HEALTH, ENVIRONMENT AND AGRICULTURE COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP
Mr CD Crawford MP
Mr JR Martin MP
Mr R Molhoek MP
Mr ST O'Connor MP

Staff present:
Dr J Rutherford—Committee Secretary
Ms R Duncan—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE TERMINATION OF PREGNANCY (LIVE BIRTHS) AMENDMENT BILL 2024

TRANSCRIPT OF PROCEEDINGS

Monday, 19 August 2024

Brisbane

MONDAY, 19 AUGUST 2024

The committee met at 10.02 am.

CHAIR: Good morning. I declare open this public hearing for the inquiry into the Termination of Pregnancy (Live Births) Amendment Bill 2024. I am Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all now share. With me today are Mr Rob Molhoek, member for Southport and deputy chair; Mr James Martin, member for Stretton; the Hon. Craig Crawford, member for Barron River; Mr Stephen Andrew, member for Mirani; and Mr Sam O'Connor, member for Bonney.

The purpose of today's hearing is to assist the committee with the examination of the Termination of Pregnancy (Live Births) Amendment Bill 2024. The bill was introduced into the parliament on 20 March 2024 by Mr Robbie Katter MP, member for Traeger, whom I acknowledge here today, and referred to this committee for detailed consideration and report.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public and witnesses that they may be excluded from the hearing at the discretion of the committee.

These proceedings are being recorded by Hansard and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask that mobile phones are turned off or placed on silent.

ADSETT, Ms Louise, Midwife, Australian Christian Lobby

NORMAN, Mr Rob, Queensland State Director, Australian Christian Lobby

CHAIR: Thank you both for being here and for your submission. I invite you to make an opening statement. Then will move to any questions we may have.

Mr Norman: Thank you, Chair and members of the Health, Environment and Agriculture Committee. Today I represent almost 50,000 Queensland supporters of the Australian Christian Lobby. The Australian Christian Lobby appreciates the careful consideration given to the Termination of Pregnancy (Live Births) Amendment Bill 2024, which addresses a critical gap in our current legislative framework. The primary objective of this bill is to enshrine in law protections for infants born alive as a result of termination procedures which will ensure that every child born alive following an abortion receives the same level of medical care and attention as any other newborn.

Currently, Queensland law allows for terminations throughout pregnancy but remains silent on the obligations towards infants born alive under these circumstances. This silence has led to a distressing lack of clarity and consistency in the care provided to these vulnerable infants which, as we will hear, has resulted in the appalling neglect and abuse of the most vulnerable newborns. Keep in mind that from 2010 to 2020, 328 infants were born alive following termination procedures in Queensland and 2022 saw almost one Queensland baby born alive following an abortion. These numbers are not just statistics; they represent real babies that deserve our compassion and protection.

Queensland Health guidelines are prone to change and are insufficient to protect our most vulnerable citizens. Currently, these guidelines allow for discretionary interpretation and lack the force of law to ensure consistent best practice care for infants born alive after a termination. This bill proposes necessary amendments to align Queensland's legislation with that of South Australia and New South Wales, where the duty of care owed to all newborns is unequivocally equal, regardless of the circumstances of their birth. The bill will insert a new section into Termination of Pregnancy Act clearly stating that any duty of care towards an infant born alive as a result of an abortion is identical

to that of any other infant. This legislation will remove the ambiguities and ensure that healthcare practitioners provide appropriate medical care and treatment that every newborn is entitled to as a basic human right.

Our advocacy for this bill is rooted in the belief that all human life is valuable and deserving of protection. Article 6 of the Universal Declaration of Human Rights affirms the right to life, liberty and security of all individuals. Similarly, article 24 of the Convention on the Rights of the Child mandates the highest attainable standard of health and medical care for each child. This bill is a step towards fulfilling these international obligations.

In conclusion, the ACL strongly supports the Termination of Pregnancy (Live Births) Amendment Bill 2024, and we urge the committee to unanimously endorse this bill and recommend its passage by the Queensland parliament. Thank you, Chair and members. I would now like you to hear from Louise Adsett, who is a practising clinical midwife.

Ms Adsett: Good morning. I would like to thank you, Chair, and committee members for allowing me to speak to this public hearing about the babies born alive after an abortion. First and foremost, I am a mother of three girls. Secondly, I am a clinical midwife who has worked in maternity and birth suite units for approximately 14 years. I currently work in a birth suite unit where my role and the role of my midwife colleagues is to ensure women and babies receive safe, effective care to prevent harm and adverse outcomes from occurring. This includes death. We are skilled in resuscitation of mothers and newborns. We also provide care to mothers who have lost their babies in utero unexpectedly.

Over the last few years, however, the midwives within the unit have been required to provide care for women who do not want their babies, and the fact is that these babies are perfectly healthy, with no abnormalities. These are social terminations or psychosocial or for financial reasons, and because of the Termination of Pregnancy Act 2018 women can access a termination at any gestation for any reason. The only difference is that after 22+1 weeks of gestation there must be two medical officers to approve the abortion and the baby is killed by feticide and delivered by the midwives as stillborn. I am a conscientious objector when it comes to providing care for women aborting their babies; however, I have provided care for many women who have unfortunately lost their babies at similar gestations to those who are now getting abortions for any reason at any gestation. I am also happy to make myself available to hold the baby who is born alive after an abortion.

Sadly, in the birth suite unit in my hospital work where every new birth is celebrated and protected, there has been an increase in the number of social terminations at later gestations, and this is now common. We have had babies born alive after terminations from 15 to 22 weeks—born alive, gasping for air, moving and having a palpable heart rate, fighting for their lives as we are humans designed to do. From what I have directly witnessed or been told by my colleagues, we have been present at the time these babies were alive for anywhere from two to 20 minutes to three to five hours. Parents of these babies who are born alive after abortion do not want to see or hold them. This means the only person left who could possibly hold them is a midwife or a nurse.

If this were a pregnancy loss of a wanted baby, the mother and father would usually comfort that baby while the baby was alive until they pass. In a termination of pregnancy where a baby is unwanted, babies are sometimes born into witch's hats or kidney dishes and taken out of the room immediately, at the parents' wishes. If alive after abortion, the bereavement midwife or a regular midwife providing care for the woman holds the baby until the baby stops gasping or moving or no longer has a palpable heart rate. Sometimes babies born alive after an abortion are put into witch's hats and are covered, taken out of the room and die while in that witch's hat. This is distressing to many of the midwives as they are unable to provide any medical care for the baby but are limited to providing comfort care only, which is merely wrapping and holding the baby. We are so often short-staffed and some of the time midwives and doctors will provide this care for the terminated baby while caring for the labouring woman. At times we have had women who have lost their babies at term, which is a gestation of 37 weeks onwards, in the room next to women who are terminating their babies—unwanted babies.

To give you the first example, a mother made a decision to abort her baby at 21-plus weeks of gestation. The process began in the morning with Misoprostol given throughout the day. The process took all day and the baby was only delivered during the early hours of the night shift, where skeleton staff was on duty. This baby moved vigorously, gasped for breath and had a palpable heart rate. To make it clear, this baby was alive. It was over 400 grams, so the baby was a good weight. The parents of this baby did not desire to see or hold this baby. Midwives and doctors were left holding this little

life while they continued to provide care for other women who were birthing and welcoming babies into the world. This baby boy fought for his life for five hours before taking his final breath. This is not an uncommon occurrence.

Just recently a mother decided to abort her baby at 19 weeks. The same Misoprostol regime was started and this little baby was born alive—again, moving, gasping for air and having a palpable heart rate and, once again, weighed over 400 grams. This was a busy shift and the midwife who took over care from the bereavement midwife when this baby was delivered was distressed and shocked that the baby was alive at 19 weeks and they could not hold it. The baby was taken to the pan room and, as the mother declined to hold that baby, even knowing it was alive, the midwife who was providing care for this baby and mother who was terminating was also providing care for another lady who had decided to terminate her baby at a later gestation but had not had a feticide. As this was a busy shift and we were short-staffed, it was suggested that this little baby be put into the dirty pan room and covered and be left on its own to take its final breaths alone. As the baby kept on breathing for longer than anticipated, thankfully another midwife was able to hold the baby while doing work until the baby took its final breaths. This baby was alive for almost three hours.

These are just two of many examples that occur in not only birth suites that I work in but also birth suites across Queensland. In these accounts which I tell you, I was either on shift or my colleagues have told me about their experiences. My colleagues are very often distressed about what they have seen and participated in, as am I. These babies deserve better. They deserve to have the same rights that all of us human beings have, and I hope that the live births bill will be the first of many steps taken to protect and give rights to babies born alive after abortion. I thank you for your time and for listening.

CHAIR: Thank you, Louise, and thank you very much, Mr Norman. Louise, how long have you been a midwife?

Ms Adsett: Fourteen years.

CHAIR: It is a really difficult and sensitive subject, no doubt, to talk about. Most members here know that in my previous career I was a paramedic for 30 years and have been able to deliver a number of really beautiful babies. Sometimes, not related to termination or abortion, people have delivered a baby at 16 weeks or 18 weeks. It is a really difficult, sensitive and emotional time for the parents when the baby is not viable or does not breathe. If you take out termination of pregnancy, sometimes people spontaneously give birth in the second trimester. Do you see where I am coming from here? A number of people will have a baby spontaneously. What do we do there?

Ms Adsett: Place the baby on the mother's chest for comfort because all the baby knows is their mother.

CHAIR: Even if the baby is not breathing?

Ms Adsett: Yes.

CHAIR: I agree, 100 per cent. It is a really emotional and sensitive time. Thank you for that. Did you read the other submissions from RANZCOG and QNMU?

Ms Adsett: I cannot say I did, no.

CHAIR: I might let you go to that, if you want. I will see if other members have any questions and then I can come back to that.

