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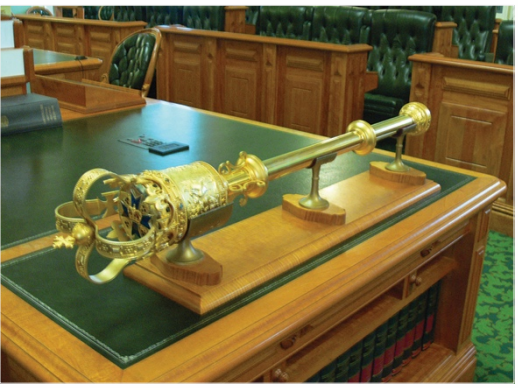
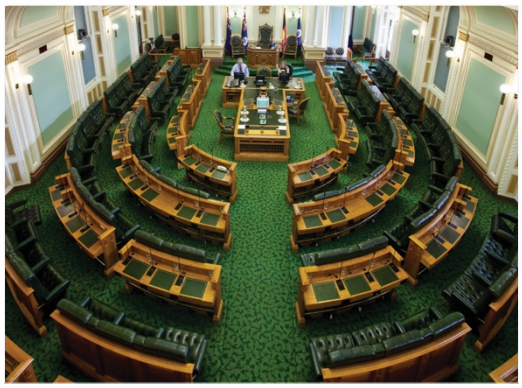
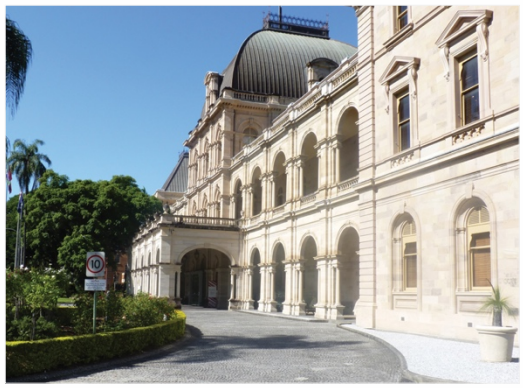

Health and Other Legislation Amendment Bill (No. 2) 2023

Report No. 3, 57th Parliament
Health, Environment and Agriculture Committee
March 2024

Health, Environment and Agriculture Committee

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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 Health and Other Legislation Amendment Bill (No. 2) 2023.

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*.

Whilst this Bill has several elements in it, each worthy of comment, I will restrict my commentary to 2 elements of the Bill.

Over recent years and previous terms of government as either a member or Chair of the former iterations of this committee, we have undertaken work in the areas of nurse-patient ratios resulting in passing of previous Bills that increased nurse-patient ratios in both acute wards and in the State's residential aged care facilities. I am therefore pleased to again be able to table a recommendation for this Bill that amends the *Hospital and Health Boards Act 2011* to introduce minimum midwife-to-patient and baby ratios in maternity wards, in which all babies will be counted, including stillborn babies requiring services from a midwife. I also commend the QNMU for their ongoing advocacy in this important area of health care.

As a regional MP and having come from a 30-year background delivering primary care as a former Intensive Care Paramedic in North Queensland, I fully appreciate that anyone living in rural, remote and Indigenous communities must have equality and access to health care. I am pleased to see that this Bill includes amendments which address barriers to accessing medical termination of pregnancy, including by allowing appropriately qualified and trained midwives and nurses to perform medical termination of pregnancy, and nurse practitioners and endorsed midwives to prescribe MS-2 Step.

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 Queensland Health.

I commend this report to the House.

Aaron Harper MP
Chair

Recommendations

Executive Summary

This Bill makes amendments to the *Hospital and Health Boards Act 2011,* the *Termination of Pregnancy Act 2018*, the Queensland Criminal Code, the *Powers of Attorney Act 1998*, the *Mental Health Act 2016,* and the *Public Health Act 2005.* These proposed changes support access to healthcare, promote quality improvement and patient safety in public health facilities, and improve the operation of health legislation in Queensland.

The committee published 38 submissions, held 2 public briefings with Queensland Health and convened a public hearing during which we heard from 18 witnesses. After considering the submissions and testimony we received and reviewing the Bill (including its explanatory notes and its statement of compatibility with human rights) for compliance with the *Human Rights Act 2019*, the *Parliament of Queensland Act 2001* and the *Legislative Standards Act 1992*, we are recommending that the Bill be passed.

Our assessment of the Bill's compliance with issues of fundamental legal principle found the Bill has sufficient regard for the rights and liberties of individuals, and the institution of Parliament. We carefully analysed one of the Bill's proposals, regarding a regulation making power to be inserted into the *Termination of Pregnancy Act 2018*, to ensure it sufficiently regards the institution of Parliament. We also find that the Bill is compatible with human rights.

