ABORTION LEGISLATION REFORM BILL 2023

Consideration in Detail

Resumed from 15 August.

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

Debate was adjourned after the clause had been partly considered.

Ms L. METTAM: We are continuing to look at clause 8, which deals with a number of matters, particularly those surrounding mature minors. For our benefit, can the minister explain the difference between a mature minor and a child who is not a mature minor?

The ACTING SPEAKER (Ms A.E. Kent): Member for Vasse, for the sake of Hansard, can you clarify which page or item we are on?

Ms L. METTAM: Sorry. It is clause 8, page 17, proposed section 202MM, "Consent to performance of abortion on children who are not mature minors".

Ms A. SANDERSON: A mature minor is a minor who is Gillick competent. "Gillick competence" is a term that relates to children's ability to consent to medical procedures and treatments. A Gillick competent child has sufficient understanding and intelligence to consent to their own medical treatment. They are sometimes also called a mature minor. Gillick competence comes from a landmark English case in which it was first recognised by the court that a minor might be competent to make decisions without parental consent. The case held that the parental right yields to the child's right to make their own decisions when they reach the sufficient understanding and intelligence to be capable of making up their own mind. The idea is to ensure children are protected from wrong decisions made by parents in which there might be irreversible wrong outcomes for the child by giving the child decision-making power.

Ms L. METTAM: Can the minister clarify who determines Gillick competence and how? Is it the medical practitioner or health practitioner? Can it be a nurse practitioner?

Ms A. SANDERSON: It will be determined by the health practitioner looking after the child. Medical practitioners, endorsed midwives and nurse practitioners are all equally trained in assessing the Gillick competence of their patients.

Ms L. METTAM: Can a minor who is not considered to be a mature minor—does not have Gillick competence—successfully refuse an abortion if the parent or guardian believes that it is in the best interest of the child to have one?

Ms A. SANDERSON: When there is a difference of view between a minor and a parent, the medical practitioner or health practitioner would then refer it to the jurisdiction of the court. There is no medical or health practitioner who would forcibly impose a decision on an unwilling patient, whether they are mature or not. In that instance, they would not have competency in decision-making, but when there is a conflict between the minor and their parent, it would be appropriate to refer it to the court.

Ms L. METTAM: I understand what the minister says about this issue moving into particularly challenging territory. Would the medical or health practitioner use their discretion to refer such a matter to the Children's Court? Is that the court that this would be referred to?

Ms A. SANDERSON: These are probably incredibly rare circumstances, but challenging to navigate. There are legal requirements around informed consent and Gillick competency that a minor has to demonstrate. If there is genuine uncertainty about that, there is likely to be more than one practitioner, as they would bring in a social worker and a counsellor and work in a more multidisciplinary approach. It is not a matter of discretion; it is the clinical judgement and experience exercised around the policy and guidelines for seeking informed consent from the patient. It would be extremely unusual for an abortion to be performed on an unwilling patient, and a number of questions would be raised about that. Practitioners have to operate under strict guidelines and policies, not just for their registration, but in their employment. Discretion is not the right word; it would be clinical judgement.

Ms L. METTAM: We touched on this before, but what are the obligations of practitioners for minors who are under the age of 13 years seeking an abortion?

Ms A. SANDERSON: It is a legal requirement in Western Australia for doctors, nurses, midwives, teachers, police officers, boarding supervisors and ministers of religion to report all reasonable beliefs of child sexual abuse to the Department of Communities. There is no age limit. In all circumstances when abuse or coercion is suspected, it must be reported, regardless of the age. Section 124C of the Children and Community Services Act sets out the content requirements for a mandatory report. After receiving the report, the reporting service must send a copy to the Western Australian police. The reporting service then conducts an initial assessment, including what action might be required, which may involve referring the matter to the child protection district office for further investigation, and they may be contacted by the police.

