



**Deputy Premier of Western Australia  
Minister for Health; Tourism**

Our Ref: 25-22365

Hon Brian Ellis MLC  
Chair  
Standing Committee on Environment and Public Affairs  
Parliament House  
PERTH WA 6000

Dear Brian

Thank you for your letter of 1 September 2011 regarding Petition No 127 – Requested Inquiry into Late Term Abortion.

A detailed response to your letter and its attachments, including the petition submitted by Hon Kate Doust MLC, is provided below.

**Legislation**

In Western Australia, abortion where the pregnancy is greater than 20 weeks gestation is available under s.334 (7) of the *Health Act 1911* (the Health Act), which provides:

- (7) If at least 20 weeks of the woman's pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless —
  - (a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and
  - (b) the abortion is performed in a facility approved by the Minister for the purposes of this section.

Currently King Edward Memorial Hospital (KEMH) is the only approved facility in WA for the purposes of s.334(7)(b). The changes to the Health Act were made under the *Acts Amendment (Abortion) Act 1998* which received Royal Assent on the 26 May 1998.

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## **Members of the Panel**

The medical panel referred to in s.334(7) (the Panel) was formally established in accordance with the legislative requirements in 1998. All members of the Panel hold medical qualifications. They have been selected because they have experience in relevant areas such as obstetrics, gynaecology, psychiatry, paediatrics or anaesthesia<sup>1</sup>. They are senior experienced clinicians who are aware of and comply with their legal responsibilities as set out in s 334(7). In order to protect the safety of the medical staff involved in this highly sensitive area of clinical care the names of the doctors on the Panel are not made publicly available<sup>2</sup>.

## **Identification of a severe medical condition of pregnancy**

Late termination of pregnancy only occurs in identified clinical circumstances so the majority of medical terminations occur at less than 20 weeks gestation<sup>3</sup>.

Before the Panel is approached to consider whether the performance of a termination after 20 weeks gestation is justified, the clinical situation is examined extensively by a team of experienced clinicians from a range of clinical areas to determine the best case management. Areas of expertise can include but are not limited to genetic services, feto-maternal medicine, neonatology, obstetric medicine, medical imaging and pathology services. There is always extensive consultation with the woman and where appropriate, her partner<sup>4</sup>.

## **Action after diagnosis**

If there is a diagnosis of a serious medical condition affecting the infant or the mother where the gestation of the pregnancy is greater than 20 weeks, the treating doctor counsels the mother and advises her of the availability of a termination of pregnancy under the Health Act. The role of the Panel and the application process is discussed. In accordance with good clinical practice and the requirements of section 334, the mother's informed consent is obtained.

Not all women decide to explore the option of applying to the Panel for approval of a medical termination of pregnancy at greater than 20 weeks gestation. Some mothers apply to the Panel and obtain approval for the termination of their pregnancy but later decide not pursue this option. In some cases, after approval has been given by the Panel, the fetus dies in utero or preterm labour occurs naturally before the medical termination can be arranged. In these situations the case is not a medical termination of pregnancy. All such cases are dealt with in a sensitive and professional manner with a range of support services provided through KEMH to help the mother come to terms with the situation.

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<sup>1</sup> Jan E Dickinson, 'Late pregnancy termination within a legislated medical environment', 2004, *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 44, 337, 338.

<sup>2</sup> Dickinson, n 5, 337; *Health Act 1911 (WA)* s334(6).

<sup>3</sup> Dickinson, n 5, 339.

<sup>4</sup> Dickinson, n 5, 337-341.



It is for these reasons that the actual number of abortions greater than 20 weeks that are performed may vary from the number of approvals granted under section 334(7) of the Health Act.

### **Assessment criteria applied by the Ministerial Panel**

Once the application for an abortion at greater than 20 weeks is made, the Chairperson convenes the Panel to assess the application. Depending on the circumstances of the case, the Panel may meet on a number of occasions before a decision is made<sup>5</sup>. Each application to the Panel is carefully examined. Termination of pregnancy after 20 weeks equates to approximately 0.5% of the overall abortion rate for Western Australia<sup>6</sup>.

A severe medical condition in the infant could include severe congenital malformations of central nervous system such as neural tube defects, genetic disorders, cardio-thoracic malformations or overwhelming intra-uterine infection<sup>7</sup>.

