Parliamentary Committees



Termination of Pregnancy (Live Births) Amendment Bill 2024

Report No. 15, 57th Parliament

Health, Environment and Agriculture Committee

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Health, Environment and Agriculture Committee

Chair	Mr Aaron Harper MP, Member for Thuringowa
Deputy Chair	Mr Robert (Rob) Molhoek MP, Member for Southport
Members	Mr Stephen (Steve) Andrew MP, Member for Mirani
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	Mr James Martin MP, Member for Stretton
	Mr Samuel (Sam) O'Connor MP, Member for Bonney*
	Mr Tony Perrett MP, Member for Gympie*
	Mr Brent Mickelberg MP, Member for Buderim*
	* Mr Tony Perrett MP and Mr Brent Mickelberg MP substituted for Mr Rob Molhoek MP between 4 March and 4 June 2024. Mr Sam O'Connor MP was elected Deputy Chair for the period 4 March to 9 June 2024.
Committee Secretariat	
Telephone	+61 7 3553 6626
Email	heac@parliament.qld.gov.au
Technical Scrutiny Secretariat	+61 7 3553 6601
Committee webpage	www.parliament.qld.gov.au/heac

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All web address references are current at the time of publishing.

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Chair's foreword

This report presents a summary of the Health, Environment and Agriculture Committee's examination of the Termination of Pregnancy (Live Births) Amendment Bill 2024.

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament. The committee also examined the Bill for compatibility with human rights in accordance with the *Human Rights Act 2019*.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill. I also thank our Parliamentary Service staff and Mr Robbie Katter MP, Member for Traeger.

I commend this report to the House.

Aaron Harper MP
Chair

Recommendations

Executive Summary

This report presents the Health, Environment and Agriculture Committee's examination of the Termination of Pregnancy (Live Births) Amendment Bill 2024. The stated objective of the Bill is to enshrine in legislation the protections for babies born as a result of a termination of pregnancy procedure. To achieve this objective the Bill proposes an amendment to the *Termination of Pregnancy Act 2018* to insert a new section to apply when a termination of pregnancy results in a 'live birth'.

The committee received 647 submissions to its inquiry and held a public briefing and a public hearing in Brisbane.

The committee received many submissions from supporters of the Bill who were concerned about reports of babies born with signs of life following termination procedures, reported numbers of live births, and statements that medical practitioners do not have a duty to provide care for a baby in such circumstances. In contrast, the committee was advised that among health practitioners there is no confusion about live birth, that a baby born alive in Queensland has legislative protections, and that incorporating clinical considerations in legislation risks restricting the ability of health practitioners to provide evidence-based care.

We also received evidence indicating that the changes proposed by the Bill would result in serious adverse effects on access to termination of pregnancy services and undermine patient autonomy and patient-centred care.

We noted that stakeholders, both supporting and opposing the Bill, highlighted the problem of insufficient staff in maternity departments, and the importance of sufficient resources and staffing to provide appropriate support to patients. Consequently, the committee has recommended that the Queensland Government continue efforts to elevate staffing levels in termination of pregnancy health service provision.

The committee considers the Bill has sufficient regard to fundamental legislative principles and is compatible with the *Human Rights Act 2019*. However, the committee noted that the explanatory notes contain several inaccuracies and deficiencies, and that the statement of compatibility does not contain sufficient information to facilitate understanding of the Bill in relation to its compatibility with human rights.

Having considered the policy objectives of the Bill, its compliance with the *Legislative Standards Act 1992* and the *Human Rights Act 2019*, and the evidence provided by stakeholders, the committee has recommended that the Bill not be passed.

1 Introduction

1.1 Policy objectives of the Bill

The stated objective of the Termination of Pregnancy (Live Births) Amendment Bill 2024 (Bill) is to enshrine in legislation the protections for babies born as a result of a termination of pregnancy procedure. The explanatory notes state that the Bill is intended to remove any doubt that babies born in these circumstances are entitled to the same degree of medical care and attention as a baby born in any other way.

The Bill amends the *Termination of Pregnancy Act 2018* (Termination of Pregnancy Act) to:

- insert a new section to apply when a termination results in a live birth
- state that nothing in the Termination of Pregnancy Act prevents a 'relevant person' for the termination from exercising any duty to provide the person who is born with medical care and treatment that is clinically safe and appropriate to the person's medical condition
- clarify that the duty owed by a registered health practitioner to provide medical care and treatment to a person born as a result of a termination is no different than the duty owed to provide medical care and treatment to a person born other than as a result of a termination
- define 'relevant person' for a termination resulting in a person being born, as a registered health practitioner who performed the termination, and other practitioners, including students, present at the time.

1.2 Background

Termination of pregnancy is legal in every state and territory in Australia. In each jurisdiction the legislation includes provisions concerning the number of weeks of gestation at which more than one doctor must approve the termination procedure. In Queensland, for termination of a pregnancy greater than 22 weeks, the Termination of Pregnancy Act requires 2 medical practitioners to agree that the termination should be performed having considered all of the woman's circumstances and the professional standards and guidelines that apply to performance of the termination.[1]

Most jurisdictions have clinical guidelines for the provision of care in termination of pregnancy, including guidelines for care in the uncommon situation that a baby is born with signs of life following a termination procedure.[2] The *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*[3] (Queensland Clinical Guideline) includes guidance for live birth following a termination of pregnancy, and states: 'Live birth following a termination of pregnancy is

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1 *Termination of Pregnancy Act 2018,* s 6. The Act provides for an exception to these requirements in an emergency, to save the woman's life or in the case of a multiple pregnancy another unborn child's life (s 6(3)).

2 See for example, NSW Health, *Framework for Termination of Pregnancy in New South Wales*, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2021_018.pdf; NT Department of Health, *Northern Territory Clinical Guideline – Termination of Pregnancy*, https://health.nt.gov.au/__data/assets/pdf_file/0008/1178549/nt-clinical-guideline-termination-of-pregnancy.pdf. Note: following the commencement of the *Abortion Legislation Reform Act 2023* (WA) in March 2024, the WA Department of Health has released the *Interim abortion care clinical guidelines*, under license from Queensland Health (*Queensland Clinical Guidelines – Termination of Pregnancy*), see https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Abortion/Abortion-care-clinical-guidelines-interim-engagement-version.pdf.

3 Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf.

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'.[4]

The legislation in New South Wales and South Australia include provisions which state that the Act does not prevent a registered health practitioner from exercising any duty to provide a person born as a result of a termination with medical care and treatment that is clinically safe and appropriate to the person's medical condition.[5] New South Wales explicitly links that provision back to a requirement for a registered health practitioner to comply with professional standards and guidelines.[6]

In Australia most terminations occur during the first trimester of pregnancy. Approximately 1 per cent are performed after 20 weeks gestation, 'usually because of late diagnosed major structural anomalies, genetic syndromes, severe fetal growth restriction, or maternal conditions in which continuation of the pregnancy would be significantly detrimental to the mental or physical health of the woman'.[7]

'Live birth' is defined by the World Health Organisation as 'the complete expulsion or extraction from a woman of a fetus, irrespective of the duration of the pregnancy, which, after such separation, shows signs of life'.[8] Signs of life may include 'beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached'.[9]

In November 2023, the Minister for Health, Mental Health and Ambulance Services and Minister for Women reported the total number of live births following a termination of pregnancy in Queensland (with these resulting in an outcome of neonatal death) for the previous 5 years,[10] as shown in Table 1.

Table 1: Termination of pregnancy resulting in live births by gestation weeks for admitted patients, 2018–2022

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

4 Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf, p 24.

5 *Termination of Pregnancy Act 2021* (SA), s. 7; *Abortion Law Reform Act 2019* (NSW), s. 11.

6 *Abortion Law Reform Act 2019* (NSW), s. 11 note.

7 Rosser, S, Sekar, R, Laporte, J, Duncombe, DJ, Bendall, A, Lehner, C, Portmann, C, McGrath, P, Lust, K, Ganter, P, Kumar, S, 'Late termination of pregnancy at a major Queensland tertiary hospital, 2010–2020', *Medical Journal of Australia*, 2022, 217 (8): 410-414, doi: 10.5694/mja2.51697.

8 World Health Organization, 2019/2021, International Classification of Diseases, Eleventh Revision (ICD-11), 11th Revision, https://icd.who.int/en

9 Australian Government, Australian Institute of Health and Welfare, METEOR Metadata Online Registry, https://meteor.aihw.gov.au/content/733187. See also *Public Health Act 2005*: s 214 provides that 'baby born alive' means a baby whose heart has beaten after delivery of the baby is completed, and 'baby not born alive' means a baby who has shown no sign of respiration or heartbeat, or other sign of life, after completely leaving the child's mother, and has been gestated for 20 weeks or more, or weighs 400 grams or more.

10 Minister for Health, Mental Health and Ambulance Services ad Minister for Women, Answer to Question on Notice No. 1496 asked on 16 November 2023, https:// documents.parliament.qld.gov.au/tableOffice/questionsAnswers/2023/1496-2023.pdf.

Life sustaining interventions are not usually recommended for any live birth up to 22+6 weeks[11] gestation. Between 23 and 24+6 weeks gestation, there is a high risk of death of the fetus despite treatment, or survival with profound impairment and/or poor prognosis for long term survival, with treatment guided by parents' wishes and the baby's clinical condition.[12] It is standard care to provide active treatment for the birth of a normally formed fetus at or more than 25 weeks gestation.[13] In the case of termination of pregnancy however, where the expectation of the procedure is the end of the pregnancy and death of the fetus, feticide[14] is recommended at gestations greater than 22+1 weeks to avoid a live birth.[15]

The Member for Traeger stated in his introductory speech that the Bill was required in order to legislate that all babies born alive in Queensland 'are to be afforded proper medical care and treatment', because:

> In just the last two years that we have data for, 90 Queensland newborns were born alive after an abortion and did not have a legislative right to care and to be treated equally like all other newborns.
>
> …The government and indeed the opposition may suggest that this bill is not required as Queensland Health put in place a guideline last year to direct that care is given. However, the way this was done in the dead of the night, without much notice given and certainly no public notice, it can be changed just as easily in the dead of the night again back the other way. For something so important, I do not think we can rely on just a procedure and a guideline that sits in Queensland Health. This needs to be legislated. I think it is very important for Queensland to see that it is legislated—that we care about the human rights of those kids.[16]

1.2.1 Consultation on the Bill

According to the explanatory notes, the Bill 'is the result of a growing movement to enshrine in law the recognition of the basic human right of babies born as a result of a termination of pregnancy'.[17] No further evidence or explanation of 'a growing movement' was supplied.

The explanatory notes also state, without details, that consultation on the Bill was 'undertaken with stakeholders across the spectrum, including legal experts on human rights and members of the medical fraternity'.[18]

1.3 Inquiry process

The committee held a public briefing and a public hearing (see Appendix A for a list of witnesses at these public proceedings) and received 647 submissions to the inquiry (see Appendix B for a list of submitters).