The Children and Community Services Act 2004 defines a child as under 18 years of age, and in the absence of positive evidence of age, it means a person who appears to be under 18 years of age. There is an age limit when that kicks in. It is anyone up to the age of 18 years who the reporter reasonably suspects is being abused. A mature minor, for example, would not be exempt from mandatory reporting if a clinician reasonably suspected that there was coercion or child sexual abuse. However, there is an exclusion. It is not the intention of mandatory reporting legislation to capture instances of informed consensual sexual activity, as long as the activity is age and developmentally appropriate. Again, that is determined by the best clinical judgement of those practitioners. The individual circumstances of each case has to be considered, and if the reporter forms a reasonable belief that sexual abuse of a child has occurred or is occurring, a report must be made.

Ms L. METTAM: In cases when the minor is under 13 years of age, in addition to the mandatory reporting, do health or medical practitioners involved in that procedure have further obligations?

Ms A. SANDERSON: Mandatory reporting in and of itself is an obligation that all health practitioners take very seriously. There is also non-mandatory reporting for a range of concerns that can be reported to, and welcomed by, the Department of Communities, such as concerns about the wellbeing of a child due to physical or emotional abuse or neglect, including exposure to family and domestic violence. These do not necessarily enliven mandatory reporting, but the Department of Communities encourages notification to enable authorities to assess the circumstances and take action to protect a child or other children when necessary.

Medical practitioners and health practitioners are duty bound by their own codes of conduct and codes of ethics to report suspicions and ensure that their patients receive the best possible care. A practitioner who is not satisfied that a minor is acting voluntarily and/or without coercion is able to liaise with other professionals to determine the case. It is highly likely that they will bring in counsellors or social workers and provide support to that child. They would also pick up the phone and call the Department of Communities if they had concerns about whether this was a mandatory reporting requirement and to get some guidance on how to do that.

Ms L. METTAM: Ensuring that minors have the counselling support they require is obviously very important, particularly in situations in which young children undertake these procedures without the support of their parent. I know the minister touched on this, but can the minister provide some more clarification of the obligations for counselling or information to be provided to minors who are undertaking such a procedure, potentially without the support of a family unit?

Ms A. SANDERSON: Health practitioners face this issue every day. It is not something that will occur just under this bill; it happens now. It is rare that children will present pregnant, but it does occur. More often, they present with sexually transmitted infections. Health practitioners are skilled and experienced at screening STIs and in understanding the circumstances under which it occurs and supporting a child through that. This bill does not seek to add any further mandatory requirements for counselling or information outside of what is best clinical practice and the best judgement of the clinician who is supporting the child. There are already significant obligations under the mandatory reporting requirements, their own code of conduct, their ethical requirements and their own practice to ensure that their patients are supported in a multidisciplinary sense if required. This is happening now. When children present with STIs, they are supported and treated, and work is done with them. Nurses in particular will work with children to understand how an infection occurred and the circumstances in which it occurred, to keep those children safe.

Ms L. METTAM: Can the minister explain the principle around proposed section 202MM, "Consent to performance of abortion on children who are not mature minors"? As I understand it, it is to provide legal clarity on the ability of a parent or guardian to consent to the abortion of a non–Gillick competent child. Can the minister provide an overview of the principle of this proposed section?

Ms A. SANDERSON: The bill before us will provide clarity that parents will be able to provide permission. The reason that is being included is that there is no case law in WA pertaining to a parent's or guardian's ability to give consent for their child to have an abortion. Several judges in Queensland's Supreme Court have taken a very conservative approach and stated that abortion sits outside the scope of the medical treatment that a parent may decide for their child. Essentially, if a parent and a child agree that an abortion is required, they still have to go to the Supreme Court. To avoid that, we have been very explicit in this bill that a parent in Western Australia may decide and may essentially give informed consent. Does that clarify the member's question?

Ms L. METTAM: Yes. How does this compare with other states?

Ms A. SANDERSON: Queensland is very conservative. In other states, the language used is extremely loose and a bit wishy-washy, if not silent on this. To avoid any doubt or complicating already complicated situations, we determined that we would be specific and explicit in this bill about a parent's right to provide informed consent.

Ms L. METTAM: I thank the minister for that clarification. We touched on cases that are reported to child protection. Is the minister able to provide how many cases are reported to child protection in relation to offences against minors?

Ms A. SANDERSON: That is not data that the Department of Health holds. It is managed by the Department of Communities and the act that they manage.

