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Ref: RK07633-CP

31 May 2024

Health, Environment, and Agriculture Committee
Parliament House
Cnr George and Alice Streets Brisbane QLD 4000
Via email: heac@parliament.qld.gov.au

Dear Chair and Committee,

Re: Public submissions to the Committee Inquiry into the Termination of Pregnancy (Live Births) Amendment Bill 2024.

Introduction

622 submissions were published on the Committee website, with 30 unavailable to review because they were designated as 'confidential'. Of the remaining 592, the overwhelming majority (580) were in support of the *Termination of Pregnancy (Live Births) Amendment Bill 2024* (hereafter "the Bill)". Only 5 were opposed to the Bill, with the residual not articulating a clear position. That 98% of submissions supported the Bill is evidence of strong community support for its passage.

This response summarises the views and evidence put forward by different submitters, focusing most closely on the submissions from those with medical and health expertise.

Views of the health community

There were six submissions by health representative bodies.[1] Their submissions are summarised below according to five key areas of discussion and disagreement amongst these bodies.

- **Is there sufficient evidence to justify the Bill?**

Although RANZCOG asserts the Bill is "redundant in the absence of any justifiable evidence",[2] other medical peak bodies disagree.

The submission of ACM supports "legislation stipulating that comfort measures should be provided for the baby [if they are considered unlikely to survive] until they are no longer alive, and that the infant should be treated with respect and dignity at all times".[3] They also identify that in other scenarios life-sustaining treatment may be appropriate, "The ACM agrees that health professionals should not be restricted from escalating situations in which life-sustaining measures may be indicated to babies born alive as a result of termination, if the long-term prognosis for the individual baby is deemed to be positive by the multidisciplinary team".[4] PHPA also supports a legislative right to care for babies born alive after an abortion in its submission.

Contrary to what the RANZCOG submission asserts, there is ample evidence that abortion survivors exist. The medical and ethical considerations referred to by RANZCOG in their submission, are made to support clinical scenarios where the expected outcome is what the abortion procedure intended,

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to end the baby's life prior to their natural death. These same medical and ethical considerations fail to cater for the clinical scenarios where the baby is born alive post abortion. It follows then, they will not be well understood and uniformly practised as RANZCOG claim, and as evidenced by coroner, media and whistle-blower reports of babies who do not receive appropriate care in these circumstances. Evidence and grounds to establish the Bill are based on an identified gap in current legislation, to provide appropriate care, for babies born alive at birth, as highlighted by these reports.

Furthermore, although rare as a proportion of the total number of abortions in Queensland each year, there is evidence of increasing numbers of live births following abortion at both pre- and post-viable gestations in Queensland.

Table 1: Live births following abortion by gestation weeks (Queensland)[5]

	Gestation weeks			
Year	**<20 weeks**	**20 to 28 weeks**	**>28 weeks**	**Total**
2018	11	17	0	**28**
2019	5	42	0	**47**
2020	7	34	1	**42**
2021	10	30	1	**41**
2022	13	35	1	**49**

- **Does the Bill represent emotional manipulation?**

According to QNMU the rationale for the Bill is not evidence-based but "presents a dangerous precedent by introducing unnecessary regulations based on emotional arguments and misinformation".[6] However, other submitters acknowledge the Bill addresses the need to protect a child born alive after an abortion from pain and suffering. For example, ACM recognises that a baby born alive after an abortion may experience distress, stating:

> If the baby is showing signs of distress, seizures or air hunger, palliative care medications should be considered and administered. Medications should be titrated to achieve optimum symptom control, with minimal side effects".[7]

This indicates the importance of providing care to a child born alive after an abortion.

- **Does the Bill prevent access to abortion?**

Although three health bodies (RANZCOG, QNMU and ASHM) argue that the passage of the Bill would impede access to abortion by creating barriers, this was not identified as being a likely risk or problem by the other three health bodies (ACM, ACN and PHPA). Although the Bill addresses a rare and somewhat distressing aspect of abortion, it does not create a barrier to abortion, as the abortion has already occurred. The Bill's focus is on the medical care provided to the baby following an abortion.

Furthermore, as abortion is a unique medical procedure, it cannot be compared to other medical procedures, because it directly impacts the life or death of another human being (the fetus/baby) without their consent. Once a baby is born alive, upholding the universal human right to access care

(whether it be active or palliative, depending on the clinical circumstance) outweighs concerns held about reducing barriers for women to access abortion.