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11 22+6 weeks means 22 weeks and 6 days gestation.

12 Queensland Health, *Queensland Clinical Guideline: Perinatal care of the extremely preterm baby*, Guideline No. MN20.32-V2-R25, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0023/142259/g-viability.pdf, p 15. The guideline notes: 'The 'best interests of the baby' is the legal principle that underpins all decisions relating to resuscitation. There is no statutory or common law definition of viability or of when resuscitation should or should not be provided.' (p 10).

13 Queensland Health, *Queensland Clinical Guideline: Perinatal care of the extremely preterm baby*, Guideline No. MN20.32-V2-R25, 2020, p 15.

14 The administration of a pharmaceutical agent to cause fetal death prior to commencing a termination of pregnancy. See also section 2.6.1 of this report.

15 Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf.

16 Queensland Parliament, Record of Proceedings, 20 March 2024, p 758.

17 Explanatory notes, p 4.

18 Explanatory notes, p 4.

Over 75 per cent of the submissions accepted by the committee were campaign (online form) submissions addressed to 'Parliament House, Canberra'.[19]

1.4 Legislative compliance

Our deliberations included assessing whether or not the Bill complies with the Parliament's requirements for legislation as contained in the *Parliament of Queensland Act 2001*, *Legislative Standards Act 1992* (LSA) and the *Human Rights Act 2019* (HRA).

1.4.1 *Legislative Standards Act 1992*

No issues of fundamental legislative principle were identified.

1.4.1.1 Explanatory notes

The explanatory notes contain incorrect references to provisions to be inserted in the Termination of Pregnancy Act. The section, *Achievement of Policy Objectives,* refers to 'new section 8B', 's 8B (1)', 's 8B (2)', and 's 8B (3)'.[20] The provisions in the Bill which correspond with these sections are: new section 9A, s 9A(1), s 9A(3), and s 9A(2), respectively.[21]

The meaning of 'participant in person's birth' is also described in the explanatory notes as 'clarifies that the subjects to whom this section applies are the same as those outlined *Termination of Pregnancy Act*',[22] however the term 'participant in person's birth' is not included in the Bill.

1.4.2 *Human Rights Act 2019*

Section 39 of the HRA requires portfolio committees to report to the Legislative Assembly if the Bill is not compatible with the human rights and about the statement of compatibility tabled for the Bill.

Human rights issues identified by the committee are discussed in section 2 of this report.

1.4.2.1 Statement of compatibility

A statement of compatibility was tabled by the Member for Traeger when introducing the Bill as required by s 38 of the HRA. The statement of compatibility is extremely brief. It states only that in the Member's opinion:

> …the Termination of Pregnancy (Live Births) Amendment Bill 2024 does not contravene any human right listed under Part 2, Division 2 and 3 Human Rights Act 2019.
>
> It does not restrict an individual's civil and political rights, such as freedom of movement, freedom of thought, freedom of expression, property rights, privacy and reputation or recognition and equality before the law.
>
> In fact, it enhances compliance with the *Human Rights Act 2019* by stipulating full and equal human rights protection for all Queensland children born alive in the state.

Committee comment

The explanatory notes contained several inaccuracies in its specification of relevant provisions of the Termination of Pregnancy Act to be amended by this Bill. The explanatory notes also do not provide a definition of 'live birth' as appears in the title of the Bill to aid understanding. In explaining the

[19] See submissions 135 – 626, 628 – 645, 647. It is noted that the Commonwealth Senate Community Affairs Legislation Committee conducted an inquiry into the Human Rights (Children Born Alive Protection) Bill introduced into the Senate in 2022; see https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ChildrenBornAlive2022.

[20] Explanatory notes, pp 3-4.

[21] Bill, cl 4.

[22] Explanatory notes, p 4; Note: grammatical errors are as appear in the explanatory notes.

provisions proposed by the Bill, the explanatory notes utilise a term - 'participant in person's birth' - which does not appear in the Bill.

The statement of compatibility does not contain sufficient information to facilitate understanding of the Bill in relation to its compatibility with human rights.

The Member for Traeger gave no basis for why he might suspect a reversal of the Queensland Clinical Guideline to occur away from the current existing practice with respect to live births, especially given that guideline encodes conduct which is in line with standard medical practice for live births.

1.5 Should the Bill be passed?

The committee is required to determine whether to recommend that the Bill be passed.

Recommendation 1

The committee recommends the Termination of Pregnancy (Live Births) Amendment Bill 2024 not be passed.

2 Examination of the Bill

This section discusses key issues raised during the committee's examination of the Bill.

Submissions in support of the Bill referred to reported numbers of babies born alive as a result of terminations of pregnancies,[23] a need to legislate a duty of care,[24] alignment of the Termination of Pregnancy Act with legislation in other jurisdictions,[25] and human rights issues.[26] Many of these submitters also expressed opposition to abortion.

Stakeholders opposed to the Bill were concerned about the interpretation of data cited in support of the Bill,[27] the proposal to legislate health practitioners' existing duty of care,[28] potential effects on access to termination of pregnancy,[29] and conflict with patient-centred care.[30]

2.1 Reported cases and interpretation of data

The explanatory notes state that 'according to government figures, between 2010 and 2015, 204 babies were born alive after a termination procedure aged 20 weeks or more'.[31] This statement refers to a question on notice asked of the Minister for Health and Minister for Ambulance Services in May 2016. The Minister's answer provided different data for the period, stating that 132 babies were born with signs of life between 2010 and 2015.[32] The Minister's answer also noted:

23 See for example submissions 23, 52, 97, 134.

24 See for example, submissions 55, 57, 79, 90, 109, 124.

25 See for example submissions 54, 57, 97, 115, 118, 120.

26 See for example submissions 11, 14, 44, 53, 69, 82, 97.

27 See for example submissions 122, 131; also The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, correspondence, 28 August 2024.

28 See for example submissions 10, 93, 122, 130, 131, 646.

29 See for example submissions 93, 122, 130, 131, 646.

30 See for example submissions 131, 646.

31 Explanatory notes, p 1.

32 Minister for Health and Minister for Ambulance Services, Answer to Question on Notice No. 779 asked on 11 May 2016, https://documents.parliament.qld.gov.au/tableoffice/questionsanswers/2016/779-2016.pdf. The Minister's answer provided figures for 11 years from 2005 to 2015 which summed to 204 instances.

> There are almost always severe circumstances leading to a small number of women who choose to terminate a pregnancy after 20 weeks gestation. ...I am advised these numbers represent less than 0.05% of the total number of live births each year (including all hospitals in Queensland, both public and private hospitals combined). I am further advised that this percentage has remained relatively stable over time.[33]

The explanatory notes state that 'more recent research suggests the number of babies born alive in these circumstances in Queensland is growing'[34] and discuss survival rates for extremely preterm births, including that 'a 2023 study of 29 babies born at 22 weeks found that with active intervention at birth these babies had a survival rate of 82.8%'.[35] When introducing the Bill, the Member for Traeger also provided detailed accounts of 2 cases of babies born with signs of life following termination procedures from reports of coroners in the Northern Territory and New South Wales, and of a third case in Queensland, reported in a newspaper in 2023.[36]

Submitters who supported the Bill expressed their distress about these details of babies born with signs of life following termination procedures being 'left to die' without care, and about statements that medical practitioners do not have a duty to provide care for a baby in these circumstances.[37] For example as one submitter, Kendal Fraser, stated:

> I was shocked to find out this week that babies born alive after abortion are not afforded standard human rights and are abandoned and left to die in the most inhumane settings. This is mind boggling to me, that in a first world country, we can't come up with laws to navigate live births after abortion…[38]

In support of the Bill, many submitters also referred to the numbers of live births resulting from terminations of pregnancies reported in the explanatory notes and elsewhere.[39]

In contrast, problems with the use of cumulative jurisdictional data without context and information selectively extracted from research studies were highlighted by several submitters. Submissions included that:

- data collection does not accurately capture termination of pregnancy outcomes and 'there is no way, based on published statistics of any reliable measure, to differentiate the babies born following an abortion, from other perinatal deaths in this group (i.e. late miscarriages, unexplained stillbirths, etc.)'[40]
- the findings of the 2023 research study cited in the explanatory notes,[41] which found an 82.8% survival rate of neonates born at 22 weeks of gestation with active management have been misrepresented, as the study '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

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33 Minister for Health and Minister for Ambulance Services, Answer to Question on Notice No. 779 asked on 11 May 2016, https://documents.parliament.qld.gov.au/tableoffice/questionsanswers/2016/779-2016.pdf.

34 Explanatory notes, p 1, referencing data from Queensland Health 'Perinatal Annual Reports for 2010–2020, Table 10.13 in each report'.

35 Explanatory notes, p 1, referencing Motojima, Y, Nishimura, E, Kabe, K, Namba, f, *Management and outcomes of periviable neonates born at 22 weeks of gestation: a single-centre experience in Japan,* Journal of Perinatology, 2023, Nov;43(11):1385-1391, doi: 10.1038/s41372-023-01706-4.

36 Queensland Parliament, Record of Proceedings, 20 March 2024, p 758; see also explanatory notes, p 2.

37 See for example submissions 2, 13, 15, 113, 183, 207, 213, 259.

38 Submission 213, p 1.

39 See for example submissions 23, 52, 97, 134.

40 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, correspondence, 28 August 2024, p 2; see also Children by Choice, submission 131, p 5.

41 Explanatory notes, p 1, referencing Motojima, Y, Nishimura, E, Kabe, K, Namba, f, *Management and outcomes of periviable neonates born at 22 weeks of gestation: a single-centre experience in Japan,* Journal of Perinatology, 2023, Nov;43(11):1385-1391, doi: 10.1038/s41372-023-01706-4.

would provide a clearer picture of actual survivability at birth)'.[42] Further, the quoted survival rate 'excludes neonates with major congenital anomalies', and all neonates born at 22 weeks included in the study 'received intensive, invasive medical intervention, a third of which died before the age of 18 months, and of those that did survive, 38.9% showed moderate or severe neurodevelopmental impairment'.[43]

It was submitted that reference to a 2023 news article in the explanatory notes as evidence to justify the Bill is misleading. The Queensland Nurses and Midwives' Union (QNMU) noted that the article 'clearly indicates that the parents made a shared, informed decision to have a termination of pregnancy, and that their distress was because they were not provided the opportunity to "have been with [the baby] when she passed" and not because the baby was born alive nor because of the absence of medical interventions'.[44] Children by Choice submitted that the article:

> …highlights that the distress experienced by the parents stemmed from systemic failures in healthcare delivery, particularly the lack of opportunity to be present with their child during the termination procedure. The distress was not attributed to the neonate being "born alive" or the absence of medical interventions, but rather to the denial of the opportunity to bid farewell to their child in a compassionate and dignified manner.[45]

2.1.1.1 Member for Traeger's response

In response to the criticism from submitters that framing the news article example as 'representative of public concern regarding the need for legislated medical intervention in late-stage terminations of pregnancy is disingenuous and misleading',[46] the Member for Traeger stated that 'this was neither asserted in the Explanatory Notes nor the Second Reading Speech' and that the reference 'was to expose the need for the Bill because she [the baby born with signs of life] was left in an empty hospital room for 7 minutes until her death, not as evidence of public concern'.[47]

2.2 Duty of care

The Bill is intended to remove any doubt 'that the duty owed by a registered health practitioner to provide medical care and treatment to a person born as a result of a termination is no different than the duty owed to provide medical care and treatment to a person born other than as a result of a termination'.[48] Submitters supporting the Bill asserted that a duty of health practitioners to provide medical care and comfort should be legislated.