Ms L. METTAM: I am still dealing with the same clause, but a different section—proposed new section 202MN, "Unqualified person must not perform abortion", otherwise known as backyard abortion, as it has been termed. I note that the purpose of this section is that those who are unqualified would no longer be considered committing a crime under this section, in circumstances in which they are administering the abortion in good faith. Can the minister explain this? I imagine there could be circumstances in which what might be described as a backyard abortion has a legitimate reason, and it might be more than medical malpractice. Is there scope for individuals to be recognised in the law as being negligent?

Ms A. SANDERSON: I do not want to paraphrase, so the member can tell me if I am wrong. Is the member asking whether someone is completely unqualified, as in not a medical practitioner whatsoever?

Ms L. Mettam: Like criminal liability.

Ms A. SANDERSON: They would be operating outside of their scope—for example, the gentleman who allegedly put mifepristone in his ex-girlfriend's drink. Essentially, it is not intended that the factual scenarios presented in so-called fetal homicide be prosecuted as offences against proposed new section 202MN, although both the current section 199 of the Criminal Code and proposed definition make it notionally possible for a person to be charged with the offence of abortion, when they harm a pregnant woman. This could be by assaulting them with the intention of causing them to miscarry. This has never been done under section 199 of the Criminal Code and it is unlikely that the Director of Public Prosecutions would do so via proposed new section 202MN. This position is put beyond doubt by the offence being located in the Public Health Act 2016, and made to apply to unqualified persons, which impliedly makes the qualifications of the accused person central to the offence. There are other provisions that the DPP would use, and has used, to prosecute that offence.

Ms L. METTAM: Can the minister clarify what constitutes an unqualified person in this section and are there thresholds attached to what is considered unqualified care when it comes to pharmacists or prescribers, and health and medical practitioners?

Ms A. SANDERSON: It depends on the stage of the pregnancy as to whether someone is qualified. Clause 8 captures that an unqualified person is someone who is not a medical practitioner. For example, if a nurse practitioner was to attempt a surgical abortion on a woman more than 23 weeks pregnant, she is unqualified under this act; it is only a medical practitioner who is qualified. A pharmacist is not qualified to perform an abortion. They are authorised under the act to dispense the medication, but it is a qualified person who prescribes the medication. Does that make sense?

Ms L. METTAM: Yes. Does the minister have any figures on how many cases might have been captured by this new amendment over the past 12 months, or any figures to indicate how many professionals might have been captured by the performance of an abortion by unqualified persons?

Ms A. SANDERSON: We are not capturing data based on this bill and these provisions. I think that is what the member is asking. We do not capture that data. The police would potentially capture data of people who had breached the existing legislation, although I am not aware of any. But we are not able to present data that is formulated to reflect this current bill.

The ACTING SPEAKER (Mr D.A.E. Scaife): Before I give you the call, Leader of the Liberal Party, I just say that I allow these sorts of questions and I know that the minister is answering the questions in good faith, so I encourage that, but I do not think that questions about data and who has committed various offences or examples in the community are strictly consideration in detail questions, which should be restricted to the clause and the bill itself. I want to make sure that I am not setting a precedent by allowing the questions, but I will certainly allow things to keep going, because I think it is all in good faith.

The Leader of the Liberal Party with a further question.

Ms L. METTAM: Thank you, Acting Speaker. I refer to proposed section 202MP(3) and (4). Clinicians have advised that they support ongoing mandatory notification of abortion, regardless of the gestational age at which the abortion is performed. This information is obviously important for assessing health care trends, which include the progressive decline in terminations for adolescent women, and planning healthcare education and interventions, as well. As I understand it, regardless of the outcome, all births at greater than 23 weeks' gestation are subject to mandatory notification through the Midwives Notification System, and the important information that this data provides for healthcare planning justifies the retention of mandatory reporting of abortion. It is obviously important that late-term abortions are reviewed by healthcare organisations that perform the procedures, and reporting the reasons for late abortions, which I understand is standard in the United Kingdom, is important to this process and confirms to the public of WA that late abortions are performed in only very serious situations or conditions. For

the provision of data, can the minister please outline exactly what changes are being implemented and what data will now be provided?