- **Does the Bill misrepresent fetal viability?**

PHPA provides the most comprehensive guide on current clinical practice for the perinatal care of the extremely preterm infant. Its submission states:

Between 22 and 24+6 weeks' gestation, counselling is provided by Neonatologists to discuss whether active or palliative care will be provided after the baby is born. This is because at this gestation, these infants are at high risk of complications from their extreme prematurity, which can result in a poor prognosis for long term survival. Should a preterm birth of a normally formed fetus be imminent, it is standard care to provide resuscitative interventions (active treatment) to infants born alive at or greater than 25 weeks' gestation. Although the majority of parents after counselling, would request resuscitation (active treatment) be provided for infants born at 23 and 24 weeks' gestation, some families make an informed decision for palliative care. Currently, life sustaining interventions are not usually recommended for infants born at 22 weeks, but have been considered in certain circumstances.[8]

The joint submission by ACM and CAN identified the increasing prospects of success for premature babies at earlier gestational ages, stating:

> Neonatal viability depends on factors affecting survivability. It must also be noted that over the ten years between 2005 and 2015, there has been an increase in the percentage of healthcare professionals who consider the chance of neonates, born at 24 and 25 weeks, surviving after resuscitation. In alignment with this data, the number of healthcare professionals who would agree with parental wishes not to resuscitate a neonate has decreased over this period.[9]

- **Does existing clinical practice negate the need for the Bill?**

RANZCOG argued that existing clinical practice suffices in a situation of a live birth following an abortion, stating, "There are well-established guidelines and professional standards to guide clinical practice in this area. Further legal regulation will be confusing and unhelpful".[10] RANZCOG cites its own clinical practice guideline on abortion care as the source for its claim.

However, RANZCOG's clinical practice guideline on abortion care is conspicuously silent on the standard of care required for a baby born alive following an abortion. The guideline does not identify either a foetus in-utero or a baby ex-utero as a patient, therefore it follows that there is no guidance given to health professionals, should a live birth follow an abortion. Therefore, it is disingenuous for RANZCOG to claim that health professionals "already owe a duty of care to all their patients, including babies born alive whether this happens following an abortion or otherwise", given its own guidelines is silent on the appropriate level of care for babies born alive following an abortion. The failure of the RANZCOG's guideline on abortion care to provide instruction on the situation addressed by the Bill, is precisely a reason why the Bill should be passed.

Furthermore, ACM recognises the need for babies born alive following an abortion to be recognised in midwife patient ratios, noting that newborns and stillbirths are included. ACM states:

> These maternity departments are busy and already understaffed. Midwives are required to support babies at the end of life as well as provide physical care and emotional support to the woman and her family, and at times this process can take hours. An appropriate workforce to provide care for babies born alive after termination is imperative to ensure adequate support for women and babies".[11]

- **Is a baby born alive after an abortion a 'patient?**

Three health representative bodies clearly identified a baby born alive after an abortion as a patient. PHPA stated, "An infant that survives an abortion and is of viable gestation, should be considered a patient".[12] ACM advocated for the inclusion of babies born alive after an abortion as a patient to address midwife patient ratios. ACM stated, "The recent *Health and Other Legeislation Bill (No.2) 2023*

which includes newborn babies in midwife, patient ratios is to be applauded…No mention is made of babies born alive following a termination of pregnancy. It is important to ensure these babies are included in patient ratios as part of the roll out of the Bill".[13] The joint submission by ACM and the Australian College of Nursing (ACN) also advocated for medical care to be provided to babies born alive following an abortion on the basis that they were a patient, stating:

> ACM and CAN advocate for access to medical care and treatment for all people, including neonates. This section [s 3] of the amendment supports health professionals involved in the termination procedure and the dignity of life for babies born alive after a termination. It is essential when exploring the amendment involving 'duty of care' that the ACM and CAN acknowledge the need to address the complexities inherent in the termination procedure.[14]

- **Who should decide on the appropriate level of care for a child born alive after an abortion?**

According to RANZCOG, the decision of whether and how to provide care to a child born alive after an abortion should be made by the mother and her doctor. RANZCOG states:

> Moreover, given that the clinical practice and scenarios are always going to vary, RANZCOG supports that the decisions regarding care of a child born alive, independent of the circumstances, should be a matter between the woman/pregnant person and their treating health practitioners. To this end, RANZCOG opposes "abortion exceptionalism", namely the creation of laws that treat abortion differently from any other medical procedure.[15]

As abortion is the only medical procedure which seeks to kill a vulnerable human being without their consent, there is a strong argument for additional laws and safeguards around the regulation of abortion.

Further, the deferral of the decision regarding care of a child born alive to the child's mother and her health practitioners means that the child's best interests will not be taken into account. This is because the child's mother sought to end the child's life via abortion and was supported to achieve this through the aforementioned health practitioners. Arguably, in a situation such as this, those who set out to kill the child are not the most appropriate people to determine care of the child following abortion.