Mr MOLHOEK: I start by thanking you, Louise, for sharing that perspective. It is a very challenging issue. When we had the debate about termination of pregnancy we were allowed a conscience vote. A number of us crossed the floor many times to try to reduce the period to 22 weeks because, like you, we did not think that a life should be terminated for, as you put it, psychosocial or financial reasons. What I am wrestling with is this: if we were to do all we could to save those live births, where would we go from there? Do we need to introduce broader abortion laws or guardianship laws or make other provisions so that those children could actually end up in a healthy, viable family if they are not wanted? What is the ACL's view around what you do with an unwanted child who is born and viable?

Mr Norman: I think we have to remember that this is a human rights bill. This is not an argument about abortion. Abortion law has been passed—it has gone through—and now we have consequences of the law that has been passed. The law has been incomplete. It has failed us. These are not just statistics; these are real babies. In my discussions with Louise and other people involved

as health practitioners, these people are suffering PTSD because they are experiencing real human beings being born and left to die in ridiculous circumstances. We would not do that with any other member of society. The moment these little babies take a breath, they are actually citizens of Queensland and we are failing them.

All we are saying is that this bill needs to pass. This is a human rights bill and these children, regardless of whether or not they are viable, deserve all the protections we can offer any newborn. That is our position. We are not pro abortion, obviously. We think that once you introduce laws that take another life you then have to deal with the consequences. This particular bill is urgently required because, even with the latest changes to Queensland Health's guidelines, we are still seeing babies neglected and dying alone. They are real people. We have to fix this. We have to get it through this side of the election.

I think it has been a bit of a ploy that the findings of this committee have been delayed until after the last sitting week, which is absolutely ridiculous. I would call upon all of you to rush this thing through and get it voted on before the election. Just get it done. We have to get it done. The people of Queensland will be proud of this. When we speak to people about this situation, they do not believe us. They say, 'No, that's not happening.' The Queensland health figures are there. There are people like Louise who are testifying to it. We just have to get it fixed. It does not matter what side of the House you are on. This is not a political issue; it is a human rights issue.

Mr MOLHOEK: Going back to my question, in your opinion does the legislation go far enough in terms of the rights of the child if the bill were to be passed? What does the future of that child look like if they are unwanted? Do the current adoption laws provide for that or do there need to be amendments to the bill to accommodate those sorts of provisions?

Mr Norman: We need to get this through first. We need to think about adoption laws and all the other options. Again, that is a consequence of bad legislation being passed in the past. Yes, we do need to look at all those options.

CHAIR: Sadly, we are on a tight timeframe. Thank you very much, Mr Norman and Louise, for sharing your experiences.

CLIFF, Mr Matthew, Chief Executive Officer, Cherish Life Queensland

PURCELL, Mrs Donna, President, Cherish Life Queensland

CHAIR: Thank you both for being here. Would you like to start with an opening statement and then we will move to questions?

Mr Cliff: Committee, thank you for your time. I am going to use my time this morning to speak to some of the objections of those who are opposing this bill. I will be using Children by Choice's submission as an example of the arguments of those who are opposing it. There are seven key objections.

The first objection is to say that this bill is not evidence based. One main issue for them is our reliance on the perinatal data. However, the perinatal data is actually just one area of evidence that supports this bill. As our submission states, there are also numerous eyewitness testimonies from Queensland nurses and midwives, as we have just heard, and even from coroners. Plus, and most importantly, we have the testimonies of those who have actually survived the procedure itself. In fact, there is a network dedicated to the survivors of these procedures called abortionsurvivors.org. Therefore, the objection that the bill is not evidence based is untrue.

Next, according to Children by Choice's submission, the bill demonstrates a fundamental misunderstanding of abortion outcomes by conflating live birth with signs of life. I think it is important to look at the definition of the terms in the Queensland guidelines. Here is the definition of 'live birth'—

Signs of life may include: beating of the heart, pulsation of the umbilical cord, breath efforts, definite movement of the voluntary muscles, any other evidence of life.

Apparently, when a baby is born alive after a failed abortion attempt and their heart is beating, we are wrong to say that the baby is alive and that it is a live birth. Likewise, when a baby is born alive after a failed abortion procedure and makes breath efforts, otherwise known as breathing, again we are wrong to say that this baby is alive and that this is a live birth. There is no misunderstanding here at all and I believe most Australians can see through this. We would not apply those definitions to wanted babies so why are we applying them to unwanted babies?

Another objection is that this bill seeks to legislate abortion care rather than keep it under the purview of healthcare professionals. Here is the issue: in any other circumstance in which a child is born, immediately that child has rights assigned to them by law. It is the legislative body that protects that child, and rightfully so. What those who are opposing the bill are suggesting is that because of the circumstances of the birth of these children they should be denied their legislative right for protection. This is exactly what the bill seeks to address. This bill will ensure that is not based on how a person interprets life or understands a guideline but, again, it provides a legal right to life.

Next, according to Children by Choice—

The proposed legislation should be based on accurate and transparent representations of public sentiment rather than emotional manipulation.

We agree. The issue is that the public are grossly unaware that this takes place. We are more than happy to have this conversation publicly. Most Australians, again, would be horrified to know that this is taking place. They say we are misrepresenting public sentiment. Unfortunately, in their submissions they do not even mention any public testimonies.

The next objection is that this bill creates further barriers to the abortion procedure. They state—

Laws that knowingly target and legislate health care available to pregnant people experiencing disadvantage, and to pregnant people and their families experiencing distressing diagnoses, is inequitable and creates further barriers ...

This is so misleading because, again, this bill does not affect abortion in any way at all. It creates no barriers whatsoever. Again, all this bill is doing is legislating health care for babies who have been born alive as a result of a failed abortion procedure.

Next, those opposing the bill state—

Legislative interventions like the *Termination of Pregnancy (Live Births) Amendment Bill 2024* fail to consider these low survival rates, and the medical expertise, availability and financial resources required to enable advanced neonatal care for premature births.

I want to ask a question: is 204 babies born alive and left to die from 2018 to 2022 a low number? Let me tell you that if one baby was born alive and left to die then this bill would still be worth it.

Finally, they state—

... mandating supposed "human rights" measures for foetuses with medical conditions incompatible with life or detrimental to the mother's health violates prevailing medical and ethical care standards.

This is perhaps the most deceptive of all. This bill in no way is mandating supposed human rights measures for fetuses. This bill is mandating human rights for children who have been born alive. If a child is born with a condition that does not allow them to live long, if a child is born and the mother does not want that child, does that mean that we are just to let the baby die without giving him or her every opportunity to support life? Of course not. The Children by Choice submission states—

Children by Choice emphasises the importance of patient-centred care, wherein healthcare practitioners prioritise the individual needs and preferences of each patient to ensure quality, compassionate care and optimal patient outcomes.

My question here is: what about the patient centred care and the prioritising of needs and preferences of the babies born alive? Are they not patients, too? Why do those opposing the bill feel the need to completely dismiss the needs of the most vulnerable patients of all, babies fresh out of the womb? Again, most healthcare practitioners are horrified that this takes place.

To conclude, all of the arguments I have made above you will hear again in some form or other in the speeches after the break. Here is the reality: for the abortion industry, the fact that babies are born alive as a result of failed abortions is an inconvenient truth. Therefore, they are trying to minimise and brush under the carpet the reality of this happening. Do not be misled. We ask you to stick to the issue of what this bill seeks to address and we ask that you keep in your minds and your hearts the testimonies like we just heard before. This committee has the opportunity to rectify this reality and we urge and implore you to let this issue be voted on. Children are not a choice; they are a gift. Every child, wanted or unwanted, deserves to be treated with the same dignity and respect as any other Queensland-born child. Thank you and God bless.

CHAIR: Thank you, Mr Cliff. Donna, do you want to add anything?

Mrs Purcell: No, thank you.

Mr ANDREW: I am absolutely gobsmacked. I would not treat my dog like that, and I am sure 90 per cent of Queenslanders would not either. These are living aborted fetuses—breathing, with a soul—and you tell me that the people of Queensland do not understand it. Why is there such confusion around, with the references you have made to other submissions? What is the situation confusing? It is pretty easy to tell if something is alive or not. I have worked in industries where I know what is alive and what is not. In your mind, why is there such confusion?

Mr Cliff: I feel like there is a failure to really understand the consequences of the abortion laws that are in place at the moment. That is one issue. There is a real lack of education for the public. Again, not many of these testimonies are shared by mainstream media. The only opportunity that people have of hearing horrific testimony like this is basically from us at the moment. That is why we are thankful to Robbie for putting this legislation forward, because it gives us some exposure and it lets Queenslanders know what is happening.

Mr MOLHOEK: Please do not take this question as a lack of support for the bill. Based on what you are saying, if the Queensland legislation essentially provides a right to life and medical care to anyone who is born then you could almost argue that we do not need this bill. We just need to follow our own rules. Perhaps this is a question in terms of technical scrutiny or a question for the Health Ombudsman or we may need some further advice. Perhaps there are already implied protections in current legislation that we are not following. That is what I thought I heard you say. We already have the law in place to protect live births but we are asking health practitioners to disregard those laws by withdrawing care.

Mr Cliff: This is the confusion. The reality is: why have guidelines if the rules are there? Do you know what I mean? Having clarity with regard to what are the rights of these children would be absolutely beneficial.

Mrs Purcell: I just have an observation about the previous speaker, Louise, who is a midwife. I was pretty shocked myself to hear that, under the old guidelines prior to this change, if babies were born alive they were to be wrapped and given some sort of protection but even that is not being observed now, let alone the fact that we have a new set of guidelines that say that you could assess the baby to see whether there are signs of life. Where do we go if the guidelines that are meant to be observed by all hospitals handling this type of situation are not being observed to start with? Why would they then suddenly decide: 'It's a baby, so we better do what we have to do'?

Mr MOLHOEK: It sounds to me that you are saying that the guidelines are in conflict with our law.

