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 —
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> (a) all relevant medical circumstances; and
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> (b) the person's current and future physical, psychological and social circumstances; and
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> (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.
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> (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
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> …
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> 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 —

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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.