulant prescribers provide urine drug screen results to the Department of Health as part of the application process for authorisation to prescribe.

(3) No.

FIRE AND EMERGENCY SERVICES — TECHNICIANS

1002. Hon MARTIN ALDRIDGE to the Minister for Emergency Services:

I refer to the shortage of Department of Fire and Emergency Services mechanical technicians, auto-electricians and radio technicians.

(1) By FTE, how many mechanical technicians are currently employed; and, by FTE, how many positions remain vacant?

(2) By FTE, how many auto-electricians are currently employed; and, by FTE, how many positions remain vacant?

(3) By FTE, how many radio technicians are currently employed; and, by FTE, how many positions remain vacant?

Hon STEPHEN DAWSON replied:

I thank the honourable member for some notice of the question. The Department of Fire and Emergency Services advises —

(1) Four FTE are currently employed, and four roles remain advertised and open to suitably qualified applicants.

(2) One FTE is currently employed, and one role remains advertised and open to suitably qualified applicants.

(3) Six FTE are currently employed, and two roles remain advertised and open to suitably qualified applicants.

I should say that that information is current as of today's date.

EDUCATION — TRANSPORTABLE SCHOOL BUILDINGS

1003. Hon NICK GOIRAN to the Leader of the House representing the Minister for Education:

I refer to the department's decision to slow down the installation of transportable school buildings due to the depth of the footings required until the Aboriginal Cultural Heritage Regulations are repealed.

(1) When was the impact of the new laws on the installation of transportable school buildings first drawn to the attention of the minister?

(2) How many transportable school buildings are currently pending installation?

Hon SUE ELLERY replied:

I thank the honourable member for some notice of the question. The premise of the member's question is false. There has been no impact on the installation of transportable school buildings related to the Aboriginal Cultural Heritage Act.

PUBLIC AND SOCIAL HOUSING

1004. Hon STEVE MARTIN to the minister representing the Minister for Housing:

I refer to public and social housing in Western Australia.

(1) Can the minister provide the total number of the following in Western Australia, as of the nearest available date —

  (a) social houses; and

  (b) public houses?

(2) How many public houses are currently vacant?

(3) How many applications, representing how many individuals, are there currently for the —

  (a) public housing waitlist; and

  (b) priority public housing waitlist?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. I answer on behalf of the Minister for Agriculture and Food. The following information has been provided by the Minister for Housing.

(1) Since the Cook government's record investment of $2.6 billion into social housing and homelessness measures, the state government has added more than 1 500 homes, with a further 1 000 under contract or construction. Some of these properties may not be reflected in this data as the data often takes time to be transferred wholly into the Department of Communities' systems across regional offices.

As at 31 July, there were 43 795 social houses, of which 36 383 are public houses.

(2) The vacancy number is always a single-point-in-time number that fluctuates for a range of reasons, including maintenance, refurbishments and redevelopments waiting for re-let. People move in and out of public housing properties for a range of reasons, including moving into aged care or alternative accommodation, changes in family composition or other life circumstances. If maintenance is undertaken to return a property to service, it is undertaken so it can be re-let in clean, safe and working order.

As at 31 July 2023, 1 395 returning properties were in the process of either being re-let to people on the public housing waitlist or returning to stock after the completion of refurbishment or maintenance, to be allocated to people on the public housing waitlist. As at 31 July 2023, 426 non-returning properties were undergoing further assessment and may be considered for redevelopment.

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

SYNERGY AND HORIZON POWER — DISCONNECTIONS

1005. Hon Dr STEVE THOMAS to the parliamentary secretary representing the Minister for Energy:

I refer to both Synergy and Horizon Power and each month from 1 June 2023 to 31 August 2023.

(1) How many residential disconnection notices have been issued for each entity?

(2) How many residential disconnections have occurred for each entity?

(3) What was the number of applications received and hardship utility grants scheme payments made for each entity from 1 June 2023 to 31 August 2023?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. I have been advised that, due to the amount of information required, it will not be available today. Therefore, I ask Hon Dr Steve Thomas to put the question on notice. It says until tomorrow, but I am saying to put the question on notice, because that does not make a great deal of sense.

Hon Dr Steve Thomas: On notice until tomorrow?

Hon MATTHEW SWINBOURN: It says, "put the question on notice until tomorrow", but I do not think the last two words make any sense, so put the question on notice.

SOUTH COAST MARINE PARK — INDICATIVE MANAGEMENT PLANS

1006. Hon COLIN de GRUSSA to the parliamentary secretary representing the Minister for Fisheries:

I refer to the Minister for Environment's response to question without notice 977, asked on 31 August 2023, regarding the proposed south coast marine park.

(1) When did the Department of Primary Industries and Regional Development provide comment to the Department of Biodiversity, Conservation and Attractions about the indicative management plans for the Wagyl Kaip, Wudjari, Ngadju and Mirning?

(2) Did the comment provided by the Department of Primary Industries and Regional Development contain information detailing the potential economic impact of the draft indicative management plans on the commercial fishing industry and/or local communities?

(3) Has DPIRD received feedback from the comments provided to the Department of Biodiversity, Conservation and Attractions; and, if so, in what form and on what dates?

Hon KYLE McGINN replied:

Honourable member, what is the number of that question?

Hon Colin de Grussa: It is 1143.

Hon KYLE McGINN: It does read that this question was asked by Hon Dr Steve Thomas, but it has word for word what Hon Colin de Grussa said so I will provide the answer.

The following answer has been provided to me by the Minister for Fisheries.

(1)–(3) DPIRD provided comment on potential commercial fishing impact to DBCA on the Wudjari, Wagyl Kaip and Ngadju draft indicative joint management plans, draft IJMP, on 6 June 2023 and the Mirning draft IJMP on 7 June 2023. A response was received via email on 7 June 2023.

LOCAL GOVERNMENT, SPORT AND CULTURAL INDUSTRIES —
STAFF — WORKING FROM HOME

1007. Hon TJORN SIBMA to the parliamentary secretary to the Minister for Culture and the Arts:

I refer to the policy and practice of working from home at the Department of Local Government, Sport and Cultural Industries.

(1) How many staff at the department have been approved to work from home?

(2) How many State Emergency Service officers have been approved to work from home?

(3) Has the director general received approval to work from home?

Hon SAMANTHA ROWE replied:

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

(1) As at 12 September 2023, 205 staff have received approval to work from home but they are not necessarily working from home on a regular basis.

(2) No SES officers have been approved to work from home.

(3) The director general has not sought a work-from-home arrangement.

POLICE — MENTAL HEALTH SUPPORT

1008. Hon PETER COLLIER to the minister representing the Minister for Police:

I refer the minister to his response to question without notice 969 asked on Thursday, 31 August, which indicated for the first time that the overall growth in both internal and external support services had increased from 15 to 22 positions.

(1) How many of the seven new positions have been provided internally and what is their specific role?

(2) How many of the seven new positions have been provided externally and what is their specific role?

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 Police.

For the awareness of the honourable member, the increase is in support services, not positions. The Western Australia Police Force advises that the relevant personnel are undertaking external operational duties and are not available to provide a response within the required time frame. A response will be provided to the honourable member on Thursday, 21 September 2023.

ELECTORAL ENROLMENT

1009. Hon NEIL THOMSON to the parliamentary secretary representing the Minister for Electoral Affairs:

I refer to the answer to question without notice 970 asked on 31 August and note the systemic under-enrolment in regional areas when assessing enrolment rates as a proportion of census data.

(1) Is Electoral Boundaries WA or the Western Australian Electoral Commission aware of the significantly wider than average gap between enrolment and adult population of regional districts when compared with metropolitan districts, which I referred to as structural under-enrolment but might better be described as systemic under-enrolment in regional areas?

(2) Has Electoral Boundaries WA or the WA Electoral Commission undertaken an analysis of the reasons for this?

(3) Given the claims of increased enrolment in the lead-up to the Voice referendum, is there any statutory reason for Electoral Boundaries WA not updating its enrolment dataset before finalising the proposed regional boundaries?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. The following answer has been provided to me by the Minister for Electoral Affairs, whom, for the member's future reference, I represent.

(1)–(2) The Western Australian Electoral Commission—along with its joint electoral roll partner, the Australian Electoral Commission—is always studying enrolment rates across the state. It is conscious of varying enrolment trends in regional districts across Western Australia, including areas of sustained population growth and decline. There is no uniform systemic under-enrolment in regional areas. The issues and reasons for varying enrolment across all electoral districts varies based on some common factors, as well as the particular characteristics of each district.

(3) The determination of the relevant day is set out in section 16E of the Electoral Act 1907, which states that the state must be divided into districts as soon as practicable after the day that is two years after polling day for each general election for the Assembly. The roll close for the distribution took place on the relevant day, which was 13 March 2023, in accordance with the act. Section l6G of the Electoral Act 1907 requires the commissioners to divide the state into districts in accordance with the enrolment levels determined at the relevant day.

LANDGATE — TELEPHONE CALLS

1010. Hon BEN DAWKINS to the minister representing the Minister for Lands:

(1) How many phone calls has Landgate received in the last five business days prior to today?

(2) What was the average wait time for those calls?

(3) How many callers of those calls opted for a call back?

(4) How many of those callers who opted for a call back received a call back and what was the average wait time before the callers received a call back?

Hon MATTHEW SWINBOURN replied:

On behalf of the Minister for Agriculture and Food, the following information has been provided by the Minister for Lands, and it was correct as at 31 August 2023 when the question was asked.

(1) It received 1 598 phone calls.

(2) It was 24 minutes and 26 seconds.

(3) The number was 590.

(4) All 590 callers received a call back.

BICYCLE NETWORK PLAN

1011. Hon Dr BRAD PETTITT to the minister representing the Minister for Transport:

I refer to the *Western Australian bicycle network plan 2014–2031*.

(1) How many kilometres of on-road bike lanes have been installed since the 2017 update of the WABN plan?

(2) How many more kilometres of on-road bike lanes will be installed to complete the WABN plan?

(3) How many of the completed on-road bike lanes are protected bike lanes?

(4) How many of the planned on-road bike lanes will be protected bike lanes?

Hon STEPHEN DAWSON replied:

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

(1) Approximately 240 kilometres of cycling infrastructure has been delivered, of which 1.43 kilometres is classified on-road.

(2) This is yet to be determined as the long-term cycle network defines the network by function—primary, secondary and local routes—rather than form. Form is determined during the design process.

(3)–(4) All on-road bike lanes delivered under the WABN plan are, and will continue to be, protected as unprotected on-road bike lanes are not eligible for funding.

VARANUS ISLAND GAS PLANT — ALLEGED INCIDENT

1012. Hon WILSON TUCKER to the parliamentary secretary representing the Minister for Mines and Petroleum:

I refer the minister to a document tabled in the Australian Senate by Australian Capital Territory Senator David Pocock on 16 February 2023 containing a statement by an alleged whistleblower regarding an oil spill that allegedly took place sometime in March 2022 at the Varanus Island gas plant, which is located 300 kilometres off the coast of Karratha.

(1) Has the state government completed an investigation or is it currently carrying out an investigation into this alleged incident?

(2) If the state government has completed an investigation into this alleged incident, what were the findings of that investigation?

(3) Is the state government aware of an investigation into this alleged incident either internally by Santos or externally by a third and independent party?

(4) If yes to (3), does the state government expect to be informed of the findings of this investigation; and, if so, when?

Hon MATTHEW SWINBOURN replied:

I thank the member for some notice of the question. The following answer has been provided to me by the Minister for Mines and Petroleum.

(1) The Department of Mines Industry Regulation and Safety is currently carrying out an investigation into the alleged incident.

(2) The investigation is ongoing.

(3) Yes, DMIRS is aware of an internal investigation by Santos.

(4) Santos informed DMIRS of the findings of its internal investigation on 22 March 2023.

MEDICAL CANNABIS — ORAL HEALTH

1013. Hon Dr BRIAN WALKER to the Leader of the House representing the Minister for Health:

I refer the minister to recent research undertaken in the United States that shows that 90 per cent of dental students felt they would benefit from more education around cannabis and its potential impacts on oral health.

(1) What training, if any, is offered to dental students and, indeed, practising dentists here in Western Australia in regard to cannabis use and oral health?

(2) Will the WA government include additional dental training within the scope of its feasibility study into the establishment of a medicinal cannabis advisory service, as supported in principle in the government's response to the recommendations of the recent Select Committee into Cannabis and Hemp; and if not, why not?

Hon SUE ELLERY replied:

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

(1) Cannabis use and its impact on oral health is included within the Doctor of Clinical Dentistry training at the University of Western Australia. Training courses on pain management and medicinal cannabis are available to dental practitioners.

(2) The scope of feasibility studies into the establishment of a medicinal cannabis advisory service could include any registered health practitioner who may have reason to access such a service for the prescribing, administration or supply of a medicinal cannabis product.

ABORIGINAL RANGER PROGRAM

1014. Hon SOPHIA MOERMOND to the parliamentary secretary representing the Minister for Environment:

I refer to the media statement issued today regarding the Aboriginal ranger program, which has created more than 650 ranger jobs on country since 2017.

(1) Of the 650 ranger jobs created, what percentage of these roles were offered at full time?

(2) If these 650 positions were not offered full time, what is the number of full-time equivalent positions since 2017?

(3) If the positions were not offered full time, what was the average number of hours offered to each ranger?

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) The 650 jobs pertain to the total number of ranger employment opportunities offered in phase 1 of the Aboriginal ranger program. Full-time equivalent data was not gathered for phase 1 of the ARP. As an improvement to the program, this information is now being sought in phase 2 reporting.

(2) Not applicable.

(3) This data is not sought from Aboriginal organisations so cannot be provided or accurately estimated.

FIRE AND EMERGENCY SERVICES — OPERATIONAL FLEET

1015. Hon MARTIN ALDRIDGE to the Minister for Emergency Services:

I refer to the Department of Fire and Emergency Services operational fleet and the 263 fire appliances identified during budget estimates as being in operation beyond their approximate service life.

(1) In answer 17 to the questions prior to hearing, why did the minister advise the committee that there were zero vehicles in operation beyond their indicative service life when there are more than 260?

(2) Why did the minister give evidence to the committee in response to a question from Hon Colin de Grussa at public hearings that "the answer provided pre-estimates is correct" when it was not?

Hon STEPHEN DAWSON replied:

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

(1)–(2) For the member's benefit, "service life" refers to an asset period of life in service to DFES. As the assets are all within service, no appliances are considered beyond their indicative service life by the vehicle manufacturers themselves. The Department of Fire and Emergency Services advises that at the time of budget estimates, 263 vehicles were beyond their intended service life to DFES; however, as they are still serviceable and remain in a safe operating condition, they can continue to be used by DFES brigades, groups or units until they are replaced.

MAIN ROADS — DATA COLLECTION

1016. Hon NICK GOIRAN to the minister representing the Minister for Police:

I refer to the Auditor General's twenty-fifth report on 12 June 2023, which states —

> … despite being aware they are not permitted to, MRWA has continued to collect anonymous data from local road users under the Surveillance Devices Regulations 1999.

(1) Is the Western Australia Police Force aware of the report?

(2) Is the minister aware that the Minister for Transport has been unable or unwilling to assure the house that Main Roads Western Australia is now complying with the regulations?

(3) What steps has the WA Police Force taken with Main Roads WA to enforce these regulations?

(4) Further to (3), when were those steps taken?

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 Police.

I refer the honourable member to question on notice 673 asked on 20 June 2023.

ABORTION LEGISLATION REFORM BILL 2023

Committee

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

Clause 1: Short title —

Committee was interrupted after the clause had been partly considered.

Hon NICK GOIRAN: As we adjourned for the taking of questions without notice, we were midway through the consideration of clause 1; in fact, I would say far beyond midway through the consideration of clause 1. Essentially, I just want to finalise consideration of the process after 23 weeks' gestation, and then the only remaining issue that I personally intend to take up under clause 1 is the process for the registration of births and deaths post–an abortion.

With regard to abortion post–23 weeks, we have been comparing and contrasting late-term abortions under the current law and what it will be like moving forward. The threshold will change from 20 weeks to 23 weeks' gestation, and it will still be the case that two medical practitioners will need to be involved, albeit they will no longer need to be practitioners from the ministerial panel.

The proposed legislation states that the primary practitioner and the second practitioner, whom I have referred to as the consulting practitioner, both need to reasonably believe that performing the abortion is appropriate in all the circumstances. Is it intended that reasonably believing that performing the abortion is appropriate in all the circumstances post–23 weeks will continue to be the justification that has applied under the current law for late-term abortions by the panel?

Hon SUE ELLERY: The judgement will be a clinical one, but there is a prescription, if you like, that applies under the current provisions at 334(7)(a) of the Health (Miscellaneous Provisions) Act 1911 that states that the performance of the abortion is not justified unless two practitioners who are members of the panel have agreed that the mother or the unborn child has a severe medical condition that, in the clinical judgement of those two medical practitioners, justifies the procedure. That may well be a judgement that is reached by the two medical practitioners under the new arrangements, but we are not prescribing it, because they would take into account the best interests of the patient, and the clinical presentation—that is the word I was trying to think of—of the patient. We are not prescribing it. It may well include that case, but it might be other reasons.

Hon NICK GOIRAN: What would be a reason for a primary or consulting practitioner to reasonably believe that performing the abortion at, let us say, 25 weeks, just to pick a gestational age, is not appropriate in all the circumstances?

Hon SUE ELLERY: It really will depend on the circumstances of the presenting patient. We do not intend to prescribe in here what they should exclude or include. It will depend entirely on the circumstances that are presented to them and their best clinical judgement. They may seek specialist advice from others. It will depend on all those circumstances, but they will make that clinical judgement themselves.

Hon NICK GOIRAN: We have had 25 years of experience in Western Australia with this, so that must count for something. In addition, the government has undertaken a consultation process. That must count for something. We are not providing any guidance, but we are saying that two medical practitioners have to comply with the law. Remember the discussion that we had earlier when I think we were both a little—perhaps "critical' is too strong a word, but for the lack of a better description—critical of what had happened as a result of the 25-year decision to use the language of counselling within the definition of informed consent. Rightly or wrongly, some medical

practitioners have perhaps interpreted that language of informed consent in a particular way and thought that they needed to provide some kind of comprehensive counselling, whereas another fair-minded practitioner would say, "No. Actually, all I am required to do is provide information. I don't have to provide any counselling per se." The minister can see how important understanding and interpreting the legislation is. The government has chosen at this particular provision to say to practitioners, "We are leaving it to you to reasonably believe that performing the abortion is appropriate in all the circumstances." It must mean something either based on historical experience over 25 years or on consultation or some other information that is not presently before the house. I would like to know what that is. For example, I know that there is an amendment on the supplementary notice paper that seeks to prohibit an abortion occurring for sex selection simply because it has been identified at a scan that the unborn baby is female. I am not a medical practitioner. I am not going to have a role in any of this, but in my nonclinical opinion that would not be appropriate in all the circumstances. If a medical practitioner hears from a woman who says that they would like to have an abortion at 25 weeks' gestation because they are going to have a girl, could a medical practitioner comply with the legislation and say, "I reasonably believe that in these circumstances performing the abortion is appropriate"?

Hon SUE ELLERY: I take the honourable member to proposed section 202ME, "Performance of abortion by medical practitioner at more than 23 weeks" —

> (2) In considering whether performing an abortion … is appropriate in all the circumstances, a medical practitioner must have regard to —
>
> > (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.
>
> (3) Subsection (2) does not limit the matters to which a medical practitioner may have regard in considering whether performing an abortion on a person is appropriate in all the circumstances.

Those are the parameters that the bill will put in place for the things that a practitioner needs to take account of when performing an abortion at more than 23 weeks' gestation.

Hon NICK GOIRAN: I will not pursue this any further at this time only because we can reasonably take this up when we get to clause 8 and, as the minister says, proposed section 202ME. But I will conclude my consideration of clause 1 by asking the minister: what is the current process for the registration of a birth after an abortion has taken place? I do not propose to go back into the debate on whether there is such a thing as a live birth after an abortion. I am absolutely clear in my mind that there is such a thing and that answers to Parliament have confirmed that that is the case. If a live birth occurs after an abortion has taken place, what is the current process with regard to the registration of that birth? If that baby then dies, whether that be nine minutes later or two hours later or whatever period of time, what is the process for recording the death of that baby? To conclude this point, will any of that change as a result of the bill currently before us?

Hon SUE ELLERY: The information that has been provided to me is a response to a question, so it is probably easiest if I read it that way. The question is: is a neonatal death post abortion registered as a birth? The response is: in accordance with section 13(1) of the Births, Deaths and Marriages Registration Act —

> If a child is born in the State, the birth must be registered under this Act.

That act is not being amended, therefore any live birth that occurs after an abortion procedure must be registered with the Registrar of Births, Deaths and Marriages, and similarly the death must be registered.

Hon KATE DOUST: I think we started a conversation about this briefly the last time we sat and the minister referenced the births and deaths legislation. Hon Nick Goiran put forward a scenario in which a baby is born alive after an abortion and then passes away. The bill before us changes the Coroners Act retrospectively, so in that scenario the live birth and death of that child, as I understand it, will not be looked into—that is a totally different question—but if the coroner is not looking into it and there is no record of that birth, what is the jump point from the coroner looking at that to the parents seeking to register a birth or death, which has not happened legally in the eyes of the coroner, I suppose? I am curious about how we make that jump.