Mrs Purcell: No. What I am trying to say is that the guidelines even as they are do not seem to be observed, and that is from the witness of a midwife.

Mr ANDREW: Chair, I have one more question.

CHAIR: Sorry, member for Mirani. We are tight on time. I am trying to clarify something in my mind. You quote those numbers and you talk to failed abortions. Do you have any idea how many people miscarry in Queensland? Can you give us an idea of the numbers of babies that are born prematurely—and this has nothing to do with the termination of pregnancy—with no signs of life? Do you have any context there? Removing the subject of termination of pregnancy, people miscarry. Sadly and tragically, it happens.

Mrs Purcell: Yes, of course. No. I do not particularly have any idea myself of numbers.

CHAIR: My experience is that the parents are absolutely gutted by that experience.

Mr Cliff: Yes. We have experienced that in our families as well. Of course, that is horrendous. My concern is that we are trying to create a straw man here. That is not the issue; the issue is where babies are being born alive.

CHAIR: I am just trying to clarify the number of terminations of pregnancy that you have quoted and the number of people who miscarry at a number of weeks. I am trying to get that in my head. I apologise to everyone here. We are very tight on time. We could have this discussion for a long time. Thank you both very much for your attendance here today.

FOGARTY, Professor Gerald, Executive Member, Prolife Health Professionals Australia

LAI, Dr Melissa, Director, Prolife Health Professionals Australia

CHAIR: Thank you both for being here today. I apologise we are running a couple of minutes over. We will go straight to an opening statement.

Dr Lai: Good morning. Thank you for the opportunity to attend this hearing. My name is Dr Melissa Lai. I am a neonatologist by profession and current Director of Prolife Health Professionals Australia. I am here today with Professor Gerald Fogarty, who is one of PHPA's senior executive members. He is also a professor of medicine from the University of New South Wales. I would like to say from the outset that the views we present today are representative of our organisation and not those of my current employer.

PHPA represents health professionals whose practice is governed by the scientific fact that a human life begins at fertilisation and that these infants, regardless of gestational age, should be treated as patients and their rights to life should be considered in clinical decision-making, whether in utero or ex utero. This bill identifies a current gap in the legislation and therefore care for what happens to babies if they are born alive after a termination-of-pregnancy procedure.

The current Queensland guidelines on page 24 state that if a baby is born with signs of life 'provide care appropriate to the individual ... circumstances and in accordance with best practice guidelines'. This leaves the care provided to these infants up to the care provider's discretion. If a mother underwent the termination-of-pregnancy procedure for a fetus that is of non-viable gestation or has a life-limiting condition then it would be appropriate to offer that baby palliative care. If a mother underwent the termination-of-pregnancy procedure for a baby who is of viable gestation and has no life-limiting condition then the baby that is alive should be given the same care, which may include active treatment, as for any baby born in any circumstance.

PHPA recommends that all babies born after a termination-of-pregnancy procedure should have comprehensive data collection and the condition of the baby at the time of birth clearly documented. There is currently no legislation for providing neonatal care to infants born alive after a failed abortion according to the Termination of Pregnancy Act 2018. The following recommendations are made. Infants who are born alive after a failed abortion who are of viable gestation and have no need for palliative care should be offered active treatment and, if required, placed for adoption. Infants who are born alive after a failed abortion who have reasons to receive palliative care should be offered palliative care. Comprehensive data collection should be mandatory for all babies born alive following an abortion. Demographics of gestational age, sex, birth weight, the reason for the abortion, the care provided after birth and, if applicable, the time of death should be recorded. All pregnant women undertaking a second- or third-trimester abortion should be counselled of the risks of a live birth after a termination-of-pregnancy procedure and the possible outcomes of the infant receiving treatment, whether palliative or active, which includes adoption.

CHAIR: Professor Fogarty, did you want to add anything?

Prof. Fogarty: No. I am very happy to support Melissa in this.

Mr ANDREW: Thank you for the information this morning. Does this bill address the misinterpretation of the situation that exists now in Queensland with aborted fetuses born alive?

Dr Lai: I think it does because there is a gap in the care provided. If you think about when a mother comes to a therapeutic decision with an obstetrician that the baby is to be terminated—so that is part of the termination-of-pregnancy procedure—that is the expected outcome.

Mr ANDREW: But it does address the moral understanding or issue of misinterpretation of whether that fetus is alive or not and how that fetus should be dealt with.

Dr Lai: There are nuances in the care. As I stated in my address, it depends on what is the indication of why the termination-of-pregnancy procedure is done. If a baby is not of viable gestation or if it was done because the baby has a life-limiting condition then it should be afforded palliative care. Currently, what that looks like, from what members of PHPA have told us confidentially, is that it falls back on to the birth suite staff—that is, the midwifery staff—to make that decision.

Mr ANDREW: Does it allow all human beings to be treated equally as far as that is concerned—souls of human beings?

Dr Lai: It falls back on the staff to make that decision. If they happen to be very busy in their shift, there have been reports that these babies are left without observation. If the decision is not for active treatment then pretty much you are waiting for that baby to have a natural death, and that can be minutes to hours.

Mr ANDREW: Everyone should be treated equally.

Dr Lai: They should be treated equally and receive observations and offered palliative care. If they have signs of distress, they should be given medications. In general, comfort care usually just involves wrapping the baby and keeping them warm. They are not as agitated. If there are signs of distress then they should be offered that, yes.

Mr O'CONNOR: Doctor, could you expand on your view on the Queensland Health guidelines? Quite a number of submitters were in favour of the more comprehensive guidelines that were updated last October. You referenced them. The view seems to be that people support the guidelines but they want this legislation to mandate that health practitioners have to follow those guidelines. Can you run through why you think that will work?

Dr Lai: I will give an example of where this bill has been passed in New South Wales and South Australia. The New South Wales guideline does include a line which talks about assessment of the baby at birth. If the baby does not have a life-limiting illness or if it is of viable gestation, it actually recommends that the neonatologist be called to assess that baby. That is currently missing in our guidelines. When you think about why the woman went to get a termination-of-pregnancy procedure, the expected outcome is for the baby to pass, to die. That is the expected outcome. We are talking about babies who have not died.

Mr O'CONNOR: Do you have any data from those two jurisdictions—New South Wales and South Australia—to compare to Queensland data to show that the legislated form of this improves outcomes?

Dr Lai: I do not have it today, but I am happy to provide that on notice.

CHAIR: We will take that on notice.

Mr MARTIN: I refer to RANZCOG, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and their submission. They have said that the bill is unnecessary in that health professionals already have a duty of care to their patients, including babies born alive after termination, whether this happens following an abortion or otherwise. There are well-established guidelines and professional standards to guide clinical practice in this area. Could you respond to that on behalf of your organisation?

Dr Lai: I feel like I have answered that question in that it does fall on to the health practitioner at the time. The majority of these cases will be where a baby is not of viable gestation or they have a life-limiting illness. What usually happens at the moment is that these babies are cared for by the birth suite staff. Whether they have the resources to do that—it has been brought to our attention that they often do not. You might have a midwife who is looking after that kind of baby and then gets called to an emergency. Especially in a situation, potentially, where the mother has decided they do not want to cuddle that baby, then it is falling back on the staff to do that task. If they get called to an emergency, they will leave that baby to attend to another emergency. In terms of what RANZCOG has said—that that is already being provided—I think we have had enough communication with our members to say that this is still a gap that is being seen in the clinical space.

CHAIR: A recent bill was passed in this parliament with baby-to-nurse or baby-to-midwife ratios. Do you think that is helpful, particularly when someone has lost a baby? Again, this is a very distressing time. Do you think that is a good step forward in terms of what you were just saying in relation to resourcing?

Dr Lai: Yes, but the difference is, say, if the baby has a life-limiting condition and the mother decides not to have a termination-of-pregnancy procedure. What happens then is that the parents will hold that baby until they naturally pass. In a termination-of-pregnancy procedure there will be times when the mother does not want to hold that baby and then that will fall back on the staff, so I think it definitely points to that difficulty in staff ratios, yes.

CHAIR: I am just mindful of time. We did have a question on notice. Dr Lai, if we could have a response by Monday, 26 August that would be helpful for the committee.

Dr Lai: No problem.

CHAIR: Thank you very much to both of you for your contribution.

Dr Lai: Thank you so much.

HOWE, Dr Joanna, Professor of Law, University of Adelaide

CHAIR: I welcome Dr Joanna Howe from the University of Adelaide.

Dr Howe: Thank you, Chair, and thank you to the committee for having me here today. I will make a short statement to give us ample time for questions. The first point that I would like to make is that there is no existing positive legal duty to provide care for these babies, so that goes to your question, Mr O'Connor. At present, in the guidelines we have a provision that says healthcare providers may provide comfort support strategies, so that is a policy framework that exists for children who are born alive after an abortion. It is a discretionary provision. It is not a mandatory provision to provide care and comfort for a child born alive after an abortion, so that is a glaring omission in the current guidelines. Even over and above that, with an abortion the goal of that procedure is to end the life of the child which is why we need clear legislative protection—a positive legal duty—in the law. Because the object of an abortion procedure is to end the life of a child, that is why we need a positive legal protection in the law, so we need an act of parliament that makes it clear that if a child survives a termination they are to be treated no differently to any other child born in Queensland.

South Australia and New South Wales are the two states that have introduced this legislative protection in the last couple of years—2019 in New South Wales and 2021 in South Australia—and what we see there, as Dr Melissa Lai said, is the development then of comprehensive guidelines that deal with the situation of a live birth following an abortion. It goes beyond saying that at the moment health practitioners are not complying with the law. There is just a complete lack of clarity in the law. Because this is an unusual, unintended situation, we do need Robbie Katter's bill, which is a very simple bill. All it does is introduce birth equality—the idea that any child born in Queensland is entitled to equal protection under the law. It is a very simple change but what it does do is create a positive legal duty that does not exist in Queensland at present. The guidelines are a policy framework that at this point are insufficient because they are discretionary rather than mandatory. A positive legal duty would rectify that.