Any severe medical condition that threatens life of the mother and is not responding to conventional treatment may require medical termination of pregnancy. In such rare situations the preferred treatment option is to manage the mother's condition to allow the infant to reach 23 weeks gestation and then induce labour. Sadly this is not always possible and if the Panel considers it justifiable in the circumstances, a termination may be performed.

### **Management of delivery process**

In accordance with KEMH Clinical Guidelines, all terminations after 20 weeks are managed in the delivery suite by senior experienced midwives and doctors who have been involved in the care of the mother. Immediate access to emergency services is available should this be required.

KEMH staff are aware that these cases require sensitive and clinically appropriate care. Best practice is followed in managing the post birth period to ensure the mother has necessary psychological support. The diagnosis of a serious medical condition in the fetus or the mother and the subsequent decision to terminate the pregnancy is extremely difficult for the mother, father and families as well as the clinical staff involved in the care of the mother.

### **Management of 'born alive' babies**

On rare occasions, after a medical termination of pregnancy is undertaken, the newborn has a heartbeat or appears to make attempts to breathe after birth<sup>8</sup>. This does not necessarily indicate viability, but in accordance with the KEMH Guidelines

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<sup>5</sup> Dickinson, n 5, 338.

<sup>6</sup> Department of Health Database as quoted by Dickinson n 5.

<sup>7</sup> Dickinson, n 5, 338.

<sup>8</sup> Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Profession*, (3<sup>rd</sup> ed, 2009,) 447-452.

on Assessment of Newborn<sup>9</sup>, the attending midwife is obliged to record this as a live born infant.

The concerns raised in relation to 14 infants born after termination of pregnancy allegedly being reported as born alive are being further assessed to enable the circumstances to be reviewed and further comment made. Our initial enquiries indicate that a reporting error has occurred and there were eight babies 'born alive' at greater than 20 weeks gestation. The remaining six babies were less than 20 weeks gestation.

It is important to note that after every delivery a medical decision is made in regards to care if the infant breathes or has an established heartbeat. Where termination of pregnancy has been undertaken because the infant will die in any event, active resuscitation would be distressing to the parents and inappropriate for the infant. The health, size and anatomy of the infant all impact on the feasibility of resuscitation. This is a clinical decision made by the treating medical staff following the birth.

### **Perinatal and Infant Mortality Committee**

The role of the Perinatal and Infant Mortality Committee is set out in s336A of the *Health Act 1911*.

### **Process**

The process undertaken by the Panel involves extensive medical review and investigation of the fetal condition prior to a decision to terminate the pregnancy occurring. As the cause of the death of the infant can be established through the assessment process of the Panel and post-delivery examination, further review to determine cause of death by the Committee is considered unnecessary.

### **Documentation and reporting discrepancy**

The concern raised about the reason for termination of pregnancy after 20 weeks being listed as 'suspected fetal abnormality' is simply a reporting error.

In each case where the Panel agrees that the performance of an abortion after 20 weeks is justified, it completes a Panel Approval for Termination of Pregnancy Form<sup>10</sup>. This is a confidential form held on file by the Chairperson of the Panel as a record of approval. Currently no record is made of unsuccessful applications.

A separate notification on the prescribed Form 1 is made through the Abortions Notification system once the medical termination has occurred. This form contains no identifying information and is filled in by the doctor in attendance and forwarded to the Performance, Activity and Quality Division of the Department of Health. As the Form 1 is used for all abortions, not just abortions after 20 weeks, the list includes

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<sup>9</sup> KEMH Guidelines on Assessment of Newborn.

<sup>10</sup> Panel Approval for Termination of Pregnancy, KEMH Form, held in confidence.



reference to 'suspected fetal abnormality'<sup>11</sup>. This criterion does not apply to cases where panel approval has been given, and it appears that the doctor has completed the form incorrectly.

Two data collection processes relate to termination of pregnancy after 20 weeks: one is hospital based and the other is based at the Department of Health. In each case the data is collected for different reasons, by different areas and at different times in the process. As a consequence the information obtained from the two data sources will vary. Human and system factors may also impact on the quality of the data available and the information extracted from the reporting systems.

KEMH is currently reviewing the hospital process to improve the information capture for termination of pregnancy greater than 20 weeks cases. A blank copy of the current form has been enclosed for your reference.