Hon SUE ELLERY: I am not sure that I made myself clear when I provided that answer. I think the member might be conflating two things in that question. If the child is born in this state, the birth must be registered under the act. If a neonatal death occurs post abortion—nine minutes later—that birth must be registered, and nothing is changing with regard to how we record or register births. Similarly, the death must be registered, and nothing is changing with how we record the death. That has nothing to do with whether or not it is reportable to the coroner. In the event that the death occurs after a birth, both the birth and the death are registered, and nothing is changing in that respect.

Hon KATE DOUST: This is probably also my last question on clause 1, and it is a fairly general question. The minister referred to this issue a couple of times as anecdotal information, and I know that the Minister for Health has made reference to this issue as well as being one of the drivers behind the need to change from the 20 to 23-week threshold, if you like. The reference is to the number of women who have had to leave the state to seek an abortion. I know that the minister has said that she has anecdotal information, but I am not too sure where the Minister for Health's information comes from. How do we officially know how many women have actually had to leave the state to seek a late-term abortion and are those records maintained? I want to know whether it is anecdotal or empirical information that is available.

Hon SUE ELLERY: I actually provided an answer to this when we last debated the bill. There is no collection of data on women who have chosen to go interstate to get an abortion. During the course of the consultation on the drafting of the bill, I am advised that clinicians indicated that they know that their patients had made that decision, but that information was not collected. Short of doing some kind of border control, we do not know the numbers, and so I do not have that information.

Hon NICK GOIRAN: Before we move off clause 1, I know that there has been only the briefest of breaks, if we would even describe it as a break, for the taking of questions without notice, but has any of the information that was taken on notice become available since that time?

Hon SUE ELLERY: I have the form 1, so I was going to use this to compare with the categories of data that were published in the sixth report that we referred to for 2018 to 2021. I could table this but I will read it out. This is the notification —

Hon Nick Goiran: This is the existing form 1.

Hon SUE ELLERY: Correct. I will compare the information that is collected on this compared with the data that we will collect in the future. Currently, we will collect the name of the practitioner. We will not collect the address of where the procedure was performed. We will do gestational age in ranges. How we will include the method of termination is not determined, but we could ask for broad categories—for example, surgical versus medical. How we will include the reason for termination of the pregnancy is not yet determined, but we could ask for broad categories of reasons. For the patient's age at the last birthdate, we will again do that in ranges. We will not ask for the origin of the patient. We will not ask for the postcode. We will ask for region only.

Hon NICK GOIRAN: My recollection is that if a fetal anomaly has been suspected or detected, it is included in the form 1. I probably have it in my file here but I do not readily have it available to me.

Hon Sue Ellery: As part of the reasons, honourable member.

Hon NICK GOIRAN: Is it intended that that will continue to be the case moving forward?

Hon SUE ELLERY: No.

Hon NICK GOIRAN: Right. And why not?

Hon SUE ELLERY: The decision about whether to perform an abortion is made according to the categories that we have canvassed slightly before. We most recently canvassed the ones in respect of more than 23 weeks. The policy position is that this is about the best interests of the patient presenting. There could be a range or a combination of reasons that that termination is carried out, but it has not been deemed necessary that as a matter of course we should collect that information. It might be that at some point in the future, the Chief Health Officer decides that it is of some public health benefit to collect the information on a certain category of reasons, but, essentially, that is the reason.

Hon NICK GOIRAN: Earlier today, when the minister was providing some information that had been taken on notice about why the practice of feticide had been introduced in Western Australia in 2017, the minister mentioned a couple of conditions. One was trisomy 18 and the other was anencephaly. I think I understood the minister to say that that information was part of the reason that feticide was introduced in 2017. That information would be available to the government only because the information had been collected in the form 1s. Please do not hear me for one moment here making a case for feticides. I am not making a case for anything that is happening at the moment, but I accept and acknowledge that the collection of data has changed a practice. I am not, again, suggesting that feticide never took place before 2017, but a very deliberate decision was made in 2017 to say that, in essence, from now on we will have this practice as a matter of course and there will be exceptions to that. Why was that possible? It is because data was collected. It seems then counterintuitive that we would then say we will not collect this information anymore.

Proponents of the bill might say we helpfully collected data on anencephaly over a time, but we do not want to know that anymore. I find that at this point a little irrational and I would be asking whether there is any further information to justify not providing these reasons anymore. Trisomy 18 is an example the minister has given as well. There is an amendment on the supplementary notice paper standing in my name in regard to Down syndrome. Down syndrome is otherwise known as trisomy 21. Imagine for a moment if my amendment is not successful. I know it does not require too much imagination, but imagine that were the case. Moving forward, we will not know whether in

Western Australia late-term abortions for Down syndrome are happening if the data is not being collected. People are entitled to have a view to say it should be okay at 30 weeks' gestation to have an abortion for Down syndrome. I do not obviously hold that view. Others are entitled to have a different view on that. I do not understand why we would take a policy position or otherwise to say that we will not collect that data.

Hon SUE ELLERY: Under the form 1, the specific reference to trisomy 21 or other is not required. Information is currently collected on the reason for termination; reason other than fetal abnormality; suspected fetal abnormality; actual fetal abnormality, specified if known; and selective reduction of multiple pregnancy. It does not accurately—depending on how it is filled in as well—specify a particular abnormality, so that goes to the member's question specifically. Also, I am advised that because it is so general in nature, it has not been relied upon to assist to inform public policy, if you like. King Edward Memorial Hospital for Women might keep information that it uses to inform its practice and that might be around the method that is used, but collecting that kind of information across the board has not provided the level of, to Kevin Rudd it, "specificity", that the member referred to, and because of the general nature of it, I am advised that it cannot be of any help to the Chief Health Officer in directions to take public health policy.

Hon NICK GOIRAN: I will make this observation, and we will take this up a little later. How do I say this charitably? I respectfully disagree with what the minister has just said insofar as the legislation before us specifies that both of the two medical practitioners for late-term abortions are going to have to reasonably believe that performing the abortion is appropriate in all the circumstances. Again, I am not the Chief Health Officer and I have no intention of ever applying for the job. However, if I were the Chief Health Officer, I would like to know that what we have said here in "reasonably believing that performing the abortion is appropriate in all the circumstances", having considered all the relevant medical circumstances, the person's current and future physical, psychological and social circumstances, and the professional standards and guidelines commonly accepted by members, is actually being enforced and complied with. Earlier I gave the example of someone at 28 weeks' gestation saying that they did not want to have a girl. I cannot imagine that the Chief Health Officer, whether they are male or female, would be happy with that. They would want to know that that is not happening in Western Australia. Maybe the Chief Health Officer would also say, "I don't think it is appropriate as part of the professional standards and guidelines for a 34-week unborn baby with Down syndrome to be terminated." I think that would be appropriate. If we are going to regulate this system, it is essential to maintain the data. I will take this up a little further when we get to clause 8, and specifically proposed section 202ME.

To conclude this point, the only reason we are here is that we were just checking whether anything had come back about what had been taken on notice. I take it there is nothing further.

Hon Sue Ellery: I have nothing further.

Hon WILSON TUCKER: We had a conversation earlier about the information related to an abortion that the Chief Health Officer can request from a clinician. We spoke about some of the exclusions and the minister mentioned that the information that can be provided to the CHO is through guidance. Is the request by the CHO —

Hon Nick Goiran: Direction.

Hon WILSON TUCKER: There is a direction by the CHO about the possible information—I think we were calling it the pro case—with those exclusions in mind. The minister mentioned that, because it is at the direction of the CHO, she cannot give the chamber an example. I am curious because the amount of possible information related to an abortion is a known scope. Is that an undertaking that the minister can provide in terms of the upper bounds of the possible information that could be requested as part of this direction from the Chief Health Officer?

Hon SUE ELLERY: I am not really sure what the honourable member is asking me. I know that he has had some conversations with the minister, and I will have more to say about that when we get to that particular provision. The act sets out the parameters that the Chief Health Officer cannot collect information on. Unless I can understand where the member is going a bit more specifically, I am not sure that I am in a position to provide him with any more information.

Hon WILSON TUCKER: By way of explanation, there is only so much information related to an abortion that can be collected. When the Chief Health Officer issues a direction to capture information related to an abortion, it cannot include everything under the sun; it has to be related just to an abortion. That scope should be known. I am asking about the scope of possible information related to an abortion.

Hon SUE ELLERY: I cannot be specific, other than to take the honourable member to proposed section 202MQ, which is on page 23 of the bill. It lists the purposes for which the Chief Health Officer may record, use or disclose information, and that goes to the provision, monitoring, planning and evaluation of health services. One of the points I was making about a direction is that there may be some reason that we cannot contemplate now that the Chief Health Officer becomes aware of and he wants to test the veracity of whether it is an issue. The upper limits, if you like, are the provisions of the bill, but there might be something that data is able to be collected on but we cannot anticipate what it might be about at this point. I do not think I can take it much further than that.

Hon WILSON TUCKER: I will leave it there for now and when we get to the clause, I will think about a different way of approaching what I am trying to get to.

Will the collection of information change? How is information related to an abortion currently being captured? Is there a system with a name and will that system change under this legislation?

Hon SUE ELLERY: There is a form 1, which is a piece of paper that has a series of questions on it. If the member is talking about the technology, I do not have that information here. I am advised that during the implementation period, the agency will be looking at some kind of electronic system, but I do not know what that might be at this point. So that people do not have to physically fill in a form, scan it and send it, which is what they do now, the agency is looking at developing some of kind of electronic system.

Hon WILSON TUCKER: Currently, it is an analogue process. The form is called a form 1, and we are moving towards an electronic system in the future. The implementation will change and the fields of information that are captured in relation to an abortion will also change. Is that correct?

Hon SUE ELLERY: Yes. I went through that a little earlier; the honourable member might have been out of the chamber on urgent parliamentary business. I went through the difference between what is collected now and what will be collected in the future.

Hon NICK GOIRAN: There is one point that was taken on notice that is still to be made clear. In due course, we are going to get an explanation of what data that is presently included in the triennial reports will no longer be included because it will not be able to be captured anymore. We went through a few examples. At the moment, the age range is reported, and that will continue to be the case moving forward, but there was some suggestion that some things in these reports will not be able to be provided in the future, and that has been taken on notice.

Clause put and passed.

Clause 2: Commencement —

Hon KATE DOUST: I am going to ask a question that I have not asked since I was in opposition. Clause 2(b) provides that other than part 1, the rest of the act will come into operation on a day fixed by proclamation. Can the minister provide an indication to the chamber of that particular time period?

Hon SUE ELLERY: We anticipate that it will be six months from assent.

Hon KATE DOUST: Is that because regulations need to be drafted?

Hon SUE ELLERY: There is a range of things, including in the health and justice systems, that we need some time to prepare for with the changes. There are revisions to a suite of policies and clinical guidelines—for example, the information collection system that I was just talking about with Hon Wilson Tucker. Some regulations will also need to be put in place.

Hon KATE DOUST: Is the minister able to provide to the chamber an outline of the areas of the bill—soon to be the act at some point—that regulations will be drafted for?

Hon SUE ELLERY: Regulations will be required around the provisions for nurse practitioners and endorsed midwives as prescribing practitioners; regulatory materials sitting underneath the Health (Miscellaneous Provisions) Act, including consequential amendments to the Health (Notification by Midwives) Regulations; and the repeal of the Health (Section 335(5)(d) Abortion Notice) Regulations.

Hon KATE DOUST: Prior to the commencement of the whole of the act, in due course, what plans does the government have to provide information or guidance notes to medical practitioners about these changes?

Hon SUE ELLERY: I just read out some of that in my answer to the member. There is provision for a suite of policies and clinical guidelines in both the public and private health settings around the consent-to-treatment policy; information for medical practitioners on their legal obligations under the act; information collection; standard information regarding the relevant contact details for the patient to locate or contact a registered health practitioner; the provision of education to health service providers and registered health practitioners about the new legislation; and the development of processes and training within a number of internal and external bodies. The Women and Newborn Health Service recognises that, aligned with the abortion legislation reform, there will need to be a review and modification of the current care of women seeking abortions and their aftercare. The State Administrative Tribunal will need to make changes in line with its new jurisdiction over adults who are unable to give consent to the performance of an abortion, and the Department of Justice, in respect of courts, will need time to align its practices and for the development of the materials that will be required to assist its staff with the management of abortion-related materials.

Hon KATE DOUST: Given that a significant number of other acts will be amended and there is quite a substantial change in the shifting time frames and that a whole series of other matters will be incorporated into this new legislation, and given that the minister said it will be possibly six months before proclamation, does the government have any plans to distribute information about all these changes and their implications to the general public or health consumers?

Hon SUE ELLERY: Yes. That will be part of the implementation process as well. I think there was a reference to providing consumers with information that I just read out. If I did not read it out, it is on that list.

Hon NICK GOIRAN: The minister mentioned that one of the policies or clinical guidelines that will be worked on in the next six months is the consent-to-treatment policy. I understood from our deliberations on clause 1 that the intention was that we would no longer need informed consent under the statutory definition but, rather, under the common law one, and therefore it will be the same as any other procedure. Why would anything need to be done to the consent-to-treatment policy?

Hon SUE ELLERY: We will need to make sure that people understand that there is a difference in that the common-law provision will prevail, but for those who operated under the previous bespoke version of informed consent, which we spent a lot of time talking about, we will make sure that people understand that we cannot rely on that bespoke definition any longer.

Hon NICK GOIRAN: Will the consent-to-treatment policy document be publicly available?

Hon SUE ELLERY: I am advised that if it is a mandatory policy, it would generally be available only to the health practitioners who need to use it. I am happy to take on notice the question of whether or not something in them would preclude them from being made public, but, as a matter of practice, they are used by practitioners and probably include quite technical information in some areas and I am not sure whether they would be of any great value to members of the public. But I am happy to take on notice whether or not they would be made public.

Hon NICK GOIRAN: The consent-to-treatment policy itself will be a different standalone document from, presumably, the consent-to-treatment policy that exists with regard to any other medical procedure. I appreciate the point the minister is making that she will want to inform practitioners that, if they thought they were operating under the statutory definition previously, they must be made aware that they will not be operating under the existing regime. I am trying to understand exactly what is being created here. If a consent-to-treatment policy exists for medical practitioners in Western Australia to say what the policy is for any particular treatment they are providing, would we not simply refer everybody to that? A moment ago, I was referred to a question without notice from June. Similarly, would the government not refer people to the existing consent-to-treatment policy?

Hon SUE ELLERY: There are a couple of things. The context of the conversation was what we will use that six months for and why we need it. Part of that is around educating and informing practitioners that the regulatory regime has changed. I am also advised that the current policy of informed consent includes a line to the effect of: this does not apply to abortion-care services. To that extent, that will need to be changed.

Hon NICK GOIRAN: The other point that was made just moments ago when considering clause 2 and the six-month period to prepare for the full operation of the act was that the State Administrative Tribunal will have a new jurisdiction to make decisions for adults who cannot provide consent. We discussed under clause 1 what the current regime is for minors who are found not to have capacity to consent, and the minister's answer was that in that situation, at the present time, the Children's Court is the court of jurisdiction and that that will change to the Family Court and the Supreme Court for minors. Clearly, moving forward to adults without the capacity to consent, that jurisdiction will be the State Administrative Tribunal. What is the court of jurisdiction at the present time for adults without capacity?

Hon SUE ELLERY: There is currently no court of jurisdiction. A 2015 State Administrative Tribunal decision found that informed consent can only be given under section 334 of the Miscellaneous Provisions Act by the individual concerned and cannot be given by a guardian under the Guardianship and Administration Act. When it has been required to happen, it may be performed if serious danger presents to the physical or mental health of the woman concerned, but that is a clinical decision. There is currently no jurisdiction to make that decision.

Hon NICK GOIRAN: Have no applications been made to the Supreme Court for an order in circumstances in which an adult has not had capacity?

Hon SUE ELLERY: No advice is available to me that any application of that nature has been made.

Hon NICK GOIRAN: By implication, the scenario is that there is an adult without capacity, no court of jurisdiction, apparently, according to the advice. We cannot comply with the provisions under the act, so therefore it results in a pregnancy going to term and a live birth. I cannot imagine that that would be the case, unless the minister is suggesting that this is one of the scenarios in which people have gone interstate.

Hon SUE ELLERY: A clinical decision is made based on whether there is a serious danger to the physical or mental health of the patient. I am advised that clinical decisions have been made relying on that in those circumstances.

Hon NICK GOIRAN: Yes, because that is one of the criteria that allows a medical practitioner to proceed, but they still need to have the consent of the person. They cannot get the consent of the person if the person does not have capacity, hence the need, in the case of children, for an order from the Children's Court. I appreciate that we are on clause 2, so it is not a critical point with regard to its passing, but I encourage further consideration of this point and maybe a more expansive answer can be provided at a later stage.

Clause put and passed.

Clause 3 put and passed.

Clause 4: Section 199 deleted —

Hon MARTIN ALDRIDGE: I want to take the minister to her media statement in her capacity as Minister for Women's Interests on 21 June 2023, entitled "Cook government introduces historic abortion bill". It states —

- Abortion will be fully decriminalised with the Criminal Code offence to be repealed

…

Abortion will be fully decriminalised, with the Criminal Code offence to be repealed, but it will still remain an offence for an 'unqualified person' to perform or assist with an abortion.

Will it remain a criminal offence for a person to perform an unlawful abortion?

Hon SUE ELLERY: For an unqualified person, yes, it will.

Hon MARTIN ALDRIDGE: So it will remain a crime. I am a little confused because when I read the commentary around this matter—this media statement is a case in point—the dot points under the heading state that "abortion will be fully decriminalised".

Hon Sue Ellery: Do you think this is some kind of gotcha moment, really?

Hon MARTIN ALDRIDGE: No, but I think there is a factual error in the government's media statement, which says that it will continue to remain a criminal offence to unlawfully perform an abortion in Western Australia. The minister just confirmed that in her response.

On page 2 of the explanatory memorandum, at clause 3, which is meant to read "clause 4", it says —

… the other amendments complete the decriminalisation of abortion, aligning WA with other jurisdictions.

Is it the case that we are indeed aligning ourselves with other jurisdictions? I certainly do not think the first part of the statement is correct because we are not completing the decriminalisation of abortion. The second part of the phrase says that we are "aligning WA with other jurisdictions". To the best of my recollection, when the debate kicked off about this community consultation, I think what was driving it initially was this issue of the criminal offences associated with abortion and that somehow Western Australia was an outlier. The discussion paper released by WA Health entitled *Abortion legislation—Proposal for reform in Western Australia* includes a helpful table on page 19, which refers to the criminal offences for unlawful terminations. In fact, we are consistent with every other jurisdiction in Australia, with the exception of the ACT, which uses its Health Act 1933. Every other jurisdiction in Australia regulates or includes offence provisions within their criminal codes. Have things moved on since the discussion paper of November 2022? The explanatory memorandum suggests that we are aligning ourselves with other jurisdictions.

Hon SUE ELLERY: If the member looks at the detail in the table that he referred to, he will see that we align on the proposition that the person performing the abortion must be a qualified person. We are also aligned on other elements that are not related to the Criminal Code. On some elements, we are not aligned; we take a different position on some elements. Where we align on the Criminal Code is that abortions in the other jurisdictions, as will be the case in Western Australia if this bill passes—it is out of the Criminal Code—can only be performed by a qualified person.

Hon MARTIN ALDRIDGE: I think the contention has been where we have effectively been regulating—the risk is that we regulate registered healthcare practitioners by application of the Criminal Code to their practice. The discussion paper states —

Under section 199 of the *Criminal Code,* —

Which we are seeking to delete via this clause —

abortion is lawful in WA, as long as it is performed by a medical practitioner in good faith and with reasonable care and skill, and the performance of the abortion is justified under section 334 of the *Health (Miscellaneous Provisions)* …

We are removing that provision, so we are still retaining the "unqualified person" criminal offence but we are shifting it out of the Criminal Code and putting it into the H(MP). Why have we chosen to no longer use the Criminal Code for the regulation of unlawful abortions when it appears that every other state and most territories, with the exception of the ACT, continue to use the Criminal Code to regulate this practice?

Hon SUE ELLERY: The abortion offence is currently located in the Criminal Code under a chapter titled "Offences against morality".

Sitting suspended from 6.00 to 7.00 pm

Hon MARTIN ALDRIDGE: Just before we broke for dinner, the minister was about to embark on a reply so I thought I might give her the opportunity to reflect on her notes.

Hon SUE ELLERY: I had made the point that the abortion offence is currently located in that part of the Criminal Code titled "Offences against morality". We want to move the offence to provisions under the Public Health Act to reinforce that we see this as a public health matter. It also has the advantage of, for the main part, consolidating laws relating to abortion in a single statute. That approach is similar to the one taken in South Australia, as an example.

Hon MARTIN ALDRIDGE: Far from this being a gotcha moment, I think it is important, and I said it in my contribution to the second reading debate, that we do not send the wrong message to the community around the consistently strong regulation that applies and will continue to apply appropriately around abortion care. I do not think it is correct to say that we are decriminalising abortion. I certainly do not think it is correct to say that we are fully decriminalising or completing the decriminalisation of abortion. Nor is it correct to say that we are aligning ourselves with other jurisdictions in the application of the Criminal Code because, as I pointed out from the government's own document, we will be joining the Australian Capital Territory as the only other jurisdiction in which the offence provisions will not be in the Criminal Code. We will be an outlier. We will not be the norm. I accept what the minister has said about the need to address particularly the issue that medical practitioners face. Obviously, the minister also has an issue with the title of the section in the Criminal Code. I was not aware of that, but Parliament can also change the titles of sections. We can shift sections. We can do anything we like, especially when the government has control of both houses, Hon Dan Caddy. None of those things are insurmountable but I want to draw this to people's attention. Section 199(5) of the Criminal Code is a section we will delete. I do not know whether the minister has access to it. The provision reads —

> A reference in this section to performing an abortion includes a reference to —
>
> (a) attempting to perform an abortion; and
>
> (b) doing any act with intent to procure an abortion,
>
> whether or not the woman concerned is pregnant.

