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 BA Mickelberg MP
Mr ST O'Connor MP

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

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

TRANSCRIPT OF PROCEEDINGS

Monday, 29 April 2024

Brisbane

MONDAY, 29 APRIL 2024

The committee met at 10.00 am.

CHAIR: I declare open this public briefing for the inquiry into the Termination of Pregnancy (Live Births) Amendment Bill 2024. I am Aaron Harper, the 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 Sam O'Connor, the member for Bonney and deputy chair; Stephen Andrew, the member for Mirani; Brent Mickelberg, the member for Buderim, who is substituting for Rob Molhoek, the member for Southport; James Martin, the member for Stretton; and Craig Crawford, the member for Barron River. The purpose of today's briefing is to assist the committee with its examination of the Termination of Pregnancy (Live Births) Amendment Bill 2024. The bill was introduced into the parliament on 20 March 2024 by Robbie Katter, the member for Traeger, who joins us today, and referred to this committee for detailed consideration and report.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Witnesses are not required to give evidence under oath, but intentionally misleading the committee is a serious offence. These proceedings are being recorded and broadcast live on the parliament's website. I remind committee members that Mr Katter is here to provide factual and/or technical information about the policy background of the bill and debate should be left to the floor of the House.

HOWE, Prof. Joanna, Professor of Law, University of Adelaide (via teleconference)

KATTER, Mr Robbie, Member for Traeger

CHAIR: Thank you for agreeing to brief the committee. I invite to you make some opening comments after which the committee members might ask questions.

Mr Katter: Thank you, Mr Chair. I will try to give a broad overview on what the amendment hopes to achieve and will be happy to take questions afterwards, as you say. The catalyst for this amendment was recognising that between 2010 and 2015 more than 30 babies per year were born alive. These were planned abortions that resulted in babies being born alive. It is hard for people to get their head around how this happens. I am not here to give technical advice, but babies can be born alive following abortion, pre and post viability. Importantly, the threshold of viability continues to shift in pregnancy because of medical advances in how best to care for extremely premature infants. I guess that is a fact that we can all appreciate. They can pull babies out earlier and earlier now, but once they are out, there are better chances of survival with modern technology.

A 2023 study of 29 babies born at 22 weeks found that with active intervention at birth these babies had a survival rate of 83 per cent. An early study which is cited in South Australia's perinatal practice guidelines for extremely premature babies found the rate of survival at hospital discharge was 83 per cent for infants born at 25 weeks gestation and admitted to intensive care, 68 per cent at 24 weeks and 54 per cent at 22 to 23 weeks gestation. The point is that there is, you might say, a reasonable rate of survival for babies that come out depending on how advanced or mature that pregnancy was. There have been babies for which there had been planned abortions that have come out and survived. In 2018 a study reported in the Journal of Obstetrics and Gynaecology reviewed 241 late-term abortions without feticide on babies between 20 and 24 weeks gestation and found that more than half the babies were born alive with a median time of survival of 32 minutes, with one baby surviving for over four hours.

A lot of debate goes on around abortion, but this amendment focuses on human rights. I think we can take all the abortion debate out. When a baby comes out of the womb it is breathing the same air that we breathe. I think it is pretty easy to recognise that that is a human being that should have the same human rights as any other human being sucking the same air on this planet. That is really

the central point of this amendment: that those kids enjoy the same human rights that anyone else does. This has been recognised by Queensland Health by a change in the guidelines. Guideline 5.4.3 says—

> Live birth following a termination of pregnancy is an uncommon outcome. If a baby is born with signs of life, provide care appropriate to the individual clinical circumstances and in accordance with best practice guidelines.

That was changed mid to late last year in the dead of the night.

The obvious question the committee will ask is: if the guideline is there then why enshrine it in legislation? Perhaps it is self-evident by what I have just said. If it can be changed in the dead of night one way then it can easily be changed back. I think it is a pretty important issue to protect the human rights of those babies. I think we have an obligation as a parliament to protect those rights and enshrine them in legislation and I would probably ask: why not? It may be arbitrarily changed subject to the whims of the government of the time if it is just left as an operating guideline. It is curious to me that it was not promoted or advertised or acknowledged publicly that it was changed. You can read into that whatever you will. I do not really read a lot into it, but it seems to me that there was some benefit seen in not making it public. That could be an effective theory, I think.