Ms A. SANDERSON: Under the current act, forms prescribed under section 335 of the Health (Miscellaneous Provisions) Act are used to report or notify the Chief Health Officer that a patient has received an abortion. The forms are not and will not be tabled or published. There is always a need to balance public interest with access to information. The information does not fall in the scope of section 82 of the Financial Management Act. This bill will repeal the reporting of those provisions under the Health (Miscellaneous Provisions) Act. This includes any reference to abortion or collection of abortion information from those forms and introduces a new framework about the collection, use, management and disclosure of abortion information.

We consulted quite extensively with particularly clinicians on what is useful for service planning and, essentially, that is how we landed with those provisions in the bill. It is data collection for the purpose of service planning to improve access to services and understand trends, as the member rightly outlined, and it is essential for looking at how we can improve those health outcomes for women. The data collection is really to identify issues and trends regarding access to services and appropriateness of preventive sexual health services, crisis services, contraception and sexual health services; to identify issues and trends; to assess the appropriateness of abortion services and issues such as rural and remote access to services; and to identify language, financial or other barriers. Metrics are key to the analysis of these types of trends, such as the broad demographics of the person, so whether they hold Aboriginal status or identify as culturally and linguistically diverse, or the broad location, such as rural versus regional. In the bill, we have specifically outlined exclusions to the kind of data that can be included so that we protect people's privacy. It is a statistical summary of information. It cannot include any particulars from which it may be possible to ascertain the identity of a person on whom an abortion has been performed or a person who has performed or who has assisted in the performance of an abortion. It also cannot include the postcode, suburb or address of a person who has received an abortion or someone who has performed an abortion. It also cannot include the age of a person on whom an abortion has been performed other than an age category including a range of not less than five years—under 15, 15 to 19 and so on. It cannot include a particular race or nationality of a person. It cannot include the exact gestational age, other than a range, and that is outlined in the bill, or the particular reason for an abortion having been performed on a person, including any particular clinical reason. It cannot include the particular clinical method used to perform an abortion, or the particular clinic details, or outcomes associated with the admission of a hospital or a person on whom an abortion is performed.

Essentially, that is to provide broad service planning information without compromising people's privacy. There are consistent questions from the upper house and certainly questions in Parliament on details of clinicians who have performed abortions and details of the circumstances that women have found themselves in. We have given broad regional areas. The reason we have not given specific postcodes is in small country towns, particularly if someone has had a late-term abortion, if that data appears as a postcode, it can be very easy to identify the individual referred to. We have provided for regional areas, and we have used the same regional areas that the WA Country Health Service or Health uses for planning, so Pilbara, Gascoyne, Kimberley and so on and so forth.

Ms L. METTAM: The minister mentioned the gestational age of the fetus and said that it is in general terms. It is noted on page 22 of the bill. Will that include late term, post–23 weeks?

Ms A. SANDERSON: Yes, it will.

Ms L. METTAM: Will the data capture all terminations? Are there any terminations that will not be captured by this data?

Ms A. SANDERSON: The Chief Health Officer will make a direction to all practitioners that this is the data that is required to be reported to the Chief Health Officer's office. It is very difficult, as it is now, to police and monitor every GP consult. Clinicians work under the requirements of the law. An important part of that six-month implementation period will be educating clinicians in their obligations under the new laws.

Ms L. METTAM: How will the information be captured for those who prescribe an abortion drug for under nine weeks? Will the information be reported on the prescription of that drug?

Ms A. SANDERSON: That will be determined in the six-month implementation period. The Chief Health Officer's office is working through what that looks like. It is likely to be an online reporting mechanism for those clinicians.

Ms L. METTAM: How will this information or these reporting obligations be communicated to health professionals?

Ms A. SANDERSON: The Chief Health Officer's office has good in-reach into all clinics and primary care clinics. It will also work with the Australian Medical Association, the Royal Australian College of General Practitioners, King Edward Memorial Hospital for Women, MSI Australia and those services that we know are engaged in this practice. Regular communication goes from WA Health out to primary health settings, as we have seen over COVID. It has good in-reach into those clinics and will make its obligations known.

Ms L. METTAM: Will these changes still enable data to be compared over time?