Some submitters also stated that health practitioners should be required to actively sustain the lives of all babies born with signs of life as result of a termination, suggesting that medical technology and resources are available that could be used to restore babies born with signs of life to 'full health'.[49]

Dr Elisha Broom, fellow of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and RANZCOG Councillor, who is a practising obstetrician and maternal fetal medicine subspecialist in Queensland, told the committee that the Bill would not change current practice or legislative protections for babies born with signs of life, as 'despite evidence given, there

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42 Queensland Nurses and Midwives' Union, submission 122, p 4.

43 Queensland Nurses and Midwives' Union, submission 122, p 4.

44 Queensland Nurses and Midwives' Union, submission 122, p 5.

45 Children by Choice, submission 131.

46 Children by Choice, submission 131, p 5; also Queensland Nurses and Midwives' Union, submission 122, p 5.

47 Mr Robbie Katter MP, Member for Traeger, correspondence, 31 May 2024, p 5.

48 Bill, cl 4, proposed new s 9A(3).

49 See for example submissions 2, 32, 101, 205.

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'.[50] As Dr Broom explained:

> …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.
>
> …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.[51]

2.2.1 Queensland Clinical Guideline

Queensland Health has the Queensland Clinical Guideline[52] to assist healthcare professionals provide care to women requesting termination of pregnancy.

Some submitters noted recent changes to the Queensland Clinical Guideline and supported including the considerations for care of a baby born with signs of life that are described in the current version (October 2023) of Queensland Clinical Guideline in the Termination of Pregnancy Act.[53]

In contrast, other submitters opposed to the Bill were concerned that including clinical considerations in legislation risks restricting the ability of health practitioners to provide evidence-based care. Children by Choice, for example, emphasised that healthcare guidelines need to remain responsive to new knowledge to ensure the provision for optimal care, noting that the World Health Organisation's abortion guidelines 'have undergone regular changes in line with evolving gold-standard care'.[54]

Figure 1 is an extract from the Queensland Clinical Guideline which shows the guidance for circumstances of a live birth following a termination.

[50] Public hearing transcript, Brisbane, 19 August 2024, p 13.

[51] Public hearing transcript, Brisbane, 19 August 2024, p 14.

[52] Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf.

[53] See for example, submissions 55, 57, 79, 90, 109, 124.

[54] Submission 131, p 7.

Figure 1: Extract from the *Queensland Clinical Guideline – Termination of pregnancy*

5.4.3 Born with signs of life

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.

Table 23. Born with signs of life

Aspect	Consideration
Information sharing	• If appropriate to clinical circumstances, discuss with the woman before the procedure, the potential for live birth including: ○ Preferences for awareness of live birth (e.g. informed immediately at time of birth or information delayed) ○ The woman's wishes and preferences for care of the baby, which it is acknowledged may change during the course of the termination and following birth ○ Desire for engagement in any subsequent care ○ Expected fetal appearance and/or clinical course relevant to circumstances ○ Legal requirements for birth registration and management of fetal remains ○ Refer to Definition of terms and Section 5.4.1 Birth registration
If born with signs of life	• Provide care appropriate to the individual clinical circumstances and in accordance with best practice guidelines
Palliative care	• Where the baby is born with signs of life and survival is determined to be unlikely, active treatment (e.g. gastric tubes, IV lines, oxygen therapy) is not indicated or recommended as these may prolong palliation and cause distress ○ Handle gently and carefully, wrap and cuddle/hold to provide warmth and comfort ○ Offer opportunities to engage in care provision (e.g. cuddling/holding) as desired • If parents do not wish to be involved in palliative care provision, healthcare providers may provide comfort support strategies
Service support	• Establish local procedures for the management of live birth • Provide sensitive emotional support and reassurance to parents • Offer counselling and support services to women, partners and healthcare professionals involved with care of a live born child

Source: Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020.

The explanatory notes state that despite the Queensland Clinical Guideline, 'there remain ambiguities that require addressing', namely:

> First, if a live birth occurs following a termination and the baby has no life-limiting condition and is on the threshold of viability (ie. after 22 weeks and 6 days) or older, it should be clearly stipulated that life-sustaining medical care should be provided to the child irrespective of parents' wishes.
>
> Second, if a live birth occurs following a termination and survival is deemed unlikely, it should be clearly stipulated that if parents do not wish to provide comfort care to the baby, there is a legal obligation on healthcare providers to do so until the baby is no longer alive.[55]

The explanatory notes further assert that 'there is no particular reason why a practitioner would take heed of the guidelines or be subject to scrutiny for not following them'.[56]

2.2.2 Established duty to provide care

Medical, nursing and midwifery practitioners in Australia have a duty to make the care of patients their primary concern and to practise medicine safely and effectively. The *Good medical practice: a*

[55] Explanatory notes, p 3.

[56] Explanatory notes, p 3.

code of conduct for doctors in Australia (Code of Conduct),[57] issued under s 39 of the Health Practitioner Regulation National Law, sets out the principles of good medical practice and describes the standards of ethical and professional conduct expected of all doctors registered to practise medicine in Australia. The Code of Conduct states that it 'complements the Australian Medical Association Code of ethics and is aligned with its values. It is also consistent with the Declaration of Geneva and the International code of medical ethics issued by the World Medical Association'.[58]

Nurses and midwives in Australia are bound by Codes of Conduct set by their registration board, the Nursing and Midwifery Board of Australia.[59] Nurses and midwives are also bound by Codes of Ethics set by the International Council of Nurses and the International Conference of Midwives.[60]

Stakeholders opposed to the Bill, including RANZOG and QNMU, stated that the existing duty of care owed by health practitioners made the Bill unnecessary, and further regulation would be unhelpful.[61] RANZCOG, for example, stated that the Bill is 'without merit (medically or legally)', as 'health professionals already owe a duty of care to all their patients, including babies born alive whether this happens following an abortion or otherwise' and that 'there are well established guidelines and professional standards to guide clinical practice in this area'.[62] As RANZCOG explained:

> RANZCOG's clinical practice in abortion care is evidence-based and our Fellows and Associates adhere to strict professional standards and guidelines to ensure care is safe and effective. There is no need for a separate Bill (or any law, for that matter) to instruct doctors on how to provide appropriate care for a patient in specific circumstances. Clinical and ethical considerations should be applied to the same standard, as would apply in any other clinical situation. This Bill is redundant in the absence of any justifiable evidence or grounds for the introduction of the Bill outside of medical and ethical considerations that are already well understood and uniformly practised. No such evidence or grounds have been provided.[63]

Similarly, a medical practitioner working as a maternal-fetal medicine subspecialist in a tertiary hospital in Queensland, who is involved with counselling patients and performing termination of pregnancy procedures primarily but not exclusively for the purpose of managing major fetal anomalies identified during prenatal testing, submitted that the proposed amendment 'is unlikely to change practice in any way which is of benefit to women and babies of Queensland'.[64] The doctor described the current situation:

> In almost all cases, terminations of pregnancy at 22 weeks are carried out by administering a lethal injection to the fetus, followed by induction of labour. After birth, the baby is provided with respectful care in exactly the same way as for any other stillborn baby. In cases where there is a lethal anomaly that

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57 Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, 2020, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx#.

58 Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia*, 2020, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx#, p 3.

59 Nursing and Midwifery Board of Australia, *Code of conduct for midwives*, 2022, and *Code of conduct for nurses,* 2022, https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx.

60 See International Council of Nurses, *The ICN Code of Ethics for Nurses*, 2021, https://www.icn.ch/sites/default/files/2023-06/ICN_Code-of-Ethics_EN_Web.pdf; and International Confederation of Midwives, *International Code of Ethics for Midwives*, https://internationalmidwives.org/wp-content/uploads/eng-international-code-of-ethics-for-midwives.pdf.

61 See for example submissions 10, 93, 122, 130, 131, 646.

62 Submission 93, p 2.

63 Submission 93. p 3.

64 Submission 10.

> is expected to lead to death of the baby in the neonatal period, and the parents have chosen not to have the lethal injection, the baby after birth is the subject of a perinatal palliative care plan.
>
> In the case of terminations performed at less than 22 weeks, and in the case of a baby being born alive (which may happen as early as 17-18 weeks), the provision of neonatal care (other than comfort care) in terms of active resuscitation is completely inappropriate, as the perinatal outcomes prior to 22 weeks are very poor and with a very high mortality and morbidity rate (close to 100%). Babies born prior to 22 weeks after spontaneous births in Queensland (i.e. not as a result of a termination of pregnancy procedure) are not usually provided with active resuscitation. If the purpose of this amendment is to require active resuscitation to be offered to babies born alive prior to 22 weeks this is not consistent with good medical practice.[65]

Likewise, the QNMU submitted that professional codes of conduct and established clinical practices enabled nurses and midwives to provide appropriate care:

> Nurses and midwives practice under robust ethical frameworks and professional codes of conduct and are well-versed in their duty to provide compassionate care while adhering to evidence-based best practices across all cases, including late-stage terminations. Nurses and midwives are also uniquely positioned to uphold a person's reproductive autonomy and provide a safe space for open communication throughout pregnancy, and to provide the palliative and post-mortem care required in these sensitive situations.
>
> The Bill unnecessarily imposes undue legislative pressure on health practitioners, potentially creating confusing and contradictory requirements that undermine established best practices and existing organisational policies and procedures.[66]

The national Women's Sexual and Reproductive Health Coalition chaired by the National Health and Medical Research Council Centre of Research Excellence in Women's Sexual and Reproductive Health and Primary Care (SPHERE Coalition) submitted that the Bill 'reflects a poor understanding of the realities of clinical decision making' and 'interferes with the responsibility and obligations of medical providers to offer patient-centred care and their ability to meet established medical and professional ethics standards in delivery of clinical services'.[67]

An answer to a question on notice to the Minister for Health, Mental Health and Ambulance Services and Minister for Women in November 2023 regarding decisions about care in the event of a live birth following a termination of pregnancy, reflects these submissions. At the time the Minister stated:

> In relation to the very uncommon outcome of a live birth following a planned termination of pregnancy, I am advised that decisions about the care appropriate to the individual clinical circumstances are made by the registered health professionals providing clinical care to the woman/family and the baby at the time of the live birth.
>
> The decision as to what care to provide, is informed by a comprehensive assessment of the individual circumstances, including review of the clinical history (e.g., diagnosis of a life-limiting condition in the baby) and the use of expert clinical judgement.[68]

2.2.2.1 Member for Traeger's response

The Member for Traeger disagreed that decisions about care of a baby born with signs of life should be a matter between the woman/family and health practitioners, and that the clinical judgement of treating health practitioners could be relied on these situations:

> … the deferral of the decision regarding care of a child born alive to the child's mother and her health practitioners means that the child's best interests will not be taken into account. This is because the

[65] Submission 10.