It is an important fact that the present guideline with respect to babies born alive came into effect in October 2023. Prior to that date, the clinical guidelines with respect to any babies born with signs of life recommended not to provide life-sustaining treatment. It is explicit that that includes things like gastric tubes, IV lines and oxygen therapy. The guidelines include local procedures for the management of live births, offering counselling and other services to parents, handling the baby gently and wrapping to provide warmth and offering parents opportunities to engage in care provision, cuddling, holding. If parents do not wish to be involved in palliative care provisions, the guidelines stipulate the healthcare providers may provide comfort and support strategies. This avoids those situations where, in the past, if a baby was born with compromised health—it may not—a nurse or midwife may be discouraged or withheld swaddling, caring, comforting the baby or providing any necessary assistance and this says that they must now do that. To take the matter a bit further, while it is not covered in this amendment I think it illustrates the point, it is giving dignity. A percentage of these babies do not make it, but they should be afforded the same dignity, avoiding those situations where kids are being tossed into industrial waste bins in plastic wrapping, however often that has occurred. We know from inquiries that that has been done. It may not happen often, but I do not think anyone would agree that that is a good outcome, and that should be avoided at any cost.

With this amendment bill we want to remove any doubt that a baby born alive as a result of a termination of pregnancy procedure has the same right as any other baby born in normal circumstances. That reflects the equal treatment of all babies born in Queensland. Just to finish off, it brings us into line with South Australia and New South Wales. The same laws exist there. I am happy to take questions.

CHAIR: I will ask Professor Joanna Howe if she wants to provide an opening statement before we move to questions.

Prof. Howe: To echo what Mr Katter has said, I think it would be important to recognise a couple of the instances where this has occurred. The statistical data shows us the scale of the issue, but there are a couple of known reports, one of which is from Queensland. The *Courier-Mail* last year reported the instance of baby Xanthe, born at 19 weeks at Queensland's Royal Brisbane and Women's Hospital. Her parents went in for the abortion at 19 weeks after a diagnosis of Down syndrome. It was not expected that a live birth would occur so it was an unintended live birth after an abortion. The parents were not informed when Xanthe came out alive and Xanthe was placed in an empty hospital room separate to her parents and lay there alone for seven minutes until she passed. After that, at some point there was an off-hand comment made by a hospital staff member, and that was actually how her parents found out that she was born alive and then left to die. She is an example, a concrete example, of what this is like. It is not always the case that a child is left alone to die after an abortion, but the case of baby Xanthe, which happened in 2020, shows how it can happen and the circumstances under which it happens.

There are other cases from other states. The coronial report of Greg Cavanagh, the NT coroner at the time, gave the case of Jessica Jane. She was a baby girl. Again, the mother went in for an abortion, for a socio-economic reason this time. She had given a gestational age for the child that did not appear to be accurate so when Nurse Williams delivered the child—again it was an unintended live birth—she saw Jessica and, on the coroner's evidence, it seems like Jessica was aged about 22 to 23 weeks. She came out with good Apgar scores, she was wriggling, making noise, crying et cetera. Nurse Williams did not know what to do and, according to the coroner, rang the doctor who ordered

the abortion or gave the green light for it. He did not give any further advice to her about how to proceed so she wrapped Jessica in a blanket, put her on a metal kidney dish in an empty room and left the room for 80 minutes.

In that same year there was another coronial investigation, this time by Janet Stevenson, the deputy coroner for New South Wales. This was a case that went through the hospital. It had been an intended live birth. The child had a cardiac issue that was diagnosed and so the parents decided to go with an abortion. The child was induced alive and the parents originally held the child, according to the coroner's report. After that at some point, even though it was an intended live birth, the chain of custody for the child was lost and the child was later found alive in a medical waste bin. Again, the coroner in that case, Janet Stevenson, as well as Greg Cavanagh in the Jessica Jane case, was scathing of how the child was treated in both instances.

CHAIR: You just quoted the New South Wales coroner's report. Was the first case a Queensland or Northern Territory case?

Prof. Howe: There are two coroner's reports. Jessica Jane was from the Northern Territory; Greg Cavanagh. The second one, the unnamed baby at Westmead Hospital, was with the New South Wales deputy coroner. As far as I am aware, there is not a Queensland coronial investigation into a child born alive, but there was a newspaper report in the *Courier-Mail* last year.

CHAIR: I am not doubting the *Courier-Mail*'s accuracy. Can you provide the committee with those two reports, if that is possible?

Prof. Howe: Absolutely, yes.

CHAIR: I have you down as a professor and a doctor. Are you a practising doctor or professor? Have you delivered any babies? I am not sure what your qualifications are, I am sorry.