This is why ACM acknowledges that a baby born alive after an abortion will require the appointment of individuals other than their parents to ensure guardianship and care. ACM states:

> In the case of a baby born alive following a termination and receiving life-sustaining treatments, the parents may not wish to assume custody of the baby. Consideration must therefore by given to ensuring that appropriate immediate and ongoing guardianship of the baby is established, with involvement of social work and counselling support for the parents, and a view to kinship care as a first preference, or alternatively permanent adoption for the baby.[16]

This is further emphasised in the joint submission by ACM and ACN, which states:

> It is essential to have a process to support health practitioners, parents and/or Child Services to ensure appropriate care is provided. This should be discussed the developed during the consent consultation before the procedure to ensure the safety of the persons involved, including the newborn.[17]

- **What support should be provided to health professionals, pregnant women and others involved in termination where there is a possibility of live birth?**

The joint submission by ACM and ACN proposed an additional amendment to the Bill stipulating the need to offer counselling given the high potential for distress. They suggested adding an amendment which states, "The duty owed by a registered health practitioner is to offer counselling options to the woman or any other parties involved in the termination of pregnancy procedure".[18] They go on to state:

> Further, ACM and ACN recommend that before and following the termination of pregnancy, every woman should have access to counselling services facilitated by registered counsellors, psychologists or mental health practitioners. This should include the potential outcomes of the termination to ensure the woman's informed consent, unaffected by altered mental state. Additionally, it is crucial to inform the woman about the possibility of a live birth and her duty of care to the fetus if it is born alive.[19]

In its separate submission, ACM identifies the impact on health professionals caring for a woman and baby after a termination, stating:

> Grief, compassion fatigue, burnout and secondary traumatic stress are frequently experienced by midwives providing care for women undergoing late pregnancy termination. **Caring for a baby born alive as a result of a termination adds an additional layer of emotional impact to an already challenging experience.[20]**

Other submissions

Professor Joanna Howe, a scholar at the University of Adelaide, provided a comprehensive submission on the issue of children born alive after an abortion in Australia. Her submission contained data from other states and territories and from two coronial reports. In particular, her analysis of a case of an unnamed baby at Westmead Hospital, discarded in a medical waste bin whilst still alive after an abortion, was particularly concerning. Her submission also highlighted a study in the *Journal of*

Obstetrics and Gynaecology which reviewed 241 late-term abortions without feticide on babies between 20-24 weeks gestation and found that more than half the babies were born alive, with a median time of survival of 32 minutes and one baby surviving for over four hours (267 minutes).[21] Her submission noted that despite the recommendation of feticide, babies are born alive following an abortion in Queensland (e.g. 49 in 2022) and that this can occur unexpectedly (e.g. baby Xanthe).

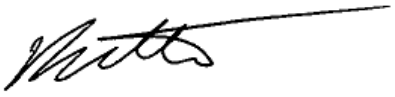
Submissions were also made by pro-abortion advocates (e.g. **Children by Choice**) and anti-abortion advocates (e.g. **Cherish Life**). The former contained several factual errors. First, it asserted the 'absence of evidence-based justification' and seeks to downplay the experience of pain and suffering of a child born alive after an abortion, referring to this child as merely showing 'signs of life' rather than actually being alive.[22] These errors are addressed above using Queensland health data of annual live births following abortion and evidence provided in the submissions by ACN, ACM and PHPA, as to the experience of neonates and the care required to address their situation. Second, it fails to acknowledge the live born child as a patient, stating that the Bill is 'fundamentally at odds with patient autonomy and patient-centred care principles'.[23] This callous approach fails to account for the 'the safety of the persons involved, including the newborn' identified explicitly in the submission by ACM and ACN.[24] Third, it asserts that the use of Xanthe's story was cited 'as representative of public concern regarding the necessity for legislated medical intervention'.[25] This was neither asserted in the Explanatory Notes nor the Second Reading Speech by Mr Katter. Where reference was made to Xanthe's experience, it was to expose the need for the Bill because she was left in an empty hospital room for 7 minutes until her death, not as evidence of public concern. Fourth, the submission claims that 'a miniscule proportion of terminations' are performed over 20 weeks and thus the Bill addresses

a problem that does not exist.[26] However, the use of percentages rather than raw numbers is misleading, given the high total number of abortions in Australia each year.[27] The submission by anti-abortion group **Cherish Life** drew attention to the human rights of all persons born in Queensland and the need to provide care to both, relying on data from coronial, media and health reports to substantiate its position.

The submissions by two religious groups (**Australian Christian Lobby** and the **Archdioceses of Brisbane**) emphasised the dignity of the human person and the protection of all children, born in a nation state under international law, to indicate their support for the Bill.

Conclusion

The overwhelming majority of submitters were made by individuals supporting the passage of the Bill based on grounds of human rights, science and philosophy, ethics and morality or religion. It is for these reasons that I continue to advocate for this bill to be passed.



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