I want to clarify that this section is being replaced by proposed section 202MN in the Public Health Act. Will it remain an offence for somebody to attempt to perform an abortion or do any act with intent to procure an abortion?

Hon SUE ELLERY: It is intended to be included. I refer the member to proposed section 202MB(1) on page 7 of the bill.

Hon MARTIN ALDRIDGE: The minister has just referred me to proposed section 202MB(1) —

> A person ***performs an abortion*** on another person if the person does any act with the intention of causing the termination of the pregnancy of the other person.

Is this just another way of saying "attempting to perform an abortion"? It is not necessarily that a person performs the abortion, but that they "attempt" to perform an abortion. I just want to make sure that is covered under the definition found in proposed section 202MB(1).

Hon SUE ELLERY: Yes, if the honourable member looks to the ordinary meaning of the words "if the person does any act with the intention of causing the termination of the pregnancy".

Hon MARTIN ALDRIDGE: The current offence provision in section 199 of the Criminal Code has a penalty of $50 000. If the abortion is carried out by a person who is not a medical practitioner, that person is guilty of a crime and is liable to imprisonment for five years. What will the penalties be if an offence is created against the new provision?

Hon SUE ELLERY: New section 202MN(1) makes it a crime for an unqualified person to perform an abortion on another person. Proposed subsections (3) to (8) set out who that unqualified person is. The penalty for the offence will be increased from five to seven years, which aligns with Queensland, South Australia, New South Wales and the Northern Territory. Victoria has a penalty of 10 years and the Australian Capital Territory has a penalty of five years.

Hon MARTIN ALDRIDGE: We have established that the offence with respect to an unqualified person will increase from five years to seven years. Proposed section 202MN says that it will remain a crime for an unqualified person to perform an abortion on another person, and that penalty is increasing from five to seven years. It is important to have that on the record because it stands in contrast to the government's claim that abortion will be fully decriminalised as a result of this bill. In fact, it will remain a criminal offence and the penalties are increasing from five to seven years under this government's bill.

Hon KATE DOUST: I have just been listening to this discussion. We will probably come back to it at a later stage, but I am wondering: on how many occasions have abortions by unqualified persons or illegal abortions been performed since 1998?

Hon SUE ELLERY: I am advised that the agency checked with the Western Australia Police Force and the Director of Public Prosecutions. We can go back only as far as 2009. Prior to that, records were not kept electronically so we are not able to access them. There have been no prosecutions since 2009.

Clause put and passed.

Clauses 5 to 7 put and passed.

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

Hon NICK GOIRAN: Chair, as we commence the consideration and scrutiny of clause 8, I might note for your attention in managing the bill that clause 8 is by far the most substantial provision in the bill. It begins at page 5 of the bill and we do not get to clause 9 until page 25, so some 20 pages of legislation deal with this single clause. The supplementary notice paper has a number of amendments under clause 8. In fact, at this point in time all the amendments relate to clause 8.

My understanding from past rulings is that once an amendment has been considered in respect of a portion of clause 8, we cannot then go back to an earlier part of clause 8 to make any amendments. I want to seek your advice and confirmation that that is intended to be the ruling as we consider this very substantial provision.

Secondly, if an amendment has been moved to a particular part of clause 8, is it still in order for a member to ask questions regarding earlier provisions in clause 8 without necessarily moving an amendment?

The CHAIR: Hon Nick Goiran, this is an area in which there has been some confusion previously during the Committee of the Whole stage of the bill. There is a standing order on moving forward and not going back, but that relates to clauses, not provisions within a clause. Here we are dealing with substantial amendments at clause 8 and so my advice is that we can deal with them in whichever way the house desires within clause 8, but we cannot go back and now deal with matters in clauses 7 or 6. It probably would be orderly for the committee, but I am at its will, to move through the clause as orderly as possible from the beginning to the end, notwithstanding a member's right to move back and ask a question on an earlier part of clause 8. The amendments can be dealt with in an order different from as they appear on the supplementary notice paper.

Hon KATE DOUST: It has been a while since I have done one of these. Given that we have got such a diverse number of amendments pertaining to this clause—I am just trying to think back to how we used to do it—my preference would be that I have a number of questions outside of the amendments that I have on the supplementary notice paper, and so I would like to work through all those questions throughout the clause and then perhaps come back to deal specifically with the amendments if that is possible.

Hon NICK GOIRAN: Thank you for that guidance, chair. I must get on the record that I am relieved to hear that that is the approach that is now to be taken by the Legislative Council. I must say, I never quite understood why there was a period when we seemed to take a different approach, so if that is going to be the approach, which is essentially flexible with how we will deal with a substantial clause like clause 8, it makes perfect sense to me. I meant to indicate for the benefit of the Leader of the House, at least for my part, my intention, and it also goes to Hon Kate Doust's point, to systematically work through clause 8 in any event, including as has been mentioned, on the supplementary notice paper.

I see Hon Ben Dawkins has an amendment standing in his name that relates to page 8 of the bill when this bill begins at page 5, and I would not want the honourable member to move an amendment at page 8 and then the rest of us to be unable to ask questions about pages 5, 6 and 7. Having had that clarified, I might just proceed with my line of questioning to the honourable minister.

Conveniently, the best place to start is proposed section 202MA, which deals with the terms used. One of the terms that is used is "abortion drug". It relates also to the Medicines and Poisons Act 2014. Are the types of drugs that are used to procure an abortion a medicine or are they a poison under the Medicines and Poisons Act?

Hon SUE ELLERY: The bill defines an abortion drug as —

> … a medicine of a kind used to cause the termination of a pregnancy of a person;

"Medicine" has the meaning that is given to it in section 3 of the Medicines and Poisons Act 2014—that being a substance that is a schedule 2, 3, 4 or 8 poison. The word "medicine" under the Medicines and Poisons Act includes those substances that are on schedules 2, 3, 4 or 8. The poisons that fall within each of these schedules are contained within the national Standard for the Uniform Scheduling of Medicines and Poisons, which can be referred to as the poisons standard.

Hon NICK GOIRAN: I appreciate that this is what the bill says, but would it be equally accurate to have the term "abortion drug" state, "means a poison of a kind used to cause the termination of a pregnancy of a person" and then have a definition that says, "poison has the meaning given in the Medicines and Poisons Act 2014, section 3"?

I know the minister is not going to do this and I know the government is not going to do this; I am trying to get confirmation as to whether there would be any material difference other than preference or choice of language between using the word "medicine" or "poison" as the terms "abortion drug" and "medicine" apply?

Point of Order

Hon Dr BRIAN WALKER: I have a point of order. On the wording here, speaking as a medical practitioner, all medicines are described as poisons.

The CHAIR: There is no point of order. You are able to seek the call and make that point, but there is no point of order.

Committee Resumed

Hon SUE ELLERY: I thank the honourable member for that contribution. "Medicine" has a definition, and it includes the poisons—if the member wants to use that word—that I have read out. There is no intention by the government to change it. "Medicine" has a defined meaning in the act and it is appropriate to use that term.

Hon NICK GOIRAN: I understand this better. The minister indicated that the type of what is being described here as a medicine is listed as a poison under the Medicines and Poisons Act; is that right?

Hon SUE ELLERY: "Medicine" has the meaning as given in section 3 of the Medicines and Poisons Act, being a substance that is a schedule 2, 3, 4 or 8 poison. The definition of "medicine" includes four lists of things that are also called poisons.

Hon NICK GOIRAN: To my point, it would not be inaccurate to suggest that an abortion drug is, in fact, a poison.

Hon SUE ELLERY: It has a specific meaning to those who use it. The meaning is set out in the Medicines and Poisons Act. The member can choose to interpret that as he wishes, but for clinicians, it has a meaning. The meaning is set out in the Medicines and Poisons Act, and that is why it is referred to in this part of the legislation.

Hon NICK GOIRAN: Is the minister saying that every poison is a medicine?

Hon SUE ELLERY: Not all poisons are medicines, but medicines can include poisons. The bill has been drafted with the use of the word "medicine" because that can include poisons. If we were to take out the word "medicine" and put in the word "poison", that would not necessarily mean that we were talking about medicines, because not all poisons are medicines.

Hon NICK GOIRAN: Not every poison is a medicine, but is an abortion drug a poison? Obviously, the answer is yes, because the minister indicated that it is in one of the schedules that she referred to earlier, so it is definitely a poison. Is she saying that it is to be considered a medicine by virtue of the fact that it is a poison?

Hon SUE ELLERY: No. I am saying that the word "medicine" has a specific clinical meaning that is set out in the Medicines and Poisons Act. It is appropriate to use the word "medicine" in this context because the definition of "abortion drug" relates to the definition of the word "medicine", which has a very specific meaning.

Hon NICK GOIRAN: At line 19 on page 5, the term that is used is, curiously, "person". Why has it been deemed necessary to define "person"?

Hon SUE ELLERY: What is the best way to describe it? The word "person" is used, I guess, because the current arrangements refer to adults and minors, whereas it is intended that the legislation before us now will cover everybody, irrespective of their age. Within that, certain provisions will apply to certain age groups—we have talked about some of those already—but the definition is there to indicate that the law will apply to all.

Hon NICK GOIRAN: If the definition set out here at lines 19 through to 21 was not included and we just saw in the legislation the word "person", which was undefined, would it mean the same as what is being defined here at lines 19 to 21, or have we changed how the word "person" would otherwise be interpreted?

Hon SUE ELLERY: It is included for the purpose of clarity. I suppose it is arguable that if it were not in there, it would still apply to persons. To be clear, one of the changes we are making is to the arrangements that apply currently under our legislation that are different for minors compared with adults. We want to make it clear that we are making a difference. I am advised that the drafting position was that the definition recognises that abortion is a medical treatment that can be accessed by both adults and children, each under varying circumstances and for different reasons.

Hon NICK GOIRAN: I think, at the very least, that perhaps we might be able to agree that the definition of "person" has been included, as the minister said, for absolute clarity so that there can be no confusion. I guess it is to be absolutely safe so that no-one who reads this legislation could possibly be confused about what a person is. They will have the benefit of this definition at page 5 at lines 19 to 21. I just make the observation that I hope that the principle of clarity—the importance of having something in the bill even when it is obvious—will apply consistently throughout all 50-odd clauses of the bill, not just to clause 8.

On page 6, at line 16 is the definition of "relevant health profession". That includes proposed paragraph (f) —

> a health profession that is prescribed by the regulations for the purposes of this definition;

Which health professions are intended to be prescribed?

Hon SUE ELLERY: The bill introduces the term "relevant health profession" to give effect to the provisions in the bill that will enable certain registered health practitioners and students to carry out particular acts when requested to do so; for example, to be part of a multidisciplinary team. The bill defines "relevant health profession" to mean any of the following professions that are listed in the bill in front of us. Prescribing a health profession for the purpose of the definition of "relevant health profession" relates to a number of clauses in the bill. For example, a student in a relevant health profession is authorised to assist in the performance of an abortion under certain conditions—

they are set out in proposed sections 202MG and 202MJ—and the student assisting must be under the supervision of a registered health practitioner in the relevant health profession. There are a lot of Rs in there, honourable member. It is important to understand that there is a difference between relevant health profession and registered health practitioners, who are constrained by the rules applying to their scope of practice, for example.

Hon NICK GOIRAN: Under the bill, a relevant health profession will mean Aboriginal and Torres Strait Islander health practice, medical, midwifery, nursing and pharmacy. Then there is this extra provision, which says —

> (f) a health profession that is prescribed by the regulations for the purposes of this definition;

Is the government intending to prescribe any such health profession?

Hon SUE ELLERY: No, there are no current plans. This is one of those provisions that I know the honourable member loves around a kind of—what is the expression?

Hon Nick Goiran: Safety purposes?

Hon SUE ELLERY: Correct. That will do. It is in the event that some policy change is needed.

Hon NICK GOIRAN: Minister, again, I hope that the inclusion of provisions for safety purposes—not necessarily out of necessity, but for safety—such as the inclusion of the definition of "relevant person" for clarity, will apply consistently throughout all 50-odd clauses of this bill.

My last question about proposed clause 202MA is by reference to the definition of "relevant person". It is also found at page 6. It says —

> ***relevant person*** means —
>
> (a) a registered health practitioner who is authorised under Division 2 to perform an abortion; or
>
> (b) the chief executive of a health service provider that provides health services that include, or are related to, the performance of abortions under Division 2;

It is obvious what is meant by a health service provider that provides health services that include the performance of abortions, but what is intended by the phrase "or are related to, the performance of abortions"?

Hon SUE ELLERY: I am conscious that my advisers are taking a little bit of time to find other examples. It could include a pharmacy in which there is a role around dispensing medication, but I am just trying to see if there are other examples.

Hon Dr BRIAN WALKER: Having been in the situation, I might be of some assistance here. What might happen is that the retained products of conception might need to be dealt with. The womb may need to be evacuated, and following that, there may be a postpartum bleed or things like nausea, hypovolemia, a simple headache or insomnia. A number of things could happen during the normal care and duties of a doctor looking after a woman going through a procedure, and all matters related to that abortion need to be treated for the comfort of the patient.

Hon SUE ELLERY: If it is some assistance, proposed section 202MP states that the Chief Health Officer can direct certain people to give information. It continues —

> The Chief Health Officer may, for a purpose referred to 11 in section 202MQ, direct a relevant person to give to 12 the Chief Health Officer such demographic or clinical 13 information …

Using the example of a pharmacy, it might be that the Chief Health Officer wants to map or understand where dispensing is happening, particularly in regional areas. I do not have any examples other than that, honourable member.

Hon NICK GOIRAN: I might just pause at this point for the benefit of members and the minister as she is managing this bill and the substantive clause. I indicate that I have no further questions to ask on proposed section 202MA. I have questions on basically every other provision in clause 8, but I might just pause there to see if there are other questions at this point.

Hon KATE DOUST: I do not specifically have questions, but I thought I might start generally talking about a couple of the amendments that I have on the supplementary notice paper. I am not going to actually move them at this point. Given that the supplementary notice paper has been rejigged today, I just wanted to indicate to the minister that when we finally get to it, my intention is to deal with the first three amendments standing in my name, 3/8, 4/8 and 5/8, together. They are all directly connected to each other. The first two basically seek to enable the third in that part of the bill, if you like.

The reason I have sought to move those amendments is that I have looked at this part of the bill, which picks up on page 8 under proposed section 202MC and goes through the new arrangements for an abortion to occur leading up to 23 weeks, where we have seen the threshold shift from 20 weeks. Proposed section 202MD then leads into who would actually be legally able to provide the abortion at that point. Proposed section 202ME then moves on to refer to an abortion that would be provided beyond the 23 weeks. Each of those proposed sections, particularly 202ME, refer to the circumstances or arrangements that would need to be taken into consideration, particularly for

a post–23 weeks abortion. Working through the proposed subsections we can see they refer to how the primary practitioner will need to have regard to a range of factors and will have to reasonably believe that performing the abortion is appropriate in “all the circumstances”. That phrase “all the circumstances” is repeated on at least three occasions in this part of the bill.

I will say this ahead of dealing with any of the amendments listed in my name: it is not my intention to seek to delete elements of this bill in a way that the government would see as being detrimental.

It is my intention to try to add to the bill—to pick up on what I see as some gaps that we need to be very clear about and to have that clarity, transparency and guidance, if you like, for the practitioners who will be involved. Just so that members know, a number of the amendments to the bill that I have put forward have been directly picked up, with some minor tweaks to fit into the Western Australian context, from the South Australian legislation that was enacted a couple of years ago.

It is a bit disconcerting not seeing the time on the clock, but I am sure that somebody will let me know when I am due to run out.

The legislation in South Australia was called the Termination of Pregnancy Act 2021, if members want to look at it. My first significant amendment of the three that are referenced on the supplementary notice paper will not take away from what the government has already included in the bill, where it is saying that in the circumstance of the post-2023 arrangement, which is essentially a new set of arrangements in which we will have moved the boundary, they very much relate to a much later abortion than we have traditionally been used to in this state. All I am trying to do is replicate what happened in South Australia, where a series of examples were inserted in the legislation to give the medical practitioners who were involved some sort of guidance about the things they should take into consideration when trying to make a decision about whether or not later term abortion was appropriate in the circumstances. Members will see that the amendment sets out a range of different types of examples. I am hoping, but not holding my breath, that the things that were considered appropriate in South Australia will be taken into account by this government as well.

These matters are not necessarily ones that will be taken into account to the exclusion of anything else; they will not be fixed. Doctors might take into account a raft of other reasons or factors when working with the woman in question about how she will manage her decision. I imagine that a decision taken at that point of gestation would be devastating for most women because they would have gone beyond the halfway mark of a pregnancy. Whenever I reached the 22-week mark in each of my pregnancies, I always thought I was stepping into safer territory because I knew that if I delivered a baby at 22 weeks—early, in Western Australia, as I said earlier—I fully expected that the health system would step up and do everything it possibly could to sustain that life. That goes back to today’s earlier discussion about the difference between 22 weeks and 23 weeks. I think there are a whole lot of factors. I picked up a lot of the examples pretty much directly from the South Australian legislation.

The first thing that we should be looking at is whether it is essential to perform an abortion on the affected fetus if there is a multiple pregnancy. I would be looking to take into account how that would impact prematurity and any other consequences for the surviving fetus, and also take into account whether any serious abnormalities had not been identified.

Part of my earlier comments today and, in fact, the last time that we started the debate, was about how technology has rapidly advanced in the screening and analysis of the stages of pregnancy and detecting any abnormalities, life-impacting problems or viability issues for the baby, and whether these would also severely impact upon the health of the mother. That is also picked up at a later stage of this amendment. It also takes into account whether the person found out that there were problems at a much later stage of the pregnancy, and was not able to deal with making a decision about progressing with the pregnancy prior to 20 weeks’ gestation, or 23 weeks’ gestation in this case.

Another issue we have not really talked about is taking into account whether a woman had been coerced into having an abortion, whether there are any language or cultural issues, issues around rape, incest, sexual abuse and those sort of factors, or looking at the psychological profile of the carrying mother to see whether there were mental health or other issues.

The CHAIR: The question is that clause 8 do stand as printed. Hon Kate Doust has the call.

Hon KATE DOUST: There is a range of factors, including that final point on the supplementary notice paper about whether or not the patient has a deteriorating maternal medical condition or late diagnosis of a disease. We know that, unfortunately, on some occasions a woman is pregnant and the pregnancy goes through to a late stage, and she then finds out that although the baby might be okay, she might have a life-threatening health issue of her own. This could be a cancer that has presented at a late stage or some other type of health issue, and a decision needs to be made about whether she carries that child to term or not because of the negative impact upon her own life if she made a different decision. This is not about taking away; it is about giving clarity, advice or guidance to the medical practitioners who are functioning in this area.

It would also give the community guidance about the circumstances that most people would look to when engaging in a late-term abortion. I think we all understand—we may not all accept—that there are circumstances, particularly when there is a non-viable pregnancy or a threat to the life of the woman carrying the child, in which these decisions are ultimately made.

Based on the data from the government's own reports and discussions we have had, when we talk about the late-term abortion stage of 20 weeks' gestation—but now to be 23 weeks and beyond—it is really about only one per cent of all those pregnancies that are listed. That is what we are told. One would imagine it is a relatively small number in the grand scheme of things. When I get to formally move the amendment, it is not my intention to string this out too far, but I put on the record that I think that the South Australia legislation has put in some very good safeguards in a range of areas. This amendment is one of them. It is about providing a framework, if you like, for operating within that particular circumstance. I hope people will give some consideration to supporting that amendment when it is moved. As I said, it is not about taking anything away; it is actually about trying to add some value or clarity to this bill, and I think the community expects to see that.

I was keen to do this because of previous experience. I am thinking of the surrogacy legislation of 2008; just before that we had another bill. Initially, that legislation was quite skeletal, and we found that the real meat on the bones was not in the legislation or the regulations; it was tucked away in notes and directions managed entirely separately by the Chief Health Officer or the director general of the department. I did not think that was entirely satisfactory, because people need to know exactly what we are doing in this space. What are the ground rules and the frameworks? We should be open about these things. If this is about giving some guidance to people working in this area, I think it would be a positive thing.

I say to members: we get these opportunities very rarely. I appreciate that people are probably locked into particular positions, but I encourage members to think about the amendments that are being moved throughout this clause. I hope members give some consideration to providing some support for them, because they actually spell out quite clearly situations in which a late-term abortion can be considered appropriately.

Hon BEN DAWKINS: I was not entirely sure where Hon Nick Goiran got to—are we up to proposed section 202MB? I do not have a question on that proposed section, but if anyone else does, perhaps they can go ahead with it.

Hon Dr BRIAN WALKER: This is also not a question, but I thought I might give a response to the very carefully considered words of my esteemed colleague Hon Kate Doust. They were all meant in a very good spirit, and I take them on board as they are meant, but I would like to stand up and give some protection, if you like, to the medical profession. One thing I can state with absolute confidence, after many years practising in this area, is that the last thing we doctors want is more politicians telling us what to do. It is not the case that the general public needs to have a word about what doctors do. Doctors need to have a strong code of ethics and the strong moral guidance that is inculcated in an excellent education—and we have that in this nation—to do the right thing. The more we put down exceptions, possibilities, what can be done here and what might be done there, the more we are putting up limitations so that doctors are scattering to find out what the law actually says before they can do something.