Prof. Howe: I am a professor of law at the University of Adelaide. I did my doctorate in law at the University of Oxford as a Rhodes Scholar. I am not a medical doctor; I am a doctor of law.

CHAIR: Thank you very much. Robbie, in your opening statement you quoted figures between 2010 and 2015. It is in your explanatory notes as well.

Mr Katter: Yes.

CHAIR: Do you have any figures from after the Termination of Pregnancy Bill was passed up till now in Queensland?

Mr Katter: I will let Dr Howe speak to this. My understanding is that since the change in the abortion laws here in Queensland up to 22 weeks—the name of the type of abortion escapes me—you are more likely to get more. I think we would have every right to expect that number would be higher now. I will let Dr Howe speak to that. They are older figures, but I expect there would be more now.

CHAIR: Do you have any data there, Doctor, that can help us?

Prof. Howe: In the last three years the number of babies born alive after an abortion in Queensland has been over 40 each year. I can provide the specific numbers to the committee on notice, along with the coronial reports. My understanding is that it has been over 40 every year for the last three years. In the most recent year there were 43 babies born alive after an abortion in Queensland.

Mr O'CONNOR: Robbie, just to be clear, you support the guideline that Queensland Health updated last year but you think it would have more weight if it were enshrined in law. That is what this is about. It is about making sure that it cannot be easily changed. This bill is about putting the key parts of the guideline in law.

Mr Katter: Yes, like New South Wales and South Australia.

Mr O'CONNOR: The guideline goes a little further on some of the comfort options that can be offered to parents. Your amendment is basically the core part of that guideline as it relates to children born alive.

Mr Katter: Yes. It is mostly from a human rights perspective. It has been acknowledged that they should change it. If it has been done in other states by legislation—I would argue that it is such an important thing to protect from those horrible circumstances we have heard about before—why wouldn't you enshrine it in legislation? Again, anything can happen with a change of government or a change of leadership. If it is changed on a whim, it can be changed back on a whim.

Mr ANDREW: Thank you, Mr Katter, for introducing such a morally superior bill. Some of the situations outlined by Professor Howe have shocked me. I cannot believe it. I cannot believe that there is misery like that happening in our society at this time. Generally, the situation should be

enshrined. You are worried about regulations changing that. Is there anything else you would like to see added to that guideline? Is there something from different perspectives you have heard about through your consultation that could be added to bolster this legislation?

Mr Katter: As we pointed out before, there are some things in the guideline that, for want of a better word, are softer, particularly around counselling. I have always felt that counselling is needed before or after these issues are taken on, but there is no real priority there. A lot of people are in a distressed state and maybe do not seek counselling. It would be nice to see that mandated in some respect. That could be one idea. We have not put that in. We just kept to the central point. I offer that as another area of interest that we have identified. I think it is really important for those involved to have counselling. Again, I acknowledge it is in the guideline. It is nice to have some of those things more heavily entrenched in legislation.

Mr CRAWFORD: How do we define a person from a clinical perspective? This is a fairly quick moving space in a clinical environment. Are we talking about a heartbeat? Are we talking about spontaneous respirations? Are we talking about all of the above? I am interested to know because obviously decisions have to be made quickly. I am interested to know under law how we would define a person as being born.

Prof. Howe: Robbie, I am happy to answer that.

Mr Katter: I was inclined to pass that straight to Dr Howe. I was wondering whether I would say something but I will flick straight to you, Dr Howe.

Prof. Howe: From a legal perspective, once a child is expelled from the mother's womb the child is then an independent legal person. At that point the medical practitioners have to make an assessment about whether that child is showing signs of life. At that point signs of life can be limb movements. They can be pulsations. They can be breathing. Medical practitioners are well versed and experienced in how to ascertain whether signs of life exist. It is at that point of expulsion you would have an independent legal person under Australian law.

CHAIR: I am trying to get an idea of what you consider is viable. Then I will follow that up in context. Taking away termination—this is deeply personal too for a lot of people who miscarry. I have attended miscarriages in my former clinical career where the mother has miscarried the foetus at 16 weeks. What is viable in your mind when you talk about active supports? Can you give us an idea of what you consider viable in terms of gestational period?

Prof. Howe: To respond to something that you just said, this bill would not take away termination at all for anyone in Queensland. I want to be clear about that. It mirrors section 7 of the Termination of Pregnancy Act in South Australia, which does allow a termination right up until birth. The only difference that this section permits is to make sure that a child who is born alive after an abortion is treated no differently to any other child born in Queensland. It replicates the South Australian situation. It does not impact access to an abortion at all.