### **Guidelines and procedures at KEMH**

Clinical practice guidelines and procedures have been developed for the medical termination of pregnancy to ensure best clinical management and compliance with the legislation. These guidelines and procedures are subject to ongoing review. A copy of relevant guidelines and procedures can be provided on request.

In addition, an information pack has been developed to assist women dealing with the difficult and heartbreaking decisions to be made when a diagnosis of a serious medical condition in the mother or infant is made late in pregnancy. The Perinatal Loss team is actively involved in the care of these women and their families and has a range of services and pamphlets available. Further information on this service can be provided on request.

### **Privacy and confidentiality issues**

Women who elect to undergo a termination of pregnancy at any gestation have a right to privacy and confidentiality of health information. In circumstances where the termination of pregnancy occurs because of a severe medical condition and involves an application to the Panel for an approval for termination of pregnancy the circumstances are even more distressing, and the mother is extremely vulnerable to psychological harm.

Due to the small number of cases and the rare clinical conditions that lead to a greater than 20 week termination of pregnancy, the release of clinical information must be of a general nature to prevent a breach of confidentiality. It is essential that any information that may lead to the identification of the woman is limited.

In order to ensure the safety of the medical staff involved in this difficult area of clinical care the names of the medical staff on the Panel remain confidential.

### **Number of cases**

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<sup>11</sup> Form 1, Department of Health prescribed form, completed and submitted as required by Health Act 1911 s 335(d) and (e).

As previously advised to Hon Nick Goiran, in my letter to him dated 22 August 2011 containing a detailed list from the Department of Health Database, the number of abortions after 20 weeks has increased slightly from 2004, however the number remains between 30 and 40 cases per year. According to a review of Department of Health data of the 464 approved terminations between 1998-2010, 12 were for maternal reasons and the others were for a serious medical condition affecting the infant<sup>12</sup>.

The increase in the population and overall birth rate in Western Australia will result in a proportionate increase in serious medical conditions of pregnancy. In 2008 the reported rate of birth defects was 3.6% of all births and stillbirths<sup>13</sup>. Other factors to be taken into account are the significant advances in medical technology and genetic markers that have resulted in the ability to better identify serious fetal disorders and genetic conditions over the past twelve years.

### Summary

This is a difficult and complex area of health care affecting a small number of women each year. The decision to terminate a pregnancy at greater than 20 weeks gestation is considered to be a significant clinical issue. A woman whose pregnancy is complicated by a serious medical condition affecting herself or her infant is managed by a multidisciplinary team of highly competent and experienced clinical staff. The situation is handled with sensitivity and the mother's right to make choices about her ongoing clinical care is respected. The importance of patient confidentiality is well recognised by hospital staff. Medical staff are aware of the legal requirements imposed on the medical Panel and the reporting obligations required by the legislation.

I trust your queries have been adequately answered. Please advise me if you should require any additional information or references in relation to the issues covered in this response.

Thank you for writing to me on this important matter.

Yours sincerely



Dr Kim Hames MLA  
DEPUTY PREMIER  
MINISTER FOR HEALTH  
21 SEP 2011

Att.

<sup>12</sup> Letter n24 data from Department of Health Database reported August 2011.

<sup>13</sup> Carol Bower, Edwina Rudy, Ann Callaghan, Jennifer Quick, Peter Cosgrove and Natasha Nassar (2009) *Report of the Birth Defects Registry of Western Australia 1980-2008*, 4.

Health Act 1911

**Health (Section 335 (5) (d) Abortion Notice) Regulations 1998**  
**Notification by Medical Practitioner of Induced Abortion**

To Executive Director, Public Health

Under section 335 (5) (d) of the Health Act 1911, I \_\_\_\_\_  
(please print full name)provide notice<sup>1</sup> of an abortion I performed, at \_\_\_\_\_  
(address where procedure performed)on \_\_\_\_\_  
(date of abortion)

1. Gestational age at date of abortion (best estimate): \_\_\_\_\_ weeks

2. Method of termination: (tick one or more)

- |  |                          |     |
|--|--------------------------|-----|
| Vacuum aspiration (suction curettage)          | <input type="checkbox"/> | (1) |
| Dilatation and curettage (sharp)               | <input type="checkbox"/> | (2) |
| Dilatation and evacuation                      | <input type="checkbox"/> | (3) |
| Vaginal prostaglandin or analogue instillation | <input type="checkbox"/> | (4) |
| Other (specify) _____                          | <input type="checkbox"/> | (5) |