The second argument that a couple of you have mentioned today—and I think it was good to ask some of the witnesses—is about RANZCOG's position. In its submission RANZCOG has said there are existing guidelines so we do not need this bill. They said it is unnecessary. If you look at the RANZCOG submission and check out the footnote, they actually refer to their own abortion care guidelines. RANZCOG has a practice guideline on abortion care. They argue that this bill is unnecessary because of their own guideline, but if you look at the abortion care guideline from RANZCOG there is no mention of a live birth following an abortion, so there is nothing in there about what should happen and what the practice guidelines are for that clinical scenario where there is a live birth following an abortion. For them to reference their own abortion care guideline that does not actually reference this at all and does not give any guidelines to midwives and nurses who are on the ground dealing with this situation to me felt quite disingenuous that that was their response.

The only other thing I could think of when they said that existing guidelines cover this is that perhaps they are referring to the Queensland termination-of-pregnancy guidelines but, as I mentioned in my first point, these are clearly insufficient because they only give a discretionary power to midwives that they may provide comfort. There is not a mandatory requirement to treat these babies as persons, which they are under Queensland law. Under the Public Health Act 2006, a baby born alive is defined as a baby whose heart has beaten after delivery of the baby is completed and 'delivery' is defined as the expulsion of the baby from the mother, so existing guidelines do not cover this situation.

The third point goes to your question, Chair, about whether these babies are counted as patients and how we deal with the staffing issues. Something that was very telling from the Australian College of Midwives submission is that they were very grateful that the Miles government has improved the midwife-to-patient ratios, but what the Australian College of Midwives note in their submission is that these babies who are born alive after an abortion are not counted as patients for the purposes of midwife-to-patient ratios, so they fall through the gaps. This means that, in a situation where there is a live birth following an abortion and midwives are caring for the mother and they are caring for other babies in the ward, these babies who are born alive after the abortion and who can survive for hours are not treated and counted as a patient, so what we are relying on is the goodwill of the midwife to hold that child, to wrap that child and to care for that child.

What Dr Melissa Lai said is that if a child is in distress then medication might be needed and the midwife would then have to get a script written from the doctor to get morphine for that child potentially. I am not a medical doctor and you may want to clarify with Dr Melissa Lai what sort of

medication would be needed in that situation, but that is my understanding. The issue here is that there is a clear gap in the legislation because these babies who are born alive after an abortion are not counted as patients and the midwives themselves are telling us in their submission that this causes them an enormous emotional toll and it causes distress.

I have personally interviewed midwives—and I will be sharing these on my YouTube channel—who have told me that when a baby is born alive after an abortion they have done what they can, but then the call bell will ring and they will have to just leave that baby and they feel extremely distressed about having to do that. Another midwife told me of a baby being left in the dirty pan room just because there was no-one to care for that baby because there was no positive legal obligation and this was not counted in the ratios. The reason I have flown from Adelaide to Queensland today is to appear before you to implore you that this bill is fundamentally important for birth equality in Queensland. It is a simple piece of legislation. It will not affect a woman's right or ability to get an abortion, but it will ensure no Queensland baby is left to die.

CHAIR: Thank you very much, Dr Howe. We appreciate it. I will go to questions from my left first and then—

Mr ANDREW: That explains everything to me.

Mr MOLHOEK: I am actually fine, Chair.

CHAIR: Okay. I just wanted to come back to that point where you said discretionary, not mandatory. This is actually pretty deeply personal when you have family members who have—and it is nothing to do with termination of pregnancy—passed a baby at 20 or 21 weeks. I think it is, from what I have observed, up to the clinician or up to the midwife at the time to provide that care and comfort to the distressed parents because the baby has been born unviable. It is a really emotional time for the parent. Do you think that for most nurses or midwives—the words you used were 'discretionary' and 'mandatory'—it is their ethical or moral obligation that they would do their very best to care for both the baby who is deceased—born not alive—and the parents? Is this more a moral or ethical obligation of the midwife or the nurse who is attending to provide care and support?

Dr Howe: I understand it is a really distressing situation and I appreciate the committee. I will say that I really appreciate you taking your time to look at this issue and to give it the time it deserves. I think the issue with this is: if we leave it up to the midwives, that is placing an unfair burden on the midwives. Midwives typically go into midwifery because they are in the business of birthing, not killing. They are there to birth babies. There are extremely distressing situations where babies will pass. There will be stillborn babies that midwives will have to deliver, but in this clinical scenario it is a situation where the mother has gone in to intentionally end the life of her child but the child has unexpectedly been born alive. For us to turn around as a community and say that it is up to the individual midwife to then go above and beyond her workload allocation, which does not include this baby as a patient, and to juggle everything she has on her plate—the other women she is caring for in the ward, the other babies and the administrative duties that she already has—and to then say, 'We're not going to address this situation through a positive legal duty,' is really leaving that midwife in the lurch.

I have heard from so many midwives that this is a very distressing situation for them to be in. It is over and above the stress and distress of a miscarriage, because a miscarriage under Queensland's clinical guidelines is before 20 weeks. We heard from Louise Adsett today that in her experience a baby was born alive and left to die after 21 weeks, so for a midwife to have to encounter that and then to take it upon herself to care for that baby—that is a wonderful thing, and I believe that most midwives do that. I have certainly heard of situations of midwives being told by their supervisor, 'We're too busy. You're just going to have to leave that baby. We're too busy.' What we need to do is fix this legislative gap, as has been done in New South Wales and South Australia, so that midwives are not the ones defending the need to cuddle and hold that baby and provide medication if that child is in distress.

I would like to bring to the attention of the committee a study from the *Journal of Obstetrics and Gynaecology* which studied 241 late-term abortions between 20 weeks and 24 weeks. Over 50 per cent of those children were born alive and the average survival time was 32 minutes. One child in that study survived for 267 minutes, so that is over four hours, so we do know that babies can survive quite some time. Saying that it is the responsibility of the midwife, without a positive legal duty protecting her, is quite difficult, I think.

CHAIR: Thank you, Dr Howe. I have just pulled up the QNMU submission and I will see if I can get a response from you. They say—

> We consider the medical rationale behind the Bill to be compromised by citing a study that selected only neonates already deemed to have a chance of survival and failed to disclose the number of neonates that were excluded from the study (which would provide a clearer picture of actual survivability at birth).

I think that is what—

Dr Howe: Yes, I saw that in their submission; I am glad you brought that up. In any study there are going to be caveats around the sample size, the selection bias and the way it was conducted, but in that particular 2018 peer reviewed study—so it did get through the peer review process; it was not written from a pro-life perspective at all—it just clinically showed the fact that, with 241 late-term abortions, if feticide is not given—and let us remember that in Queensland feticide is not mandatory before 22 weeks—the chance of live birth, as that study proves, is significant. It is one in two and it is not a matter of seconds and it is not pulsation; it is gasping for air for 32 minutes on average but up to four hours in that study. I recognise that we are not talking about a lot of babies here but we are talking about some, and what we are asking is for the Queensland parliament to approach this issue without the politics of abortion but just to recognise these are newborn babies, the abortion did not work, they have human rights and they should at least receive palliative care or life-saving treatment, whatever is appropriate.

CHAIR: Thank you very much. We have one minute left, so are there any quick questions for Dr Howe?

Mr MOLHOEK: Just to say thank you, Joanna. It is a very succinct and clear proposition you put. Thank you.

Dr Howe: Thank you, and I would like to thank the committee. I know that I can be publicly critical of different politicians on Instagram et cetera, but my view is that you are doing a very difficult job here today. That is what you were called to be in parliament to do—to represent all Queenslanders. Because these babies have been born alive under the Public Health Act, they are alive and they are Queenslanders. I thank you so much for your time today. I know it is a very difficult issue and you have different constituencies, but I hope that we can get unanimous support for this bill.

Mr ANDREW: I would like to say thank you, too, for being the voice for all of the ones who cannot talk.

Dr Howe: Thank you.

CHAIR: Thanks, member for Mirani. Thank you very much, Dr Howe. We appreciate it.

Dr Howe: Thanks, Chair.

BROOM, Dr Elisha, Councillor and Queensland State Committee Member, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

CHAIR: I now welcome Dr Elisha Broom.

Dr Broom: Thank you for this opportunity, Mr Chair and members of the committee. My name is Dr Elisha Broom. I am a fellow of RANZCOG, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and a RANZCOG councillor. I am a practising obstetrician and maternal fetal medicine subspecialist based at Logan Hospital.

RANZCOG's position on this bill is that it is wholly unnecessary in addressing a problem that is not relevant in the Queensland context with current practice. Reference to a lack of clarity is quite misleading. It runs the risk of eroding access to abortion care by vulnerable populations. We as a college urge the committee in the strongest possible terms to not recommend the bill for passage. I will explain why.

All Australians, as we know, have a right to access the full range of sexual and reproductive healthcare services, including safe and affordable abortion. This right is recognised in international law. Anytime the legal regulation of abortion is proposed, a chilling effect occurs. Whether that is the intent of the regulation or not, it does further limit access. All healthcare professionals owe a duty of care to their patients and this includes babies born alive. Comfort care—not resuscitation—is the standard of care for babies born under 22 weeks. We have called this the gestation of viability, as we have heard in the hearing today. This is regardless of the circumstances of their birth. The care for patients by healthcare professionals is governed by both professional and regulatory standards. That is whether they are 21 weeks old or 21 years old.

You have heard from the previous legal representation that once a baby is born alive they are covered by the Public Health Act. This bill would not change current practice or legislative protections for these babies. Despite evidence given, there is no confusion around what is a live birth. When a baby is born alive, it is a person in Queensland and it has legislative protections. What is really important is that under 22+1 weeks these babies are not viable and we cannot offer life-saving care, regardless of the circumstances of their birth.