[66] Submission 122, p 4.

[67] Submission 646, pp 2, 3.

[68] Minister for Health, Mental Health and Ambulance Services ad Minister for Women, Answer to Question on Notice No. 1496 asked on 16 November 2023, https://documents.parliament.qld.gov.au/tableOffice/questionsAnswers/2023/1496-2023.pdf.

child's mother sought to end the child's life via abortion and was supported to achieve this through the aforementioned health practitioners. Arguably, in a situation such as this, those who set out to kill the child are not the most appropriate people to determine care of the child following abortion.[69]

2.2.3 Professional conduct in provision of health services

2.2.3.1 Professional conduct in accordance with the Termination of Pregnancy Act 2018

Part 2, ss 5 and 6 of the Termination of Pregnancy Act require that in considering whether a termination should be performed on a woman after 22 weeks, a medical practitioner must consider:

(a) all relevant medical circumstances, and

(b) the woman's current and future physical, psychological and social circumstances, and

(c) the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination.[70]

Section 9 of the Termination of Pregnancy Act provides a mechanism to address circumstances where a registered health practitioner does not comply with the requirements for a lawful termination or conscientious objection. Non-compliance may be dealt with under the regulatory framework for considering matters of professional conduct or performance of registered health practitioners, including via:

(a) a notification under the *Health Practitioner Regulation National Law (Queensland) 2009*, or

(b) a complaint under the *Health Ombudsman Act 2013,* or

(c) a complaint or other matter referred by the Health Ombudsman to the Australian Health Practitioner Regulation Agency (Ahpra).[71]

2.2.3.2 National Scheme and Queensland Health Ombudsman

The National Scheme for health practitioners in Australia has been in place since 2010 to provide for the protection of the public so that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered to practise.

The Health Practitioner Regulation National Law (National Law) establishes, among other things, 15 health practitioner registration boards (National Boards) to regulate the registration and accreditation of 16 health professions; a framework for approving registration standards, codes and guidelines; a complaints process for managing health, conduct and performance matters; and investigation powers. Ahpra supports the National Boards in performing their functions and it is the responsibility of Ahpra and the National Boards to protect the public and prevent harm.[72]

In Queensland where there is a co-regulatory arrangement, the Health Ombudsman and Ahpra deal with a complaint or notification about health services provided in Queensland.[73] The Health Ombudsman consults with Ahpra to decide which regulator is best placed to respond to the issues raised.[74] In appropriate circumstances, the Health Ombudsman may refer matters to Ahpra. Ahpra then works with, and on behalf of, the National Board for the relevant profession to resolve the matter under the processes set out in the National Law.

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69 Mr Robbie Katter MP, Member for Traeger, correspondence, 31 May 2024, p 4.

70 *Termination of Pregnancy Act 2018*, s 6(2).

71 *Termination of Pregnancy Act 2018*, s 9(2).

72 See COAG Health Council, *Policy Direction 2019-01 – Paramountcy of public protection when administering the National Scheme*, available at https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiques/Policy-directions.aspx.

73 The Health Ombudsman and Ahpra work together under the *Health Practitioner Regulation National Law (Queensland)*.

74 See *Health Ombudsman Act 2013*, Division 2A.

Part 8 Divisions 1 to 3 of the National Law deal with notifiable conduct breaches by registered health practitioners. If a practitioner is suspected of placing the public at risk of substantial harm for practising in a way that constitutes a significant departure from professional standards, the National Law requires mandatory reporting by other health practitioners and employers to the Health Ombudsman.[75] If a registered health practitioner is suspected to have exhibited conduct or judgment that falls below standards reasonably expected of the profession, registered health practitioners can make a voluntary report to the Health Ombudsman.[76] If a registered health practitioner is found to have placed the public at risk through conduct which is a significant departure from professional standards, or which falls below the standards of the profession, significant penalties can apply including deregistration and suspension.[77]

Committee comment

Queensland registered health practitioners are required to provide termination of pregnancy services in line with current professional standards and guidelines, including the Queensland Clinical Guideline for termination of pregnancy. Doctors, nurses, and midwives are bound to provide these services in accordance with professional codes of conduct and ethics. Compliance with standards and guidelines is mandatory, with significant penalties including loss of registration for practitioners who are found to have breached guidelines and the standards of their profession. We therefore disagree strongly with the Member for Traeger's comment that there is no particular reason why a practitioner would take heed of the guidelines or be subject to scrutiny for not following them, which was advanced as one basis for why this Bill is necessary. Further, if a health practitioner were to demonstrate questionable conduct in the course of providing a termination of pregnancy service, then the independent Office of the Health Ombudsman is the most appropriate authority to investigate a complaint, as is the existing process under the National Law.

2.3 Amendments suggested by submitters

Some stakeholders from medical professions submitted that the Bill would require amendment to address their concerns about the obligations of practitioners and others involved in termination procedures. Suggestions included that the Bill would need to:

- define 'appropriate care or treatment' if legislating a duty to provide medical care and treatment to a baby born as a result of a termination[78]
- clarify 'that there is an obligation on health professionals to provide comfort measures (including palliative care medications if necessary) and afford dignity'[79] to a baby born with signs of life, and 'that there is no obligation on health professionals to provide life-sustaining measures to an infant born alive as a result of a termination of pregnancy' with this decision based on 'the individual's condition in consultation with the parents and the medical team'[80]
- include guidance for decisions about 'whether life-sustaining intervention or comfort care should be provided'[81]
- address 'the complexities inherent in the termination of pregnancy' if legislating a 'duty of care', and in a situation where a baby survives, have a process to support all involved which should

75 *Health Practitioner Regulation National Law (Queensland)*, s 141B.

76 *Health Practitioner Regulation National Law (Queensland)*, s 141B.

77 *Health Practitioner Regulation National Law (Queensland)*, Part 8, Division 7.

78 Australian College of Midwives and Australian College of Nursing, submission 123, p 3.

79 Australian College of Midwives, submission 129, p 2.

80 Australian College of Midwives, submission 129, p 2.

81 Australian College of Midwives and Australian College of Nursing, submission 123, p 3.

be discussed and developed before the procedure,[82] including counselling options[83] and information about the risks of a live birth after a termination of pregnancy procedure, and the possible outcomes of the infant receiving palliative or active treatment[84]

- clarify the definition, clinical responsibility, and supervision of a 'student' included in the proposed definition of 'relevant person'[85]
- require mandatory collection of data regarding all babies born alive following an abortion, including 'demographics of gestational age, sex, the reason for the abortion, the care provided after birth and if applicable, the time of death'[86]
- legislate that 'feticide must be performed prior to termination of pregnancy at any gestation when a live birth may occur'.[87]

Committee comment

In the committee's view, many of the issues with the Bill related to duty of care that were highlighted by stakeholders arise because decisions about the care or treatment for babies born with signs of life after a termination of pregnancy procedure are dependent on the medical circumstances in each instance. The above-listed range of suggested amendments to the Bill that would be required to support the encoding of such a duty underpins our view that the limited number of events in which a baby is born alive following a termination of pregnancy procedure are more appropriately managed by registered health practitioners according to professional and ethical standards and in the context of clinical realities.

2.4 Access to termination of pregnancy services

Stakeholders were concerned that the Bill would negatively affect access to termination of pregnancy services.[88] The committee heard that women's access to this health care would be impeded for many reasons, including because:

- experience has shown that 'the imposition of legal requirements and conditions over and above those required for other medical procedures acts as a barrier to access' to termination of pregnancy – 'whether this is intended by the regulation or not'[89]
- 'a framework already exists for providers to adhere to their duty of care' to ensure that appropriate care is administered to mother and baby, and if health practitioners are legally required to intervene regardless of the context 'this compromises their right to make clinical decisions that ensure the safety and health of the parties involved'.[90] Regulating the discretion of healthcare professionals to determine optimal care based on each patient's individual

82 Australian College of Midwives and Australian College of Nursing, submission 123, pp 3-4.

83 Australian College of Midwives and Australian College of Nursing, submission 123, p 4; Dr Melissa Lai, submission 125, p 3.

84 Dr Melissa Lai, submission 125, p 3; Australian College of Midwives and Australian College of Nursing, submission 123, p 5.

85 Australian College of Midwives and Australian College of Nursing, submission 123, p 4; see also submission 10.

86 Dr Melissa Lai, submission 125, p 3.

87 Australian College of Midwives, submission 129, pp 3-4.

88 See for example submissions 93, 122, 130, 131, 646.

89 RANZCOG, submission 93, p 1.

90 SPHERE Coalition, submission 646, p 3.

circumstances 'introduces ambiguity and undermines patient access to high-quality, legally protected healthcare services'[91] and erodes trust in practitioners[92]

- the Bill would interfere with doctor-patient relationships as decisions regarding care of a child born alive, independent of the circumstances, should be a matter between the woman and their treating health practitioners.[93] The Bill would restrict access to safe legal services for women and their families facing extremely difficult situations, as informed decisions regarding abortions over 22 weeks gestation are currently 'made by women, pregnant people, and their families in extensive consultation with health practitioners' and involve 'medical and psychological assessments, counselling, education, and support'[94]
- fear of prosecution may discourage practitioners from performing terminations[95]
- targeting and legislating health care available to pregnant people experiencing disadvantage, and to pregnant people and their families experiencing distressing diagnoses, 'is inequitable and creates further barriers in an already-stigmatised area of healthcare'.[96] This is because the small proportion of people seeking abortions presenting in the second or third trimester are more likely to be experiencing severe disadvantage or distress and are more likely to present with complex health and personal circumstances that create barriers to access to healthcare, 'including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, rape or incest, socio-economic disadvantage, drug addiction or mental health issues'[97]
- any regulation that risks limiting access to abortion disproportionately affects women and families living in rural and remote areas, especially First Nations women, whose access to medical services is already more difficult than for women living in metropolitan areas, and increases disparity.[98]

RANZCOG submitted that the issues for rural, remote and First Nations women included practical medical barriers, as well as well as serious implications for health care outcomes and choices. For example, RANZCOG explained that 'while intracardiac injections [for feticide] are available in many tertiary centres, they are unavailable in regional areas. This in turn increases the risk for rural women having children born alive, if abortions are undertaken in rural areas'.[99]

The Australian College of Midwives (ACM) also advised that 'not all health services in QLD have the capacity to provide appropriate resuscitation measures to a severely premature baby'.[100] As a result, as RANZCOG observed, health practitioners who would 'face a dilemma seeking to provide best possible care for the delivery and deciding on provision of resuscitation, if the baby is born alive … may elect to transfer or delay induction, which then will result in suboptimal treatment',[101] or be discouraged from performing abortion services based on maternal choice or major congenital

91 Children by Choice, submission 131, p 7; see also submission 10.

92 SPHERE Coalition, submission 646, p 3.

93 RANZCOG, submission 93, p 2.

94 QNMU, submission 122, p 4; see also SPHERE Coalition, submission 646, p 2.

95 RANZCOG, submission 93, pp 2, 3, SPHERE Coalition, submission 646, p 3, see also submission 10.

96 Children by Choice, submission 131, p 6, see also submission 130.

97 SPHERE Coalition, submission 646, p 2, see also Children by Choice, submission 131.

98 See submissions 93, 131, 646.

99 RANZCOG, submission 93, p 3.

100 Australian College of Midwives, submission 129, p 3.

101 RANZCOG, submission 93, p 4.

abnormalities 'due to fear of criminal liability'[102] if they are unable to provide life-sustaining treatment.