1 Introduction

1.1 Policy objectives of the Bill

According to the explanatory notes, the purpose of the Bill is to make amendments that support access to healthcare, promote quality improvement and patient safety in public health facilities, and improve the operation of health legislation in Queensland. The Bill amends:

- the *Hospital and Health Boards Act 2011* (Hospital and Health Boards Act) to –
  - clarify that, for the purposes of nurse and midwife-to-patient ratios, a newborn baby should be counted as a patient when they are staying in a room on a maternity ward with their birthing parent
  - require a Quality Assurance Committee (QAC) to disclose information about a health professional to their chief executive where the QAC reasonably believes the health professional's health, conduct or performance poses a serious risk of harm to a person
  - clarify that the chief executive of Queensland Health may, after considering a report from a clinical review or health service investigation conducted in a Hospital and Health Service (HHS), take the action the chief executive considers appropriate in relation to the matters identified in the report
  - ensure key findings, recommendations and lessons learnt from root cause analyses of serious clinical incidents can be shared with relevant staff across Queensland Health
- the *Termination of Pregnancy Act 2018* (Termination of Pregnancy Act), Criminal Code and *Powers of Attorney Act 1998* (Powers of Attorney Act) to –
  - allow additional health practitioners to perform early medical terminations of pregnancy through the use of termination drugs
  - make consequential amendments to the offence provision set out in the Criminal Code to align with the above change
  - provide for more inclusive language by replacing references to 'woman' with 'person' in termination of pregnancy provisions
- the *Mental Health Act 2016* (Mental Health Act) to clarify how Mental Health Court expert reports and transcripts may be released and used
- the *Public Health Act 2005* (Public Health Act) to exempt medical practitioners from duplicate reporting of dust lung diseases to the Queensland Notifiable Dust Lung Disease Register where there has been notification to the National Occupational Respiratory Disease Registry.

1.2 Background

Currently there are no minimum midwife-to-patient ratios in Queensland maternity wards. The Bill's amendment of the Hospital and Health Boards Act will introduce minimum midwife-to-patient and baby ratios in maternity wards, and all babies will be counted, including stillborn babies requiring services from a midwife.[1]

The explanatory speech for the Bill noted the need for other improvements to the Hospital and Health Boards Act:

> The Hospital and Health Boards Act includes a clinical incident management framework to ensure patient safety issues are addressed in a timely and meaningful way. The framework fosters a culture of safe and reliable care through analysis and learning to reduce preventable occurrences and improve patient safety.

[1] Explanatory notes, p 7.

> To encourage a focus on learning, professional development and clinical improvement, the Hospital and Health Boards Act prohibits the disclosure of information about clinical incident management, particularly information which may identify a patient or a health professional, subject to very limited exceptions. Although it is very important that these processes are subject to strict confidentiality provisions, it has been identified that changes are required to improve patient safety and ensure that the provisions are working effectively.[2]

QACs are established under the Hospital and Health Boards Act with the objective of improving and promoting safe and effective care for patients by making recommendations for care improvements. The focus of QACs is on system level issues and improvements, but sometimes, in the course of their work QACs will identify concerns about individual health practitioners.[3] However, QACs are currently prevented from reporting these concerns at a local level and must utilise existing pathways under the *Health Practitioner Regulation National Law (Queensland)* (National Law) and the *Health Ombudsman Act 2013* (Health Ombudsman Act) to report concerns about individual practitioners to the Office of the Health Ombudsman (OHO) and the Australian Health Practitioner Regulation Agency.

The Bill will require a QAC to notify a health professional's chief executive if the QAC reasonably believes that a health professional poses a serious risk of harm to a person because of the health professional's conduct or performance. The Bill will also improve the sharing of recommendations from root cause analysis (RCA) reports and ensure the chief executive of Queensland Health can take action on clinical reviews and health service investigations regardless of whether those processes were commenced by an HHS or by the department.[4]

Regulated termination of pregnancy is legal in Queensland. Medical termination of pregnancy currently can only be provided by medical practitioners who are authorised to prescribe a termination of pregnancy medication such as MS-2 Step, a Schedule 4 medicine, which is then dispensed by a pharmacist who is a registered dispenser. Recent changes approved by the Therapeutic Goods Administration (TGA) allow MS-2 Step to be prescribed by any health practitioner with appropriate qualifications and training, without the need for certification, if authorised by state or territory legislation. Dispensing restrictions have also been removed.[5] Proposals in this Bill implement the recommendations of the Commonwealth Senate Community Affairs References Committee following its 2023 inquiry into universal access to reproductive healthcare, which recommended that amendments be made to state and territory legislation to address barriers to accessing medical termination of pregnancy, including by allowing registered midwives, nurse practitioners and Aboriginal health workers to prescribe MS-2 Step.[6]

The Bill will enable nurses and midwives to perform medical terminations of pregnancy using MS-2 Step in appropriate circumstances and in accordance with their authorised activities under the *Medicines and Poisons Act 2019* (Medicines and Poisons Act). The amendments would also introduce a regulation-making power to allow additional types of registered health practitioners to be prescribed

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2 Minister for Health, Mental Health and Ambulance Services and Minister for Women, Queensland Parliament, Record of Proceedings, 30 November 2023, p 3914.

3 Explanatory notes, p 22; Queensland Health, correspondence, 23 January 2024, p 5.

4 Queensland Parliament, Record of Proceedings, 30 November 2023, p 3914.

5 Australian Government, Therapeutic Goods Administration, *Amendments to restrictions for prescribing of MS-2 Step (Mifepristone and Misoprostol)*, https://www.tga.gov.au/news/media-releases/amendments-restrictions-prescribing-ms-2-step-mifepristone-and-misoprostol.