When planned abortions at gestations of above 22 weeks occur in Queensland, feticide is routinely offered that ensures no baby above this gestation is born alive, unless they did not have the feticide as intended by the parents. There are rare scenarios. They are cases where birthing parents—for example, those whose baby has a non-survivable diagnosis with a palliative care intention—will choose to meet their baby alive and not have a feticide. Those babies are offered palliative care.

Scenarios envisioned by this bill are very emotive but they are not based on Queensland experience and they are not feasible with current practice. Any legal regulation that risks limiting access to abortion services in any way, as this bill unfortunately does, disproportionately affects disadvantaged women. Large metropolitan hospitals are familiar with a comfort-care approach for babies born under 22 weeks, but this is not the case so much in rural and regional areas. Amendments such as this have a very real risk of limiting access to abortion care at later gestations for women in rural and regional areas, particularly First Nations women.

Abortion care was enshrined in law by this parliament. This parliament should also see this amendment for what it is: it is a solution in search of a problem which does not exist in Queensland because of current clinical practice. There is a big difference between resourcing issues and what needs to be passed in legislation. This bill is a risk to equitable and safe abortion care should it be passed. Whilst you have heard some emotive and highly inflammable arguments in favour of the bill already today, we ask that you see through these to the reality of the care that is actually provided as it is described by those who actually care for these patients.

CHAIR: Thank you very much, Dr Broom. Your submission contains five main lines of argument. I want you to expand on your point around regulation. Your submission states—

> Any legal regulation that risks limiting access to abortion (as this Bill does) disproportionately affects disadvantaged women and those from rural and remote areas, especially First Nations women.

As I come from regional Queensland, I would like you to expand on that point.

Dr Broom: The reason behind that premise is that if we try and further enshrine in legislation the need for babies not to be born alive at these later gestations, what will happen is that the smaller units that are under already existing huge pressure will start to decline to provide abortion care to women at those gestations, where we know babies can be born alive. We should be clear that babies born alive at these gestations—say, 16 to 22 weeks—resulting from an abortion are not a failed

abortion. It is not an unintended, unexpected consequence. We know that these babies will be born alive but they are previable. This is an existing practice. This is what happens with the current legislation. It is not a failed consequence. In rural and regional areas, where medical practitioners are less comfortable with that circumstance and with not providing resuscitation—they provide comfort care, absolutely, but not resuscitation—you will find that there will be a limitation to access at those later gestations, and that disproportionately affects those women.

CHAIR: For members of the gallery, we have had a very good start in terms of commentary from the gallery. Please respect that everyone has different views.

Mr MOLHOEK: Laying aside the political and moral reflections on this issue, there is one thing that is troubling me. What I am hearing is that the law already protects the rights of a child born in the event of a failed abortion, or whatever you call it. Are the guidelines that we are providing to our medical practitioners in conflict with the law? Is asking midwives and doctors to withdraw or not provide life-saving medical support in conflict with their legal obligations under current law?

Dr Broom: There are two answers to that. One, categorically not. As the neonatologist who has already provided evidence to you would agree, under 22 weeks we cannot provide life-sustaining, life-saving care, regardless of the circumstances of a birth. Under 22 weeks, the care that is provided to these babies is comfort care, invariably called 'palliative care'. There is no circumstance in which a clinician needs to make a decision at 21 weeks about whether or not to offer resuscitative measures, because it is futile, unfortunately. We offer comfort care. There is no discord between current guidelines and current legislative protections.

Mr MOLHOEK: Beyond 22 weeks, though, what is the situation?

Dr Broom: Beyond 22 weeks in Queensland, the situation is that these mothers would have to have undergone a feticide procedure, except in circumstances where they choose not to. That is the small circumstance I mentioned where parents have a baby with lethal fetal anomalies whom they want to meet and there is a palliative care intention. Above 22 weeks, as a result of maternal psychosocial indications—a request for termination of an unwanted pregnancy in Queensland—these babies have a feticide. They are not born alive. That situation does not exist in Queensland.

Mr ANDREW: As reported in the *Courier-Mail*, in 2020 Zanthe was born alive in a Queensland hospital. Not once have any of the witnesses attacked the abortion laws—I have not seen that. What I have seen is people standing up for the rights of living souls who were the result of failed abortions.

Dr Broom: As am I. I would remind the member of parliament that I also stand up for the rights of living souls, and that is what I do in my daily practice.

Mr ANDREW: You said in your opening statement that it will erode those laws. Have you had anything to do with dealing with these things personally?

Dr Broom: Yes, I have.

Mr ANDREW: We have had midwives in here speaking about—

Dr Broom: I'm sorry: can you clarify your question?

CHAIR: Member for Mirani, let's not argue with the witness.

Mr ANDREW: I am trying to understand. No-one has attacked the abortion laws. Why would we not consider strengthening a mandate to look after a living soul after it has been born damaged and give it that little bit time and love—

CHAIR: Let's go to the question.

Mr ANDREW:—as we do as humans, like even animals do for their newborns.

Dr Broom: These babies are human; they are not animals.

Mr ANDREW: I know that. That is what I am—

Dr Broom: As I have already mentioned, there are existing regulation and legislative protections for babies born alive.

Mr ANDREW: If it was not happening we would not be sitting here. I cannot understand how we can say that this is not happening.

Dr Broom: I am not saying it is not happening. I fail to see your question, member, I am sorry.

Mr ANDREW: The point is: do you believe we should strengthen laws to look after living souls after they have been born after they have been aborted?

Dr Broom: No. I will again explain why. As I have already explained, they are already covered under existing legislation. This legislation will not strengthen the rights of the child; it will erode access, particularly for the most vulnerable women in our state, to abortion care. It will not add in any way, shape or form to the care of children.

Mr MOLHOEK: The ACL submission said that there were about 30 live births per year. How is it possible to have 30 live births a year post 22 weeks if feticide is a common practice?

Dr Broom: In respect of the numbers you are reporting, there are numbers in previous submissions where they break down the gestation of birth between 20 and 28 weeks. The difficulty there is that the live births you are reporting are probably the 20- to 22-weekers who do not have a feticide and who are not viable at the time of their birth. There will be some babies born in Queensland as a result of a termination of pregnancy at later gestation. They are very few and they are the ones that I specifically mentioned. They are babies with lethal fetal anomalies whose parents have chosen to end the pregnancy but who want to meet their baby alive and have their baby die in their arms.

Mr MOLHOEK: So those numbers would be included, presumably, in that 30?

Dr Broom: Presumably those babies will be the 20- to 22-weekers.

CHAIR: Can you expand on the type of fetal abnormalities?

Dr Broom: Most babies who we know will pass after birth have significant lethal cardiac abnormities or neurological abnormalities—for example, babies born with anencephaly, babies who do not have a skull. We know that they will pass after birth and their parents might choose to meet them alive and hold them as they pass rather than have a feticide.

CHAIR: Thank you for your clarification.

Mr O'CONNOR: A previous presenter mentioned your submission's reference to the guidelines. Is it the RANZCOG guidelines or the Queensland Health guidelines that your submission was referencing?

Dr Broom: It was referencing the RANZCOG abortion guidelines, because our position is that those abortion guidelines deal with the practice of abortion. They do not deal with the care of the baby after it is born alive because that is currently covered in legislation.

Mr O'CONNOR: Are you aware of any other circumstance that requires the legislation of clinical guidelines?

Dr Broom: Not that is necessary, no.

CHAIR: Can you give us an idea of how many births there are a year in Queensland? You can take that question on notice if you need to.

Dr Broom: I will take it on notice. I will very quickly get you an answer.

CHAIR: I am trying to gain an understanding of the numbers and the number of babies born premature as well.

Dr Broom: I very happy to provide those statistics, yes.

CHAIR: Thank you.

Mr ANDREW: Have you superimposed the upgraded guidelines of New South Wales and South Australia on your guidelines, and are there any shortcomings?

Dr Broom: There are no shortcomings in the guidelines or the legislation. There are shortcomings in resources for maternity units in Queensland—absolutely—and everyone here today would agree with that.

Mr MARTIN: We heard from previous submitters that there is a gap in the legislation when it comes to the duty of care in that there is no positive obligation. Could you respond to that? What is the duty of care or obligation of a doctor or nurse in that situation?

Dr Broom: In terms of our duty of care for anyone born alive or anyone alive, it does not matter how old they are; we have a duty of care to provide care to that patient. The difficulties that you heard in some of the earlier emotive statements are around poor resourcing, not around a lack of a duty of care.

CHAIR: Can I get on the record your qualifications?

Dr Broom: I am an obstetrician—so I am a FRANZCOG—and I am a maternal fetal medicine subspecialist.

CHAIR: Thank you very much for your contribution. We appreciate it.

WARRINER, Ms Michelle, Queensland Branch Chair, Australian College of Midwives Queensland Branch (via videoconference)

WEATHERSTONE, Ms Alison, Chief Midwife, Australian College of Midwives Queensland Branch (via teleconference)

CHAIR: Welcome. Would you like to start with an opening statement?

Ms Warriner: I am waiting for one of our other members. Is it okay if we wait one more moment so she can log on as well? Will time permit?

CHAIR: Sure. Whilst we wait, whereabouts are you at the moment?

Ms Warriner: I was going to join you face to face, but I apologise: we had two births overnight, so I am out at the Strathpine clinic. I am a clinical manager for the Birthing on Country midwifery service. I am actually out in our Strathpine clinic now.

CHAIR: We will give her a moment. I am just trying to keep to time. I understand if you have been busy overnight.