For example, a case in point: at what point do we actually want to save someone's life? Do we need to check the legislation to see whether it is legal to do so? Our first preference is to jump in there, get a line in, get some bloods going and do something to save their life. We do not have time to asked permission: does this person want to be saved? That is a classic case. The first priority is to save lives. I cannot think of any doctors who like doing abortions; it is not a hobby for doctors, it is something that is done because it has to be done. Take, for example, the case of: which of these infants are we going to exterminate to allow the pregnancy to carry on to term? I challenge anyone here to take pleasure in doing that; it simply is not the case.

When we are out there on the front line, working on these very difficult problems, we do not need more limitations or boundaries being put up by well-meaning people who do not actually work in the field. We may be taking some advice, but they do not actually have to deal with the patient or the ramifications. Doctors take that badly. We need to be trusted to do our job. The clearer the boundaries that are set, with ethics and good morals in place, the better we can offer care to our patients. What I heard just now was well meaning, but I found myself taking offence at it. No offence was intended, but people do not realise what we do and how we feel when we are doing it. I put a call out to respect the medical profession and trust us to do the right thing. The problem we face here is that people are not trusting us to do the right thing and want to prescribe this and that and exceptions in terms of what doctors can and cannot do. That will make it very difficult for doctors on the front line to do what needs to be done, because we are taking a political view and not a medical view for the benefit of the woman and the child. I will leave it at that for members to consider. I am standing up in defence of my colleagues.

Hon MARTIN PRITCHARD: I understand that the amendment has not been put, but it caught me a little bit by surprise. The amendment seems to set out mitigating circumstances to encourage the doctor to perform a late-term abortion. Am I getting that right?

Hon KATE DOUST: They are factors for the doctor to take into consideration when looking to perform an abortion after 23 weeks. The member is probably surprised that I am moving something like that.

Hon NICK GOIRAN: I would like to dive into the next provision, which is proposed section 202MB, "Performance of abortion", but I will first quickly respond to Hon Dr Brian Walker. I absolutely take on board what the honourable member said. As I think I said on one of the earlier clauses, or perhaps during the second reading debate, it would be good if doctors unanimously shared the view of Hon Dr Brian Walker about the need for medicine to be practised ethically and morally. It would be good if that were the case, but that is not always the case. I do not intend any disrespect or to cause any offence to Hon Dr Brian Walker, but just as he comes to the chamber with a wealth of medical experience, part of the small contribution that I make to the chamber is as a former lawyer who practised in medical negligence. Medical negligence claims occur all too often because a small minority of medical practitioners act in a careless, dangerous and, sometimes, even reckless fashion. That is why we need the Parliament of Western Australia to provide some kind of framework for those individuals. That is probably not necessary for the honourable member—I have every confidence that he would act in an ethical and moral fashion—but unfortunately not all his colleagues have a history that reflects that noble intention.

Following those introductory remarks, proposed section 202MB, "Performance of abortion", states —

> (1) A person performs an abortion on another person if the person does any act with the intention of causing the termination of the pregnancy of the other person.

Would an intentional assault on the stomach of a pregnant woman be captured?

Hon SUE ELLERY: The short answer is no. The honourable member would be aware that, of course, Criminal Code offences are applicable to harming a pregnant woman, but that is not intended to be captured in this bit.

Hon NICK GOIRAN: The minister says no, but an intentional assault on the stomach of a pregnant woman would meet the limbs of the definition. It says there must be "any act". The intentional assault on the stomach of a woman is "any act". Does it have the intention of causing the termination of that person's pregnancy? Yes, because what I was indicating would be an intentional assault on the stomach of a pregnant woman. We know this because, sadly, there have been too many incidents of domestic violence in which this has actually happened.

We might have been in government and the Leader of the House might have been in opposition at the time. I seem to recall that amendments were moved essentially to create an extra sentencing consideration for the judge in those circumstances. A whole other debate could be had. In New South Wales, they have Zoe's Law and an extra offence because some people, including me, would say that a second person has been injured and, in this particular instance, killed as a result of that. Why would an intentional assault on the stomach of a pregnant woman not be captured by the definition in proposed section 202MB(1)?

Hon SUE ELLERY: It is not the policy intention. I understand the point that the honourable member is making. If he reads the plain words, they could capture anything, including a deliberate kick or punch to the stomach that results in the loss of the pregnancy. That is why I made the point before that that would constitute an assault, and other provisions in the Criminal Code would deal with that. It is not the government's intention that a matter like that will be dealt with in the provisions of this bill.

Hon NICK GOIRAN: It is not the government's intention, but it may still happen. I appreciate that the Leader of the House has put it on the record. The maximum offence that will apply for an unlawful performance of an abortion under this legislation has a maximum penalty of seven years' imprisonment. What would be the maximum offence for the scenario I gave—which I believe is captured by the legislation, notwithstanding the government's intention—of the intentional assault on the stomach of a pregnant woman?

Hon SUE ELLERY: Under section 294 of the Criminal Code, via section 1(4A), causing the loss or the intention to cause the loss of a pregnancy is encompassed in grievous bodily harm to the person and attracts a maximum penalty of 20 years' imprisonment. I am just going down to see whether any other elements attract a different term of imprisonment. No, the maximum is 20 years' imprisonment.

Hon NICK GOIRAN: I thank the minister for that information. Why, then, is unlawful abortion in this instance only limited to a maximum penalty of seven years when the other provision has a maximum of 20 years?

Hon SUE ELLERY: The policy context is trying to ensure that we do not find ourselves in a situation in which women have to rely on backyard abortions. The way that that scenario plays out is that a woman will be seeking an abortion, and that is an entirely different scenario from a woman finding herself being physically assaulted. She has not chosen to be physically assaulted if she is in the scenario captured by the other elements of the Criminal Code that I just read out. It is to capture the unqualified person seeking to perform an abortion, as opposed to those other elements of the Criminal Code that go to a deliberate assault on a person with the intention of causing harm to the person. That is opposed to a woman in very difficult circumstances seeking a backyard abortion. That is the policy context. There is a difference in the imprisonment penalties. It reflects the different policy contexts.

Hon NICK GOIRAN: Can we read into this provision 202MB that an unlawful abortion will lead to the maximum penalty of seven years' imprisonment, but there will be an element of consent from the person, and that is how the minister distinguishes it from the other scenario in which there is no consent and there is an intention of assault on a person that is worthy of 20 years in jail?

Hon SUE ELLERY: The definitions in the clause we are looking at now need to be read alongside the references to unqualified persons. I am advised that advice from the Director of Public Prosecutions was sought on what the level of imprisonment should be, and that advice was acted upon. There is a difference in what we are trying to regulate versus somebody in a violent situation making a deliberate decision to cause physical harm. We are trying to ensure that we deal with the regulation of qualified people and that unqualified people are not trying to perform a service for a woman. There is a difference in the context of the two.

Hon NICK GOIRAN: I indicate I have nothing further at 202MB.

Hon KATE DOUST: Earlier tonight we talked about illegal abortions and unauthorised people and I asked the question about prosecutions. I imagine that is directly related to this clause.

Hon Sue Ellery: It is MN, honourable member.

Hon KATE DOUST: I will just ask, attached to that. This is really about safeguarding. It is a contingency arrangement to prevent—the minister used that very old-fashioned term—"backyard abortions"; I do not know what else it would be called. Is this basically a contingency to scare people away from conducting themselves in this way? Based on the figures we already have from the government that a significant number of women have very early stage abortions and tend to go to private practices, it would appear from that information that for the vast majority, if not all, women who seek an abortion there is already a legal venue with appropriate legally qualified people to conduct the procedure. Why is there still a need to have this provision in place? In what circumstances does the government believe that a backyard abortion would still be performed in Western Australia?

Hon SUE ELLERY: Honourable member, it is not the case that abortion care is accessible to all those who seek it across Western Australia. With this bill, we are trying to make it accessible. It is not the case that getting the approval of two members of the ministerial panel is an easy process. It is not the case that the service is available across the geographic spread of Western Australia. We do not know the number of women who choose to go interstate for abortion care; we touched on that before. I do not know the figure for so-called backyard abortions, but clinicians still report that they deal with the consequences of backyard abortions when they go wrong for a woman's health, which inevitably they do. Proposed section 202MB defines the performance of abortion because then we go on to set out the parameters within which an abortion can be performed. This should not be read by itself; it has to be read in connection with all the other elements.

Hon BEN DAWKINS: I think I might be right in saying that we have discussed proposed section 202MB and it is the appropriate time to move my amendment. I move —

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

In the course of attending briefings, it occurred to me from a commonsense point of view how the law currently stands. I should say phase 1; Hon Nick Goiran educated us about some terminology. Obviously, we are talking about phase 1.

Hon Sue Ellery: That's his terminology, member.

Hon Nick Goiran: In fairness, I invented that term to try to have some kind of way of describing this because I don't think you can necessarily say that an abortion at 19 weeks is an early-term abortion.

Hon BEN DAWKINS: I make no judgement in adopting Hon Nick Goiran's terminology. I use it simply for convenience so that I can be clear about what I am talking about. Certainly, amendments on the supplementary notice paper standing in the name of Hon Kate Doust refer to "after phase 1". It is helpful to bear that in mind. I am not in any way suggesting that later-term abortions cannot be accessed. Certainly, if we pass the amendments standing in the name of Hon Kate Doust on the supplementary notice paper about those considerations for later term abortions, we will solve a lot of the problems that Hon Dr Brian Walker talked about in terms of ethical standards and boundaries. Looking at the supplementary notice paper, the boundaries for late-term abortions will be addressed very well with what Hon Kate Doust has proposed. In any case, it is as simple as this. Based on information I received during the briefings, it appears that if phase 1 is extended beyond 20 weeks, potential problems will arise. One such problem, which has been explained to me by people such as Professor Joanna Howe, is that at 21 weeks, the mother will effectively have to go into labour and the aborted fetus will have to pass through the birth canal. Prior to 21 weeks' gestation, I am advised that that does not occur. As I said before, it seems to me that there is quite a bit of reasoning behind the 20 weeks' gestation period, which was introduced by a female Labor MP, and I think that there was quite a lot of logic behind her doing that.

Furthermore, I believe that there is some debate around the idea of a failed abortion. I have not followed this as closely as perhaps I could have, but I believe the government has indicated that there is not necessarily any such thing as a failed abortion. I am talking about when we get up to 22 weeks' gestation. However, the information I have been presented with is that there is such thing as what we could call a failed abortion—I believe that this only happens when we get up to 22 weeks—that is, aborted babies being born and drawing breath. There is then a whole cascading effect and string of consequences that arise about whether care is to be delivered to that child.

The information I have been provided is that, in the absence of specific provisions relating to whether that baby needs to be given care, babies have been left to take their final breaths on the bench, or, in one case, I believe, effectively in a rubbish bin, as I said previously. I find it very distressing to talk about that. The logic is telling me that if we stay at 20 weeks, we avoid the fact that an aborted baby has to pass through the birth canal, and we also avoid the additional problems I have talked about with so-called failed abortions and the questions about whether care should be provided to that child.

That is really the extent of my logic in moving this amendment. I do not think there should be any misinterpretation of what I have tried to say, as there was last time. I am simply saying it because, to me, it avoids a lot of ethical questions. As I have said, this is what the current act, introduced by a female Labor MP, states as the cut-off point for phase 1. I see nothing offensive in simply saying that we stay at the current gestation period for phase 1. That is really the extent of my amendment—simply to avoid a lot of the problems that will occur if we extend phase 1 further.

Hon SUE ELLERY: This is one of a series of amendments in Hon Ben Dawkins's name throughout the supplementary notice paper in which he seeks to delete "23" and insert "20". The first point I make is that this proposed change in arrangements to the way that abortion care is sought for late-term abortions is a key policy change in the bill. The proposition that the government would somehow change a key policy in the bill at this point of the process is ambitious. That is perhaps a generous word I could use. This is a key part of the changes that we seek to make.

I can address a couple of points the member made. One is a reference to the current arrangements of around 20 weeks being what a former Labor MP put in place 25 years ago. If I can paraphrase, if it was good enough then, it is good enough now. That just denies the whole history of what happened in the debate 25 years ago. It was a classic example of politics being the art of what is possible and achievable as opposed to what might be gold standard or best practice. The arrangements in a number of elements of the existing regulatory frameworks were not a function of what is the best way to provide abortion care in Western Australia. It was a function of what could get through the house in a very different make-up of the house. I do not think it is an accurate description of how we got to the point we are at now.

The second point made by the honourable member was that, essentially, if we delete 23 weeks and keep it at 20, we would avoid the ethical considerations. What we would be avoiding is the clinical circumstances that women find themselves in. It is the case that detailed anatomy scans are performed at 18 to 22 weeks. By increasing the gestation limit, we will allow women the time to make the decisions they need to make based on the information provided to them in those scans. That is the key of this policy change. In Western Australia, it is particularly pertinent because of our geography; it is hard to get the scans. It is hard to get access to those parts of abortion care for people who are not in metropolitan Perth. They need the time to get the scans required and to assess them. Bear in mind, by this point, many of these women have been carrying a much-wanted, much looked forward to pregnancy and they find themselves in a position, as a consequence of the scans, of having to make a decision that they never wanted to make. It is not about just swapping back to 20 weeks to avoid the ethical considerations. It is about needing to confront the clinical situation that these women find themselves in whereby a late-term abortion is required.

I think it is also worth noting that, throughout the development of the bill, the Department of Health, the Chief Health Officer and the Minister for Health have consulted widely with peak bodies, industry representatives, patient–consumers and, of course, practitioners. The community consultation, to which there were some 17 000 responses, also showed majority support to increase the gestation age at which the additional requirements will apply. The public discussion paper, as noted I think by Hon Martin Aldridge, contemplated a 24-week change. Health practitioners themselves and stakeholder–consumers presented a range of views on the most appropriate limit. The Minister for Health hosted two clinical round tables with the Australian Medical Association, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and various public and private providers of abortion care. I was at both of them. We reached the position that 23 weeks was probably the best consensus point we could land on. Although I appreciate the points of view put by the honourable member, this is a key part and we do not resile from it. It is central to the policy of the bill before the house that these changes be made and we will not be supporting the amendment to change them.

Hon MARTIN PRITCHARD: I will not be supporting the amendment. I accept much of what the minister has indicated about the point at which a woman can have all the information required to make a very hard decision. That has been set at 23 weeks, and I support that.

I wanted to stand to say two other things. One, I think the member indicated that if we moved it to 20 weeks, there would no longer be abortions after 20 weeks. That is not the case, of course. It would just move them from an early-term to a late-term abortion.

The other thing is about what the honourable member mentioned about doctors—sorry, I am just a little upset on behalf of doctors. I have received a lot of emails, as most members have, and I cannot believe that there would be doctors, even those who are not as good as Hon Dr Brian Walker in his ethical approach to his work, or nurses leaving a fetus in a bin or on a table. I just would not attribute that to doctors and nurses, who have seen us through very hard times over the last few years, so I would like to jump to the defence of doctors as well.

Hon BEN DAWKINS: I thank Hon Martin Pritchard and also the minister for that. I do not intend to speak much further on it, just to clarify the point I made about a so-called aborted baby that had drawn a breath, I think it was at, shall we say, 22 weeks, being left in a bin. That is the information I was provided. It was no reflection on the doctors involved. It is merely the discussion around if that scenario occurs, what obligations there are, if any, to provide resuscitation or medical care to that baby. As I said, Hon Martin Pritchard, in the absence of any provisions around what medical care is required to be delivered to a baby in that situation, obviously, there is nothing to prevent a baby taking its last breath in that situation whether it be in a kidney dish or, as I believe in one instance, in a rubbish bin. That was no reflection on doctors. That was just the case that we have this interminable situation in which there is terrible doubt about what should be done with a baby born in that circumstance.

I will just finish by saying the minister and also Hon Martin Pritchard said something about me limiting abortions to 20 weeks' gestation. That is simply not the case. I referred to phase 1. Phase 2 under this amendment would then be after 20 weeks. I am again referring to some of the amendments proposed by Hon Kate Doust. I know that the minister has talked about remote locations and social situations, and I see that there are many things that we can build into the phase 2 abortions, which I say should be after 20 weeks, that would recognise the rights of women in remote locations who have been subject to abuse et cetera. It could be catered for in what we would call phase 2 abortions. In no way am I seeking to deny people the right to access abortion in these situations—as I said, remote situations, abusive situations. It is simply the case it would become a phase 2 abortion. I understand that even phase 2 abortions under this proposed bill will potentially become more accessible because of the removal of the ministerial panel. That is a good thing. Please do not misrepresent me and say that I am saying that there should not be any abortions after 20 weeks and that they should not be accessible for people in hardship situations. They should be. There is scope, particularly with the amendments proposed by Hon Kate Doust, for all those situations to be taken into account in what would become a phase 2 post–20-week abortion.

Hon AYOR MAKUR CHUOT: I rise to say that I do not support the amendment. I just want to make a comment; I do not know whether this is a direct comment to Hon Ben Dawkins. I think he needs to—again, I do not want to be pointing fingers—be prepared with his points. For me, English is my fourth language and I am really, really struggling to understand what he is trying to amend. I was able to understand it when the minister was giving him the answers, so I would really appreciate that in the future it would be great if he could stick to the point.

The CHAIR: Order! Members, I want to issue a general caution about reflecting personally on members. It is going to be a long and, at times, probably emotional debate, and I think we need to try to be respectful of each other's positions even if we do not agree with them.

Hon NICK GOIRAN: At the outset, I understand that the explanation the minister has provided—I acknowledge what she has said—that the change of the late-term gestational threshold from 20 weeks to 23 weeks is a key plank or pillar or element of the purported reforms in the bill before us. That is the point the minister has made and it is well put. I would, however, also equally acknowledge that Hon Ben Dawkins and, in fact, any other member is quite entitled to hold a different view from the government. Just as much as the government may say that it believes that a key part of the reform is to move the late-term gestational threshold from 20 weeks to 23 weeks, another member would be quite within their rights to choose a different gestation or threshold, whether that be 22, 21, 20 or even a lesser period. That is why this matter has attracted a conscience vote for all members of Parliament.

In order to explain why the government has chosen to extend what I have referred to as phase 1 abortions from up to 20 weeks to now being up to 23 weeks, the minister has also helpfully indicated that the government has indicated a desire to cater for scans to take place around about the 19 through to 22–week mark to give a woman who has had a scan sufficient time to make a decision as a result of that.

At the moment, as has been identified by the minister and the Minister for Health and others, there is a small number, proportionally compared with the overall number of abortions in Western Australia, of late-term abortions. They are in the realm of about let us say 70 a year, as an inexact figure, but having observed the statistics on this for a long period, I think to say about 70 at the present time is a fair, rough estimate. This bill, of course, will push the late-term gestational limit to 23 weeks, so one might think that that might result in fewer late-term abortions moving forward because there are fewer weeks in which they can occur. Obviously, it is not as simple as that because, for example, there will no longer be a ministerial panel and there is a suggestion that the panel has been conservative in its approach, whereas, moving forward, a person can have any two doctors approve a late-term abortion. But the point that the minister has made is, at the end of the day, the government says that this is important because of the scans that are happening and to give a woman enough time to be able to make a decision about those scans.

Are the scans that the minister is referring to for fetal anomalies?

Hon SUE ELLERY: Yes is the short answer.

Hon NICK GOIRAN: The scans that the government would like to cater for and capture to give a woman sufficient time are scans for fetal anomalies. I take it that they are not, by definition, scans for the sex of the unborn baby.

Hon SUE ELLERY: That is not the purpose of the scans.

Hon NICK GOIRAN: If a scan that takes place at 21 weeks identifies that the unborn baby is a girl, it is not the intention of the government that that type of scenario would be captured in these less-restricted phase 1 abortions. Will a medical practitioner still be able to proceed with an abortion at 21 weeks when the only scan that has taken place and been the genesis of the consultation has identified that the unborn baby is a female?

Hon SUE ELLERY: There is a range of reasons why a late-term abortion might be performed, including the mother's health. The reason that we went to 23 weeks was, as I have outlined, that there are scans that are available and taken at a particular point that can identify fetal abnormality. That is a factor in the consideration, but it is not the only factor. There may well be other reasons related to the mother's health that mean that a late-term termination is required.

The CHAIR: Can I just clarify for all members that we are still dealing with the amendment that the words to be deleted be deleted.

Hon NICK GOIRAN: Yes, I certainly am, because in order to understand whether we are going to agree with Hon Ben Dawkins's amendment, we need to understand exactly why there is a proposal to move from 20 to 23 weeks. At the moment, it is 20 weeks. Under the bill, it will be 23 weeks, and Hon Ben Dawkins is seeking to take it back to 20 weeks. In order for us to understand that, we need to understand why it was 20 weeks in the first place and why the government is saying that we now need to make it 23 weeks. The minister has helpfully explained that the reason the government has said this is that there are scans that take place during this particular gestational range that identify fetal abnormalities, and the government would like the pregnant woman to have the opportunity to consider an abortion prior to hitting the late-term gestational range. One of the explanations that the minister has just provided was about the mother's health, but an abortion after 23 weeks can still take place based on the mother's health.

Hon Sue Ellery: Yes, honourable member. Maybe I misunderstood your question. I thought you were saying to me that the only reason that an abortion would be performed after 23 weeks was that there was some abnormality with the fetus. I thought that was the proposition that you were putting to me.