Ms A. SANDERSON: Yes, they will. Obviously, the data will be difficult to compare from this bill versus the last bill because they are different subsets of data. But certainly, trends over time and aggregated data will allow trends to be identified and compared over time.

Ms L. METTAM: What data, if any, will not be captured any longer? Will any data no longer be captured?

Ms A. SANDERSON: Without reading it all into *Hansard*, proposed sections 202MP(3) and 202MP(4) identify all the data that will not be collected, and that it is not to include.

Ms L. METTAM: Regarding the data that will no longer be captured, the minister said it is under proposed section 202MP(4), which includes —

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

Can the minister explain that proposed paragraph?

Ms A. SANDERSON: We currently collect very specific gestational ages of abortions, for example at 13 weeks or at 21 weeks. It will move to a gestational age range, for example nine to 12 weeks, 12 to 16 weeks, 16 to 20 weeks, 20 to 24 weeks and so on and so forth. It will be a broader range. The other things that will not be included, which are currently included in the form 1, which is the statutory form, are some of the very antiquated terms for methods of termination and so on and so forth. That will no longer be required.

Clause put and passed.

Clauses 9 to 14 put and passed.

Clause 15: Section 306C inserted —

Ms L. METTAM: Regarding a review of the act being undertaken after five years, can the minister provide further details on this? First and foremost, what aspects will be reviewed?

Ms A. SANDERSON: A statutory review is a standard clause. It is a determination of the terms of reference that will be decided by the minister at the time. For example, it could be a review of whether the act is operating as Parliament intended or whether the minister at the time determined to broaden the review, for example, requirements and so on and so forth. It is a determination for the minister at the time.

Ms L. METTAM: Will it utilise the data that is being provided and will it compare WA with other jurisdictions?

Ms A. SANDERSON: Again, it will be a determination for the minister at the time. For example, if I were the minister, I would not, because that would not be the purpose of the statutory review. Again, it really depends on the terms of reference set by the government of the day.

Clause put and passed.

Clause 16 put and passed.

Clause 17: Act amended —

Ms A. SANDERSON: I request permission to swap out one of the advisers.

The ACTING SPEAKER (Mr D.A.E. Scaife): Permission granted.

Ms A. SANDERSON: Thank you. May I also take the opportunity to provide additional information that I committed to providing yesterday, with the indulgence of the Acting Speaker. Yesterday, I committed to providing additional information on whether other Australian jurisdictions have a framework to enable registered health practitioners to perform an abortion. I can advise that South Australia and Victoria both have statutory mechanisms to enable registered health practitioners to perform an abortion in their own right. New South Wales, Queensland, Tasmania, the ACT and the Northern Territory currently do not enable other registered health practitioners to perform an abortion; however, the Queensland government has already indicated that it intends to amend its legislation to reflect the new Therapeutic Goods Administration guidelines and allow health practitioners to prescribe medical abortions.

The ACTING SPEAKER: Just before I give the call to the Leader of the Liberal Party, I ask the minister to confirm which adviser has left the chamber and who has joined us.

Ms A. SANDERSON: Yes. Dr Clare Huppatz, the Deputy Chief Health Officer, has left the chamber, and we are joined by Sara da Motta.

Ms L. METTAM: We started consideration in detail today by covering off on questions about the provisions captured in this clause, but can the minister explain the importance of clause 17 in relation to the Children's Court of Western Australia?

Ms A. SANDERSON: Essentially this will normalise the process for informed consent around medical decisions for minors, which will be in the Supreme Court, not the Children's Court. A special provision in the current abortion legislation requires that decisions go to the Children's Court so it will bring it into line with other healthcare decisions that need to be made for minors. The new bill will also introduce the concept of a mature minor, which is absent in the current law.

The clause will amend section 20 of the act to remove the exclusive jurisdiction of the Children's Court of Western Australia to hear and determine all applications made with regard to a child under section 334 of the Health (Miscellaneous Provisions) Act, which will be repealed. This change is consistent with the new framework for abortion to be established by the bill with regard to children deemed to be mature minors or non-mature minors. Under section 334(8)(a) of the HMP act, to be repealed, a parent of a child 15 years or younger seeking an abortion is required to be informed and have an opportunity to be involved in the counselling process and medical consultations, and subsection (9) provides that a dependent minor may apply to the Children's Court for an order that the custodial parent should not be given the information and opportunity referred to in subsection (8)(a). The repeal of this section will mean that parental involvement is not mandated in the same way and it is not required in order for a child to consent and provision for an application to the Children's Court is not needed.

