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Hon Peter Foster MLC
Chair, Standing Committee on Environment and Public Affairs
Harvest Terrace, Parliament House
PERTH WA 6000

By email: env@parliament.wa.gov.au

Dear Mr Chairman,

PETITION NO. 033 – RELEASE OF CORONER’S COURT RECOMMENDATION.

I refer to your letter dated 25 October 2021 requesting a written submission regarding the request of the release of the Coroner’s Court Recommendation.

Background

The general genesis of this matter was ten years ago when in 2011, [Hon Ed Dermer MLC asked QON 3211](#)¹ in the Legislative Council (WA) for the numbers of instances a live child had been born as a result of an abortion procedure since the enactment of the Acts Amendment (Abortion) Act No. 15 of 1998.

The specific genesis of this matter was some three years ago when on 10 April 2018, [in response to QON 651](#)², it was revealed that:

As at 19 May 2017, a total of 27 cases of abortion procedures resulting in the live birth of a child have been reported between July 1999 and December 2016.

This number was then changed to 26 in an answer to [QON 2060](#) answered on 14 May 2019.³

Whether the number was 26 or 27, there has been significant concern that Western Australian babies have been born alive but then not provided the same standard of health care (or indeed any health care) that a baby of the same gestational age would ordinarily receive. This concern has been heightened in light of the non-reporting of these child deaths.

Reportable deaths and the Coroner’s recommendation for law reform

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

¹ [QON 3211](#) asked by Hon. Ed Dermer MLC. Abortions in Western Australia – Live Child Birth. Answered on 15 February 2011

² [QON 651](#) asked by Hon Nick Goiran MLC. Abortion – Signs of life after procedures. Answered on 10 April 2018

³ [QON 2060](#) asked by Hon Nick Goiran MLC – Abortion – Signs of Life After Procedures. Answered on 14 May 2019

I subsequently wrote to the Coroner to report these deaths the following day on [19 September 2018](#).⁴

Since that time, I have written to the Coroner's Court from time to time to obtain updates. In addition, I have asked questions of the Department of Health to ensure that the information being requested by the State Coroner was being provided in a timely fashion. I was advised that an investigation was underway.

More recently, however, the Coroner's Court replied that they had reviewed the material provided by the Department of Health and made recommendations to amend the Health (Miscellaneous Provisions) Act 1911.

I have asked both the Coroner's Court and Attorney General John Quigley, for a copy of these recommendations and have been denied this request on multiple occasions.

On 17 June 2020, the Attorney General replied to QWN 623 ⁵

The Coroner's Court recommendation to amend the Health (Miscellaneous Provisions) Act 1911 was prepared for the Attorney General's discussion with the Minister for Health and ultimately the cabinet. These discussions are yet to take place. The Attorney General is not in a position to disclose these recommendations until such discussions with his cabinet colleagues have taken place.

On 13 May 2021, the Attorney General answered QWN 118 ⁶

The Attorney General has not yet discussed the matter with the full cabinet. Given the Coroner's Court recommendation to amend the Health (Miscellaneous Provisions) Act 2011 was prepared for the ultimate deliberation of the cabinet, the Attorney General is not in a position to expand on the recommendation. He can, however, confirm that there was only one recommendation from the Coroner's Court, and the Department of Justice and the Department of Health are working together to progress the matter at a departmental level.

Introduction of Feticide

In the interim, in June 2017 King Edward Memorial Hospital introduced the practice of feticide for terminations of pregnancy after 22 weeks, including those for lethal abnormalities. ⁷

Northern Territory Coronial Inquiry and its relevance to Western Australia

I have attached the outcome of the N.T. Coronial Inquest⁸ into the death of Jessica Jane. Baby Jessica Jane was delivered alive on 14 July 1998 at Darwin Private Hospital following an

⁴ [Abortion Procedures](#) – Live Births Statement in W.A. Parliament. 19 September 2018

⁵ [QWN 623](#) asked by Hon Nick Goiran MLC. Abortion – Live Births. Answered 17 June 2020

⁶ [QWN 118](#) asked by Hon Nick Goiran MLC. Abortion – Live Births. Answered 13 May 2021

⁷ [Letter from Hon Roger Cook to Hon Matthew Swinbourn MLC](#) dated 27 July 2018

⁸ *Inquest into the death of Jessica Jane*, File No 9815022 101/98, Delivered on 10 April 2000, Darwin

attempted abortion between 22-23 weeks gestation and died 80 minutes later.⁹ Her death was reported to and investigated by the Coroner, with the findings released on 10 April 2000.

It is worth noting the final comments of the Coroner, Mr Greg Cavanagh:

In my view, the fact that her birth was unexpected and not the desired outcome of the medical procedure, should not result in her, and babies like her, being perceived as anything less than a complete human being. Similarly, the fact that her death was inevitable should also not have the same result. The old, the infirm, the sick, the terminally ill are all entitled to proper medical and palliative care and attention. In my view, newly born unwanted and premature babies should have the same rights. The fact that her death was inevitable should not affect her entitlement to such care and attention.

The N.T. Coroner made 3 recommendations.

Firstly, that protocols be put in place to ensure children who survive termination procedures are assessed for gestational age and viability by a medical practitioner or paediatrician. Secondly that the management and staff of all hospitals and clinics in the Northern Territory and medical practitioners should be made aware of their legal obligations to report the deaths of such children to the Coroner. Thirdly, that the protocols should apply to all hospitals and clinics.¹⁰ These recommendations could well be applied to the current situation in Western Australia.

Public Interest

In the conclusion of the inquest, in relation to the role of the Coroner, the point is made that the public have a right to be informed and take part in any debate and the coronial process is the means by which they are informed.

The Coroner says “This is why it is important that these deaths be reported to the Coroner”.¹¹

This may seem like an obvious conclusion; however, these standards are not currently applied in our own State.

There is considerable public interest in the recommendation that the Coroner has made.

Recommendations

In this context I would recommend that the Committee inquire into the following questions:

1. What is the Coroner’s Court recommendation to amend the Health (Miscellaneous Provisions) Act 2011?

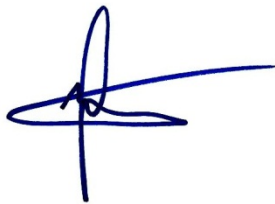
⁹ *Inquest into the death of Jessica Jane*, File No 9815022 101/98, Delivered on 10 April 2000, Darwin

¹⁰ Paragraph 34, *Inquest into the death of Jessica Jane*, File No 9815022 101/98, Delivered on 10 April 2000, Darwin

¹¹ Paragraph 35, *Inquest into the death of Jessica Jane*, File No 9815022 101/98, Delivered on 10 April 2000, Darwin

2. How are the Department of Justice and the Department of Health working together to progress the matter at a departmental level?
3. Is there a compelling reason why the recommendation is not able to be made public?

I thank you for the opportunity to lodge this submission and make myself available to appear before the Committee to elaborate on any particular aspects. I have no objection to my submission being made public. Indeed, given that the petition pleads for transparency, it would be perverse for me to request that my submission be kept secret to the committee.



**Shadow Attorney General; Shadow Minister for Child Protection and Industrial Relations
Secretary to the State Parliamentary Liberal Party**