RANZCOG further submitted that 'many women may be forced to abandon what they would elect to do, due to the inability to find a service locally'[103] or face added costs and physical stressors associated with visiting a larger centre with abortion services, as well as separation from their communities, families, and support networks during a psychologically and physically challenging time.[104] Further, the Bill would adversely affect First Nations people's right to practise their culture by limiting First Nations women's opportunity to deliver 'on country' 'which is an important cultural aspect in their lives', as it is 'for babies to 'die' on country'.[105]

Mrs Fridae King from the QNMU explained how limited access to services can delay termination of pregnancy care and result in termination procedures needing to be performed at later gestations, which have higher risk of a baby born with signs of life:

> 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.[106]

Other stakeholders submitted, in support of the Bill, that it would not affect access to abortion,[107] and that failure to pass the Bill 'could undermine public confidence in the healthcare system's ability to prioritize patient care and uphold ethical standards', also suggesting that this could lead to 'broader implications for healthcare access and quality'.[108]

2.4.1.1 Member for Traeger's response

In response to concerns that the Bill would impede access to termination services, the Member for Traegar stated that the Bill 'does not create a barrier to abortion, as the abortion has already occurred', that 'the Bill's focus is on the medical care provided to the baby following an abortion',[109] and:

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

102 RANZCOG, submission 93, p 3.

103 RANZCOG, submission 93, p 3.

104 RANZCOG, submission 93, p 3.

105 RANZCOG, submission 93, p 3.

106 Public hearing transcript, Brisbane, 19 August 2024, p 21.

107 See for example submissions 90, 110, 269, 320, 432, 461.

108 Name withheld, submission 320, p 2.

109 Mr Robbie Katter MP, Member for Traeger, correspondence, 31 May 2024, p 2.

be active or palliative, depending on the clinical circumstance) outweighs concerns held about reducing barriers for women to access abortion.[110]

Committee comment

Access to termination of pregnancy, including the option to terminate a pregnancy at a later gestation when necessary, is an important aspect of reproductive health care.

We find submissions that the Bill has the potential to negatively affect the availability of legal termination services persuasive. Some health practitioners may be reluctant to provide these health services because of the uncertainty created by imposing additional and unnecessary legal obligations on their existing duty of care. Creating further legal obligations around later gestation termination of pregnancy is likely to disproportionately impact women for whom access to health services is already challenging, including Aboriginal women and Torres Strait Islander women, and women in rural and remote areas.

We note that the Member for Traeger has not responded to such concerns in a substantive way.

2.5 Resourcing issues

The personal effect on health practitioners, particularly nurses and midwives, in the event of a baby being born with signs of life following a termination procedure, was raised by some stakeholders, both supporting and opposing the Bill.

Those supporting the Bill were concerned about the mental health of staff involved being adversely affected.[111] Stakeholders also highlighted the problem of insufficient staff to manage situations. Ms Louise Adsett from the Australian Christian Lobby, gave evidence at the public hearing about her experiences as a registered midwife, stating:

> 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.[112]

Ms Beaman from the QNMU also advised that 'absolutely it is traumatic for the staff' and that 'there is a level of trauma, too, for the families involved'.[113] Ms Beaman further explained that:

> …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.[114]

The ACM advised that maternity departments in Queensland 'are busy and already understaffed. Midwives are required to support babies at the end of life as well as provide physical care and emotional support to the woman and her family, and at times this process can take hours'.[115] The ACM described how staffing arrangements can mean a midwife may be 'caring for multiple other women

110 Mr Robbie Katter MP, Member for Traeger, correspondence, 31 May 2024, p 2.

111 See for example submission 142, 271, 369, 452, 490, 491, 545, 552, 617.

112 Public hearing transcript, Brisbane, 19 August 2024, p 3.

113 Public hearing transcript, Brisbane, 19 August 2024, p 20.

114 Public hearing transcript, Brisbane, 19 August 2024, p 20.

115 Submission 129, p 5.

and live babies at the same time as supporting a family through a late termination' which results in 'inadequate time to provide appropriate support for the woman and baby, and emotional distress and burn out for the midwife'.[116]

The critical nature of appropriate resources and staffing to provide adequate support for women and babies after termination was stressed by submitters and other witnesses.[117] This includes ensuring sufficient funding for termination of pregnancy care teams and allocating funds for social workers across all services to enhance the quality of care and promote positive outcomes for both patients and staff.[118]

2.5.1.1 Member for Traeger's response

Following evidence given at the public hearing, the Member for Traeger stated:

> 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?[119]

2.6 Service delivery issues

Other issues requiring planning and provision of care were raised by some stakeholders. The ACM and the Australian College of Nursing jointly submitted that 'providing care and treatment to a newborn born as a result of termination requires consultation with the birth mother, and consent needs to be considered'.[120] Further, a situation where the newborn survives 'should be discussed and developed during the consent consultation before the procedure to ensure the safety of the persons involved'.[121]

The ACM suggested 'appropriate immediate and ongoing guardianship' of a baby born alive following a termination and receiving life-sustaining treatments needs to be considered, as the parents may not wish to assume custody of the baby, and that this should involve 'social work and counselling support for the parents'.[122]

Some submitters emphasised the importance of patient-centred care (the provision of medical care that is compatible with patients' personal goals, wishes and preferences related to the care provided) stating that the Bill would interfere with the duties of providers to administer patient-centred care and their ability to meet established medical and professional ethical standards in the delivery of clinical services.[123]

Children by Choice noted the need to address 'systemic challenges' rather than 'obscuring the issue with vague references to "survivability" and shifting blame onto healthcare providers and patients'.[124]

2.6.1 Feticide

Feticide, which involves injection of a pharmaceutical agent to ensure fetal death prior to commencing induction of labour, is recommended as standard care for terminations of pregnancies of gestations

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116 Submission 129, p 5.

117 See for example submissions 93, 129, 131; also public hearing transcript, Brisbane, 19 August 2024, pp 9, 13, 15, 20, 23.

118 Australian College of Midwives, submission 129, p 5; Children by Choice, submission 131, pp 6-8.

119 Public hearing transcript, Brisbane, 19 August 2024, p 26.

120 Submission 123, pp 3-4.

121 Submission 123, p 4.

122 Submission 129, p 3.

123 Children by Choice, submission 131, p 6; SPHERE Coalition, submission 646, p 2.

124 Submission 131, p 8.

greater than 22+1 weeks in the Queensland Clinical Guideline.[125] The RANZCOG *Clinical Guideline for Abortion Care* recommends that feticide should be considered for abortions at or beyond 22 weeks pregnant, and notes that although feticide is usual practice, 'it may be appropriate to perform an abortion without feticide if the fetus has a condition incompatible with life, and on the request of the parents'.[126] The World Health Organisation recommends feticide be considered for abortions after 20 weeks gestation 'to avoid signs of life', noting that 'the likelihood of transient fetal survival after expulsion' increases with increasing gestational age and shorter interval between steps in the procedure.[127]

The ACM explained that feticide is an important aspect of termination of pregnancies of later gestations, and 'is performed to save suffering for both mother and baby'.[128] Performed for the majority of terminations after 22 weeks gestation, 'effective use of feticide, accompanied by appropriate assessment of the success of the procedure, makes the incidence of a live birth following a late termination extremely unlikely'.[129] As noted in section 2.3 above, legislating mandatory feticide for termination of pregnancy was suggested by the ACM to remove the chance of a live birth following termination.[130] The ACM recommended further investigation to determine the earliest gestation at which babies are born with signs of life so that the Queensland Clinical Guideline and legislation 'reflect an appropriate earlier gestation to perform feticide prior to termination of pregnancy'.[131]

The explanatory notes cite results from a 2018 study which evaluated the live birth rate and duration of survival in second-trimester termination of pregnancy procedures not preceded by feticide,[132] and reported that the study 'found more than half the babies were born alive, with a median time of survival of 32 minutes and one baby surviving for over four hours (267 minutes)'.[133]

The study analysed data on 241 terminations for fetal anomalies or genetic abnormalities which occurred over a 14-year period. In 122 cases (50.6%) there were signs of life after termination procedures without feticide. Higher gestational age was associated with a higher chance of live birth, and severity of fetal anomalies associated with increased chance of stillbirth. The study found that the data cannot be extrapolated to all fetuses and that the results were potentially limited by selection bias, as women more likely declined feticide for pregnancies with the most severe fetal anomalies and those with a lower gestational age because survival expectation was lower.[134]

RANZCOG noted that contemporary evidence suggests that most parents and health care professionals prefer fetal death prior to termination to ensure there is no risk of live birth, but that 'in

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125 Queensland Health, *Queensland Clinical Guidelines: Maternity and Neonatal Clinical Guideline – Termination of pregnancy*, Guideline No. MN19.21-V9- R24, 2020, https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf, p 21.

126 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Clinical Guideline for Abortion Care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand*, 2023, https://ranzcog.edu.au/wp-content/uploads/2023/10/Clinical-Guideline-for-Abortion-Care.pdf, pp 18-19, 38.

127 World Health Organization, *Clinical practice handbook for quality abortion care*, 2023, https://iris.who.int/bitstream/handle/10665/369488/9789240075207-eng.pdf?sequence=1

128 Submission 129, p 3.

129 Submission 129, p 4.

130 Submission 129, p 4.

131 Submission 129, p 4.

132 S Springer, M Gorczyca, J Arzt, S Pils, D Bettelheim, J Ott, *Fetal Survival in Second-Trimester Termination of Pregnancy Without Feticide*, Obstetrics and Gynecology, 2018, 131(3), p 575.