Hon NICK GOIRAN: No, that was not my proposition. I accept that it happens for more reasons than that. Do we agree with Hon Ben Dawkins that it should be 20 weeks, which is what it is at the moment, or should we agree with the government, which says that it should be 23 weeks? The reason that the minister has given is the scans, but the scans have nothing to do with the mother's health. The scans have to do with identifying that the unborn baby has a fetal abnormality. Are fetal abnormalities always incompatible with life?

Hon SUE ELLERY: It is not just about compatibility with life. That may well be the circumstance, but it is not just that. There is a range of factors, some of which we canvassed in earlier debates, about why an abortion may be chosen at that point, but it is not just about the compatibility with life.

Hon NICK GOIRAN: It is not just about compatibility with life, but one thing it is not about is the type of scan to determine the sex of an unborn baby; we are talking about scans that identify a fetal anomaly and, as the minister indicated, that may or may not be compatible with life. I think the language that was used in the inquiry undertaken by the Standing Committee on Environment and Public Affairs some years ago when Hon Matthew Swinbourn was the chair was whether or not the unborn baby had a lethal abnormality. As I understand it, the government would like to give these extra few weeks—it is an extra three weeks, to be exact—to cater for this particular scenario. Is the minister able to indicate to us the types of scans or the kinds of circumstances that the government is expressly concerned about? Perhaps I will ask this question first: can the scans identify whether an unborn baby has anencephaly?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: Thank you. Let us say that a scan has occurred and the baby is at 21 weeks' gestation. At the present time, that 21-week pregnancy would be able to be aborted only under the provisions that allow for a ministerial panel. If Hon Ben Dawkins's amendment is successful, the anencephaly case would continue to take place under the provisions here, which would require that the primary practitioner would have to reasonably believe that performing the abortion was appropriate in all the circumstances, and they would have to consult with a second practitioner. I understand that the government is saying that a case of anencephaly would meet that definition. If a medical practitioner agreed to an abortion because there had been a diagnosis of anencephaly, the government is saying that would meet that particular definition.

Hon Sue Ellery: It might.

Hon NICK GOIRAN: Did the minister say "might"?

Hon Sue Ellery: It would depend on all the circumstances, honourable member.

Hon NICK GOIRAN: Is the diagnosis at the time of the scan only one factor that would be taken into account?

Hon Sue Ellery: Yes.

Hon NICK GOIRAN: What other factors would be taken into account?

Hon Sue Ellery: The mother's point of view.

Hon NICK GOIRAN: The mother's choice?

Hon Sue Ellery: Correct.

Hon NICK GOIRAN: That would be the case irrespective of whether we were operating under phase 1 or 2. The system is the same. Help me understand what the problem is with Hon Ben Dawkins's amendment. If the anencephaly case of 21 weeks could result in an abortion under his amendment or under the government's amendment, the only difference is that if his amendment is successful, two practitioners would be involved instead of one.

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

SKILLSWEST CAREERS AND EMPLOYMENT EXPO

Statement

HON PETER COLLIER (North Metropolitan) [8.44 pm]: I rise to make a few comments regarding some comments made by Hon Pierre Yang in the last session about the SkillsWest Careers and Employment Expo. I would like to comment on two issues. First, I am delighted that Hon Pierre Yang went to the SkillsWest expo and glad that he thoroughly enjoyed it. It is a wonderful thing, and I say that because I started it back in 2010. It was a time when I desperately wanted to promote the training pathway as a very viable option to students who did not want to go to university. I worked very closely with Chris Wharton, one of the assistant editors of *The West Australian,* which promoted it. For three months leading up to the SkillsWest expo, the newspaper used to do two profiles on apprentices each week to promote training as a viable employment pathway. As ambassadors, we had Danny Green one year, then Dale Alcock one year, and Ryan Stokes another year. We had an ambassador to promote training as much as we could so that people, as I said, would see training as a treasured possession and that they would have a qualification that would open doors for them all over the globe. That is the first thing I would like to say. I am delighted that the government has continued with it and that Hon Pierre Yang enjoyed it.

Are the clocks not working, President?

The PRESIDENT: Correct, honourable member. The Clerks will give you a two-minute warning.

Hon PETER COLLIER: A one-minute warning or something—I can talk under water!

The PRESIDENT: Noted. Thank you, honourable member.

Hon PETER COLLIER: Thank you.

The second thing that I would like to mention relates to some comments by Hon Pierre Yang about the Aboriginal workforce development centres. He said —

> I also wish to take this opportunity to correct the record. On 13 June 2023, Hon Peter Collier said —
>
> > We opened five Aboriginal workforce development centres in Geraldton, Kalgoorlie, Broome, Bunbury and the city centre. We provided avenues of employment for Aboriginal people and the big miners and employment companies throughout Western Australia. You guys shut them. That is a real shame, because tens of thousands of Aboriginal people accessed those Aboriginal workforce development centres. That was such a bad call. I did not do it because I thought it was a good idea. Aboriginal people asked for it. That is why I opened them. They were working well, and I hear that from a lot of people I am still in communication with in the education sector.

Hon Pierre Yang continued to state —

> I wish to advise that the Aboriginal workforce development centres continue to exist as part of the jobs and skills centres, with no diminishment in funding, and the services have not been closed.

The record did not need to be corrected. All five of the Aboriginal workforce development centres that I opened have been closed—no bones about it. I will go through that to clarify the situation. In their various manifestations, workforce development centres have had different titles, whether they were called workforce development centres, the current jobs and skills centres, careers centres et cetera. They were all in one with everyone combined together—Aboriginal people, members of the ethnic community and kids that had just come out of school—as just development centres. They have been that way for the last two and a half decades.

When I first took over as Minister for Training and Workforce Development, I said to the then director general of the Department of Education and Training, Sharyn O'Neill, and to the then first director of the Department of Training and Workforce Development, Ruth Shean, that providing training and opportunities for Aboriginal people was one of the most significant thing that I wanted approached and dealt with. I really wanted to make opportunities for Aboriginal people throughout Western Australia. As a result of that, on 1 September 2009, I launched the Training Together–Working Together Program to improve training and employment opportunities for Aboriginal people. The Training Together–Working Together committee, which had 19 members, had co-chairs—Keith Spence, the chair of the State Training Board, and Sue Gordon, a former magistrate of the Children's Court. In addition, most of the 19 members were Aboriginal people. Vanessa Davies was from Acacia Prison; Carol Garlett was from

the Aboriginal Education and Training Council; Glen Kelly was from the South West Aboriginal Land and Sea Council; Margaret Quartermaine was from Marr Mooditj Training, a registered training organisation; and Ian Trust was from the Wunan Foundation. It was a great period of my life. This committee went all over the state to try to access the views of Aboriginal people and organisations, and mining companies to try to enhance employment opportunities for Aboriginal people. There were dozens of consultation workshops. I went with them to a lot of these workshops. The committee received 37 written submissions and 11 employer case study contributions. Essentially, dare I say it, I wanted to give Aboriginal people a voice. I keep on saying that I am not Aboriginal, but I grew up with the Wongathas in Kalgoorlie. If we were going to provide employment opportunities, I wanted to ensure that we did what the Aboriginal people wanted, not what Peter Collier wanted.

On 4 June 2010, I launched Training Together–Working Together at Crown Perth. I have a copy of the document here. It is a magnificent document, which has really survived the test of time. I highly recommend members read it. Andrew Forrest from the Minderoo Foundation and my very good friend David Wirrpanda launched it. They came up with some really good suggestions.

I really want to talk more about this. The document went right through the recommendations. It states —

> There is a lack of connection—we need to join the dots.
>
> …
>
> There are job opportunities for Aboriginal people but employers do not know how to successfully engage with them—there is an opportunity to increase employer involvement and commitment to employing Aboriginal people.

I read it again over the weekend. I am so proud of that committee and what it came up with. The current government could do a lot worse than go back and look at that document. It provided wonderful recommendations for Aboriginal people. Two recommendations of the five are pertinent, including —

> Recommendation 1: The Minister for Training and Workforce Development to establish the Aboriginal Workforce Development Centre (AWDC) to oversee the implementation of a more holistic, systematic, statewide approach to training of Aboriginal people that leads to successful employment outcomes.

I did that. I established that workforce development centre. Then there was this important recommendation —

> The Minister for Training and Workforce Development to establish Aboriginal Workforce Development Hubs … in each of Western Australia's nine regions to directly link local Aboriginal people and local employers. The Hubs would be established as independent, not for profit organisations with boards of management consisting of local Aboriginal leaders, employers, community representatives and service providers.

I said we will start with five, so I established five out of the nine. I opened all five of them—one in Bunbury, one in my home town of Kalgoorlie, one in Geraldton, one in Broome and one here in Perth. The point was that they were serviced and the staff were fundamentally Aboriginal; they had great communications with all the employers in the area. They were localised.

Importantly, they were independent of the workforce development centres. That is what the Aboriginal people wanted. They did not want to be part of a whole gamut, which the government has done now. That was my point. As I said, they were standalone, autonomous Aboriginal workforce development centres. We have done a complete circle. They were amalgamated as overall generic workforce development centres. I asked Aboriginal people what they wanted, took them out and made them autonomous, independent Aboriginal workforce development centres, and the current government put them back in. We have done a complete circle. That is what happened. That is my beef. They are still there. Quite frankly, when they are there in that great big conglomerate, we have a real problem. Aboriginal people wanted a standalone facility. They were so successful. At a time when the whole nation is talking about providing Aboriginal people with a voice, they provided me with a voice, and I delivered. I listened to them. I provided them with exactly what they wanted.

Please, Labor Party, in your heart, give them back their autonomous, independent Aboriginal workforce development centres.

ARTHUR LEGGETT, OAM

Statement

HON DAN CADDY (North Metropolitan) [8.54 pm]: I rise briefly tonight to wish Arthur Leggett, OAM, a very happy birthday. Arthur is a true living legend of Western Australia, and last Friday he turned 105, which is just incredible.

Arthur is one of our oldest living veterans. He served in both North Africa and Europe during the Second World War. As part of the $2^{nd}/11^{th}$ Infantry Battalion in the 6th Division of the Second Australian Imperial Force, he was involved in actions against the Italians across Libya. In 1941, he was sent to Greece with the AIF to defend against the German attack in what is now known as the Battle of Crete.

I have spoken about the Battle of Crete before; it is closely tied to Western Australian history, not least because HMAS *Perth* was a key military asset in that battle. Having survived that battle and, in fact, most of the war unscathed, she took damage from the very last salvo from the Axis forces. This, in turn, led to her coming back to Fremantle to be refitted, before eventually heading up to the Sunda Strait, where she was sunk.

Back to 1941: the German forces attacked the Allies, and the Allies were pushed back to the island of Crete. Axis forces then invaded Crete in the first major invasion by air. When I say "by air", I mean the first ever major invasion by paratroopers; I think they were known as Fallschirmjäger, although German is not my strong suit. Many were shot from the sky, but eventually the Germans overwhelmed the island, and Mr Leggett and about 17 000 other Allied troops were captured. He was not only a prisoner of war and put to work but also part of a death march, in which Allied POWs were marched through the Czechoslovakian Alps in the middle of winter to get to Bavaria.

That is just absolutely incredible. They do not come much tougher than Arthur Leggett. The fact that he is still going strong aged 105 is testament to his inner strength. Earlier this year, I had an opportunity to have a chat with him and his daughter Sue about his experiences, and I talked to him about his life. He is a true Western Australian hero and, on behalf of all us, I wish him all the best for his 105th year.

SKILLSWEST CAREERS AND EMPLOYMENT EXPO

Statement

HON PIERRE YANG (North Metropolitan — Parliamentary Secretary) [8.56 pm]: I want to thank Hon Peter Collier for his contribution, especially in relation to the Perth SkillsWest Careers and Employment Expo—a great initiative, as he said, that started during his time as Minister for Training and Workforce Development.

However, I was a little taken aback by the second part of his speech. The thing is, on 13 June 2023, Hon Peter Collier said in this place —

> We opened five Aboriginal workforce development centres in Geraldton, Kalgoorlie, Broome, Bunbury and the city centre.

He then said —

> We provided avenues of employment for Aboriginal people and the big miners and employment companies throughout Western Australia. You guys shut them.

That is my point: we did not shut them; they are continuing. As a matter of fact, I did not want to get too political on the last occasion, but one of the Aboriginal workforce development centres was in a high-rise building in the city centre. How could that be of service to Aboriginal people when it was in the middle of the city in a high-rise building? It is just impractical, and I thought it was pretty disappointing that Hon Peter Collier actually made the second part of his contribution. The record needed to be corrected. We did not shut them; we actually expanded them, and they are part of the jobs and skills centres throughout Western Australia.

I think this government has a lot to be very proud of in supporting all Western Australians, including Aboriginal brothers and sisters, and that needed to be corrected.

House adjourned at 8.58 pm

QUESTIONS ON NOTICE

Questions and answers are as supplied to Hansard.

ENVIRONMENT — CARBON ABATEMENT AND SEQUESTRATION

1494. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to the following statement on under Point 5 of Page 693 of *Budget Paper No 2 – Volume 2 of the 2023–24 State Budget Papers*: "The Department will continue to explore carbon abatement and sequestration opportunities on existing and proposed conservation estate, to optimise benefits to the environment, biodiversity and Traditional Owners.", I ask:

(a) which agency is responsible for the management of carbon stores on Department of Biodiversity Conservation and Attraction (DBCA) managed land;

(b) what was the estimated total amount of carbon stored in native vegetation, soils and other natural carbon stores on DBCA managed lands in each of the following years 2005, 2010, 2020, and 2023 respectively;

(c) what method does the DBCA use to assess carbon stores on DBCA managed lands;

(d) will the Minister table the details of this method in (c);

(e) does the DBCA or the State Government report emissions from DBCA managed lands to the Commonwealth under the National Greenhouse and Energy Reporting System or any other reporting system;

(f) will the Minster table any information that has been provided to the Commonwealth Government by DBCA over the last 3 years for the purposes of assessing carbon emissions from lands managed by DBCA, or more generally for the purposes of the national greenhouse accounts;

(g) are DBCA land management activities covered within the scope of the Government's commitment to net zero emissions from government operations by 2030;

(h) what are the estimated actual carbon emissions per year (not net emissions) resulting from prescribed burning operations undertaken by DBCA;

(i) what is the estimated total amount of carbon sequestered annually by forests and other vegetation per year on lands managed by DBCA;

(j) how does DBCA predict that a drying climate will affect this rate of sequestration;

(k) what is the estimated amount of carbon stored in peatland soils in DBCA managed lands, per hectare and in total;

(l) what is the rate of accumulation for carbon stored in peatland soils in DBCA managed lands;

(m) how many hectares of peatland have been burned, or affected by prescribed burning operations over the last 5 years;

(n) what is the estimated total amount of carbon that has been emitted as a result of prescribed burns and escaped prescribed burns in peatland systems:

    (i) over the last 5 years; and

    (ii) over the last 50 years;

(o) what is the estimated total amount of carbon that has been sequestered by peatland systems managed by DBCA:

    (i) over the last 5 years; and

    (ii) over the last 50 years; and

(p) how long does DBCA estimate will be required before these areas of peatland return to their previous levels of carbon storage?

Hon Darren West replied:

Please see the response to *Standing Committee on Estimates and Financial Operations 2023–24 Budget estimates – Additional questions* question 3 from Hon Brad Pettitt MLC.

BIODIVERSITY, CONSERVATION AND ATTRACTIONS — CARBON STORES

1495. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to the Department of Biodiversity Conservation and Attractions (DBCA) Statement of Financial Position on Page 707 of *Budget Paper No. 2 – Volume 2*, and I ask:

(a) who owns the carbon that is stored in DBCA managed lands;

(b) what is the estimated net present value of this carbon;

(c) is this value reflected in DBCA non-current assets;

(d) if no to (c), why not;

(e) has any of the carbon stored on DBCA managed lands been registered with the Titles Registrar under the *Carbon Rights Act 2003 WA*; and

(f) if yes to (e), will the Minster provide details of such registrations?

Hon Darren West replied:

(a) Please see the response to *Standing Committee on Estimates and Financial Operations 2023–24 Budget estimates—Additional questions,* question 2 from Hon Brad Pettitt MLC.

(b) The Department of Biodiversity, Conservation and Attractions is unable to estimate the net present value of the total amount of carbon stored in lands that it manages because there is no comprehensive data at the required scale to support such an estimation.

(c)–(f) Please see the response to *Standing Committee on Estimates and Financial Operations 2023–24 Budget estimates—Additional questions,* question 2 from Hon Brad Pettitt MLC.

FOREST MANAGEMENT PLAN 2014–2023 — CARBON STORES

1496. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to Department of Biodiversity, Conservation and Attractions (DBCA) Service Area 8—Implementation of the Forest Management Plan described in several places in the *2023/24 Budget Papers*, including page 700 of *Budget Paper No. 2 – Volume 2.* I also refer to page 80 of the current *Forest Management Plan 2014–23*, which states that DBCA will "report on carbon stores in the next draft forest management plan." I ask:

(a) has this report been completed;

(b) if no to (a), why not;

(c) will the Minister table this report;

(d) if no to (c), why not and when will it become available;

(e) what is the total estimated amount of carbon stored in Forest Management Plan (FMP) lands currently; and

(f) what was the total estimated amount of carbon stored in FMP lands in 2014, when the current FMP commenced?

Hon Darren West replied:

(a) No.

(b) As reported in the *Mid-term review of performance of the Forest Management Plan 2014–2023* and the *End-of-term review of performance of the Forest Management Plan 2014–2023* (End of Term review), no carbon measurement plots were able to be established during the term of the current Forest Management Plan and no report has been prepared.

(c) Not applicable.

(d) Not applicable.

(e) The draft *Proposed Forest Management Plan 2024–2033* estimated that the total carbon stock (excluding soil carbon) in 2020 was close to 1000 million tonnes CO2-equivalents. This figure was calculated in response to public submissions and made public as referral documentation for consideration of setting a level of assessment under the *Environmental Protection Act 1986* by the Environmental Protection Authority.

(f) The *Draft Forest Management Plan 2014–2023* provided an indicative above and below ground carbon stock estimate in the live standing trees in the south-west forests, projected to 2014, as 164 million tonnes, which is 600 million tonnes CO2-equivalents.

WESTERN AUSTRALIAN STATE FLAG — HEMP

1497. Hon Dr Brian Walker to the Leader of the House representing the Premier:

With WA Day behind us, and 4 July fast approaching, I refer the Treasurer to reports from North Dakota, where the State legislature recently passed a resolution encouraging the purchase of US flags made of hemp, noting that "historians assert that the first United States flags were made from hemp", with the end product being both stronger than cotton and fading "less than other fabrics", and I ask, how many State flags does the Government purchase annually, and at what cost?

Hon Sue Ellery replied:

This detailed information is not readily available, and to collate this information would divert staff—across every government department or agency—away from their normal duties. Therefore, it is not considered to be a reasonable or appropriate use of government resources and I am not prepared to allocate the State's resources to provide a response.

PAYROLL TAX

1498. Hon Dr Steve Thomas to the Minister for Finance:

For each of the following payroll levels, how many employers were liable to pay payroll tax and what was the total payroll tax collected in Western Australia in both the 2021–22 and 2022–23 financial years:

(a) $1,000,001 to $1,100,000;

(b) $1,100,001 to $1,200,000;

(c) $1,200,001 to $1,300,000;

(d) $1,300,001 to $1,400,000;

(e) $1,400,001 to $1,500,000;

(f) $1,500,001 to $1,600,000;

(g) $1,600,001 to $1,700,000;

(h) $1,700,001 to $1,800,000;

(i) $1,800,001 to $1,900,000;

(j) $1,900,001 to $2,000,000;

(k) $2,000,001 to $2,500,000;

(l) $2,500,001 to $3,000,000;

(m) $3,000,001 to $3,500,000;

(n) $3,500,001 to $4,000,000;

(o) $4,000,001 to $4,500,000;

(p) $4,500,001 to $5,000,000;

(q) $5,000,001 to $10,000,000;

(r) $10,000,001 to $50,000,000;

(s) $50,000,001 to $100,000,000; and

(t) Over $100,000,000?

Hon Sue Ellery replied:

(a)–(t) The information is current as of 21 August 2023.

	2021–22 Financial Year		2022–23 Financial Year	
	Employers	Tax	Employers	Tax
$1,000,001 to $1,100,000	703	$2,390,101	544	$2,417,587
$1,100,001 to $1,200,000	688	$5,798,463	597	$5,433,357
$1,200,001 to $1,300,000	614	$8,126,693	571	$8,246,632
$1,300,001 to $1,400,000	569	$9,603,132	516	$9,243,572
$1,400,001 to $1,500,000	502	$10,279,965	462	$10,226,195
$1,500,001 to $1,600,000	505	$12,648,790	471	$12,490,101
$1,600,001 to $1,700,000	431	$11,895,689	403	$11,876,590
$1,700,001 to $1,800,000	425	$12,168,402	398	$13,760,472
$1,800,001 to $1,900,000	373	$12,885,844	398	$13,726,817
$1,900,001 to $2,000,000	377	$13,418,327	371	$13,097,174
$2,000,001 to $2,500,000	1,402	$61,673,656	1,340	$64,281,353
$2,500,001 to $3,000,000	1,073	$60,628,020	1,171	$65,834,293
$3,000,001 to $3,500,000	840	$53,805,155	902	$61,596,654
$3,500,001 to $4,000,000	702	$52,162,248	733	$55,559,303
$4,000,001 to $4,500,000	580	$45,174,829	677	$53,748,903
$4,500,001 to $5,000,000	483	$44,519,639	545	$52,770,694

$5,000,001 to $10,000,000	2,717	$290,381,511	2,800	$330,381,484
$10,000,001 to $50,000,000	3,649	$704,369,611	3,859	$860,500,869
$50,000,001 to $100,000,000	978	$390,833,933	984	$414,941,937
Over $100,000,000	2,242	$2,721,538,897	2,309	$3,009,080,443

WA COUNTRY HEALTH SERVICE — HEALTH STAFF TRANSPORT

1499. Hon Dr Steve Thomas to the Leader of the House representing the Minister for Health:

I refer to the transport of health staff from Perth to regional Western Australia by the WA Country Health Service, and I ask, for the 2022–23 financial year:

(a) what was the total number of flights for doctors transported to the Great Southern region;

(b) what was the total cost of those flights in (a);

(c) what was the total number of flights for nursing staff transported to the Great Southern region;

(d) what was the total cost of those flights in ;

(e) what was the total number of flights for other medical staff transported to the Great Southern region; and

(f) what was the total cost of those flights in (f)?