6 Australian Senate Committee Community Affairs References Committee, May 2023, *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia,* Recommendation 20, p 78, https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000075/toc_pdf/EndingthepostcodelotteryAddressingbarrierstosexual,maternityandreproductivehealthcareinAustralia.pdf.

to perform medical terminations of pregnancy using MS-2 Step in the future. As is already the case, doctors will remain the only health practitioners authorised to perform either surgical or medical terminations of pregnancy for gestations nine weeks and above.

The Bill also removes gendered language from the Termination of Pregnancy Act and related provisions in the Criminal Code and Powers of Attorney Act. The Termination of Pregnancy Act currently only authorises terminations in Queensland to be performed on a 'woman'. This language is not inclusive of people who are gender diverse or do not identify as women, such as transgender men, who may also require reproductive health care. The Bill will ensure that all pregnant people can lawfully access termination of pregnancy care in Queensland.

The Mental Health Act currently deals with the admissibility and use of an expert's report received in evidence by the Mental Health Court where it relates to the same offence being determined by a criminal court. The use of expert reports in this instance is limited to determining a person's unsoundness of mind, fitness for trial, and/or consideration in sentencing the person.[7] These limitations are necessary to ensure that relevant evidence is available in criminal proceedings, while at the same time protecting the privacy of a person's health information and allowing a person to participate in Mental Health Court proceedings without fear of self-incrimination.[8]

The Bill would extend the admissibility of Mental Health Court expert's reports by providing these are also admissible at the trial of the person for any other offence alleged to have been committed by the person, and would also expand the circumstances in which expert reports which have been filed in the Mental Health Court Registry, but not formally received in evidence, can be released to third parties such as mental health service providers. The Bill further proposes to allow transcripts of Mental Health Court proceedings, which might contain information about a person which could be relevant to criminal proceedings, to be similarly admissible.

The explanatory notes advise that over 100 stakeholders had the opportunity, in September 2023, to provide written feedback on consultation papers relevant to the Bill. A targeted consultation on the proposed amendments to the Termination of Pregnancy Act was convened with stakeholders including Queensland Nurses and Midwives' Union (QNMU), Children by Choice, the Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Australian College of Midwives. In addition, five consultation sessions on the amendments to the Mental Health Act were convened with stakeholders including the President of the Mental Health Court, Legal Aid, the Director of Public Prosecutions, the Public Advocate, Queensland Law Society (QLS), and the Mental Health Lived Experience Peak.[9]

We did not receive feedback about the consultation process from the majority of submitters to this inquiry. The Australian Medical Association Queensland branch (AMAQ) submitted in respect of the proposed amendments to the Termination of Pregnancy Act, that 'these proposals come at short notice and without clear justification or evidence-base'.[10]

1.3 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*, the *Legislative Standards Act 1992* (Legislative Standards Act) and the *Human Rights Act 2019* (Human Rights Act).

[7] Explanatory notes, p 6.

[8] Explanatory notes, p 6.

[9] Explanatory notes, p 15.

[10] Submission 12, p 2.

1.3.1 *Legislative Standards Act 1992*

Fundamental legislative principles are the principles relating to legislation that underlie a parliamentary democracy based on the rule of law. These principles include requiring that legislation has sufficient regard to rights and liberties of individuals and the institution of Parliament as required by section 4 of the Legislative Standards Act. Our assessment of the Bill's compliance identified one issue, which we discuss below at Section 2.2.2, regarding the potential for the Bill's proposal for a regulation making power to be inserted into the Termination of Pregnancy Act to have insufficient regard to the institution of Parliament.

Part 4 of the Legislative Standards Act requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly and sets out the information an explanatory note should contain. Explanatory notes were tabled with the introduction of the Bill. The notes contain the information required by Part 4 and a sufficient level of background information and commentary to facilitate understanding of the Bill's aims and origins.

1.3.2 *Human Rights Act 2019*

The Human Rights Act protects fundamental human rights drawn from international human rights law.[11] Section 13 of the Human Rights Act 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.

A statement of compatibility was tabled with the introduction of the Bill as required by section 38 of the Human Rights Act. The statement contained a sufficient level of information to facilitate understanding of the Bill in relation to its compatibility with human rights.

Our assessments of the Bill's compatibility with the Human Rights Act are included below. We find the Bill is compatible with human rights.

1.4 Should the Bill be passed?

The committee is required to determine whether or not to recommend that the Bill be passed.

Recommendation 1

The committee recommends the Health and Other Legislation Amendment Bill (No. 2) 2023 be passed.

[11] The human rights protected by the Human Rights Act 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; Human Rights Act, s 12.

2 Examination of the Bill

This section discusses key issues raised during the committee's examination of the Bill. It does not discuss all consequential, minor or technical amendments.

2.1 Amendments to the *Hospital and Health Boards Act 2011*

2.1.1 Midwife to patient ratios

While the Hospital and Health Boards Act provides for minimum nurse and midwife-to-patient ratios in Queensland public health facilities to be prescribed in the Hospital and Health Boards Regulation 2023 (Regulation), the ratios prescribed in the Regulation presently only apply to 'an acute ward in which health services are provided to adult patients'.[12] The wards that midwives work on are not currently prescribed in the Regulation.