Ms Warriner: I am just texting her now. As Alison is connecting, I am really happy to start our opening statement. I would like to introduce myself. My name is Michelle Warriner and I am the chair for the Australian College of Midwives committee in Queensland. Thank you for having us here today. Thank you for the opportunity to appear at this hearing today. ACM acknowledges the lived experiences of women, families, midwives and healthcare workers and encourages anyone impacted by today's inquiry to seek additional support if required. The Australian College of Midwives is the peak professional organisation for midwives in Australia and supports the rights of all women to reproductive health care including the choice to terminate a pregnancy. Universal access to termination-of-pregnancy services is a human right. All healthcare practitioners including midwives are bound by a duty of care to all human beings in their care, including babies born alive after termination.

Intervention provided for a baby born alive after a termination should be decided by clinical practice and what is appropriate based on the clinical circumstances as each situation is individual. Multiple clinical guidelines already exist to provide safe frameworks and guide clinical care in these rare circumstances, for example, termination-of-pregnancy care Queensland clinical guidelines.

The Australian College of Midwives supports the proposed change ensuring that comfort measures are provided for babies born alive if parents are unable to or do not with wish to provide this care. It is very important to determine and plan an appropriate workforce to facilitate this care. Workforce shortages are evident across all disciplines and in all areas of health care in Queensland. The midwifery workforce is currently under immense pressure in Queensland and, indeed, across Australia, and this pressure increases as geographical remoteness increases. Queensland midwives are reporting levels of trauma, with some considering leaving the profession due to this pressure. Midwives are required to support babies at the end of life whilst also providing care to other families.

An appropriate workforce to provide termination-of-pregnancy care is imperative to protect the current workforce, ensuring adequate support for women and families. Families requiring care for termination, especially late termination, should be cared for in a one-to-one continuity-of-care relationship with a known midwife. Midwifery continuity of care reduces the need to repeat painful and distressing information to multiple care providers and is an emotionally supportive model of care during traumatic experiences. In addition, counselling should be offered both for midwives and for women and families. Midwives should receive specific training in bereavement counselling in undergraduate degrees and as continued professional development opportunities.

Feticide is part of the standard care of terminations after 22 weeks and one day and is stipulated in the Queensland clinical guidelines on termination of pregnancy. Effective use of feticide accompanied by appropriate (audio missing) of the success of this procedure makes the incident of live birth following a late termination extremely unlikely. It is evident in Queensland that access to maternal fetal medicine services that provide feticide intervention is under-resourced and understaffed across the state. Increasing these services is imperative to provide safe termination-of-pregnancy services in Queensland.

Finally, any changes to the current legislation need to be carefully thought through. It is imperative that restrictive and/or legislative barriers to termination-of-pregnancy care do not result in barriers or reduced access to termination-of-pregnancy services for women in Queensland. It is important that any changes do not result in a reduction in termination-of-pregnancy services, particularly for women in rural and remote areas of Queensland or for First Nations women and families, where disparity already exists and barriers to universal access are evident.

CHAIR: Thank you very much. You have just reminded me how difficult it is for people to access those services. We had a Marie Stopes clinic in Townsville close down. What does that do to the public system?

Ms Warriner: We have found clinically that the reduction of Marie Stopes options of care or maternal fetal medicine delays the option of services such as feticide and that obviously increases the gestation in these pregnancies.

CHAIR: I will move to questions to my left first.

Mr MOLHOEK: I will ask the same question I have been asking. Perhaps it is a bit subjective. Is there a conflict between the guidelines and the laws in terms of the provision of care? Are we putting medical practitioners in a compromising position because either the law is not clear or the guidelines are in conflict with the law?

Ms Warriner: I think that is a really great question. From the Australian College of Midwives perspective, that is a question we can take on notice.

Mr MOLHOEK: I am hoping to put that question to the technical scrutiny people as well. It would be interesting.

CHAIR: You are doing all the heavy lifting now because Alison has not been able to join us.

Ms Warriner: She has joined me on the phone from my end, so she is here.

Mr MOLHOEK: She is providing moral support.

CHAIR: Obviously the point you raise is resourcing. That is across just about every sector, but health is certainly feeling it in a forever growing and ageing population. Thank you very much for your contribution. We have heard you. If we could make more midwives appear, we would. Thank you very much. I have no further questions. You do have a question on notice. Could we have a response by Monday, 26 August?

Ms Warriner: Yes, absolutely.

CHAIR: You have got us back on time so thank you very much. We appreciate it.

Ms Warriner: Thank you for your time today. It was lovely to see you again.

CHAIR: Thank you. You, too.

BEAMAN, Ms Sarah, Secretary, Queensland Nurses and Midwives' Union

KING, Mrs Fridae, Organiser, Queensland Nurses and Midwives' Union

LEE, Ms Julie, Research and Policy Officer, Queensland Nurses and Midwives' Union

CHAIR: I now welcome QNMU, regular contributors to the committee. Who would like to start with an opening statement before we go to questions?

Ms Beaman: Good morning and thank you for the opportunity to appear at this public hearing today. I would like to acknowledge the traditional owners of the lands on which we meet, the Yagara and the Turrbal people, and pay my respects to their elders past and present. I also pay my respects to First Nations people present today.

The vast majority of QNMU members and in the nursing and midwifery profession are female. The topic of termination of pregnancy has a disproportionate impact on the professional, social and personal lives of our members and of the nursing and midwifery workforce. It is predominantly midwives and nurses who are by the side of women and pregnant people who choose to undergo a termination of pregnancy before their care, during their care and after their care. The involvement of nurses and midwives cannot be underestimated.

We wholeheartedly welcome the legislative reform which enables authorised midwives and nurse practitioners to register as MS-2 Step providers. This is a huge step forward in supporting equitable access for women and pregnant people all across Queensland by recognising the challenges that women face in accessing safe abortion in a timely and affordable manner. We also welcome the legal recognition of the clinical and professional skills, knowledge and experience of midwives and nurses in providing termination services. As outlined in our submission, midwives and nurses practise under extremely robust ethical frameworks and professional codes of conduct. The Nursing and Midwifery Board of Australia is clear that midwifery and nursing practice is steeped in woman centred and person centred practice which respects people's ownership of their health information, their rights and preferences while protecting their dignity and empowering choice. We take this duty to uphold a women's reproductive autonomy and choices about her body seriously, so when a pregnant person has made the complex and often mentally, physically and emotionally challenging decision to have a termination, that decision must be respected whether or not we agree with it.

The difficulties of accessing early termination services and the closing of private termination-of-pregnancy providers has played a role in the increase in the number of late terminations taking place. If women had safe, timely and affordable access to termination services in their communities they would not need to have late abortion, which carries the risk of babies being born with signs of life. We should also be cautious about the terms 'live birth' and 'born alive', which are suggestive of assumed viability. Babies around the 22-week gestation mark are generally on the cusp of viability, but this is not guaranteed. This means that while a baby may be birthed with a heartbeat it is unlikely to show signs of life such as movement, breathing or making sounds. Regardless of whether the baby shows physical movement, it is not generally viable. We, therefore, prefer to use the term 'sign of life', which is more reflective of the clinical presentation without making assumptions regarding viability.

Ultimately, we consider that determining viability should be left to the clinical and professional judgement of the registered health practitioner involved in each specific case as the people who are authorised, competent and educated to do so. We are, therefore, opposed to the state compelling health practitioners and health professionals to act in a way that may be at odds with a pregnant person's decision to terminate. This bill unnecessarily imposes legislative pressure on health practitioners which risks creating confusion and contradictory requirements and fails to recognise the clinical judgement of health practitioners to make informed decisions and provide evidence-based and compassionate care.

This bill projects a misinformed narrative onto termination of pregnancy that is steeped in outdated moral judgement and emotional manipulation by exploiting what is an extremely rare scenario. This bill presents a misleading understanding of abortion care in actual practice by the actual practitioners who are working alongside women and pregnant people. This bill disregards the scientific and clinical realities of fetal viability and disparages the accumulative years of training, experience and knowledge of abortion providers. We see this bill as creating yet another barrier to women accessing abortion. At a time when Queensland is making such positive strides towards reproductive rights by supporting women's access to early abortion, it is unfortunate that this bill seeks to impose unnecessary conditions on late abortions.

CHAIR: Thank you. Before I go to questions, I will take you to your submission. It states—

> We consider the medical rationale behind the Bill to be compromised by citing a study that selected only neonates already deemed to have a chance of survival and failed to disclose the number of neonates that were excluded from the study (which would provide a clearer picture of actual survivability at birth). The Bill's reliance on inaccurate statistics and a flawed understanding of foetal viability creates unnecessary anxiety for women and pregnant people facing difficult decisions.

Can you expand on that particular statement?

Ms Lee: We have taken a look at the study that was cited in the bill. While not saying that the study itself is flawed, I am saying that the use of that study in supporting this bill is flawed because the study itself looks at neonates that have already been selected by the health professionals as deemed to be viable, whereas this bill is not necessarily only selecting children that are viable. This bill also encompasses those that are not viable. Therefore, we feel that the information gleaned from this research does not directly translate to support this bill.

CHAIR: So you are talking about fetal abnormalities and those are not counted within that?

Ms Lee: That is my understanding of the study. I was not involved in the study; however, the study does make clear that neonates that were deemed to not have a chance at surviving have already been excluded from the study.

CHAIR: Thank you for that clarification.

Mr ANDREW: Ms Beaman, you stated that moral judgement is outdated. Is there an expiry date on moral judgement?

Ms Beaman: I think my words were that some of this is based on outdated moral judgement, not that moral judgement is outdated. In the time where women are able to make decisions about their health and make informed decisions in line with support from their medical practitioners and health professionals, I think imposing the moral judgement of society where women are able to make that informed choice is the space we need to be looking at.

Mr ANDREW: This is directly aimed at the child itself. No-one is having a go at that side of it. We are actually looking to preserve or basically give comfort to a fetus that has been aborted and still alive. That is the moral case I have.

Ms Beaman: I understand the point you are coming from and I understand this topic is very topical and also highly sensitive, so I am going to be incredibly sensitive in my response. This comes back down to the terms 'live birth' versus 'showing signs of life'. Yes, a baby born at 22 weeks may show signs of life, but that does not determine that they are actually viable. I am not saying that appropriate comfort of the family and the bub during the time between being potentially born with signs of life and passing does not need to be provided. That is not the topic of discussion today.