Hon Sue Ellery replied:

The following information pertains to flights booked by WA Country Health Service (WACHS) Great Southern.

(a) 121 trips

(b) $55,068.15

(c) 13 trips

(d) $3,660.88

(e) 6 trips

(f) $1,802.13

WA COUNTRY HEALTH SERVICE — HEALTH STAFF TRANSPORT

1500. Hon Dr Steve Thomas to the Leader of the House representing the Minister for Health:

I refer to the transport of health staff from Perth to regional Western Australia by the WA Country Health Service, and I ask, for the 2022–23 financial year:

(a) what was the total number of flights for doctors transported to the Goldfields region;

(b) what was the total cost of those flights in (a);

(c) what was the total number of flights for nursing staff transported to the Goldfields region;

(d) what was the total cost of those flights in ;

(e) what was the total number of flights for other medical staff transported to the Goldfields region; and

(f) what was the total cost of those flights in (f)?

Hon Sue Ellery replied:

The following information pertains to flights booked by WA Country Health Service (WACHS) Goldfields.

(a) 487 flights

(b) $337,000

(c) 60 flights

(d) $31,000

(e) 219 flights

(f) $147,000

CORRECTIVE SERVICES — YOUTH FACILITIES

1501. Hon Dr Brad Pettitt to the minister representing the Minister for Corrective Services:

I refer to Page 429 of *Budget Paper 2 – Volume 2 of the 2023/24 State Budget*, and I ask:

(a) can the Minister please provide a breakdown of expenditure allocated in the 'Youth Facilities' line item; and

(b) does this funding pertain to bail houses or any other facilities which are not Banksia Hill Detention Centre or Unit 18?

Hon Stephen Dawson replied:

The Department of Justice advise:

(a) The $349,000 is currently allocated for Maintenance Upgrades. Currently the Budget is allocated to:

$200,000 to upgrade the High Voltage Switches at Banksia Hill Detention Centre.

The remaining $149,000 is currently being reviewed in line with the overall works being completed at Banksia Hill Detention Centre.

(b) No.

RACING AND GAMING — SPINIFEX BREWERY — CABLE BEACH

1502. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Racing and Gaming:

I refer to Spinifex Brewery Limited's public questionnaire—application for tavern restricted licence—Spinifex Brewery—Cable Beach, and I ask:

(a) how many questionnaires have been lodged at the Liquor Licensing Authority;

(b) how many questionnaire responses identified that respondents considered that Spinifex Brewery—Cable Beach operating under a tavern restricted license as proposed would cause any of the following:

(i) harm;

(ii) ill-health;

(iii) disturbance;

(iv) offence;

(v) inconvenience; and

(vi) annoyance; and

(c) how many questionnaire responses identified that respondents considered the amenity, quiet or good order of Cable Beach and the surrounding area will be lessened if Spinifex Brewery—Cable Beach operates under a tavern restricted licence as proposed?

Hon Darren West replied:

(a) The applicant lodged 1 public questionnaire that consisted of 196 responses.

(b) (i) harm – 0

(ii) ill-health – 0

(iii) disturbance – 8

(iv) offence – 2

(v) inconvenience – 4

(vi) annoyance – 2

(c) 14

REGIONAL DEVELOPMENT — ONE MILE JETTY

1503. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Regional Development:

I refer to the 17 July 2023 media statement titled 'Restoration works confirmed for One Mile Jetty' which announced that the State Government, through the Department of Transport, will restore up to 150 metres of Carnarvon's historic One Mile Jetty for pedestrian access, and I ask:

(a) why was the Carnarvon Heritage Group's (CHG) proposal to refurbish the One Mile Jetty, which was developed using the wide range of expertise contained with the CHG membership and the Carnarvon community; the same data and professional engineering advice to inform methodology and costings that was available to the Department of Transport; and which would provide an 800 metre jetty to the beach as opposed to a 150 metre jetty to nowhere, overlooked in preference for the Department of Transport's delivery of the project;

(b) noting that the CHG secured written support from local Aboriginal Community Controlled Organisations and the Shire of Carnarvon for their delivery of the refurbishment project, how is the Department of Transport's delivery of the project expected to cultivate greater levels of community support and deliver better outcomes for the Carnarvon community than the CHG's delivery of the project; and

(c) why is the Carnarvon community required to suffer through an additional 2 year wait for the Department of Transport to commence the project in 2025, when the CHG proposal, which has already been widely consulted with and supported by the community, could have seen the project commence immediately?

Hon Kyle McGinn replied:

The Minister for Transport and the Minister for Regional Development have agreed to a joint delivery model of the One Mile Jetty project, to be undertaken in consultation with the Carnarvon Heritage Group (CHG).

The decision was based on the Department of Transport's (DoT) expertise in the delivery of maritime infrastructure projects and their skill set in managing large complex projects and access to the necessary multiple contract management systems.

The DoT project methodology was also considered likely to result in reduced maintenance costs for the community, as more of the structure will be replaced with new material.

The State recognises the significant level of community support for the project, including Traditional Owner support, and notes further consultation proposed by DoT will be undertaken in collaboration with members of the CHG and Gascoyne Development Commission.

Regardless of the entity undertaking the project, its commencement is dependent on the completion of environmental approvals, heritage approvals and procurement of suitable timbers.

LOCAL GOVERNMENT — ELECTORAL OFFENCES

1504. Hon Dr Brian Walker to the Leader of the House representing the Minister for Local Government:

(1) Can a complaint about a local government electoral offense be made to a Local Government Council?

(2) Does a Local Government Council have the power to direct its CEO to prosecute a local government electoral offense?

(3) Does a Local Government Council have the power to prosecute a local government electoral offense through an agent appointed under *Local Government Act 1995* s.5.45(2)(a) to use Council's powers under *Local Government Act 1995* s.9.24(1)(c)?

(4) Does the Department of Local Government Sport and Cultural Industries have the power to determine/decide a *Local Government Act 1995* s.105(3) serious breach complaint made against an elected Member?

(5) In what circumstances is the Minister prepared to exercise his *Local Government Act 1995* s.9.13A power?

(6) How many times and in what circumstances has any Local Government Minister exercised the *Local Government Act 1995* s.9.13A power in the last three years?

(7) Has the *Local Government Act 1995* s.9.13A ministerial power been delegated and, if so, to whom?

Hon Sue Ellery replied:

(1)–(3) The provisions of various Acts may apply to conduct in elections.

Complaints of alleged electoral offences are best directed to the Returning Officer or to the Western Australian Electoral Commission. Depending on the type of alleged offense, a person may also make a report to the Western Australia Police Force.

(4) Section 5.116 of the *Local Government Act 1995* relevantly provides for how a complaint of an alleged serious breach is to be handled once received by the Departmental CEO. An allegation of a serious breach may then be progressed to the State Administrative Tribunal.

(5) Section 9.13A limits the circumstances in which a notice can be issued. This power only applies to continuing contravention (which is not an offence), not individual instances of non-compliance, or offences.

The State Government is continuing to deliver the largest reforms to the system of local government in more than 25 years. As part of the reforms, the State Government is working to establish new early intervention powers and mechanisms, such as Local Government Monitors, for responding to issues that emerge within local governments.

(6) Nil.

(7) No.

LOCAL GOVERNMENT — ELECTORAL OFFENCES

1505. Hon Dr Brian Walker to the Leader of the House representing the Minister for Local Government:

(1) Can a complaint about a local government electoral offence be made to the Western Australia Police?

(2) Do the WA police have the jurisdiction to prosecute a *Local Government Act 1995* local government electoral offense?

(3) Do the WA police have the jurisdiction to prosecute a *Local Government Act 1995* offense?

(4) Is a local government CEO required to pass service of court proceedings to the Council of that local government when the Local Government or any employee is a party in or to those proceedings?

(5) In what circumstances is a Local Government CEO authorised to represent a local government in proceedings in the Western Australia Supreme Court or the Western Australia Court of Appeal without reference to or the authority of the Council, having regard to *Local Government Act 1995* s.9.29?

Hon Sue Ellery replied:

(1) The provisions of various Acts may apply to conduct in elections.

Complaints of alleged electoral offences are best directed to the Returning Officer or to the Western Australian Electoral Commission. Depending on the type of alleged offence, a person may also make a report to the Western Australia Police Force.

(2) No.

(3) No.

(4) The CEO of a local government is generally responsible for providing relevant advice and information to the Council.

(5) It would be unlikely that a CEO would not engage with the Council of a local government in relation to Supreme Court or Court of Appeal proceedings involving that local government.

LOCAL GOVERNMENT — ELECTORAL OFFENCES

1506. Hon Dr Brian Walker to the parliamentary secretary to the Minister for Electoral Affairs:

(1) How many electoral offenses has the Western Australia Electoral Commission (WAEC) or WAEC contracted returning officers prosecuted since the 2019 local government elections?

(2) Which electoral offence in (1), was/were at issue and what was/were the outcomes?

(3) What changes has the WAEC made in its local government election practices having regard to the *Report of the Inquiry into the City of Perth 30 June 2020* by Tony Power SC page 19; which findings about the WAEC where it is contracted to conduct local government elections, included that whether the action taken by … the WAEC, in circumstances that suggested misconduct that occurred in relation to an election, was adequate: at page 62; … the collection of ballot papers could potentially constitute a breach of the *Local Government Act 1995* and should be addressed to ensure it does not occur: page 89, para.166; finding 2.2.2 (iii) … actions taken by … the WAEC, to ensure the integrity of the … elections were inadequate. In particular ….the WAEC … did not sufficiently investigate or take action in relation to the complaints of fraud…; … the WAEC consider and review the adequacy of its practices and procedures regarding to the handling and investigation of electoral complaints: page 75 para. 146; … the City [of Perth} and the WAEC establish a clear division if responsibilities in the conduct of … elections, including the handling of complaints: 3.4 recommendation 150, page 76; … the City engage the WAEC to provide adequate training to persons assisting in … elections: Vol.3 .4, recommendation 153, page 76?

(4) How does the WAEC mitigate the chain of custody of ballot paper risks in postal elections having regard to the outcomes in Shire of Serpentine Jarrahdale (1st Complainant) Shaye Luke Mack (2nd Complainant) and Electoral Commissioner of Western Australia (WAEC) (Intervener) Gurdeep Singh (1st Interested Party) Robert Coales (2nd Interested Party) GCLM/1354/2021 & GCLM/1297/2021?

(5) Who are the current pollsters/polling organisations other than the WAEC, including the AEC, available to WA local governments who the WAEC could/would approve and/or has approved for local government returning officers for in-person elections under its *Local Government Act 1995* s.4.20(2) powers?

(6) What engagement has/does/will the WAEC have with WALGA and/or LG Pro in establishing its practices and procedures for local government elections?

(7) What were the outcomes of that engagement?

(8) By how much have local government election voting numbers changed at each ordinary election since the introduction of postal voting in 1995?

(9) What is the estimated percentage rise in local government postal election costs since the last local government election in 2021?

(10) Why have postal election costs risen so much since the last local government election in 2021?

(11) What should local government best practice be in relation to minimising this risk or the fraudulent or misuse of local government posted out ballot papers?

(12) Are postal ballots for Local Government elections posted to property managers and not owners of leased and rented properties, or posted in such a way that they could be unlawfully intercepted by property managers?

(13) Should the delivery of the completed ballot paper to local government offices be seen to be placed in a secure ballot box and not received by a front counter employee to be later be placed in an unseen ballot box?

(14) When do WAEC appointed returning officer contracts end?

(15) To whom can an electoral offence complaint be made once a WAEC appointed Returning Officer contract has ended?

Hon Matthew Swinbourn replied:

(1) How many electoral offenses has the Western Australia Electoral Commission (WAEC) or WAEC contracted returning officers prosecuted since the 2019 local government elections?

Three.

(2) Which electoral offence in (1), was/were at issue and what was/were the outcomes?

Candidate handling electoral postal packages. This is an offence under section 4.92 of the Local Government Act. This person was convicted of that offence.

Publishing falsely authorised electoral material which is an offence under section 4.87 of the Act. Matter is currently before the courts.

Person fraudulently filling out ballot papers, which is an offence under section 4.91 of the Act. Matter is currently before the courts.

(3) What changes has the WAEC made in its local government election practices having regard to the Report of the Inquiry into the City of Perth 30 June 2020 by Tony Power SC page 19; which findings about the WAEC where it is contracted to conduct local government elections, included that whether the action taken by … the WAEC, in circumstances that suggested misconduct that occurred in relation to an election, was adequate: at page 62; … the collection of ballot papers could potentially constitute a breach of the Local Government Act 1995 and should be addressed to ensure it does not occur: page 89, para.166; finding 2.2.2 (iii) … actions taken by … the WAEC, to ensure the integrity of the … elections were inadequate. In particular ….the WAEC … did not sufficiently investigate or take action in relation to the complaints of fraud…; … the WAEC consider and review the adequacy of its practices and procedures regarding to the handling and investigation of electoral complaints: page 75 para. 146; … the City [of Perth} and the WAEC establish a clear division if responsibilities in the conduct of … elections, including the handling of complaints: 3.4 recommendation 150, page 76; … the City engage the WAEC to provide adequate training to persons assisting in … elections: Vol.3 .4, recommendation 153, page 76?

This part of the City of Perth inquiry that focused on electoral offences related to sham leases, misuse of the owners and occupiers electoral roll, eligibility relating to corporate nominees being on the owner and occupiers roll and the non-disclosure of gifts by candidates. The owners and occupiers roll and its accuracy is the responsibility of the CEO of each local government.

The Local Government Amendment Act 2023, which was passed on 11 May 2023, introduced amendments to reform the owners and occupiers roll to prevent the use of sham leases. These provisions are not yet in effect as the detail of the new requirements will be set out in regulations. It is understood that the Department of Local Government, Sport and Cultural Industries is progressing amendments to the *Local Government (Elections) Regulations 1997* to deal with some of these matters.

(4) How does the WAEC mitigate the chain of custody of ballot paper risks in postal elections having regard to the outcomes in Shire of Serpentine Jarrahdale (1st Complainant) Shaye Luke Mack (2nd Complainant) and Electoral Commissioner of Western Australia (WAEC) (Intervener) Gurdeep Singh (1st Interested Party) Robert Coales (2nd Interested Party) GCLM/1354/2021 & GCLM/1297/2021?

While the WAEC fulfils its statutory duties in relation to the Local Government Act and has robust processes in place for the safeguard of postal packages in its custody, it cannot police the behaviour of candidates and their supporters, or electors more generally. With some 1.7 million postal packages being sent to electors for the October 2023 local government elections, the WAEC follows the processes specified in the Local Government Act and relies on the community, candidates, and their supporters to act appropriately.

(5) Who are the current pollsters/polling organisations other than the WAEC, including the AEC, available to WA local governments who the WAEC could/would approve and/or has approved for local government returning officers for in-person elections under its Local Government Act 1995 s.4.20(2) powers?

The WAEC has not been requested to approve any other person to conduct a local government election.

(6) What engagement has/does/will the WAEC have with WALGA and/or LG Pro in establishing its practices and procedures for local government elections?

The WAEC has established working groups with the Department of Local Government, Sport and Cultural Industries (DLGSC) and WALGA to cover communications and training and awareness. The Local Government Act and subsidiary legislation underpins all local government election processes and procedures. Processes are outlined in the training materials provided by the WAEC to its appointed Returning Officers which is further supplemented by information also available on the WAEC and the DLGSC websites.

(7) What were the outcomes of that engagement?

The joint Working Groups aim to ensure consistency in communications and training across WAEC, DLGSC and WALGA, which includes the recent webinar provided by the WAEC, DLGSC and WALGA regarding information for prospective local government candidates about the election process, the roles and responsibilities of local government, elected members and the council, together with the role of the DLGSC as the regulator of local government in Western Australia.

(8) By how much have local government election voting numbers changed at each ordinary election since the introduction of postal voting in 1995?

The WAEC conducted postal voting for the restructure of the City of Perth in 1995. This involved amending the *Local Government Act 1960* and the *City of Perth Restructuring Act 1993*. These elections were for the new City of Perth and the Towns of Cambridge, Victoria Park and Vincent. The participation rate in these 4 local governments was 49.98%. The WAEC will conduct 115 postal elections and 9 in person elections for 2023. The participation rate for postal elections conducted by the WAEC since 1995 is set out below but it should be noted that the early figures 1995–2005 are based on smaller numbers of local governments participating in postal elections when compared to more recent years. Thus the overall number of potential electors participating in postal elections has grown progressively over the period 1995 to 2021. More detailed information is available from the Commission's website www.elections.wa.gov.au:

Election Year	Postal Participation Rate %
2021	30.20%
2019	29.10%
2017	34.50%
2015	27.50%
2013	27.76%
2011	30.94%
2009	33.37%
2007	34.34%
2005	37.34%
2003	34.95%
2001	38.00%
1999	42.00%
1997	46.50%
1995	49.98%

(9) What is the estimated percentage rise in local government postal election costs since the last local government election in 2021?

128 local governments were provided with a cost estimate in 2023 compared to the 92 local governments the WAEC conducted postal elections for in 2021, making a comparison difficult. The WAEC advised all local governments that requested a cost estimate in 2023 that costs had increased since 2021 due to the normal inflationary pressures that all suppliers have been experiencing recently as well as improvements made to the WAEC's processing procedures and education, training, complaints management, investigation and legal resources. More specific detail is provided in answer to question 10. The 2021 ordinary elections continued a growing trend of aggressively contested elections resulting in many complaints and legal action by the WAEC. It became apparent that the WAEC needed to improve processing procedures and education, training and complaints/legal resources to address this trend.

(10) Why have postal election costs risen so much since the last local government election in 2021?

Cost increases are attributed to the following factors:

An increase for some local governments in the number of elections being conducted due to the introduction of direct election provisions for Mayoral/Presidential elections (37 in 2023 compared to 12 in 2021).

An estimated increase in the number of electors of over 100,000 since 2021.

Australia Post has increased its postage fee by 11%.

A 14% increase in the cost of printing and procurement of election packages (including envelope and paper costs).

Public Service wages have increased over 6%.

Additional staffing costs arising from improved processing procedures and education, training, complaints management, investigation and legal resources identified following the 2021 ordinary elections as requiring improvement to our service delivery levels.

(11) What should local government best practice be in relation to minimising this risk or the fraudulent or misuse of local government posted out ballot papers?

Local governments should actively inform electors using their normal communication channels when postal packages are being distributed by Australia Post. Further, they should remind electors to follow the instructions in the information brochure supplied with their postal packages. Local governments should remind electors there are serious offences related to mishandling postal packages. This year the WAEC will also be informing electors when their postal packages are to be mailed-out to them. Candidates are also being reminded of the proper procedures in relation to the handling of postal voting packages and encouraged to pass this message onto any volunteers they may utilise as part of their campaign.

(12) Are postal ballots for Local Government elections posted to property managers and not owners of leased and rented properties, or posted in such a way that they could be unlawfully intercepted by property managers?

In accordance with legislative provisions electors on the Owner/Occupiers roll receive their election package via the post at the postal address that the elector supplied on the Enrolment Eligibility Claim Form that was processed by the relevant local government.

(13) Should the delivery of the completed ballot paper to local government offices be seen to be placed in a secure ballot box and not received by a front counter employee to be later be placed in an unseen ballot box?

The WAEC recommends that the ballot box should be in a location visible to the public but also in a secure location.

(14) When do WAEC appointed returning officer contracts end?

The Returning Officers are appointed until 20 November 2023. This period includes the period allowed for any Court of Disputed Return matters.

(15) To whom can an electoral offence complaint be made once a WAEC appointed Returning Officer contract has ended?

Any member of the community may make a complaint to a Returning Officer while they are appointed or at any time directly to the Commission via our website www.elections.wa.gov.au.

ROAD SAFETY — DEATHS

1507. Hon Martin Aldridge to the Leader of the House representing the Minister for Road Safety:

I refer to a report in *The West Australian newspaper* on 19 June 2023 showing Western Australia has had the highest proportional increase in road deaths and calling for more transparency on the causes of these deaths, and I ask:

(a) what data does the State Government currently have access to regarding the causes and contributing factors relating to serious road accidents;

(b) how does the Government make this data available to stakeholders, including road safety groups and local governments, to allow them to make better decisions regarding road safety; and

(c) has the Minister sought a briefing from the Australian Automobile Association regarding this matter?

Hon Sue Ellery replied:

(a) Road crash information in WA is collected by multiple agencies across multiple portfolios and collated by Main Roads WA.

(b) The Road Safety Commission compiles and publishes annual statistics on serious road crashes and their contributing factors.