Clause 12 of the Bill amends section 138B of the Hospital and Health Boards Act to clarify that a newborn baby is counted as a separate patient when they are receiving care in a maternity ward with their birthing parent.[13] The amendment defines 'newborn baby' to also include a baby who has shown no signs of life on being born and has been gestated for 20 weeks or more or weighs 400 grams or more. According to the explanatory notes, 'counting newborn babies as a separate patient to their parent will ensure midwives can provide safer, more comprehensive and more compassionate care to families'.[14]

Submissions on this proposal were received from the Australian College of Midwives – Queensland branch, Australian College of Nursing, Australian College of Nurse Practitioners, QNMU, and RANZCOG. All were supportive, with QNMU requesting amendment of the Regulation to specify a maternity ward midwife to patient ratio of 1:6. In its response to submissions, Queensland Health advised the Regulation will be amended as part of the implementation process subsequent to passage of the Bill, and during a public briefing, Ms Shelley Nowlan, Chief Nursing and Midwifery Officer for Queensland Health advised:

> In regard to actually making the legislation around those ratios, there has been an evaluation undertaken and it is currently informing the department on what that ratio number would be. We did do a trial of one-to-six and we also know that in some areas one-to-eight could potentially be the ratio number as well, depending on the acuity of the mother and the baby and the size of the maternity ward that would be supporting that.[15]

QNMU submitted during the public hearing that additional midwives would be required to meet the ratio once prescribed and called for a state workforce plan and increased funding to address staff shortfalls.[16] QNMU further submitted:

> A recent audit that the QNMU undertook of inpatient maternity wards found that individual midwives were being allocated a workload of up to 20 women and babies, or 20 individuals. This audit clearly demonstrated it is unsustainable and at times dangerous, the workloads that midwives have in Queensland midwifery services and maternity services. Research has shown that legislating minimum safe staffing for Queensland nurses has improved patient outcomes and saved lives and money….

[12] Hospital and Health Boards Regulation 2023, s 40.

[13] Explanatory notes, p 24.

[14] Explanatory notes, p 7.

[15] Public briefing transcript, Brisbane, 12 February 2024, p 6.

[16] Public hearing transcript, Brisbane, 1 February 2024, p 23.

> The benefits that will come from midwife-to-patient ratios are numerous. Supporting midwives to have more time and ability to provide the best quality care will improve outcomes for mothers, babies and the broader Queensland community and create a safer working environment for our midwives. We will continue to work with Queensland Health to ensure ratios meet the needs of the Queensland public and the midwives who work tirelessly to keep the system safe.[17]

Regarding workforce planning, Ms Nowlan on behalf of Queensland Health advised during a public hearing:

> There is national work underway with the Nursing and Midwifery Board of Australia called the Midwifery Futures project, which is about understanding the pipeline of midwives nationally. Queensland, the ACT and the Northern Territory are also working on a project at the moment to understand the workforce required for maternity services. We know that there is a balance between the number of midwives coming in and those exiting. At the moment, our current numbers are meeting workforce needs.[18]

Committee comment

Legislating minimum midwife-to-patient ratios is a nation-leading step that acknowledges the crucial role that midwives play in delivering safe, high-quality care for all Queenslanders. We note the advice from Queensland Health of its trial of a 1:6 midwife to patient and baby ratio, which is the same as that requested by the QNMU. We encourage Queensland Health to continue working with other health sector stakeholders to ensure there is a sufficient pipeline of future midwives to service Queensland's requirements once this new ratio is implemented.

2.1.1 Quality Assurance Committees

Clauses 9 and 10 of the Bill amend section 84 and insert a new section 85A to the Hospital and Health Boards Act. These amendments introduce a new obligation for a QAC to disclose information about a health professional to the health professional's chief executive where a QAC reasonably believes the health professional's health, conduct or performance poses a serious risk of harm to a person. A QAC would be required to disclose the basis for this belief and the health professional's identity to the chief executive.[19] Depending on the health professional's employment arrangements, the chief executive would be the chief executive of the department or an HHS, or the licensee of a private health facility.

The chief executive would be required to act where necessary to address any identified risks. The amendments restrict further disclosure of this information by a chief executive, except to the extent necessary to allow them to perform their functions, or to make a notification about the health professional under the National Law. The explanatory notes state these amendments are intended to enable more rapid responses to patient safety issues at a local level.[20]

The explanatory notes report 'mixed feedback' on the amendments, including concerns there may be a risk that health professionals may not wish to participate in some of the QAC processes if the information they provide may be disclosed.[21] Seven submitters addressed this proposal, including Australian College of Nursing, Australian College of Nurse Practitioners, QNMU, RANZCOG, QLS, the OHO, and the Crime and Corruption Commission.

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[17] Public hearing transcript, Brisbane, 1 February 2024, p 23.

[18] Public briefing transcript, Brisbane, 12 February 2024, p 6.

[19] Explanatory notes, p 23.

[20] Explanatory notes, p 23.