133 Explanatory notes, p 2.

134 S Springer, M Gorczyca, J Arzt, S Pils, D Bettelheim, J Ott, *Fetal Survival in Second-Trimester Termination of Pregnancy Without Feticide,* Obstetrics and Gynecology, 2018, 131(3), p 578.

rare cases, parents may choose not to have feticide because they want to hold their (non-viable) baby while it dies'.[135] RANZCOG submitted that 'in such cases, they should be supported through this intensely emotional and difficult time without there being any fear of legal consequences for the health professionals involved'.[136]

Committee comment

The committee acknowledges that where the decision to terminate a pregnancy has been made, feticide in every case at any gestation when a live birth may occur would provide certainty. We also understand that there are reasons why feticide might not be performed in some cases. The committee considers that this is a matter best guided by evidence-based practice standards rather than prescribed in legislation. This position is based on the recognition that future evidence and advances in health care may result in changes to practice standards and clinical guidelines for termination of pregnancy, including an earlier gestation recommendation for feticide.

We agree with the evidence that staff shortages have compounded an already difficult situation and appropriate resources and staffing are needed to provide adequate support for women and for babies born alive after a termination of pregnancy. The Queensland Government has recently implemented provisions designed to improve midwife and nurse to patient ratios and we expect this increased resourcing should start addressing some of these staffing issues.

The committee considers that increasing efforts by the Queensland Government to elevate staffing levels in services delivering termination of pregnancy care is more likely to optimise patient care than legislation.

Recommendation 2

The committee recommends that the Queensland Government continue to elevate staffing levels in termination of pregnancy health service provision.

2.7 Other jurisdictions

The explanatory notes state that the Bill 'brings the Queensland law into line with South Australia and New South Wales'.[137] Some submitters supported alignment of the Termination of Pregnancy Act with the law in these states.[138]

South Australian and New South Wales termination of pregnancy legislation contains provisions similar to the amendments proposed by the Bill. In New South Wales, the relevant provision regarding care of a baby born after a termination of pregnancy is explicitly linked to the requirement to observe guidelines and standards:

> …this Act does not limit a duty a registered health practitioner has to comply with professional standards or guidelines. See also section 14, which provides that the Secretary of the Ministry of Health may issue guidelines about the performance of terminations at approved health facilities and requires registered health practitioners performing terminations, or assisting in the performance of terminations, to act in accordance with the guidelines.[139]

New South Wales included this provision in its *Abortion Law Reform Act 2019* after concerns were raised that its draft Bill legalising termination of pregnancy 'somehow or other changes a health

135 Submission 93, p 3.

136 Submission 93, p 3.

137 Explanatory notes, p 3.

138 See for example submissions 54, 57, 97, 115, 118, 120.

139 *Abortion Law Reform Act 2019* (NSW), s 11 note, https://legislation.nsw.gov.au/view/html/inforce/current/act-2019-011.

practitioner's obligation to treat a child born alive following a termination'.[140] The then Chair of the NSW Standing Committee on Law and Justice, the Hon Niall Blair MLC, stated during detailed consideration of the Bill:

> I wish that I was not moving this amendment at all. It is disappointing that we find ourselves having to codify what is already in existence; having to explicitly set out what is the actual law at the moment to allay community concerns or misunderstanding as to the obligations and the intent of what people are trying to do with this bill. But we are there and, whether we like that or not, we must do something to address those concerns. As I have been moving around discussing this issue with people I have found that many in society think whatever is being said in this area is true—that there would be doctors who would allow a child who had been born to lay there and suffer until they die.[141]

In opposing the amendment during that same debate, Ms Abigail Boyd MLC stated:

> In respect of the Hon. Niall Blair's amendment, I thank him for the efforts he has made to come up with a compromise position and for acknowledging that care and compassion does already exist in our medical system. That is a really good basis from which to start. This amendment is certainly made in good faith. I have heard what honourable members have said, "If this already occurs, what is the problem in codifying it? This is a good way to appease some concerns." I think that is a slippery slope to go down. If we seek to codify everything in an unnecessary way, to double up in our legislation, our legislation will become rather weighty and full. So The Greens will not be supporting this amendment on the basis we believe it to be unnecessary.[142]

During that same debate the Hon Emma Hurst MLC, stated:

> …the purpose of this amendment is to settle misinformation. We are not convinced that it will settle misinformation. In fact, we are concerned that it could be a catalyst for more misinformation. It seeks to appease those who are spreading misinformation and, in doing so, it could encourage people to spread misinformation on other bills.[143]

2.7.1 Outcomes in other jurisdictions

Dr Melissa Lai, representing Prolife Health Professionals Australia, gave the following evidence at the committee's public hearing about differences between Queensland and New South Wales practice relating to live births following a termination of pregnancy procedure:

> **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.

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140 Hon Niall Blair MLC, Parliament of New South Wales, Legislative Council Hansard – 18 September 2019, Reproductive Health Care Reform Bill 2019, https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-79919, 11:24.

141 Hon Niall Blair MLC, Parliament of New South Wales, Legislative Council Hansard – 18 September 2019, Reproductive Health Care Reform Bill 2019, https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-79919, 11:24.

142 Ms Abigail Boyd MLC, Parliament of New South Wales, Legislative Council Hansard – 18 September 2019, Reproductive Health Care Reform Bill 2019, https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-79919, 11:45.

143 Hon Emma Hurst MLC, Parliament of New South Wales, Legislative Council Hansard – 18 September 2019, Reproductive Health Care Reform Bill 2019, https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-79919, 11:58.

> **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?[144]

Data subsequently provided by Prolife Health Professionals Australia to that question taken on notice showed that it was not possible to discern the impact of the New South Wales and South Australian legislation from publicly available data.[145]

Committee comment

The committee acknowledges that despite New South Wales and South Australia including provisions around treatment of live births following a termination of pregnancy procedure, such provisions were not without controversy. We share the concerns communicated by various members of the New South Wales Parliament Legislative Council that such a provision attempts to codify what is already in established guidelines and standards, and was only advanced by that government to respond to misinformation circulating during the termination of pregnancy law reform process.

2.8 Compatibility with human rights

In support of the Bill, many submitters referred to the human rights of the baby 'born alive'. Some of these submissions referenced international human right treaties, in particular Article 6 of the Universal Declaration of Human Rights, Article 24 of the Convention on the Rights of the Child, and Article 12 of the International Covenant on Economic, Social, and Cultural Rights.[146]

Other submitters were concerned that the Bill challenges the right to health services and the reproductive rights of women recognised in international human rights instruments and protected by s 37 of the HRA.[147]

The HRA protects fundamental human rights drawn from international human rights law.[148] Section 13 of the HRA provides that a human right may be subject under law only to reasonable limits that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom.

The statement of compatibility accompanying the Bill stated that the Bill does not contravene any human right listed under Part 2, Division 2 and 3 of the HRA.[149]

2.8.1 International human rights law

The right to life is included in a number of human rights treaties[150] and is considered a fundamental right.[151] The right must be respected at all times, and it is very difficult to justify any limitations on the right.

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144 Public hearing transcript, Brisbane, 19 August 2024, p 9.

145 Dr Melissa Lai, Prolife Health Professionals Australia, correspondence, 26 August 2024.

146 See for example submissions 11, 14, 44, 53, 69, 82, 97.

147 See for example submissions 122, 123, 129, 130, 131, 646.

148 The human rights protected by the HRA are set out in ss 15 to 37 of the Act. A right or freedom not included in the Act that arises or is recognised under another law must not be taken to be abrogated or limited only because the right or freedom is not included in this Act or is only partly included; HRA, s 12.

149 Statement of compatibility, p 1.

150 Article 6(1) International Covenant on Civil and Political Rights; article 6 Convention on the Rights of the Child (CRC), article 10 of the Convention on the Rights of Persons with Disabilities (CRPD). See generally Attorney-General's Department, *Right to life: Public sector guidance sheet,* https://www.ag.gov.au/rights-and-protections/human-rights-and-anti-discrimination/human-rights-scrutiny/public-sector-guidance-sheets/right-life.

151 HRC, *General Comment No. 36 Article 6: Right to life*, CCPR/C/GC/36, 3 September 2019.

The right to health is included in a number of human rights treaties.[152] The right to health guarantees that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity. The achievement of public health can require limitations on individual freedoms and rights. It is important to note that the right to health is not a right to be healthy.[153]

The right to family life means that the parents of a child patient should be consulted about treatment and their views should be taken into account.[154] However, parents' decisions on behalf of their child are subject to the overriding consideration of what is in the best interests of the child.[155]

Human rights are interdependent, indivisible and interrelated.[156] The right to life and the right to health are interrelated. There are cases in other jurisdictions which have noted that the right to life includes an obligation to provide access to medical treatment to preserve life.[157]

2.8.2 Rights of a 'child' born alive

Section 106 of the HRA provides that 'nothing in this Act affects any law relating to termination of pregnancy or the killing of an unborn child'. Therefore, the right to life under s 16 of the HRA does not affect the legality of termination of pregnancy in Queensland and a termination procedure does not constitute a breach of the HRA.

The explanatory notes for the Human Rights Bill 2018 state in regard to s 106 of the HRA and the right to life protected by s 16 of the HRA, that:

> Clause 16 provides for the right to life. This clause is modelled on article 6(1) of the ICCPR [International Covenant on Civil and Political Rights]. The right not to be deprived of life is limited to arbitrary deprivation of life. Not every action that results in death will be arbitrary. This right reflects the positive obligation on states in article 6(1) of the ICCPR to take positive steps to protect the lives of individuals through, for example, appropriate laws that prohibit arbitrary killing and positive measures to address other threats to life such as malnutrition and infant mortality.
>
> This clause is to be read with the savings provision in clause 106, which states that nothing in the Act affects any law relating to termination of pregnancy or the killing of an unborn child.[158]

The Department of Justice and Attorney General further advised the former Legal Affairs and Community Safety Committee during its inquiry into the Human Rights Bill in 2018, that 'the right to life is provided in cl 16, which states that every person has the right to life and has the right not to be

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152 Article 12(1) International Covenant on Economic Social and Cultural Rights, articles 10(h), 11(1)(f), 12, 14(2)(b) and 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), articles 24 and 25 of the CRC, articles 23(1)(c) and 25 of the CRPD. See generally Attorney-General's Department, Right to health: Public sector guidance sheet https://www.ag.gov.au/rights-and-protections/human-rights-and-anti-discrimination/human-rights-scrutiny/public-sector-guidance-sheets/right-health#what-is-the-right-to-health.

153 ESCR Committee, *General Comment No.14*, E/C.12/2000 (11 August 2000).

154 See Jeremy Croft, *Health and Human Rights: A Guide to the Human Rights Act 1998* (2003), https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/health-and-human-rights-web-final.pdf.

155 See Jeremy Croft, *Health and Human Rights: A Guide to the Human Rights Act 1998* (2003), https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/health-and-human-rights-web-final.pdf.

156 See Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June 1993.

157 *Treatment Action Campaign and others v Minister of Health and others (TAC)* (2002) 5 SA 721 (CC) High Court of South Africa, Transvaal Provincial Div., 12 December 2001 CASE NO: 21182/2001.