A range of data is also available from Main Roads, WA Department of Health, and via The National Coronial Information System.

(c) Yes.

KIMBERLEY FLOODS — DISASTER RECOVERY FUNDING ARRANGEMENTS

1508. Hon Martin Aldridge to the Minister for Emergency Services:

I refer to the joint media statements issued on 7 July 2023 regarding Disaster Recovery Funding Arrangements (DRFA) being activated in relation to the Kimberley floods and tropical cyclone Ilsa, and I ask:

(a) what is the total value of category C and D funding which has been requested by the State Government towards recovery grants for the Kimberley and Pilbara;

(b) for the Small Business Recovery Grants please identify:

(i) the total value of DRFA funding allocated towards this program;

(ii) the number of applications received to date;

(iii) the number of applications approved to date; and

(iv) the total funding dispersed to date;

(c) for the Medium Business Recovery Grants please identify:

(i) the total value of DRFA funding allocated towards this program;

(ii) the number of applications received to date;

(iii) the number of applications approved to date; and

(iv) the total funding dispersed to date;

(d) for the Primary Producers Recovery Grants please identify:

(i) the total value of DRFA funding allocated towards this program;

(ii) the number of applications received to date;

(iii) the number of applications approved to date; and

(iv) the total funding dispersed to date; and

(e) for the Homeowners Recovery and Resilience Grants please identify:

(i) the total value of DRFA funding allocated towards this program;

(ii) the number of applications received to date;

(iii) the number of applications approved to date; and

(iv) the total funding dispersed to date?

Hon Stephen Dawson replied:

The Department of Fire and Emergency Services (DFES) advises as of 11 August 2023:

(a) The total value of DRFA Category C and D funding for recovery grants is up to $6,234,000.

(b)–(c) (i) The total value of funding for the Business Recovery Grants is up to $2,006,000 and includes:

Funding available under the Small Business Recovery Grant—up to $1,200,000

Funding available under the Medium Business Recovery Grant—up to $675,000

Administration and Monitoring and Evaluation costs—up to $131,000

(ii) 5

(iii) 0

(iv) Nil.

(d) (i) The total value of funding for the Primary Producers Recovery Grant is up to $2,568,000 and includes:

Funding available under the Primary Producers Recovery Grant—up to $2,400,000

Administration and Monitoring and Evaluation costs—up to $168,000

(ii) 1

(iii) 0

(iv) Nil.

(e) (i) The total value of funding for the Homeowners Recovery and Resilience Grants is up to $1,660,000 and includes:

Funding available under the Homeowners Recovery and Resilience Grants—up to $1,550,000

Administration and Monitoring and Evaluation costs—up to $110,000

(ii) 14

(iii) 0

(iv) Nil.

TRANSPORT — BINDOON BYPASS

1509. Hon Martin Aldridge to the minister representing the Minister for Transport:

I refer to the Bindoon Bypass on the Great Northern Highway, and I ask:

(a) noting the most recent project update was published in July 2022, when will Main Roads provide the community with an update on the progress and status of this project;

(b) what is the total value of this project and what is the State Government's contribution towards this project; and

(c) what is the expected completion date for this project?

Hon Stephen Dawson replied:

(a)–(c) The current funding allocated to the Bindoon Bypass is $275 million, which includes a State Government contribution of $55 million.

The project is subject to the "Commonwealth Infrastructure Investment Program 90 Day Strategic Review". Following completion of the Review, a procurement timeframe and further updates to the community will be provided.

HOSPITALS AND HEALTH CAMPUSES — MAINTENANCE FUNDING

1510. Hon Martin Aldridge to the Leader of the House representing the Minister for Health:

I refer to Legislative Council Question on Notice 2519 answered on 29 October 2019 regarding the State Government's $37 million priority hospital maintenance program for regional health services and the associated tabled paper 3345 which detailed the individual works and funding for each facility, and I ask:

(a) for each of the projects listed in tabled paper 3345 please identify:

(i) the completion status of the project; and

(ii) the total funding amount expended;

(b) did the State Government fully expend the $81.5 million allocated under the maintenance program as announced in the media statement on 24 September 2019;

(c) if no to (b), what amount of funding was expended; and

(d) did the project create 1,300 jobs as promised, and how was this measured and determined?

Hon Sue Ellery replied:

(a) (i)–(ii)

Regional WA Health Facility	Completion Status	Funding Expended ($)
WACHS GOLDFIELDS		**27,251**
Leonora community Health		
Landscaping of grounds surrounding centre	Completed	27,521
WACHS GREAT SOUTHERN		**4,090,108**
Albany Block B Population Health		
Building Works Second stage roof replacement	Completed	135,787
Albany Mental Health		
Building Works Reconstructing and redesigning Acute Psychiatric Unit and courtyard	Completed	252,006
Albany Site Wide		
Hydraulic Services Mains potable water redundancy upgrade.	Completed	66,134
Building Works Installation of roof access points and roof anchor points	Completed	15,817
Building Works Provide additional storage with access to supply and wards	Completed	374,669
Building Works Part internal fitout to accommodate Infrastructure and support services staff	Completed	215,066

Denmark		
Install nurse call system	Completed	259,884
Gnowangerup		
Building Works – Install fire and smoke separation/ Generators/Boilers	Completed	42,925
Building Works Installation of roof access points and roof anchor points	Completed	15,817
Electrical Services Upgrade car park and security lighting	Re-prioritised	
Fire Services Upgrade fire ring main to standard with tanks and pumps	Design completed and remaining project funding re-prioritised	66,607
Hydraulic Services	Completed	1,543
Potable hot water ring main. Concept plans.	Completed prioritised project	4,599
Fire Services Upgrade fire indicator panel and Emergency Warning Intercom System – Gnowangerup and Kojonup	Completed prioritised project	158,716
Katanning		
Building Works Asbestos removal from hospital	Completed	127,288
Building Works Upgrade Watson house Drs Clinic	Completed	75,438
Electrical Services Electrical switchboard and wiring upgrade	Re-prioritised	
Medical Gas Services Upgrade pipe sizes	Concept completed and remaining project funding re-prioritised	4,000
Potable hot water ring main. Concept plans.	Completed prioritised project	2,776
Kojonup		
Building Works Install fire and smoke separation with auto closing doors	Re-prioritised	
Building Works Installation of roof access points and roof anchor points	Completed	15,816
Fire Services Upgrade fire ring main to standard with tanks and pumps	Design completed and remaining project funding re-prioritised	41,709
Potable hot water ring main. Concept plans.	Completed prioritised project	2,748
Mount Barker		
Building Works – Remove and replace roof over Allied Health	Completed	49,551
Building Works Installation of roof access points and roof anchor points	Completed	15,816
Building Works window replacement/. Concrete verandas brick paving	Completed	198,749
Building Works Renovate hospital entrance/waiting area/triage/Emergency.	Completed	1,818,482

Ravensthorpe		
Building Works Installation of roof access points and roof anchor points	Completed	15,816
Building Works Repairs to building subsidence	Design completed and remaining project funding re-prioritised	12,500
Fire Services Replace Fire Mains	Completed	36,980
Hydraulic Services Replace Water Mains	Re-prioritised	
Tambellup		
Building Works Installation of a triage booth	Completed	47,052
Building Works Installation of roof access points and roof anchor points	Completed prioritised project	15,817
WACHS KIMBERLEY		**4,550,433**
Broome		
Birthing Suites Upgrade/Renovation	Completed	1,506,007
General Ward Refurbishment of Older 4 Bed Wards	Re-prioritised	
Install Required Door Openers to 4 x Disabled Toilets	Re-prioritised	
Installation of Medical Air System	Re-prioritised	
Relocate Central Computer Room	Re-prioritised	
Upgrade of Staff Accommodation and Asbestos Management	Re-prioritised	
Mental Health Inpatient Unit – Wall Height Extension	Completed prioritised project	255,000
Extend Infusion Room for Telechemo	Completed prioritised project	5,470
Derby		
Derby Hospital Emergency Lighting	Completed	64,565
Derby Hospital Kitchen Vinyl Flooring	Completed	114,009
Medical Code Blue Alarm	Re-prioritised	
Mental Health Entry Ramp	Re-prioritised	
Morgue Upgrade	Completed	101,374
Old Granada Building Demolition	Completed	180,225
Theatre Humidity Control	Completed	39,063
Ward External Glass Doors	Re-prioritised	
Hospital Roofing Replacement	Completed prioritised project	223,511
Fitzroy Crossing		
New Water line/meter for all Staff Accommodation on site	Re-prioritised	
Refurbishment of dialysis room /create required clinical space	Completed	30,058
Upgrade Staff Accommodation	Completed	693,587
Halls Creek		
Asbestos Management – Staff Accommodation	Re-prioritised	
Housing properties to be demolished/asbestos management	Re-prioritised	
Upgrade Staff Accommodation	Completed	594,019

Kununurra		
Installation of a storage tank for potable water.	Re-prioritised	
IT Office replacement	Re-prioritised	
Kununurra Hospital Kitchen Vinyl Flooring	Completed	77,582
Mental Health extension of existing building on site	Completed	85,546
Piped Medical Air to ED, Maternity, Theatre and Wards	Re-prioritised	
Reconfiguration of Central Sterile Services Department Area	Re-prioritised	7,942
Repair Front Car Park Drainage	Re-prioritised	
Upgrade Admin / ED Front of Hospital	Re-prioritised	
Upgrade Rear Hospital Carpark	Re-prioritised	
Upgrade Staff Accommodation	Completed	384,742
Vinyl flooring replacement in Central Sterile Services Department and Theatre area	Completed	36,667
Lombadina & One Arm Point Clinics		
Install crimsafe screening to front verandahs	Re-prioritised	
One Arm Point		
Upgrade of Staff Accommodation	Re-prioritised	
Warmun		
Carpark Works	Re-prioritised	
Wyndham		
Asbestos Management	Re-prioritised	
Upgrade Staff Accommodation	Completed	151,066
WACHS MIDWEST		**6,210,365**
Burringurrah		
Full clinic & housing painting	Completed	81,000
Housing kitchen and flooring upgrade	Completed	75,812
Coral Bay		
Coral Bay – residence renovations	Completed	43,303
Coral Bay clinic – full internal patch and paint	Completed	8,650
Carnarvon Regional Hospital		
Full internal painting	Re-prioritised	
Roofing and gutter systems	Re-prioritised	
Ventilation/fans/ducting etc	Completed	162,568
Cue Nursing Post		
Roofing and gutter repairs	Completed	43,072
Accommodation renovations	Completed prioritised project	76,276
Carnarvon – residences		
Painting/Roofing/Gutters/Flooring/Bathrooms/Kitchen, Concrete Cancer	Completed	250,739
Residences Renovations – Robinson St X 2 Kitchen and Bathroom Renovations	Design completed and remaining project funding re-prioritised	$4,732
Residences Renovations House Kitchen and Bathroom Renovations	Completed	22,541

Exmouth District Hospital		
Exmouth – Flooring Improvements	Re-prioritised	
Exmouth – Bathroom Improvements	Completed	1,124,659
Exmouth – Ward Repainting Lighting Controls	Re-prioritised	
Exmouth – Widening Door Way to Allow Bed Access for Single Room	Re-prioritised	
Exmouth District Hospital – Full Internal and External Paint	Re-prioritised	
Exmouth District Hospital – Roofing and Gutters	Completed	165,522
Concrete Cancer Issues	Completed	631,445
Geraldton Health Campus		
Covered including wall to stop clients accessing Staff area	Re-prioritised	
Develop a common room for junior doctors	Completed	48,959
Develop Covered Footpath between buildings on the Health Campus.	Completed	$406,473
Reconfigure the Mortuary	Completed	41,030
Upgrade existing access with automatic doors	Completed	44,688
Painting internal	Re-prioritised	
Secure afterhours staff parking	Included in GHC redevelopment	
Geraldton Health Campus – Aged Care		
Flooring Replacement	Re-prioritised	
Full Internal and External Paint	Re-prioritised	
Roofing Replacement and Gutter Repairs	Completed	33,725
Geraldton Health Campus – Community Health Building		
Community Health Building – Full Internal Paint	Re-prioritised	
Community Health Building – Roofing and Gutters	Completed	174,000
Upgrade Electrical System	Design completed and remaining project funding re-prioritised	14,648
Upgrade Fire System	Completed	33,387
Geraldton Health Campus Residences		
Nurses Quarters External Painting	Completed	272,790
Nurses Quarters Wiring Upgrade	Completed	299,374
Repair failing brickwork	Completed	30,696
Kalbarri		
Kalbarri Residences – Full Internal and External Paint	Completed	55,749
Kalbarri Multi Purpose Centre – Flooring Replacements	Completed	13,082
Kalbarri Multi Purpose Centre – Lighting Upgrade to LED	Re-prioritised	
Kalbarri Multi Purpose Centre – Roofing and Guttering Repairs	Completed	58,993

Meekatharra Hospital		
Driveway and Parking Resurfacing	Design completed and remaining project funding re-prioritised	26,869
Kitchen Renovation	Completed	81,110
Walking Path Repairs	Re-prioritised	
Flooring Replacement	Completed	61,163
Full Internal and External Painting	Re-prioritised	
Laundry Renovation and Equipment Replacement	Re-prioritised	
Laundry Renovation	Re-prioritised	
Morgue Building Replacement with Viewing Room	Completed	182,903
Roofing and Gutter Repairs	Re-prioritised	
Meekatharra Residences		
Haveluck Residential Complex – Reinstatement ff Pool Facilities	Completed	120,000
Haveluck Unit Renovations – All Bathrooms, Full Internal Patch and Paint	Completed	800,000
Mount Magnet Community Health Service		
Full Internal and External Painting	Completed	69,356
North Midland Residences		
Asbestos Management	Completed	122,119
Northampton Health Service		
Bathroom Refurbishments.	Completed	464,113
Morgue Building Replacement	Re-prioritised	0
Sewage System Replacement Including Grease Trap	Completed	46,273
Sandstone Nursing Post		
Full Internal and External Paint	Completed	18,546
Roofing and Gutter Repairs	Re-prioritised	
WACHS PILBARA		**1,196,909**
Hedland Health Campus		
Cover Area for Supply Goods Receival and Wash Bay	Re-prioritised	
Karlarra House Residential Aged Care Facility		
Replacement Sewerage Lines System	Completed	610,000
Paraburdoo		
Replacement of Asbestos Sheeting to Hospital	Re-prioritised	
Region wide		
Staff Accommodation Upgrades	Completed	586,909
WACHS SOUTHWEST		**5,811,831**
Adult Psychiatry Unit		
Upgrade Fencing	Completed	108,325
Augusta Hospital		
Repaint Ceilings	Completed	26,450
Repaint Paintable Building Fabrics	Completed	22,995

Bridgetown Hospital		
Refurbish Kitchen	Completed	368,705
Repaint Paintable Building Fabrics	Completed	48,942
Replace Roof	Re-prioritised	
Upgrade Bathrooms	Completed	22,618
Bunbury – Hudson Road (Owned)		
Repaint Paintable Building Fabrics	Completed	36,340
Convert old kitchen into office accommodation	Completed prioritised project	54,840
Boyup Brook		
Install patient wandering alarm systems	Completed prioritised project	18,562
Busselton Health Campus		
Replace Existing Paving with Exposed Aggregate	Re-prioritised	
Replace Thermal Mixing Valves	Re-prioritised	
Upgrade Kits to be Retrofitted to Existing Cabinets	Re-prioritised	
Upgrade Patient Holding to Pharmacy, Pharmacy Room to Storeroom	Completed	33,387
Collie Hospital		
Install Installation Lining and Racking System	Completed	17,608
Refurbish Kitchen	Completed	368,075
Refurbish Nursing Quarters	Re-prioritised	
Repaint Ceilings	Re-prioritised	
Replace Roof	Completed	4,047,902
Upgrade Ambulance Entry Auto Doors	Completed	10,938
Upgrade Asphalt to Main Entry Point of Site	Re-prioritised	
Upgrade Bathrooms	Completed	22,618
Donnybrook Hospital		
Refurbish Old Bathroom to Hospital Equipment Store	Completed	$3,920
Repaint Ceilings	Re-prioritised	
Upgrade Bathrooms	Completed	105,550
Harvey Hospital		
Refurbish Kitchen	Completed	368,705
Harvey Hospital		
Repaint Ceilings	Re-prioritised	
Leeuwin Lodge		
Repaint Ceilings	Completed	30,221
Margaret River Hospital		
Repaint Ceilings	Completed	21,200
Nannup Hospital		
Replace Carpet with Vinyl	Completed	38,573
Northcliffe nursing post		
Replace Roof	Re-prioritised	

Pemberton Hospital		
Repaint Ceilings	Re-prioritised	
Replace Carpet with Vinyl	Completed	35,357
WACHS WHEATBELT		**6,678,076**
Beverley		
Create 2 new Ensuites (Wards)	Re-prioritised	
Create a Dirty Utility (ED)	Re-prioritised	
Replacement of Box Gutters	Re-prioritised	
Staff Quarters, Upgrade Bathrooms and Toilets	Re-prioritised	
Boddington		
Install Reticulated Suction	Re-prioritised	
Upgrade of Emergency Department including Dirty and Clean Utility rooms and Ambulance Entry	Completed	766,122
Bruce Rock		
Memorial House, Upgrade to Meet Contemporary Standards	Re-prioritised	
Corrigin		
Electrical Rewire of Aged Care Wing	Re-prioritised	
Dalwallinu		
Partial Replacement of Roof	Re-prioritised	
Emergency Department Upgrade	Completed as a priority project	1,025,180
Goomalling		
Quamby Lodge, Remediation of Damage	Completed	8,774
Roof Replacement	Re-prioritised	
Kellerberrin		
Redevelop Ambulatory Care to Meet Contemporary Standards	Re-prioritised	
Rising Damp Issue and Repointing of Brickwork	Re-prioritised	
Upgrade of Female/Male Toilets and Showers	Re-prioritised	
Kondinin		
Diversion of Storm Water from Downpipes to Central Point	Re-prioritised	
Extension of Swipe Access to Triage and Staff Station	Re-prioritised	
Replacement of Reticulated Medical Gas System	Re-prioritised	
Roof Replacement	Re-prioritised	
Emergency Department Upgrade	Completed as a priority project	1,007,141
Kununoppin		
Remediation of Damage Caused by Ground Moisture	Re-prioritised	
Lake Grace		
Creation of Triage Room	Re-prioritised	
Staff Accommodation Install FIP (Mimic panel)	Re-prioritised	
Upgrade of Bathrooms (2)	Re-prioritised	

Merredin		
Creation of Foul Linen Storage Room (extension to building)	Re-prioritised	
Creation of New Engineering Office and Workshop	Re-prioritised	
Roof Replacement	Re-prioritised	
Narembeen		
Creation of Triage Room and ED upgrade	Completed	1,030,555
Region–wide		
Electrical Rewiring of sites x 13 @ $200k	Completed	577,368
Install Fall Arrest System	Completed	211,307
Upgrade of Emergency Departments	Completed	1,264,589
Southern Cross		
Upgrade of 3 x Ensuites	Design completed and remaining project funding re-prioritised	5,858
Wagin		
Creation of Triage Room	Re-prioritised	
Roof Replacement	Re-prioritised	
Wongan Hills		
Install Reticulated Suction	Re-prioritised	
Roof Replacement	Re-prioritised	
Emergency Department Upgrade	Completed as priority project	769,466
Wyalkatchem		
Night Quarters Upgrade including Roof Replacement	Re-prioritised	
York		
Install (Fire Indicator Panel) mimic panel into Aged Care Compartment	Re-prioritised	
Upgrade 3 x Ensuites	Design completed and remaining project funding re-prioritised	5,858
Upgrade Palliative Care room and Ensuite	Design completed and remaining project funding re-prioritised	5,858

The above table captures only those maintenance projects related to tabled paper 3345.

Several projects that were re-prioritised or postponed have been approved for conversion from recurrent maintenance program funding to capital funding in order to support the delivery of critical priority WACHS projects within the Asset Investment Program. This includes expansions and upgrades to regional Emergency Departments the delivery of the new Newman Health Campus and Forward Works for the Geraldton Health Campus Redevelopment.

(b)–(c) Of the $81.5 million funding allocated under the maintenance program, a total of $22.8 million was converted from recurrent to capital funding across financial years 2019–20, 2020–21 and 2022–23 to support the delivery of critical priority works within the Asset Investment Program. Of the revised budget of $58.7 million, 94% of the program has reached final completion with a total program expenditure of $55.4 million and the remaining budget fully committed.

(d) Infrastructure and maintenance workforce figures are not held by WA Health.

HOUSING — APPLICATION WITHDRAWAL — ADVERSE HISTORY

1511. Hon Dr Brad Pettitt to the minister representing the Minister for Housing:

I refer to the 2023–24 Estimates answer to Question Prior 35, where the answer states that the Housing Authority "withdraws" housing applications for adverse history, including reasons such as "a history of disruptive behavior; significant adverse tenancy history; where there are significant community safety concerns; significant unpaid debts and no payment plan in place", I ask:

(a) for each year from 2017–18 to present, how many applicants were "withdrawn" by the Housing Authority for adverse history;

(b) how many of those applications voluntarily identified as Aboriginal or Torres Strait Island applicants; and

(c) is the Minister misleading Parliament by not providing the number of applications for public housing assistance that have been denied or withdrawn on the basis of adverse history, data which the Housing Authority does collect?

Hon Jackie Jarvis replied:

(a) The Department of Communities (Communities) supports applicants with referrals and services appropriate to their circumstances.