[21] Explanatory notes, p 15.

While noting the proposal will ensure a more rapid response after a clinical incident, the Australian College of Nursing submitted that the proposal may make clinicians less likely to participate in review processes.[22] The QNMU opposed this proposal on the basis that it does not sufficiently regard the wellbeing of health practitioners who may be subject to such disclosures and may criminalise the medical errors of health practitioners who have made genuine mistakes.[23] During the public hearing the QNMU recommended that this proposal needed to expressly require that any QAC disclosures demonstrated sufficient consideration and were not vexatious.[24]

In its response to submissions, Queensland Health addressed concerns about unintended impacts on health practitioners by noting that the range of actions a chief executive might take after a QAC disclosure would include:

> Further education, training, performance management or more serious action. Information will only be able to be shared in the rare cases where it meets the high threshold of 'serious risk of harm to a person'. Allowing direct reporting from a QAC at the local level will ensure that appropriate management or employment action can be taken by the person's employer in a timely way. Although these processes can be stressful for practitioners, the safety of patients and the public must be the paramount consideration.[25]

Queensland Health submit that the 'serious risk of harm' threshold requirement in the proposal would ensure a QAC would not act vexatiously and would only disclose information in extremely serious circumstances; further that the requirement for QAC disclosures to satisfy this high threshold would ensure health practitioners were not discouraged from participating in review processes.[26]

The Crime and Corruption Commission submitted that this proposal might trigger the obligation of a public official (such as a chief executive or a member of a QAC) to report corrupt conduct under the *Crime and Corruption Act 2001* (Crime and Corruption Act). In response, Queensland Health noted the Crime and Corruption Act required public officials to comply with an obligation to report corrupt conduct:

> Despite the provisions of any other Act (except a specific provision of the *Police Service Administration Act 1990*) and despite any obligation to maintain confidentiality. The Department considers section 39 of the Crime and Corruption Act would override the provisions of the HHB Act and a specific cross-reference to the Crime and Corruption Act in these provisions is not required.[27]

The OHO made lengthy submissions, both in writing and during a public hearing, regarding this proposal. The OHO recommends the proposal should be broadened to require a QAC to also: (1) report disclosures to the Health Ombudsman that it may report to the chief executive, and (2) disclose concerns it may report about both registered and unregistered health practitioners to the Health Ombudsman.[28]

In respect of its first recommendation, the OHO submitted:

> The amendment proposed is not sufficient on its own, in matters where serious risk arises. This is because the proposed amendment relies on the practitioner's chief executive taking immediate steps to prevent the practitioner from continuing to provide health services and informing the OHO

[22] Submission 7, p 2.

[23] Submission 26, p 6.

[24] Public hearing transcript, Brisbane, 1 February 2024, p 25.

[25] Queensland Health, correspondence, 23 January 2024, p 6.

[26] Queensland Health, correspondence, 23 January 2024, p 6.

[27] Queensland Health, correspondence, 23 January 2024, p 6.

[28] Submission 35, p 1.

> of the conduct as a matter of urgency. It is not unusual for health professionals to work at other locations, including private practice.
>
> Therefore, amending the Hospital and Health Boards Act to allow for notification to the practitioner's chief executive, will not always be sufficient. If QAC members are permitted to immediately notify my office, I can take then immediate action where necessary, to protect public health and safety, which is a key function under the *Health Ombudsman Act 2013.*[29]

Queensland Health responded to this OHO recommendation by noting the existing reporting pathway for public risk notifiable conduct concerns.[30] At a public hearing, Ms Kirstine Sketcher-Baker, Executive Director for Patient Safety and Quality with Queensland Health responded to a committee query about the OHO's recommendation that:

> **Mr SMITH:** …for registered practitioners, when the QAC makes a report to the HHS CEO, it then automatically be presented back to the Ombudsman as well; that the QAC do that instead of the HHS CEO. Is there merit in that, or are there any concerns that Queensland Health would have about the QAC making a direct report back to the Health Ombudsman?
>
> **Ms Sketcher-Baker:** Currently, if there is a registered practitioner who is a quality assurance committee member, they have mandatory reporting obligations. Their mandatory reporting obligations actually require them to report a public-risk notifiable-conduct type issue. They are issues where a registered practitioner has identified that the public are at risk of substantial harm because a registered practitioner has either practised with an impairment or they have practised in a way that constitutes a significant departure from acceptable professional standards. They are already required to do that.
>
> **Mr SMITH:** The membership on that QAC would have to independently do that anyway?
>
> **Ms Sketcher-Baker:** That is right.
>
> **Mr SMITH:** So you would just be doubling up if the QAC, as a body, put in a submission?
>
> **Ms Sketcher-Baker:** The intent of this change in the legislation is really to be able to notify the health service a lot more quickly so that they are able to consider that information and act a lot more quickly than if it is given to the Health Ombudsman because the Health Ombudsman then has time to actually consider that and then investigate and then will contact the health service. If the health service is notified more promptly, they are able to act appropriately and consider the information and then make the changes required to ensure that the public are protected.[31]

Regarding its recommendation to require disclosure by a QAC about both registered and unregistered health practitioners, the OHO submitted at the public hearing:

> The definition of a health professional in the Hospital and Health Boards Act includes both registered and unregistered practitioners. The definition means a person who is either registered under the Health Practitioner Regulation National Law or a person other than a person registered under the national law—and this is the definition—who provides a health service including, for example, an audiologist, dietician or a social worker. There are other examples such as sonographers and AINs, assistants in nursing. Our office deals with notifications and complaints or concerns around the conduct and performance of those practitioners.
>
> You would be aware that the OHO has functions and powers to take protective action in the form of immediate registration action or taking an interim prohibition order in respect of the unregistered practitioners. That is where I form a reasonable belief that the practitioner poses serious risks to public health and safety or the action is otherwise in the public interest. These actions are obviously broader than the actions available to a chief executive officer and they are

[29] Submission 35, p 2.

[30] Queensland Health, correspondence, 23 January 2024, p 6.

[31] Public hearing transcript, Brisbane, 1 February 2024, p 5.

> not specific to one place of employment. You would be aware that practitioners can move between places of employment—so they can work in more than one setting.
>
> The current wording of the amendments requires the QAC to disclose the information to the chief executive officer where they form a reasonable belief that the health professional poses a serious risk. That means that the chief executive of a service may receive information that an unregistered health practitioner is considered to pose a serious risk. However, the disclosure provisions in proposed section 85A(4) only allow the chief executive officer to notify us if the serious risk identified by the QAC forms the basis for a notification about the practitioner under the Health Practitioner Regulation National Law. There is a real gap there…
>
> There is an existing reporting pathway in the legislation. It is under section 84(1)(d) of the Hospital and Health Boards Act. It allows a member of the QAC to directly notify the Health Ombudsman. It is about when they form a view that the practitioner has behaved in a way that constitutes public risk notifiable conduct, which is defined also in the act. That is narrower than the provisions of this proposed amendment where it is requiring the QAC to notify the chief executive officer when they have a reasonable belief about serious risks of harm posed by the health, conduct or performance of the practitioner. There is a gap there. There is not a positive obligation to notify us of that serious risk. [32]

In response to this OHO recommendation about requiring QAC disclosures about unregistered health practitioners, Queensland Health submitted no reporting pathway presently exists for unregistered practitioners under the Hospital and Health Boards Act, partly because there is no existing reporting threshold. Further, while there is a reporting pathway under the Health Ombudsman Act, there is no minimal threshold.[33] Queensland Health noted:

> The inclusion of unregistered health practitioners in reporting pathways to the Health Ombudsman raises complex drafting issues about interactions with existing provisions of the HHB Act and Health Practitioner Regulation National Law.
>
> Further policy work and consultation with unregistered practitioners would be required before implementing these arrangements. Queensland Health will consult further with the Health Ombudsman about this issue and give consideration to whether legislative amendments can be included in a future Bill to address these issues.[34]

At a public hearing, Dr Catherine McDougall, Chief Medical Officer for Queensland Health advised:

> The inclusion of unregistered health practitioners requires a detailed review of existing provisions for both registered and unregistered practitioners to improve consistency and ensure reporting of all appropriate levels of risk. One of the difficulties in applying the existing regime is there are no currently accepted thresholds in which reports should be made about an unregistered health practitioner. In contrast, registered practitioners are subject to mandatory reporting for certain conduct at a specified threshold level. Queensland Health is committed to making improvements to these provisions, but it needs to be done as part of a longer term, more detailed review. Queensland Health will engage with the Health Ombudsman about these issues and seek to make these changes in a future bill.[35]

2.1.1.1 Compatibility with human rights

The QAC disclosure proposal concerns the use and disclosure of personal information, including potentially sensitive personal information. This proposal expands the circumstances in which it is permissible to disclose information obtained by or shared with QAC. Therefore, it engages the right to privacy and reputation, protected by section 25 of the Human Rights Act. Section 25 of the Human

[32] Public hearing transcript, Brisbane, 1 February 2024, p 27.

[33] Queensland Health, correspondence, 23 January 2024, p 6.

[34] Queensland Health, correspondence, 23 January 2024, p 6.

[35] Public briefing transcript, Brisbane, 12 February 2024, p 2.

Rights Act protects the right of a person not to have his or her 'privacy, family, home or correspondence unlawfully or arbitrarily interfered with' and not to have their personal reputation unlawfully attacked.

The Bill's statement of compatibility also explains that the purpose of this amendment is to:

> Protect and promote the health and safety of members of the community by ensuring information about a health professional's health, conduct or performance can be shared and immediate action can be taken to address patient safety concerns. For example, if a QAC becomes aware that a doctor has been intoxicated while working in a hospital, this information can be disclosed to the doctor's chief executive to allow immediate disciplinary action or other appropriate action to be taken to ensure patient safety in the hospital the doctor works in…
>
> Clause 10 is the least restrictive way of protecting and promoting patient safety in response to serious risks identified by QACs. The Bill will only allow sharing of identifying information to the health professional's chief executive and only in situations where a QAC has formed a reasonable belief that a health professional's health, conduct or performance poses a serious risk of harm to a person. This high threshold protects against unreasonable, unnecessary or disproportionate information sharing and minimises the risk of any arbitrary limitations on the right to privacy. In addition, the Hospital and Health Boards Act provides that a QAC must have regard to the rules of natural justice in so far as they are relevant to the functions of a committee. Finally, the Bill puts in place restrictions on further disclosure of the information by the chief executive. The chief executive must not further disclose the information, other than to the extent necessary for them to perform their functions. With these safeguards in place, the amendments are the least restrictive and reasonably available way to achieve the purpose of promoting patient safety. The purpose can only be achieved with legislative amendment.[36]

Committee comment

We commend the intent of this proposal to ensure that hospital and health services can respond more rapidly to protect patient safety once concerns about the serious risk of harm posed by a health practitioner have been identified.