In terms of the threshold of viability, in South Australia that threshold is deemed to be at 22 weeks and six days. Mr Katter alluded to in his statement that the threshold of viability is moving. We do have that Japanese study of 29 babies who were born at 22 weeks and 82 per cent survived with active resuscitation. The threshold of viability is moving earlier and earlier, but we do need to recognise that that was a small-scale study in Japan. Active resuscitation takes a lot of resources at that point that may not be available at this point in Queensland hospitals.

This bill does not mandate resuscitation for children being born alive after an abortion. All it does is mandate that, if a child is born alive after an abortion, they are treated no differently to a child born in any other situation. If medical practitioners for a wanted child born prematurely make an assessment that active resuscitation is required then that would be the obligation for a child born alive after an abortion. If a baby is born at 19 weeks and they are not going to survive, active resuscitation is not the appropriate medical response and comfort care should be provided to that child. That is all this bill that Mr Katter has introduced will do.

Mr CRAWFORD: From a legal perspective, what is the responsibility of the mother in the situation? She is obviously the lawful guardian in these situations. There is consent if we are going to deem the child born is a person. What if the mother or the parents do not consent to any resuscitation? What happens from a legal perspective in that situation?

Prof. Howe: Under the South Australian law, there are guidelines at different gestational ages. When a baby is born at a threshold of viability the parents have a say in what happens to that child. As the child is born at a more advanced gestational age—I can provide these guidelines to the committee—then a medical team in consultation with the parents make those decisions. As far as I

am aware, in South Australia parental consent is essential at very early gestation, but as the child is more advanced and the prospects of that child surviving increase then it is a medical team alongside the parents who make that decision.

Mr CRAWFORD: What happens if the parents do not consent?

Prof. Howe: I would have to take that question on notice. I will provide the guidelines that exist in South Australia to the committee.

Mr CRAWFORD: I am interested in the penalty. The bill that we have does not make any reference to what the penalty would be either from a clinical perspective or even from a parenting perspective. Should the bill be passed and someone does not follow this, are we talking about a charge of murder or clinical incompetence? I am interested to know what your thoughts would be.

Prof. Howe: There are no penalties in the bill. It merely replicates what exists in the South Australian situation and in the New South Wales situation. What that does is it creates a positive obligation on medical practitioners at the time of birth to make an assessment of how best to treat that child according to that child's best interests. If that is not followed then that is a matter for the Medical Board to look at in terms of the appropriate investigation or consequence to the medical professional. It is not based in criminal law. There is nothing in the bill that has a criminal provision.

Mr MICKELBERG: Robbie, your explanatory notes refer to life-limiting conditions for a baby born alive. Where a foetus is terminated as a consequence of a diagnosed life-limiting condition—I am not sure what the definition of that is; it may be in the existing bill or maybe you or the professor can explain that—but the baby is born alive, is it the intent that that baby would be palliated or is it the intent that the legislation would require the medical professionals to administer medical treatment to keep that baby alive?

Mr Katter: I think that the important thing to remember—and this goes back to the member for Barron River's question—is that what you are talking about is the regulation now. You could just as easily ask the same question of Queensland Health as to what the regulations are right now. Professor Howe can come in after me. As I understand it, it still comes down to the assessment of the medical team. Again, taking your point and going back to the member for Barron River's question, you are starting to drift back into arguments about abortion. You can say, on the one hand: what about in this circumstance where the parents insist that the baby be terminated but it is past 22 weeks and the baby is breathing? You would be leaving it open where you could be endorsing a situation that could accommodate a kid going in the waste bin or a kid not getting those human rights that most of us enjoy.

Mr MICKELBERG: There is a fundamental difference between ensuring that that baby—

Mr Katter: Has dignity.

Mr MICKELBERG: I accept your argument that every baby needs to be afforded appropriate human rights and provided appropriate care to make sure that they are comfortable and treated appropriately. I do not have any problem with that whatsoever. My question goes to the next step. I could have an advance care directive right now that says I do not want to be resuscitated in the event of any medical condition occurring. Similarly, people may make a decision to terminate a baby because of a medical diagnosis of a condition that may have a considerable impact on that child later in life and without medical intervention that baby may not be able to live. I am going to the next stage of intent.