All public housing applications flagged as having an adverse housing, including exhibiting serious or dangerous behaviours, poor property standards, and dangerous or illegal activity at the property, undergo an additional assistance review assessment. An applicant may be required to meet additional set criteria such as entering into a payment arrangement for their unpaid debt or being referred to appropriate support services due to their previous tenancy history.

An application may be 'withdrawn' pending further review or where the applicant does not meet their listed conditions. Additionally, this decision remains appealable under the Department of Communities Housing Appeals Policy. Some applicants may also decide to withdraw their own application voluntarily.

The below table denotes applications withdrawn by the Department under "adverse history". Applications identified as 'withdrawn' may have been escalated to a senior officer for an additional assistance review assessment. As such, the data included below may include both applications that were under review at the time, and additionally, applications that may have been reinstated to the waitlist subsequently following review.

The data also illustrates the significant downward trend in applications withdrawn throughout the term of the McGowan and Cook State Governments.

Public Housing Applications Withdrawn due to 'Adverse History' as at 31 July 2023	
Financial Year	Number of Applications Withdrawn due to Adverse History
2017–18	179
2018–19	206
2019–20	144
2020–21	88
2021–22	43
2022–23	30
2023–24 FYTD	1

*NB: The table captures applications withdrawn due to selected reasons within the category of adverse history, including 'Further Assistance Review Required', and 'Under Managers Assessment'.

(b) As the Member has previously been advised, it is not a mandatory requirement for clients seeking housing assistance to disclose their ATSI status to the Department. The table below only refers to the number of applications withdrawn where an applicant has self-identified as ATSI.

Given the voluntary nature of reporting, the below data cannot be provided with a high level of confidence.

Public Housing Applications Withdrawn due to 'Adverse History' as at 31 July 2023	
Financial Year	Main Applicant Identified as ATSI
2017–18	55
2018–19	66
2019–20	37
2020–21	29

2021–22	14
2022–23	10
2023–24 FYTD	-

*NB: 'ATSI' refers to applications where the Main Applicant has identified as Aboriginal and/or Torres Strait Islander based on latest data available.

(c) No.

PLANNING — STAKEHILL WETLANDS — BALDIVIS LANDCARE GROUP

1512. Hon Dr Brad Pettitt to the minister representing the Minister for Planning:

I refer to the Stakehill Wetland in the City of Rockingham and the Baldivis Landcare Group, and I ask:

(a) will the Minister please advise of the progress to update the 20-year-old management plan for the Stakehill Wetland site;

(b) will the Baldivis Landcare group be consulted regarding the future of this wetland;

(c) will the Minister please advise of the circumstances that have led to the Baldivis Landcare Group being evicted from their premises and having their equipment locked away from them; and

(d) will the Minister please advise what negotiations with the Baldivis Landcare Group have been, or will be entered into, regarding lease and equipment?

Hon Jackie Jarvis replied:

(a)–(b) The Department of Biodiversity, Conservation and Attractions is responsible for the Stakehill Wetland management plan. This question should be directed to the Minister for the Environment.

(c)–(d) The Western Australian Planning Commission (WAPC) has been attempting to finalise a lease agreement for a new site with the Baldivis Landcare Group (BLG) since 2020. To accommodate BLG, the WAPC organised a site for the temporary storage of the group's possessions until lease negotiations were resolved and undertook pre-lease improvements to the site, including the installation of gates, construction of a crossover, connection of power and removal of asbestos to a cost of around $25,000.

The group has not provided the information required to finalise the lease agreement, and as three years has lapsed, the temporary site is being decommissioned. In January 2023, the City of Rockingham notified the Department of Planning, Lands and Heritage that the use of the Lot is unauthorised under the City's Town Planning Scheme No.2 and section 214 of the *Planning and Development Act 2005*. Acting on its obligations, the Department issued a letter to BLG in February 2023, requesting that they remove their equipment from the Lot. The group has been notified that they can access the site to remove their equipment. To date, the group has not responded.

PRESCRIBED BURNING — REVIEW

1513. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to the Burn Severity Maps discussed in the Minister for Environment's response to petition 029, and I ask:

(a) will the Minister please provide the burn severity criteria that will be used to define each category of burn severity in each type of forest;

(b) how many burn severity maps were produced for each of the five previous years;

(c) will the Minister please table the maps in (b);

(d) if no to (b), why not;

(e) how many burn severity maps will be produced for the 2023 fire season;

(f) will the Minister please table all burn severity maps in (d) that have been completed;

(g) if no to (f), why not;

(h) will the Minister commit to making all burn severity maps publicly available as soon as they are completed; and

(i) if no to (h), why not?

Hon Darren West replied:

(a) The Department of Biodiversity, Conservation and Attractions (DBCA) is refining the process using remote sensing technology to increase the accuracy and objectivity of burn severity maps produced for areas where prescribed burning is undertaken. At present this trial mapping is available for forest areas in DBCA's three forest regions, with five severity classes applied as follows:

(i) Unburnt

(ii) Low

(iii) Medium

(iv) High

(v) Very High

Recently a burnt heath category has also been added to the severity classes due to the current inability to differentiate severity in this vegetation type.

The characteristics of these severity classes can be found in the tabled paper. [See tabled paper no 2497.]

(b) The burn severity mapping process has been developed over several years and has only been applied as a broadscale operational trial since January 2023. An indicative burn severity map is generated on request from the relevant DBCA region or district undertaking the prescribed burn. The actual area of treatment may be smaller than the total planned burn area identified. The indicative burn severity mapping product is currently being trialled operationally and requires further ground-truthing and refinement to ensure that the remote sensing output is reflecting what is represented in the field. DBCA scientists are continuing to conduct fieldwork and incorporate technological advances to inform the burn severity mapping process and improve the maps' accuracy and detail over time.

Forty-two indicative burn severity maps were produced for the period 1 January to 30 June 2023.

Year	Number of maps produced
2018–19	Nil
2019–20	Nil
2020–21	Nil
2021–22	Nil
2022–23	42

(c) [See tabled paper no 2497.]

(d) Not applicable.

(e) Indicative burn severity maps are produced according to the number of prescribed burns implemented, a process that depends on weather, fuel and climate conditions being met. It is not possible to confirm the total number of indicative maps that may be produced for 2023 as these will be produced on an as needs basis.

(f) Not applicable.

(g) Not applicable.

(h)–(i) DBCA's indicative burn severity mapping process is still being refined and additional data and technology advances should improve its accuracy. It is DBCA's intention to have a publicly available burn severity product available for all prescribed burns completed in DBCA's three south-west forest regions.

ROAD SAFETY — TOODYAY ROAD — UPGRADE

1514. Hon Dr Brad Pettitt to the minister representing the Minister for Transport:

I refer to the safety enhancements being made along the length of Toodyay Road and I ask:

(a) has the business case to support Federal funding of this project been updated with the information that the road will maintain a 100 km/h speed limit, rather than the expected 110 km/h:

(i) if yes to (a), what changes has the speed limit made on the anticipated economic benefits; and

(ii) if no to (a), why not;

(b) sealed shoulders and rumble strips have been identified by the Main Roads Western Australia (MRWA) as a low cost option to improve Killed and Serious Injured Index (KSI). What consideration was given to the installation of sealed shoulders and rumble strips as a safety measure in the agricultural parts of Toodyay Road:

(i) was any comparison of the comparative costs and benefits of rumble strips and sealed shoulders versus clearing in the agricultural areas undertaken;

(ii) if so, could those figures please be provided;

(iii) how is the bush to be cleared valued in this cost-benefit analysis; and

(iv) if not, why not;

(c) given that inflation is pushing up the cost of this project, are there any elements of the project that could be reconsidered due to cost;

(d) If yes, please state what; and

(e) what is the reasoning behind clearing 2 km on either side of the Fernie Road junction instead of widening the junction sufficiently to install a turning lane for turning right into Fernie Road:

(i) would the Minister consider a turning lane instead of further clearing (as happened at the Sandplain and Salt Valley Road junction); and

(ii) if not, why not?

Hon Stephen Dawson replied:

(a) The road is being designed to accommodate a speed limit of 110 km/h, consistent with the Business Case.

(b) Provision of sealed shoulders and rumble strips alone would not provide the desired safety improvements in this location.

Main Roads have received the required environmental approvals for this project and have undertaken substantial revegetation along Toodyay Road above and beyond approval requirements.

(c)–(d) The State Government intends to deliver the remaining upgrades to Toodyay Road by late-2026.

(e) This is to accommodate eastbound and westbound passing lanes, which are critical to reduce conflict between vehicles turning into and out of Fernie Road.

FOREST MANAGEMENT PLAN 2014–2023 — PERUP RESERVE

1515. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to the Perup Reserve "Conservation Reserve" listing in the *Forest Management Plan 2024–2033* with the specific tenure and class of reserve to be determined, and that the process had not yet started on publication of the draft plan, I ask:

(a) has the process to determine the tenure and class of the Perup Reserve begun;

(b) if yes to (a), when is it likely that this process will be complete;

(c) if no to (a), why not;

(d) what public consultation will take place in determining the class of reserve to apply to Perup; and

(e) while this process is underway, what protections are in place to protect critically endangered number habitat under the existing piece-meal reservations over the Perup Reserve?

Hon Darren West replied:

(a)–(b) Yes. The majority of the proposed Perup Reserve "Conservation Reserve" listed in the *Draft Forest Management Plan 2024–2033* (ID 270) was gazetted as nature reserve (R 54098 and R 54109) in September 2022. Reserve proposal data in the *Draft Forest Management Plan 2024–2033* is current as of June 2022. One small parcel from the original proposal remains as freehold owned by the Department of Water and Environmental Regulation and has not been reserved as constraints still exist. That parcel remains as proposed reserve.

(c) Not applicable.

(d) Not applicable.

(e) All threatened species and their habitats are protected under the *Biodiversity Conservation Act 2016*.

WASTE LEVY — EAST ROCKINGHAM AND KWINANA

1516. Hon Dr Brad Pettitt to the parliamentary secretary to the Minister for Environment:

I refer to the East Rockingham and Kwinana waste-to-energy plants respectively, and I ask:

(a) will the Minister please provide the greenhouse gas emissions profile for each facility for:

(i) annual emissions; and

(ii) lifetime emissions; and

(b) how much of the following will be emitted annually, broken down by facility:

(i) carbon dioxide; and

(ii) methane?

Hon Darren West replied:

(a) Emissions will depend on the feedstock used in the plants. Greenhouse gas emissions were estimated during the assessment and approval processes and are provided below.

(i) East Rockingham 71,339 tonnes of carbon dioxide equivalent.

Kwinana 110,574 tonnes of carbon dioxide equivalent.

(ii) East Rockingham 2,120,522 tonnes of carbon dioxide equivalent.

Kwinana Dependant on the life of the facility.

(b) A detailed breakdown of carbon dioxide and methane emissions was not required to be provided for the approvals. During operation of the waste-to-energy plants, greenhouse gas emissions will be monitored and reported.

CHILD DEVELOPMENT SERVICE — REFERRALS TO

1517. Hon Donna Faragher to the Leader of the House representing the Minister for Health:

(1) In 2022, how many referrals were made to the metropolitan Child Development Service to provide assessment, early intervention and treatment services to children for the following services:

(a) Audiology;

(b) Occupational therapy;

(c) Paediatrician;

(d) Physiotherapy;

(e) Clinical psychology; and

(f) Speech pathology?

(2) of the referrals in (1), how many were submitted by:

(a) a parent or legal guardian; and

(b) a professional?

Hon Sue Ellery replied:

(1)

Discipline name	**Number of referrals in 2022**
(a) Audiology	2,578
(b) Occupational Therapist	5,615
(c) Paediatrician	5,637
(d) Physiotherapist	3,896
(e) Clinical Psychologist	2,191
(f) Speech Pathologist	8,141

(2)

Referrer	**Number of referrals in 2022**
(a) Parent/legal guardian	769
(b) Professional	27,289

WA COUNTRY HEALTH SERVICE — REFERRALS TO

1518. Hon Donna Faragher to the Leader of the House representing the Minister for Health:

(1) In 2022, how many referrals were made to the WA Country Health Service to provide assessment, early intervention and treatment services to children for the following services:

(a) Audiology;

(b) Occupational therapy;

(c) Paediatrician;

(d) Physiotherapy;

(e) Clinical psychology; and

(f) Speech pathology?

(2) Of the referrals in (1), how many were submitted by:

(a) a parent or legal guardian; and

(b) a professional?

Hon Sue Ellery replied:

(1)

Discipline	Number of referrals in 2022[1]
(a) Audiology	1339
(b) Occupational Therapy	2787
(c) Paediatrician	7399
(d) Physiotherapy	2154
(e) Clinical Psychology	198
(f) Speech Pathology	3901

[1] Referrals as recorded in Community Health Information System (CHIS) and WebPAS

(2)

Referrer	Number of referrals in 2022
(a) Parent/legal guardian	801
(b) Professional	16977

EMERGENCY SERVICES — ACT CONSOLIDATION

1538. Hon Martin Aldridge to the Minister for Emergency Services:

I refer to the long-awaited release of the consolidation of emergency service acts, and I ask:

(a) noting that Cabinet approved the consolidation of the acts in 2019 what is the status of the initiative;

(b) when is it anticipated that an exposure draft bill will be released for stakeholder consideration;

(c) has any external stakeholder to the Department of Fire and Emergency Services been exposed to the draft Bill to date;

(d) is the Minister cognisant of the approaching southern High Threat Period and will sufficient time be allowed for stakeholders to consider the Bill in light of this;

(e) I note the DFES website advised that drafting instructions have been issued to Parliamentary Counsel's Office, on what date were such instructions issued; and

(f) when is it expected that a Bill will be introduced to the Parliament of Western Australia?

Hon Stephen Dawson replied:

(a) Consolidation of the emergency services acts is still ongoing.

(b) Early 2024.

(c) The Department of Fire and Emergency Services (DFES) continues to engage with external stakeholders regarding issues relevant to the Bill.

(d) Yes.

(e) Drafting instructions were issued to the Parliamentary Counsel's Office (PCO) following Cabinet approval to draft the consultation EDB in April 2019. Due to the COVID-19 Pandemic and other priority drafting being undertaken by PCO, drafting did not commence until August 2021.

(f) Once the Bill has been approved by Cabinet it will be introduced into Parliament.

PORTS — KIMBERLEY MARINE SUPPORT BASE

1539. Hon Dr Brad Pettitt to the Leader of the House representing the Minister for Ports; Local Government; Road Safety; Minister assisting the Minister for Transport:

I refer to the proposed privately-funded Kimberley Marine Support Base (KMSB) at Broome Port, previously named the 'Kimberley Marine Offloading Facility', the proponent of which is Kimberley Marine Support Base Pty Ltd, and I ask:

(a) has the Minister for Ports (or their predecessor) or the Minister's staff met with any shareholders or representatives of KMSB in the past two years;

(b) if yes to (a), will the Minister please table a list of what date/s these meetings occurred, who attended the meeting/s, and what was discussed at the meeting/s;

(c) if yes to (a), will the Minister table the briefing notes and minutes or notes from the meeting or meetings;

(d) if not to either (b) or , why not;

(e) have any representatives of KMSB met with the Department of Transport or Port of Broome in relation to the Kimberley Marine Support Base in the past two years;

(f) if yes to (e), will the Minister please table a list of which departments, the date/s of the meeting/s, who attended the meeting/s, and what was discussed at the meeting/s;

(g) does the Minister expect that profits from the operations of the Kimberley Marine Support Base will flow to shareholders living outside of Australia;

(h) is the Minister aware that an article appeared in the *Australian Financial Review* on June 8th 2023 about the Kimberley Marine Support Base which stated, in relation to the company's 2030 financial forecasts: "It's an ambitious forecast, and one that prospective investors in the equity raising would treat with the grain of salt given KMSB's history of troubles in trying to get the construction off the ground.";

(i) given that industries which were projected to underpin the Kimberley Marine Support Base have not materialised, does the Minister expect this will make it less likely the Kimberley Marine Support Base will go ahead as planned;

(j) if so, will the Minister please detail the projects, proponents and potential markets that will underpin the Kimberley Marine Support Base;

(k) if not to (j), why not;

(l) has the Kimberley Marine Support Base provided a revised business case to the government for the project;

(m) if yes to (l), will the Minister please provide the document;

(n) If no to (l), why not;

(o) if no to (l), will the Minister request a revised business case;

(p) If no to (l), why not;

(q) if the Kimberley Marine Supply Base were to go ahead, would it reduce the projected income for the Port of Broome;

(r) will the Minister table the future income projections for the Port of Broome should the Kimberley Marine Supply Base go ahead;

(s) what is the increase in shipping projected for 2030 for the Kimberley Marine Support Base;

(t) how much government funding has been given to the Kimberley Marine Support Base to date;

(u) has any state government funding been allocated to the Kimberley Marine Support Base in forward years, and if so, where is this funding allocation detailed;

(v) will the Minister rule out a government subsidy to the Kimberley Marine Support Base;

(w) if no to (v), why not;

(x) is the Minister aware that marine invasive species have recently been detected at the Port of Broome; and

(y) what measures will be put in place to prevent more marine invasive species from colonising the Port of Broome, the adjacent seagrass beds and Nagulagun Roebuck Bay Marine Park?

Hon Sue Ellery replied:

(a)–(d) The Minister for Ports has had an introductory briefing on the project from KMSB management on 8 August 2023. Previous Ministers have received project update briefings from time to time.

(e)–(f) KMSB has met several times with Kimberley Ports Authority to confirm commercial arrangements for the project. Dept of Transport has not met with KMSB in the past two years.

(g) KMSB has appointed Peterson Australia Pty Ltd as its facility operator, and that agreement is commercial in confidence.

(h) Yes.

(i) It is likely the project will proceed.

(j)–(k) KMSB will provide new berthing capacity to assist KPA in meeting demand from existing and future Port of Broome customers.

(l)–(p) No.

(q) KPA expects its income to increase with forecast new trade through the port.

(r) Future income from imports and exports is highly variable and will depend on many factors such as the timing of new export projects and global trading conditions.

(s) Not known.

(t) The state government has provided no funding to KMSB.

(u) No.

(v)–(w) There are no foreseeable circumstances under which a subsidy would be paid to KMSB.

(x) In 2022 a vessel arrived at Port of Broome with suspected Perna Veridis (Asian Green Mussel) which when investigated was removed from the vessel. Additional water samples were taken during the October SWASP array collections with no detections of Perna Veridis.

(y) Kimberley Ports Authority works closely with the Department of Primary Industries, and Regional Development, participating in the State Wide Array Surveillance Program (SWASP) which monitors for the presence of any new invasive marine species.

FIRE AND EMERGENCY SERVICES —
SENATE SELECT COMMITTEE ON AUSTRALIA'S DISASTER RESILIENCE

1545. Hon Martin Aldridge to the Minister for Emergency Services:

I refer to the Senate Select Committee on Australia's Disaster Resilience, and I ask:

(a) Was any employee, volunteer or volunteer association discouraged or prevented from giving evidence to the Select Committee by the Minister, his office or an agency under his control?

Hon Stephen Dawson replied:

(a) No.

FIRE AND EMERGENCY SERVICES — HANDHELD RADIOS

1551. Hon Martin Aldridge to the Minister for Emergency Services:

I refer to hand held radios supplied to the Department of Fire and Emergency Services (DFES) and Local Government BGU's and I ask:

(a) when will the ageing VHF handheld radios be replaced;

(b) are sufficient spare parts and spare radios available for the ageing radios;

(c) what is the training duration for the Complex Structural Firefighting Radios;

(d) has a volunteer focused course been developed and what is the training duration;

(e) How many Volunteer Fire and Rescue Service and Volunteer Fire and Emergency Service brigades are yet to receive and be trained on the Complex Structural Firefighting Radios; and

(f) if those identified in (e) when will they be issued with Complex Structural Firefighting Radios?

Hon Stephen Dawson replied:

The Department of Fire and Emergency Services (DFES) advises:

(a) The VHF radio replacement program will begin in the Kimberley and Pilbara regions in October 2023.

(b) Yes.

(c)–(d) The core operational and safety elements of the training for volunteers for Complex Structural Firefighting Radios will be delivered by a combination of online and face-to-face training, with an initial half-day course. Training to reinforce learnings will be completed by their DFES District Officers as a station drill and by BGUs in their regular training programs.

(e) 84 Volunteer Fire and Rescue Service brigades and 23 Volunteer Fire & Emergency Services units.

(f) Delivery of the Complex Structural Firefighting Radios is expected to commence in October 2023 and implementation concluded by 30 June 2024.

SOUTHERN PORTS — BUNBURY PORT

1560. Hon Dr Steve Thomas to the Leader of the House representing the Minister for Ports:

(1) As at 17 August 2023, what is the totality of Southern Ports land holding at Bunbury Port?

(2) Of this land holding, as at 17 August 2023, how much of this land is currently activated under the Bunbury Port land model?

(3) Within the three specific concept studies (since 2017) undertaken by Southern Ports Authority investigation suitability of Bunbury Port infrastructure to facilitate roll on roll off (RORO) vehicle trade, has the volume/area of land required for successful RORO deployment been determined?

(4) If yes to (3), what is the area of land deemed suitable to deliver RORO at Bunbury Port?

Hon Sue Ellery replied:

(1) 482 ha

(2) Total areas activated = 64 ha (leased area 59 ha, licensed areas 5 ha)

(3) The land area likely to be needed by the RoRo trade has been estimated.

(4) The most recent study estimated that 11.8 ha would be needed to accommodate the long-term forecast RoRo trade volume.