158 Human Rights Bill 2018, explanatory notes, p 19.

arbitrarily deprived of life. It is not intended that this right provide a determining statement as to when life begins'.[159]

The Bill (cl 4) would apply if 'a termination results in a person being born'. The Bill does not offer any definition of 'a person'.

The HRA (s 11(1)) provides that 'all individuals in Queensland have human rights'. Throughout the HRA there are references to 'a person' or 'every person'. The HRA does not provide a definition of a 'person' or an 'individual'.

Article 1 of the Universal Declaration of Human Rights states 'all human beings are born free and equal in dignity and rights'. Article 1 of the Convention on the Rights of the Child defines a 'child' as 'every human being below the age of 18 years of age', and states that a 'child' is entitled to the protection of their human rights.

Committee comment

Scientific, medical, and philosophical arguments about whether or when a fetus can be considered a 'person' are not settled. More relevant to the Bill's proposed amendments to the Termination of the Pregnancy Act is the broadly accepted understanding among health practitioners that 'live birth' with the presence of 'signs of life' does not equate to 'viability'. The committee accepts that the matter of fetal viability, or whether particular medical treatment or technology will be available in every situation, or whether active treatment will result in survival, are contextual matters which can only be assessed on a case by case basis by qualified health practitioners and cannot be determined universally, such as would be required to ground a legislative provision.

2.8.3 Right to health services

The right to sexual and reproductive health and autonomy is recognised in international human rights instruments and encompasses access to termination of pregnancy health care.[160]

The International Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) requires states, including Australia, to take all appropriate measures including legislation to eliminate discrimination against women, including in health care and family relations,[161] noting that the particular responsibilities of women to bear and raise children, which affect their lives and development and their physical and mental health, as well as that of their children, entitle them 'to decide on the number and spacing of their children'.[162]

The International Covenant on Economic, Social and Cultural Rights recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health',[163] including the

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159 Legal Affairs and Community Safety Committee, *Report No. 26, 56th Parliament – Human Rights Bill 2018*, p 23.

160 For a detailed analysis of international human rights related to termination of pregnancy see Queensland Law Reform Commission, *Review of termination of pregnancy laws - Report No 76*, 2018, Appendix C, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0004/576166/qlrc-report-76-2018-final.pdf.

161 Convention on the Elimination of All Forms of Discrimination against Women, *General Assembly Resolution 34/180* (18 December 1979), article 12(1), article 16(1).

162 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General recommendation No 21: Equality in marriage and family relations*, 13th session (1994). It is also recognised by the Human Rights Committee (HRC) that the right to private and family life in article 17 of the International Covenant on Civil and Political Rights encompasses women's reproductive decisions, and that the right to life requires consideration of measures 'to help women prevent unwanted pregnancies' (HRC *General Comment No 28, Article 3*, UN Doc CCPR/C/21/Rev.1/Add.10, (29 March 2000).

163 International Covenant on Economic, Social and Cultural Rights, *General Assembly Resolution 2200A (XXI)*, (16 December 1966), article 12(1).

right to sexual and reproductive health.[164] Women's right to sexual and reproductive health is recognised as essential to the fulfilment of the full range of their human rights,[165] and health services should 'be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice'.[166]

States should aim to ensure universal access, including for individuals from disadvantaged groups, to quality sexual and reproductive health care, and to respect the right of women to make autonomous decisions about their sexual and reproductive health.[167] The United Nations CEDAW Committee has also noted the obstacles for women in rural areas to accessing sexual and reproductive health care and has recommended that states should ensure that high quality health care services, including access to abortion care, are physically accessible and affordable for rural women.[168]

Committee comment

The Bill is compatible with the HRA.

The Bill applies to a 'person born as a result of a termination' and provides that nothing in the Termination of Pregnancy Act prevents a relevant medical or health practitioner from exercising any duty to provide medical care and treatment to a person that is 'clinically safe'. This appears to be consistent with the obligation to preserve life. The Bill also states that the treatment must be 'appropriate to the person's condition'. This appears to be consistent with the fact that the right to life does not mean treatment must always be provided.

Palliative care of a person is appropriate to avoid inhuman or degrading treatment. This is consistent with the Queensland Clinical Guideline which requires care appropriate to the individual clinical circumstances and in accordance with best practice guidelines to be provided if a baby is born with signs of life, and which does not recommend active interventions where survival is determined to be unlikely, as these may prolong palliation and cause distress.

The committee notes that the right to access health services protected by section 37 of the HRA is an important principle in effective reproductive health care, and we are concerned that the Bill will impair women's access to termination of pregnancy services in Queensland.

164 See Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/GC/22 (2 May 2016).

165 CEDAW Committee, *General recommendation No 24: Article 12 of the Convention (women and health)*, 20th session (1999).

166 CEDAW Committee, *General recommendation No 24: Article 12 of the Convention (women and health)*, 20th session (1999). The CEDAW and ESCR Committees recognise that the right to sexual and reproductive health and autonomy applies to children and adolescents - see for example CEDAW Committee, *General Recommendation No 24, Article 12 of the Convention (women and health)*, 20th session (1999); ESCR Committee, *General Comment No 22 (2016);* see also Convention on the Rights of the Child, General Assembly Resolution 44/25 (20 November 1989), article 24(1).

167 ESCR Committee, *General Comment No 22 (2016)*.

168 CEDAW Committee, *General recommendation No 34 (2016) on the rights of rural women*, UN Doc CEDAW/C/GC/34 (7 March 2016).

Appendix A – Witnesses at public proceedings

Public briefing – Brisbane – 29 April 2024

- Mr Robbie Katter MP, Member for Traeger
- Dr Joanna Howe, Professor of Law, The University of Adelaide

Public hearing – Brisbane – 19 August 2024

Australian Christian Lobby

- Mr Rob Norman, State Director, Queensland
- Ms Louise Adsett, Midwife

Cherish Life Queensland

- Mr Matthew Cliff, Executive Officer
- Mrs Donna Purcell, President

Prolife Health Professionals Australia

- Dr Melissa Lia, Director
- Professor Gerald Fogarty, Executive Member

Dr Joanna Howe, Professor of Law, University of Adelaide

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

- Dr Elisha Broom, RANZCOG Councillor, and member, RANZCOG Queensland State Committee

Australian College of Midwives Queensland Branch

- Ms Alison Weatherstone, Chief Midwife
- Ms Michelle Warriner, Queensland Branch Chair

Queensland Nurses and Midwives Union

- Ms Sarah Beaman, Secretary
- Mrs Fridae King, Organiser
- Ms Julie Lee, Research and Policy Officer

Children by Choice

- Ms Jill McKay, Chief Executive Officer

Appendix B – Submitters

Sub	Submitter	Sub	Submitter
1	Allan Choveaux	34	Judith Butler
2	Dorothy Long	35	Debra Bell
3	Name withheld	36	Glenda Rose
4	Paul Creighton	37	Name withheld
5	Alex Todd	38	Noel Quilliam
6	Jeremy Tibballs	39	Augarette Malki
7	Abigail Flagherty	40	Rob O'Donnell
8	Karen Johns	41	Confidential
9	Dr Timothy Coyle	42	Michael Pearcy
10	Name withheld	43	Name withheld
11	Deborah Norman	44	Jacqui Halpin
12	Name withheld	45	Alan Regan
13	Dominik Wegrecki	46	Jan Jackowiak
14	Name withheld	47	Marian Kowarzik
15	Myrna Olive Kaiser	48	Name withheld
16	Name withheld	49	Margie Lloyd
17	Ian Moncrieff	50	Jacqueline Clark
18	Name withheld	51	Kerry Barham
19	Dr Ximena Ovalle	52	Maynessa Lloyd
20	Elizabeth Stephens	53	Wendy Kefford
21	Ian Hoddinott	54	Adrian Prince
22	June Laws	55	Judith Bolin
23	Mark Hill	56	Barbara Bluett
24	Stephany Steggall	57	Paul Rogers
25	Brett Stone	58	Name withheld
26	Name withheld	59	Name withheld
27	Matthew Schaeffer	60	Confidential
28	Name withheld	61	Confidential
29	Michele Aney	62	Name withheld
30	Name withheld	63	Judith Wilson
31	Kevin Jensen	64	Rebecca Andersen
32	Irene Skinner	65	J Edwards
33	Ian Brearley	66	Andrew Berneville-Claye

Sub	Submitter
67	Peter Brown
68	Samantha Bryan
69	Name withheld
70	Leanne Daniell
71	Peter Staples
72	Nicholas Crowther
73	Cindy Mayes
74	Name withheld
75	Name withheld
76	William and Sandra Tento
77	Name withheld
78	Melissa Wynne
79	Ruth Crowe
80	Neil Westgarth
81	Katherine Spadaro
82	Archdiocese of Brisbane
83	Jenny Wake
84	Christopher Hall
85	Name withheld
86	Trish Koutrodimos
87	Ruth Fea
88	Name withheld
89	Zachary Dexter
90	Colin Apelt
91	Robert Heron
92	Keith Benn
93	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
94	Bronwyn Young
95	Alva Adams
96	Christine Thomas
97	Australian Christian Lobby
98	Les Percy
99	Name withheld
100	Edward Oddone
101	William Clifford
102	Veronica Pritchard
103	Roslyn Blackwood
104	Anne Coyle
105	Doug Gavel
106	Christopher McCormack
107	Stephen Clements
108	Carmel Park
109	Stuart Campbell
110	Name withheld
111	Brian Amies
112	Christine Hogkinson
113	David Miller
114	Tobias Kennett
115	Name withheld
116	Cherish Life Gympie
117	Name withheld
118	Name withheld
119	Lina Martin
120	Name withheld
121	Cecily Mac Alpine
122	Queensland Nurses and Midwives' Union
123	Australian College of Midwives and The Australian College of Nursing
124	Cherish Life Queensland
125	Dr Melissa Lai
126	Dr Joanna Howe
127	Name withheld
128	Ciara Ross
129	Australian College of Midwives
130	ASHM Health
131	Children by Choice
132	Confidential

Sub	Submitter
133	Renee Harwood
134	Debra Quinn
135	James Vote
136	Arthur Shepherd
137	Name withheld
138	Name withheld
139	Melissa Wolters
140	Patrick Arendse
141	Mark Vegar
142	Name withheld
143	Les Percy
144	Name withheld
145	Barbara Mann
146	Name withheld
147	Kevin Rietveld
148	Name withheld
149	Same withheld
150	Jim Stein
151	Name withheld
152	Name withheld
153	Martine Plumbe
154	Glen Vonhoff
155	Name withheld
156	Name withheld
157	Name withheld
158	Name withheld
159	Rowena Cornell
160	Name withheld
161	Marta Barake
162	Name withheld
163	Name withheld
164	Name withheld
165	Name withheld
166	Name withheld
167	Name withheld
168	Confidential
169	Name withheld
170	Deborah Tweedale
171	Name withheld
172	Leonard William
173	Name withheld
174	Name withheld
175	Sally Kehoe
176	Nathan Williams
177	Name withheld
178	Name withheld
179	Confidential
180	Confidential
181	Name withheld
182	Name withheld
183	Name withheld
184	Name withheld
185	Michele Essex
186	Name withheld
187	Margaret Moppett
188	Name withheld
189	Name withheld
190	Name withheld
191	Name withheld
192	Name withheld
193	Mary Hare
194	Andrew Jurekic
195	Erin Cleary
196	Name withheld
197	Chris Guyler
198	Name withheld
199	Nicolette Ralfe
200	Julie Gordon