Mr MOLHOEK: Ms Beaman, do you consider that there may be potential conflict between the legislative requirements to preserve life and the guidelines that we are asking our health professionals to operate under?

Ms Beaman: I know that that is the narrative being put forward. I do know also that nurses, midwives and health practitioners practise under very robust frameworks. There are a lot of professional standards to which they need to adhere including legislative standards. With something as important as this, I think anytime we are having a conversation like this the idea of reviewing the current practices and the current requirements in and around it to ensure the safe provision of care, whilst also allowing nurses and midwives to practise safely within their roles, is important.

Mr MOLHOEK: We heard earlier from some of the other presenters that there are some healthcare professionals, particularly midwives and nurses, who are found in circumstances where they are having to deal with issues that are challenging and that results in PTSD. Have you had many reports of that from your members, or are you concerned about that as an issue in terms of where the current guidelines sit?

Ms Beaman: That is a great question, and I will pass to Fridae in just a moment. More broadly, I do hear distressing stories from members around termination of pregnancy, around babies being born with signs of life following termination of pregnancy. What I think is also worth looking at from a jurisdictional point of view is that a number of jurisdictions undertake a feticide prior to termination, ensuring the baby is not born with signs of life. For a lived midwife experience, I will pass to Fridae.

Mrs King: Before I proceed, I would like to acknowledge the panel and express my concern that this discussion, which deeply impacts women, is happening with limited representation of women on the panel. The experiences and perspectives of women are essential when we are discussing issues related to their health care and autonomy. While I greatly respect the expertise and

commitment of everyone here, I believe ensuring women's voices are heard in these conversations is crucial for making fully informed decisions that truly reflect the needs and rights of those most affected. As a midwife, I am here to advocate for those women and to bring their perspectives into this room, but it is also important to recognise that true representation matters, especially in discussions of this magnitude. I appreciate that these issues touch on deeply held beliefs and can be incredibly emotive for many people, and I want to acknowledge that up-front because it is important to approach this discussion with respect and clarity. I fully respect that this is a deeply ethical and moral issue for many, and I believe it is essential to approach this with sensitivity and care, but it is important to ground our conversation in the medical facts and the realities that women and midwives face when seeking health care.

While reflective movements in a fetus may evoke strong emotional responses, they do not change the medical reality that at this stage the fetus is not viable outside the womb. These signs of life are not indicators of potential survival and they should not be conflated with the ability to live independently. When we talk about fetuses showing signs of life during a medication abortion, it is crucial to understand what it actually means in a medical context. Signs such as brief movements or reflexes are not indicators of viability, and at the stage these procedures are performed the fetus is not capable of surviving outside the womb. These movements are physiological responses, not evidence of potential survival.

One of the biggest challenges we face, particularly in rural and remote areas, is severe lack of resources. This often leads to significant delays in women accessing these critical services, and such delays can force women into later term procedures like we have heard from other speakers as well. In Gladstone, in regional Central Queensland, which is where I am from, as a midwife I can tell you that there are many stories of midwives and women up there. We have many women who come in at eight weeks pregnant who do not wish to continue with the pregnancy due to their life circumstances or their own reproductive choices. Due to the barriers in accessing the care, because the early pregnancy clinic only runs one day a week and there is limited access to GPs in the community because of reduced bulk-billing doctors, there could be a three- or four-week wait for someone to get in to see a GP. By the time they come around to the Early Pregnancy Assessment Service clinic to meet with the obstetrician to discuss the pregnancy, they are now 10 or 12 weeks. From there, they meet with them and get an ultrasound or some blood forms, which then takes another two to three weeks. By the time they actually get given a script for the medication or get to make a decision about the pregnancy, they are 17 weeks. That is the reality of what is happening in regional and remote areas. We also had the Marie Stopes centre in Rockhampton close. I highlight the immense pressure on services up there.

Ms Beaman: To further address your question specifically, absolutely it is traumatic for the staff. I think there is a level of trauma, too, for the families involved. What we are saying is that this has a level of avoidance and, whilst it is a highly sensitive topic and there are always going to be situations which fall out of the normalcy of a certain process or time frame, highlighting the incredibly rare occurrence and making that the norm, I think we need to show a level of care with that. I am absolutely fully acknowledging that there is a level of distress that comes with providing these sorts of services, and we also encourage our members to seek that support, but we also support them in being able to step back from that space.

Mr MOLHOEK: Thank you so much for that response. It was not quite what I was asking, but it is incredible—your service and the circumstances that you and your colleagues work under. You have both touched on the issue of lack of service or access to services. There has been a lot of public discourse about maternal services across Queensland generally, particularly in rural and remote parts of the state. Have you canvassed these issues with the minister and have you had any positive response about what government is planning to do to address the lack of services?

Ms Beaman: We have had a lot of conversations around ensuring that women's and girls' health is a priority for the government. The support of women and children to be able to access services regardless of where they live in Queensland needs to be a priority—we know that. It does not matter where you get sick or where you need to attend care; it needs to occur. My understanding is that the government is working on expanding those services. This does take time. I think there are also a number of reasons particular services are no longer running. I saw the list in the paper on Saturday, as did everyone else. A lot of those services have been shut for many years—and they have been shut for many years through successive governments—and there are a number of reasons they are shut. What I do know about the more recent services is that a lot of work has been done to ensure they are running properly.

With regard to services, we do have a workforce—nurses and midwives—that is more than authorised, competent and educated to be able to provide a number of services within this space. What we have is a public narrative that diminishes the work and the scope of the work they can provide. I find that incredibly sad. I think this is a time when we should be working together to ensure service is provided. This is not a medical-versus-nurse or obstetrician-versus-midwife conversation. There is enough there for all of us. There is a service that needs to be provided and I think there is space for all of that.

To your question specifically, the conversations I have had with Minister Fentiman have provided positive response. I think you have seen that in action with the recruitment that is being undertaken and the reopening of the services in Weipa. Rome was not built in a day, but there is positive work happening in that space, and our members have lobbied incredibly hard for these improvements.

CHAIR: Well said, Ms Beaman. The deputy chair knows that this committee started a primary care report in 2020. Just to take a snapshot of Far North Queensland—the member for Barron River represents that area—there were 97 GP vacancies. That was four years ago. It is telling across the entire state that it is really hard to access health care. Your point is taken. We just need to keep on keeping on.

Ms Beaman: It is not a Hunger Games about who gets what funding to advance what; this really has to come back to service provision to the community, specifically women and children.

Mr MOLHOEK: In response to that, Chair, we have had repeated reports from the Queensland Audit Office about labour force shortages and lack of planning.

CHAIR: It is right across every sector, Deputy Chair.

Ms Beaman: And further exacerbated by COVID. We have known since 2014 that there was going to be a workforce shortage. This is not just a Queensland issue; this is a worldwide issue. There was a lot of work that needed to be put into that space and it is a long time coming.

Mr CRAWFORD: Before I ask a question, I have a statement. Mrs King, your observation of this committee being six male members of parliament is a very valid one—

CHAIR: We started with two females.

Mr CRAWFORD:—and one that is not lost on me. Thank you for that. On page 3 of your submission, you make quite a strong statement. You say—

> The Bill presents a dangerous precedent by introducing unnecessary regulations based on emotional arguments and misinformation.

There has been a bit of commentary before about studies and those sorts of things, but can you unpack the 'emotional arguments' point of that and why this presents a dangerous precedent?

Ms Beaman: Termination of pregnancy at 22 weeks is a rare occurrence. What we are doing is using that rare occurrence to inform the public debate about what is quite a common procedure for women. The concept of the 22-weeker, the concept of the terminology of 'born alive'—these are the emotive narratives that need to be unpacked further and need to have a degree of caution used around them. This topic is too important and too sensitive to not listen fully or have full access to the studies and the intent of the studies that are being used. Does that answer your question?

Mr CRAWFORD: I think so.

Mr ANDREW: There are up to 30 live births a year, so it is probably not a rare occurrence in that respect. Does the QNMU believe that this bill would improve care and comfort outcomes for children born alive from abortions?

Ms Beaman: I am glad you shifted that terminology. It needs to be born with signs of life. There is an assumption there is viability when born at 22 weeks. That is an underpinning point of difference in the conversation we are having. All people, regardless of whether they are born with signs of life, whether they are ending their life or whether they are receiving care, need to be shown appropriate dignity and care within that space. That is absolutely not in question.

CHAIR: Thank you all for your contribution today.

McKAY, Ms Jill, Chief Executive Officer, Children by Choice

CHAIR: I will hand over to you for an opening statement. Then we can move to questions.

Ms McKay: Thank you for the opportunity to appear today. We are an organisation that has been advocating for reproductive rights and providing support to women and pregnant people in Queensland for over 50 years. I am not a medical professional. Before I begin I want to acknowledge something that Fridae alluded to. It is not lost on me or any of the women in Queensland that I am here presenting on a bill which deeply affects the health care of women in this state and I am doing so in front of a committee comprised of six men. I respect that each of you has been duly elected. I respect that deeply and I trust that you are here to represent the very best interests of your Queensland electorates; however, I must reflect on the irony of this situation. It is a reminder of the importance of including women's voices in discussions and decisions about our own health care.

I am before you today to strongly oppose the Termination of Pregnancy (Live Births) Amendment Bill 2024. In our view, this bill is unnecessary, is potentially harmful and risks undermining the hard-won gains in reproductive health access Queensland that have been achieved since the passing of the Termination of Pregnancy Act in 2018. Let me be clear: the current legislation already provides comprehensive guidelines for healthcare professionals to manage terminations of pregnancy. The act carefully balances the rights of the pregnant person and the professional obligations of healthcare providers, ensuring decisions are based on medical evidence, best practice and the specific circumstances of each case.