Ms L. METTAM: This clause will ensure that the Children's Court is not the exclusive jurisdiction, but can the minister imagine there might be occasions on which the Children's Court would be the suitable jurisdiction involved?

Ms A. SANDERSON: No, the Children's Court would not be involved; it will be the Family Court or the Supreme Court. That is standard for disputed medical procedures for minors.

Clause put and passed.

Clauses 18 and 19 put and passed.

Clause 20: Section 3B inserted —

Ms L. METTAM: We touched on this clause a bit earlier, it clarifies that when a child dies as a result of a lawful abortion, the death is not a reportable death for the purposes of the Coroners Act. To start with, can the minister explain the principle behind this clause of the bill?

Ms A. SANDERSON: Yesterday in consideration of this bill we went into considerable detail on the process of a late-term termination when a fetus, or baby, is born alive and that is the very informed decision of the parents that that be the case. We will remove the requirement for the death to be a reportable death because that will reflect the fact that the death was brought about by legal abortion and was an expected and very closely planned death. It would not be appropriate to require a coronial or police investigation and the questioning of families for each of those deaths unless there was a suspicion the proper process for accessing the abortion was not followed. A person who has taken the decision to terminate their pregnancy at a later stage, often due to a severe medical condition of the fetus or the mother, would be informed that they are lawfully entitled to have an abortion due to the significant medical complications involved, and once the procedure is complete they would have a legitimate expectation that no further investigation is required or would be conducted.

Ms L. METTAM: The minister rightfully stated that we did go into this in some detail when we debated another clause yesterday. To clarify, what is involved in a coronial investigation? I ask because clinicians have raised with me the situation in which a child with a lethal abnormality and the rare occasions when the death of a fetus, or a baby, is captured by this provision of the act and the distress that such an investigation may cause. I think it would be worth clarifying the situation.

Ms A. SANDERSON: That is correct. It is distressing for the family and the clinicians involved. Under the current regime, the definition of reportable death obliges the doctor to report the death to the coroner, obliging the coroner to contact the person who has undergone the abortion despite the death being not unexpected and explainable by the lawful abortion procedure that has taken place. A coronial investigation would then require statements to be obtained from the mother, reports to be obtained from the doctors performing the termination, pathologists and possibly specialists. Administrative findings would need to be made and referrals to the Registry of Births, Deaths and Marriages would be required.

From a practical point of view, when a baby is born with signs of life and passes away after birth, as we have outlined, it is a very planned and controlled process. There are good reasons why parents want to spend those last few minutes with their live child and often prefer to remain with the child for some time. Special cooling cots and equipment allows parents to remain with their child for some time to allow for family, cultural and religious processes to take place. Under the reportable death procedure, there is the potential, and it has occurred, that the baby is removed by police for the coroner, and that is incongruent with the legal and fully informed process that the family is going through and during what is already a very distressing time.

Ms L. METTAM: Further to this and in relation to a matter that was raised earlier, can the minister see any circumstances in which a termination would not be reported under the amendments that are being implemented by this bill?

Ms A. SANDERSON: On a point of clarification, is it "would be" or "would not be" reported?

Ms L. METTAM: Can the minister see any circumstances in which a termination would not be reported? I am not referring to the coroner; I am asking whether there would be any circumstances in which a termination could take place, particularly a surgical termination, and the procedure not be reported by a medical practitioner or a health practitioner.

Ms A. SANDERSON: It will be a requirement under the legislation that we are debating now. The Chief Health Officer will require them all to be reported to him. There is not a circumstance I could foresee, if a practitioner was operating legally, in which it would not be reported.

Clause put and passed.

Clauses 21 and 22 put and passed.

Clause 23: Act amended —

Ms L. METTAM: As I understand it, this clause is to enable abortion information to be exempt under the Freedom of Information Act. Can the minister please explain what the considerations were around this amendment?