Sub	Submitter
201	Name withheld
202	Name withheld
203	Name withheld
204	Sherylle Wells
205	Name withheld
206	Robyn Munns
207	Name withheld
208	Cynthia Goodman
209	Peter Jones
210	John Ervin
211	Name withheld
212	Fel Roser
213	Kendal Fraser
214	Name withheld
215	Name withheld
216	Gareth Llewellyn
217	Annette Zerk
218	Kathleen Montagna
219	Name withheld
220	Confidential
221	Robert Koomans
222	Edward Walker
223	John Brady
224	Name withheldd
225	Name withheld
226	Name withheld
227	Matt Murphy
228	Elisabeth Heal
229	Name withheld
230	Michelle Holland
231	Name withheld
232	Vicki Ford
233	Gary Levens
234	Jennifer Conomos
235	Bill Pointing
236	Name withheld
237	Name withheld
238	Name withheld
239	Name withheld
240	Name withheld
241	Name withheld
242	Therese Adolfsen
243	Name withheld
244	Name withheld
245	Name withheld
246	Confidential
247	Peter Leonard
248	Julie Salam
249	Rob Lewthwaite
250	Name withheld
251	Jonathan Stubbs
252	Name withheld
253	Name withheld
254	Mitchell O'Shea
255	Ian Wallace
256	Name withheld
257	Helen Louden
258	Maureen Johnson
259	Name withheld
260	Name withheld
261	Name withheld
262	Name withheld
263	Alexandra Elliott
264	Mary Rofe
265	Name withheld
266	Name withheld
267	Confidential
268	Name withheld

Sub	Submitter
269	Name withheld
270	Mark Windle
271	Margaret van Blommestein
272	Juna Flodine
273	Name withheld
274	Susan Lederhose
275	Name withheld
276	Confidential
277	Warren Sheehan
278	Name withheld
279	Greg McRae
280	Fred van Staden
281	Name withheld
282	Name withheld
283	Name withheld
284	Name withheld
285	Name withheld
286	Name withheld
287	Gordon Jackson
288	Helen Anderson
289	Name withheld
290	Name withheld
291	Confidential
292	Rachel Jordan
293	Name withheld
294	Name withheld
295	Confidential
296	Adelmo Salvesani
297	Name withheld
298	Vivienne Mohr
299	Sind Yoo
300	Name withheld
301	Name withheld
302	David Grace
303	Name withheld
304	Kurt Dunlop
305	Annalisa Robinson
306	Name withheld
307	Bev Lenton
308	Linda Gray
309	Name withheld
310	Pauline O'Donnell
311	Ray McDonald
312	Chantal Urban
313	Frederic Richter
314	Shane Rutherford
315	Name withheld
316	Patricia Magee
317	Julie Gordon
318	Name withheld
319	Elizabeth Scott
320	Name withheld
321	Name withheld
322	Peter Liljeqvist
323	James Hearder
324	James Rogers
325	Name withheld
326	Garth Grenache
327	Name withheld
328	Alan Baker
329	Kobus Kirsten
330	Confidential
331	Doug Howard
332	Name withheld
333	Elaine Gunn
334	Name withheld
335	Alban Hunt
336	John Attard

Sub	Submitter
337	Mellisa Claffey
338	Name withheld
339	Name withheld
340	Name withheld
341	Name withheld
342	Therese Gaynor
343	Name withheld
344	Bernie Gaynor Sr
345	Patricia Grieshaber
346	Confidential
347	Name withheld
348	Alan Vigor
349	Robin Barke
350	Name withheld
351	Matthew Sweetman
352	Name withheld
353	Susan Bishop
354	Confidential
355	Confidential
356	Name withheld
357	Name withheld
358	Confidential
359	Helen Mann
360	Dean Pfeffer
361	Tina Miranda
362	Name withheld
363	David Crowley
364	Name withheld
365	Name withheld
366	Name withheld
367	Uta Lippmann
368	Name withheld
369	Keryn Hull
370	Name withheld
371	Confidential
372	Julie Shapland
373	Name withheld
374	Name withheld
375	Name withheld
376	Leanne Hall
377	Joe Nardizzi
378	Name withheld
379	Name withheld
380	Rowan Shann
381	Name withheld
382	John Leahy
383	Name withheld
384	Name withheld
385	Name withheld
386	Majella Eva
387	Name withheld
388	Name withheld
389	Name withheld
390	Rob Roy
391	Charmaine Dyer
392	Name withheld
393	Name withheld
394	Angus Harker
395	Name withheld
396	Name withheld
397	Confidential
398	Name withheld
399	Violet Langan
400	Name withheld
401	Name withheld
402	Judy Theobald
403	Priscilla Gash
404	Confidential

Sub	Submitter
405	Carole Kirton
406	Name withheld
407	Name withheld
408	Name withheld
409	Jan Mills
410	Name withheld
411	Linda Dennis
412	Susan D'Arcy
413	Eric Whitley
414	Name withheld
415	Anthony Morris
416	Name withheld
417	Margaret Newcombe
418	Name withheld
419	Gregory O'Keefe
420	Rhonda Palmer
421	Jane and Bruce Cruickshank
422	Name withheld
423	Name withheld
424	Helen Skinner
425	Confidential
426	Wayne Brooker
427	Sharon West
428	Name withheld
429	Name withheld
430	Name withheld
431	Name withheld
432	Jacoba Lowry
433	Dr Susan Galletly
434	Name withheld
435	Anna Woning
436	David Clark
437	Name withheld
438	Peter Duncan
439	Stuart Hold
440	Jolea Davies
441	Name withheld
442	Name withheld
443	Evelyn Ray
444	Name withheld
445	Name withheld
446	Lyndon Vincent
447	Name withheld
448	Frances Tutuian
449	Patricia Grant
450	Jill Patrick
451	Robert Peterson
452	Ken Dooley
453	Name withheld
454	Anne Rogers
455	Bob Vinnicombe
456	Name withheld
457	Name withheld
458	Kerry Muir
459	Nicole Young
460	Name withheld
461	Name withheld
462	Confidential
463	Ronald Wegen
464	Name withheld
465	Name withheld
466	Faith Tautala
467	Name withheld
468	Name withheld
469	Name withheld
470	Name withheld
471	Brigitte Reich
472	Kirsty Itallie

Sub	Submitter
473	Tania Pan
474	Name withheld
475	Name withheld
476	John and Jan Kennedy
477	Srikanth Nair
478	Elizabeth McLean
479	Stephen Funder
480	Miriam McKenzie
481	Name withheld
482	Lynda MacDonald
483	Name withheld
484	Name withheld
485	Name withheld
486	Jabin Mills
487	Jacqueline Brazel
488	Name withheld
489	Name withheld
490	Natalie Gibbs
491	Name withheld
492	Name withheld
493	Trish Riddell
494	Name withheld
495	Name withheld
496	Name withheld
497	Antoon Morreau
498	Ben Peters
499	Mark Davissen
500	Angelina Veloso
501	Confidential
502	Richard Schuster
503	Jan Litzow
504	John Ilies
505	Michelle Gibbs
506	Name withheld
507	Name withheld
508	Name withheld
509	Name withheld
510	Name withheld
511	Faye Dallas
512	Name withheld
513	Name withheld
514	Name withheld
515	Elizebeth Flower
516	Name withheld
517	Terry Poole
518	Name withheld
519	Name withheld
520	Christina Gilbert
521	Name withheld
522	Lorraine Applebee
523	Name withheld
524	Name withheld
525	Name withheld
526	Name withheld
527	Greg Wright
528	Luis Barajas
529	Bradley Murch
530	Jonathan Bound
531	Name withheld
532	Jennifer Tout
533	Rosemary Woods
534	Name withheld
535	Name withheld
536	Janice Schindler
537	Malcolm McKenna
538	Name withheld
539	Name withheld
540	Name withheld

Sub	Submitter
541	Name withheld
542	Confidential
543	Ana O'Brien
544	Name withheld
545	Name withheld
546	Alexander Pollock
547	Name withheld
548	Name withheld
549	Name withheld
550	Lester Reinbott
551	Name withheld
552	Kathleen Airey
553	Name withheld
554	Name withheld
555	Name withheld
556	Robyn Holt
557	Name withheld
558	Name withheld
559	Angela Clifford
560	Glen Park
561	Name withheld
562	Name withheld
563	Name withheld
564	Name withheld
565	Geraldine O'Brien
566	Name withheld
567	Valentina Lister
568	Name withheld
569	Name withheld
570	Confidential
571	Anne Elward
572	Kerry Champness
573	Rod Motyer
574	Confidential
575	Denise Sheehan
576	Name withheld
577	Name withheld
578	Name withheld
579	Name withheld
580	Name withheld
581	Name withheld
582	Dr Vern Heazlewood
583	Name withheld
584	Bernice Anning
585	Name withheld
586	Name withheld
587	Name withheld
588	John Drake
589	Name withheld
590	Name withheld
591	Name withheld
592	Paul Ruhl
593	Glenda Hodge
594	Megan Voigt
595	Name withheld
596	Name withheld
597	Confidential
598	Confidential
599	Bev Faulks
600	Name withheld
601	Name withheld
602	Damien Murphy
603	Andrew Lamb
604	Confidential
605	Name withheld
606	Sylviya Murphy
607	Name withheld
608	Kayla Hanna

Sub	Submitter
609	Name withheld
610	Jady Parr
611	Justin Moynihan
612	Name withheld
613	Name withheld
614	Confidential
615	Vanessa Chiem
616	Jessica Hagemeijer
617	Name withheld
618	Name withheld
619	Name withheld
620	Wendy Drury
621	Roger Itallie
622	Name withheld
623	Confidential
624	Name withheld
625	Angela Siczek
626	Name withheld
627	Withdrawn
628	Kelly Davis
629	Name withheld
630	Jodee Litzow
631	Sean Corcoran
632	Name withheld
633	Rebekah Bickerton
634	Name withheld
635	Name withheld
636	Name withheld
637	Sharon Jollow
638	Name withheld
639	Daniel Ibbott
640	Marjorie Kelly
641	Name withheld
642	Name withheld
643	Name withheld
644	Name withheld
645	Name withheld
646	SPHERE Coalition
647	Name withheld