3. Reason for termination of pregnancy: (tick one)

- |   |                          |     |
|---|--------------------------|-----|
| Reason other than fetal abnormality       | <input type="checkbox"/> | (1) |
| Suspected fetal abnormality               | <input type="checkbox"/> | (2) |
| Actual fetal abnormality                  | <input type="checkbox"/> | (3) |
| Specify if known _____                    |                          |     |
| Selective reduction of multiple pregnancy | <input type="checkbox"/> | (4) |

4. Patient's age (last birthday): \_\_\_\_\_ years

5. Origin of patient

- |  |                          |     |
|--|--------------------------|-----|
| Aboriginal but not Torres Strait Islander origin     | <input type="checkbox"/> | (1) |
| Torres Strait Islander but not Aboriginal origin     | <input type="checkbox"/> | (2) |
| Aboriginal and Torres Strait Islander origin         | <input type="checkbox"/> | (3) |
| Neither Aboriginal nor Torres Strait Islander origin | <input type="checkbox"/> | (4) |
| Not stated   | <input type="checkbox"/> | (5) |

6. Postcode of residence of patient: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Medical Practitioner)**Notes**<sup>1</sup> As required by section 335 (5) (d) of the Health Act 1911 notice must be given **within 14 days** of the abortion being performed.

Forward completed form (top copy), marked **Private & Confidential**, to Manager, Maternal and Child Health Unit,  
 Department of Health, WA, Reply Paid 70042 (Delivery to Locked Bag 52) PERTH BC WA 6849

Duplicate (yellow copy) to be retained by medical practitioner  
 Form 1 last updated on 21/01/2009

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## FORM 1

(Regulation 2)

Health Act 1911

**Health (Section 335 (5) (d) Abortion Notice) Regulations 1998**  
**Notification by Medical Practitioner of Induced Abortion****To Executive Director, Public Health**Under section 335 (5) (d) of the Health Act 1911, I \_\_\_\_\_  
(please print full name)provide notice<sup>1</sup> of an abortion I performed, at \_\_\_\_\_  
(address where procedure performed)on \_\_\_\_\_  
(date of abortion)**1. Gestational age at date of abortion (best estimate): \_\_\_\_\_ weeks****2. Method of termination: (tick one or more)**

- |  |                          |     |
|--|--------------------------|-----|
| Vacuum aspiration (suction curettage)          | <input type="checkbox"/> | (1) |
| Dilatation and curettage (sharp)               | <input type="checkbox"/> | (2) |
| Dilatation and evacuation                      | <input type="checkbox"/> | (3) |
| Vaginal prostaglandin or analogue instillation | <input type="checkbox"/> | (4) |
| Other (specify) _____                          | <input type="checkbox"/> | (5) |

**3. Reason for termination of pregnancy: (tick one)**

- |   |                          |     |
|---|--------------------------|-----|
| Reason other than fetal abnormality       | <input type="checkbox"/> | (1) |
| Suspected fetal abnormality               | <input type="checkbox"/> | (2) |
| Actual fetal abnormality                  | <input type="checkbox"/> | (3) |
| Specify if known _____                    |                          |     |
| Selective reduction of multiple pregnancy | <input type="checkbox"/> | (4) |

**4. Patient's age (last birthday): \_\_\_\_\_ years****5. Origin of patient**

- |  |                          |     |
|--|--------------------------|-----|
| Aboriginal but not Torres Strait Islander origin     | <input type="checkbox"/> | (1) |
| Torres Strait Islander but not Aboriginal origin     | <input type="checkbox"/> | (2) |
| Aboriginal and Torres Strait Islander origin         | <input type="checkbox"/> | (3) |
| Neither Aboriginal nor Torres Strait Islander origin | <input type="checkbox"/> | (4) |
| Not stated   | <input type="checkbox"/> | (5) |

**6. Postcode of residence of patient: \_\_\_\_\_**Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Medical Practitioner)**Notes**<sup>1</sup> As required by section 335 (5) (d) of the Health Act 1911 notice must be given **within 14 days** of the abortion being performed.Forward completed form (top copy), marked **Private & Confidential**, to Manager, Maternal and Child Health Unit,  
Department of Health, WA, Reply Paid 70042 (Delivery to Locked Bag 52) PERTH BC WA 6849Duplicate (yellow copy) to be retained by medical practitioner  
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