The proposed amendment, however, introduces an unnecessary layer of complexity to access health care. An amendment would be stigmatising to those who seek and provide abortions. It implies a need for legislative intervention in what should remain a medical decision guided by the expertise and judgement of qualified healthcare professionals. As has been asserted today through the Australian College of Midwives, RANZCOG and QNMU, instead of introducing restrictive and stigmatising legislation our focus should be on providing support, training and resources to our healthcare workforce and meeting their needs. At Children by Choice we are committed to ensuring healthcare professionals receive value clarification training and the support they need to provide compassionate and timely care. This commitment is reflected in the community wraparound supports that Queensland Health is funding, which include training for these frontline health professionals.

Recommending the passing of this amendment would miss the mark on the real issue at hand: Queenslanders seeking abortion care need to be met with compassion, not barriers that will further delay or complicate their access to services. Our healthcare professionals should be empowered with the resources and training they need to provide the highest standard of care, not burdened with legislation that undermines their ability to make informed, evidence-based decisions. Queensland's current legislation represents a considered, balanced approach to a deeply complex issue. It respects the autonomy of the pregnant person and it adequately addresses the process for the fetus while ensuring healthcare professionals can provide the best possible care based on individual circumstances.

The reason that people seek abortion and termination-of-pregnancy care may not, and should not, be simplified to a social reason. It minimises the experience of thousands of women. At least one in four people will experience a pregnancy and seek abortion. It is an ordinary part of health care. There is no evidence to suggest that additional legislation is needed to manage the rare cases that come up. What we do need is to provide adequate support to our midwives and nurses in birthing suites so they are able to provide comfort care as needed. Leave our health professionals to do their jobs well.

In closing, I urge you to reject the Termination of Pregnancy (Live Births) Amendment Bill. Let us trust our healthcare professionals to continue doing their jobs with the care and expertise they have always demonstrated. Let's resource them well. Let's show them care and compassion for the work they do. Let's protect the reproductive rights of all Queenslanders and let's leave the current legislation as it stands. Our focus should be on supporting our workforce and ensuring that every person who seeks care in Queensland receives compassionate and supportive care.

CHAIR: Well said, Jill. Thank you very much.

Mr ANDREW: I am going to do a poll in my electorate to see how this sits because that takes the male side of my area out of it. That gives everyone an informed choice to move forward. You say it is not rare. If you put it in terms of planes, if you lose 30 out of the thousands of flights we have every year then you would have to reconsider flying.

Ms McKay: There is nothing Children by Choice is describing that talks around comfort care or fetal care. What we are saying is that we do not believe this needs to be placed in an amended piece of legislation. We need to make sure that our workforce is supported, that they are trained and that if someone is called away to an emergency in a birth suite they are supported. If someone does need to access a medical abortion, regardless of where they live in Queensland they should be able to access quality termination-of-pregnancy care.

Mr ANDREW: I am onboard. Can you explain where the bill affects the health outcomes of women?

Ms McKay: The conversations I have heard here today from other witnesses have been around an alarmist kind of space and that people seeking an abortion have no feelings or consideration or emotion in that space, and that really is between five weeks and 22 weeks. There are barriers to people accessing abortion around Queensland, as you heard from the QNMU, Sarah Beaman and Fridae, who have spoken specifically around delays to accessing health care. When you start putting an emphasis on how someone will feel through the termination process, that is a very complicated space for a person. If a woman makes the decision to end a pregnancy at eight weeks, it is a very challenging personal space to carry that fetus for such an extended period of time. To make a statement or suggest that at that point there is not a level of care for that pregnant person or that woman, when in actual fact what we would want to see is destigmatisation and a quality of compassionate care for the person going through the treatment—not a space where midwives or our health professionals are hearing things such as, 'I wasn't here as a midwife to end babies' lives', that is about how we train, how we support and how we connect to our workplace, and that is part of our submission,.

Mr ANDREW: That is 100 per cent. All I am looking at is the human rights of the child that is born. That is all I want to know.

CHAIR: We will take that as a comment.

Mr ANDREW: What do you think about that? What are your thoughts about that? You have come here as a witness telling me about the human rights of the child. Do you think they should be preserved and they should be enshrined in this legislation so they are looked after during these times?

Ms McKay: I feel like I have answered that. I think the existing Termination of Pregnancy Act handles and speaks to that well. Children by Choice's perspective, backed up by the QNMU and RANZCOG, is that it belongs with healthcare professionals to move that through. There is no need to alter the current legislation. We need to support our Queensland Health colleagues if we need to improve our clinical guidelines. Most importantly, we need to improve the experiences or the support we provide to nurses and midwives, people in birthing suites, our doctors. There are only 10 MFM specialists in Queensland for the whole state. That indicates a level of significant under-resourcing in this area. It is not the bill that needs to change; it is the resourcing and support for this sector.

Mr MOLHOEK: I do not know a lot about Children by Choice. I have a question about your counselling service. You say in your submission that there are pregnancy options and counselling services for just over 2,500 women and pregnant people each year through funding from the Department of Justice and Attorney-General. In terms of the counselling you provide, we heard earlier that there are concerns expressed about late-term abortions for psychosocial or financial reasons. Where would Children by Choice go in terms of providing advice around those sorts of issues?

Ms McKay: We talk quite specifically around children by choice. If you could imagine 2,500 conversations with people who are seeking to have a conversation about their body, that personal intimate space, between finding out they are pregnant and also the experiences across their lives and their lifestyles or their experiences of poverty, discrimination, poor health care, sexual assault and domestic and family violence, to make an assumption that there is one straight line to either 'you have the capacity' or 'you all have equal capacity to care for children', that speaks further and more specifically to the inequality in our community and the way in which women experience true parity in Queensland. Making those decisions is wide, broad and complicated, and our perspective is to work with the person who is in front of us to support them to make the decision they wish to make around their own reproductive health, their own bodily autonomy and their own life.

Mr MOLHOEK: My question is more specifically in terms of late-term terminations. If someone were to call at 35 weeks or 30 weeks and say, 'My financial circumstances have changed. I want to have an abortion,' what sort of advice or counsel would you give?

Ms McKay: That is a place for that person to engage with their medical health professional. It would also be our place to have a conversation about their personal health and wellbeing. To draw a line—which I feel like you are trying to do—through this line of questioning to suggest that Children by Choice is about advocating for abortion only completely simplifies the task that we do and minimises the experience of women in Queensland.

Mr MOLHOEK: That is the question I am trying to get to. Are you pro abortion or against abortion—

Ms McKay: We are pro choice.

Mr MOLHOEK:—or just simply trying to provide people with good advice to make a good decision?

Ms McKay: We are absolutely an all-options pregnancy counselling service. I will not be drawn into the nature of those conversations we have in that space. I can speak to the space where we advocate for people's choice in their own lives and bodily autonomy. Parenting is a fabulous thing. Parenting is a complicated thing and a challenging thing for everyone, and that is a person's choice.

CHAIR: Your submission states—

This proposed legislation restricts and undermines the informed decision-making principles of healthcare providers.

Can you address that?

Ms McKay: Essentially, we do not need legislation to be in the way of the capacity for a healthcare professional to sit with a person who is making a very personal choice about what will happen for them. We do not need that looming in the background for nurses and midwives or our other health professionals or our GPs, our doctors, our surgeons—to be sitting there with a concern they are going to be prosecuted around legislation. This is a space for people and their medical practitioners or health practitioners to have conversations around the health and wellbeing of the fetus and the decisions they are making. If you want to refer back to 35 weeks, some of these very difficult conversations are about fetal anomalies. They are heartbreaking. Sometimes people will not have an attachment to that fetus. To make the assumption that that is a lack of care from a mother to not want to comfort hold is deeply disturbing.

CHAIR: Thank you very much. I really appreciate you unpacking that. There are no final questions. Thank you for your contribution.

KATTER, Mr Robbie, Member for Traeger, Parliament of Queensland

CHAIR: I note that the member for Traeger is here and has been observing the public hearing today. I will give the member for Traeger an opportunity to make some remarks before we close. It is your bill, so it is over to you.

Mr Katter: Thank you, Chair. It is hard not to take a position of advocacy for the bill, so I will be more inclined to critique some of the things we have heard today from those opposing the bill. There seemed to be a strong gravitational pull in much of the contributions today towards a debate around abortion, women's rights and parents' rights. We have really tried to avoid that throughout the course of the bill, to recognise that this is about human rights.

I am still a little confused. There have been contributors today saying that everything is hunky-dory: 'We have guidelines, so why do we need legislation?' One reason given was the link that it blocks people from accessing abortion and having choices. I am unable to see clearly what that link is, other than an opinion-based position. That seems very subjective.

I fail to see what the problem is with providing a human right to whatever we call it—it seems pretty crude that we are trying to assign a precise metric about whether it is a living fetus and using inhuman terms. I cannot see where the cost or impost is to provide some basic human rights to ensure nothing negative happens to that kid. That is not to cast aspersions on anyone's ability or competency or even resourcing. It is just that we signal an intent to provide some dignity there.

To say that the resourcing is not there—isn't that usually the way? You demand resourcing from the government or you mandate a standard and the standard needs to be met by resourcing? If it is a debate about resourcing, I am not sure why you would be opposed to this legislation because this would set a standard that we all seem to agree on that needs to be protected. Why not introduce these laws and set the template? Again, the 'why' was that it will restrict people's access to abortion at the front end. I am not sure I understand that. I still believe very strongly in what we are trying to do here. This is a passive way of providing human rights and dignity for what I would describe as children of Queensland.

CHAIR: Thank you very much, member. We will get the transcript, and you still have the opportunity to respond in writing prior to 26 August, if you so wish. I just wanted to give you the opportunity to respond today. With those comments, we will now close the hearing. Thank you very much for your contribution. I declare this hearing closed.

The committee adjourned at 12.06 pm.