Ms A. SANDERSON: The government has determined that information pertaining to someone's access to abortion care should be exempt and should not be subject to any assessment of public interest. That could have variable results depending on the view of the agency decision-maker, who could have varying levels of experience, skill or points of view on this issue. At present, if an individual makes an application for the release of information pertaining to an abortion or abortions that have taken place, the agency holding the documents must release that information subject to the exemptions of the Freedom of Information Act. Currently, the key exemptions relevant to this context are those of "personal information" and "endanger the life and safety of any person". An agency would not be allowed to release matters that reveal personal information about an individual, whether living or dead. However, this information can be revealed if the applicant establishes that the third party has consented to their information being released, or if, on balance, the release of the information is in the public interest.

What this means is that, currently, the decision whether to release personal information about a patient will be made in each instance by an officer at the agency holding the documents. The officer can decide, for example, to release personal information about a patient or information that might identify them by default, then they are required to take reasonable steps to contact and consult that person in accordance with section 32 of the FOI act. Another reason for including a standalone exemption for the abortion information is the requirement under section 32(b) of the FOI act that if an agency intends to give access to a document containing personal information about a third party, the agency is not to give access unless it has taken such steps as are reasonably practicable to obtain the view of the third party about whether the document contains information that is exempt. That could result in a person who has accessed abortion care being contacted about an access application, causing distress or concern regarding the potential release of their personal information. The standalone exemption precludes that from happening. Essentially, at the moment, it is at the discretion of an officer in the agency. This clause will remove that discretion.

Ms L. METTAM: How does this provision about freedom of information for abortion information compare with other states?

Ms A. SANDERSON: Western Australia will be the first state to introduce a standalone exemption for the FOI act.

Ms L. METTAM: Will information such as age, gestation and the types of abortion practice still be captured under this act? What will the significant exclusions be?

Ms A. SANDERSON: The aggregated information that the Chief Health Officer will collect will not be captured by this provision. It will still be collected for the purposes of service planning and data, but the requirement for certain information and data to be collected and the exemptions of certain data that will not be collected is not captured under this provision. It will still be collected by the Chief Health Officer. This will allow the ability for any other outside third party to access that information.

Ms L. METTAM: The reason I am asking is that the information captured by the Chief Health Officer, which we have asked some questions about, is helpful information in relation to trends. Will that information be publicly available, particularly considering that there will be some restrictions under freedom of information?

Ms A. SANDERSON: Aggregated data is important for service planning. There will be no requirement for it to be published under this act and there will be no prohibition for it to be published under this act. It could be requested through the usual processes of questions on notice, for example, as is the case now. All those principles around privacy and so forth would be very carefully adhered to in the release of that information. Useful information for

service planning does not necessarily need to be confidential. Having said that, it would obviously also have to be very carefully aggregated so as not to identify individuals, particularly in regional and remote areas.

Clause put and passed.

Clause 24 put and passed.

Clause 25: Act amended —

Ms L. METTAM: This clause deals with the Guardianship and Administration Act. As I understand it, this amendment is about the appeal from the tribunal's decision relating to the consent to and the performance of an abortion. Can the minister explain the principle around this amendment?

Ms A. SANDERSON: The bill will repeal section 334 of the Health (Miscellaneous Provisions) Act 1911 that requires that for an abortion to be lawful, the woman upon whom it is performed must give informed consent. The section defines "informed consent" to include the provision of counselling and information to the woman by a medical practitioner.

Prospect of repeal of informed consent provisions in section 334 led to consideration of a new decision-making regime for adults without capacity who seek an abortion. The new provisions are based on the premise that guardians and other responsible people should not be permitted to unilaterally consent to an abortion on behalf of a person who lacks the decision-making capacity. This is due to the particular implications of such a procedure and the possibility of a conflict of interest between the guardian when one has been appointed and a represented person or person who lacks decision-making capacity. It is more appropriate in the case of an abortion decision to require an application to be made to the State Administrative Tribunal to provide consent. This is the position in other Australian states and territories with regard to abortion for people who lack decision-making capacity.

Debate adjourned, pursuant to standing orders.