We note the submission by the Health Ombudsman that health professionals may work across a number of health services, and while one health service chief executive might be taking corrective action after a QAC disclosure, chief executives of other health services at which the health professional might work, may be unaware of concerns about that health practitioner's conduct, unless one of the members of the disclosing QAC is a health practitioner who complies with their individual obligation under the National Law to notify the Health Ombudsman of a *public risk notifiable conduct* event. The Health Ombudsman holds concerns that this existing reporting requirement is narrower than the one contemplated by the QAC disclosure proposal contained in the Bill, which requires reporting of any health professional whose conduct poses *a serious risk of harm*. We urge Queensland Health and the Health Ombudsman to work together to ensure that patient safety at *all* Queensland health services is enhanced by this proposal to mandate further QAC disclosures in specified circumstances.

We further note the concerns raised by the Health Ombudsman regarding the lack of legislated reporting requirements for unregistered health practitioners and note favourably Queensland Health's commitment to addressing this gap in a future bill.

Separately, we note the potential for this proposal in the Bill to interfere with an individual's right to privacy and reputation. The extension of the existing disclosure requirements proposed by this amendment would only apply in narrow, prescribed circumstances - where there is a *serious risk of harm* - and sensitive information would only be accessible to a narrow, prescribed category of senior office holders, such as hospital and health service chief executives. We find that any limitations to the right to privacy and reputation imposed by these amendments are reasonable and justifiable. The

[36] Statement of compatibility, pp 5-6.

amendments to increase information sharing strike a fair balance between the public benefit of increasing patient safety and quality improvement, against an individual's right to privacy and reputation. Any impacts on human rights are only to the extent reasonable and demonstrably justifiable in accordance with section 13 of the Human Rights Act.

2.1.2 Clinical reviews and health service investigations

Clinical reviews are commissioned to consider potential clinical issues regarding patient safety. Health service investigations report on any matters relating to the management, administration, or delivery of public sector health services, including employment matters. The information contained in clinical review and health service investigation reports is used to establish a shared understanding within Queensland Health of local and state-wide gaps in clinical incident management and governance. At present, while a copy of a report of a review or investigation commissioned by a health service chief executive can be requested by the chief executive of Queensland Health under the Health and Hospital Boards Act, the actions the chief executive can take after considering a report are limited to issuing a direction to the HHS. [37]

Clauses 6 and 7 of the Bill amends section 135 and 199 of the Health and Hospital Boards Act to allow the chief executive of Queensland Health to take the action they consider appropriate in relation to a clinical review or health service investigation in an HHS where the reviewer, or investigator, was appointed by a health service chief executive. The Bill would enable the chief executive of Queensland Health to act in response to such reports whether they are commissioned by the chief executive or a health service chief executive.

No submitters commented specifically on this proposal.

2.1.3 Root cause analyses

The Bill includes amendments to clarify that recommendations contained in an RCA report are permitted disclosures of information. An RCA report on a serious clinical incident can be commissioned by an HHS chief executive to identify the underlying causes of a serious clinical incident and remedial measures that can be implemented to prevent a similar event from occurring. A report resulting from an RCA is confidential and legally protected under the Health and Hospital Boards Act. The chief executive can only give a copy to a prescribed patient safety entity for an authorised purpose, and that entity's use and further disclosure of the report is restricted.

Clause 11 of the Bill amends section 112 of the Health and Hospital Boards Act to permit a patient safety entity to disclose information contained in the copy of the report and certain other details of the reportable event to which the RCA report relates, to another person for the authorised purpose for which the copy of the report was given. This information could include the recommendations from the report or other key findings or lessons learned. The amendments also clarify that the act of 'disclosing' information contained in an RCA report includes giving access to this information, for example, by uploading the information in an information system.

QLS was the only submitter to comment specifically on this proposal. While supportive, QLS emphasises the importance of ensuring confidentiality of the location where the critical incident the subject of an RCA occurred, and recommended training to support implementation of changes to how RCA reports can be disclosed. [38] In response, Queensland Health noted existing provisions of the Health and Hospital Boards Act which prevent information from an RCA report being used in a way that might

[37] *Hospital and Health Boards Act 2011*, s 137; explanatory notes, pp 21-22.