The guideline that you reference talks to the fact that—and I am quoting from your explanatory notes—'in instances where a "baby is born with signs of life and survival is determined to be unlikely," the guidelines state that "active treatment" is not recommended.' Presumably if a baby is born with a medical condition that is very limiting and without significant intervention the baby would die, as I read it, that guideline would suggest that the baby is to be palliated and provided appropriate care and not necessarily medical interventions that ensure that the baby does live. They are two different things in my eyes.

Mr Katter: Do you think there is a difference between the guideline and the amendment?

Mr MICKELBERG: No, I am just trying to clarify.

Mr Katter: I will let Professor Howe go first and then I will give an answer.

Mr MICKELBERG: You were really clear at the start. Sam's question was, 'Is it your intent to implement the guideline?', and I accept your answer. I just wanted to clarify the case in those sorts of incidents.

Mr Katter: Professor Howe can answer and then I will go after.

Prof. Howe: In a situation where a child has been terminated for a condition which is incompatible with life and it has been diagnosed at that 20-week fetal abnormality scan, if the termination occurs and the child is born and it seems upon appearance that the child does not have the significant abnormality that was suspected—that can certainly occur; it has happened—at that point, if the child does not have a condition that is incompatible with life or life limiting, the obligation of the medical practitioners would be to provide health care to that child and lifesaving treatment if that child's prospects of success were reasonable. However, if the child's life-limiting diagnosis proves to be true, in that situation you are completely right: palliation and making that child comfortable is important and that would be the appropriate medical response.

Let's remember that medical practitioners do this all the time for premature babies; babies who are born early. Those assessments are made daily in hospitals by medical practitioners who are very well versed at making those kinds of diagnoses once a child is born. It is not creating additional obligations. It is just replicating what would have happened for a child who was not born alive after termination.

Mr Katter: I was going to give a more simplistic answer. The way we see it is that we are advocating that that baby has the same rights as if it was not a planned abortion. The decision that is made about palliating is more a medical decision than anything, as I see it.

Mr O'CONNOR: I wish to follow up on that and on the member for Barron River's question. The explanatory notes say that the care should be provided irrespective of the parents' wishes. Is it your view that proposed new section 9A(3) covers that, that the duty owed by a registered health practitioner to provide medical care is no different to the duty owed to provide medical care to a person born other than as a result of termination?

Mr Katter: Correct. Again, we are trying to avoid those horrible situations. Regardless of what a parent has said, we are saying, 'We don't want that baby to be dumped in a plastic bag and then in a bin.' We are trying to avoid those situations so they get the same dignity and human rights as any other baby where there was not a planned abortion.

CHAIR: I mentioned before that it is a deeply personal issue and I am very sensitive to that. In my experience, people have miscarried other than by a termination of pregnancy. Some people miscarry their babies at 18 or 19 weeks and it is entirely up to the parents what they do. In my experience, some people want to hold the baby and some people do not.

Mr Katter: Yes, I totally respect that.

CHAIR: It is very distressing for the parents. I thought I would end on that.

Mr ANDREW: Can I have one other question?

CHAIR: We have another committee waiting outside. It has to be really short.

Mr ANDREW: I was talking about penalties. Do you think throwing a baby in the bin should have a penalty attached to it? It is not a funny thing. I cannot get over it.

CHAIR: I probably do not even want to hear that language, member.

Mr ANDREW: It is not right.

Mr Katter: At the end of the day I would probably draw the committee back to the point that this is replicating what has already been done. If it was radically changing or in conflict with the current guideline, then we probably would have penalties. However, in a practical sense, this is more about enshrining what is already happening now. The penalties were not seen as a significant part of the amendment because we are really endorsing this to make sure it is happening. I do not think there is a huge appetite for people to not do this, but now they would know that that is the improved guideline and doctors would know that as well.

CHAIR: I have a final question, Robbie. I cannot remember this and I think it is relevant. When the 2018 Termination of Pregnancy Bill was voted on in the House, what was the Katter party's position? Did you support that?

Mr Katter: How is that relevant to this, Mr Chair?

CHAIR: I am just asking: did you support that?

Mr Katter: I think I know the bill you are talking about. If it is that one, we definitely did not support it.

CHAIR: I just wanted to clarify that. Thank you very much. Thank you, Professor, for your time. You did take a question on notice. We will need that information back by 16 May if that is possible.

Prof. Howe: That is possible. Thank you very much for your time, everyone.

CHAIR: Thanks very much. I declare this public briefing closed.

The committee adjourned at 10.35 am.