[38] Submission 34.

identify individual health practitioners or patients. Queensland Health states this requirement would extend to de-identifying the hospital and clinical area where the critical incident occurred.[39]

2.1.3.1 Compatibility with human rights

The RCA disclosure proposal concerns the use and disclosure of personal information, including potentially sensitive personal information. This proposal expands the circumstances in which it is permissible to disclose information obtained through the RCA process to third parties. Therefore, it engages the right to privacy and reputation, protected by section 25 of the Human Rights Act.

The Statement of Compatibility explains that the purpose of this amendment is to:

> Prevent patient harm and achieve better health outcomes for patients. The amendments will ensure learnings can be shared with relevant staff across Queensland Health who can use this information to implement quality improvements and enhance patient safety. The amendments will also support more effective monitoring of the implementation of recommendations arising from root cause analyses.[40]

The explanatory notes further clarify:

> Under the Hospital and Health Boards Act, information acquired and compiled during a root cause analysis is afforded absolute privilege. The Hospital and Health Boards Act does not allow information, recommendations and outcomes of root cause analyses to be shared beyond a small number of exceptions. This restricts the ability of the department and HHSs to ensure recommendations are implemented and to effectively facilitate the sharing of important clinical learnings as broadly as needed to promote patient safety.[41]

Under this amendment, the vast majority of these restrictions and limitations would remain in place with respect to RCA reports, however it would become permissible to share key information with the chief executive of Queensland Health. The proposal includes strict safeguards, such as provisions that make it an offence to disclose or use information from an RCA report other than for the authorised purpose, and other provisions designed to guard against misuse of information gathered during an RCA process.[42]

The statement of compatibility provides:

> The amendments have been carefully tailored, with several safeguards in place, to ensure they operate in a least restrictive way. Existing confidentiality protections in section 112(6) of the Hospital and Health Boards Act will apply to the amendments in the Bill, providing that any information disclosed by a prescribed patient safety entity must not contain information that may lead to the identification of patients or practitioners relevant to the subject matter of the root cause analysis. Any disclosures by a prescribed patient safety entity must also be for an authorised purpose, with such purposes prescribed by regulation. Additionally, the process of sharing information will be governed by existing Queensland Health directives, policy and guidelines. With these safeguards in place, the permitted disclosure of information has appropriate regard to the rights of privacy and reputation.[43]

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[39] Queensland Health, correspondence, 23 January 2024, p 6.

[40] Statement of compatibility, p 4.

[41] Explanatory notes, p 3.

[42] Statement of compatibility, p 5; see *Hospital and Health Boards Act 2011*, s 84.

[43] Statement of compatibility, p 6.

2.2 Amendments to the *Termination of Pregnancy Act 2018*, Criminal Code and *Powers of Attorney Act 1998*

2.2.1 Additional health practitioners permitted to perform early medical termination of pregnancy

Clause 22 of the Bill will insert a new section 6A into the Termination of Pregnancy Act to allow health practitioners registered in the professions of nursing, midwifery or another prescribed profession to perform a medical termination of pregnancy. The amendments clarify that a practitioner performs a medical termination if the practitioner prescribes, or gives a treatment dose of, a termination drug for use in a termination. The proposal would also permit prescribed practitioners or students who are authorised to assist in the performance of a termination by a medical practitioner, such as Aboriginal and Torres Strait Islander health practitioners, to assist the additional health practitioners in performing medical terminations of pregnancy.

The Bill makes consequential amendments to the offence provision in section 319A of the Criminal Code so that the additional health practitioners who may lawfully perform a medical termination do not commit an offence. The Bill provides that the additional health practitioners may only perform a medical termination to the extent they are authorised to do so under the Medicines and Poisons Act and its instruments, including regulations and Extended Practice Authorities (EPAs).

The explanatory notes state that:

> The Medicines and Poisons (Medicines) Regulation and EPAs for registered nurses and midwives will be amended to support the amendments in the Bill. It is intended to update these EPAs to require that termination drugs used to perform an early medical termination of pregnancy must be given in accordance with the approved medicine information available from the Therapeutic Goods Administration. This includes the approved gestational limits for the safe use of termination drugs. Referring to approvals of the Therapeutic Goods Administration provides flexibility in the legislative framework to accommodate potential changes to restrictions based on clinical evidence. It will also allow for the use of other termination drugs, if any are approved by the Therapeutic Goods Administration in the future.[44]

The explanatory notes state that giving effect to the changed requirements for prescribing MS-2 Step 'will improve access to safe termination-of-pregnancy care in Queensland by increasing access to early medical termination of pregnancy and increase choice for pregnant persons, particularly those in remote and rural areas of Queensland'.[45]

Most public submissions engaged this aspect of the Bill; only 5 of the 38 submissions accepted for publication did not address this proposal. Submitters who are opposed to it include AMAQ, Cherish Life, Australian Christian Lobby, Women's Forum Australia as well as individual submitters. Themes in opposing submissions include fundamental opposition to legal termination of pregnancy, the capability and willingness of registered nursing and midwifery professionals to provide safe end-to-end medical termination of pregnancy care, consistency of regulation across Australian jurisdictions, and removing the legal requirement for conscientiously objecting health practitioners to refer on.

Some submitters who were supportive in principle of this proposal opposed certain aspects, such as the provision of a regulation making power to allow additional types of registered health practitioners

[44] Explanatory notes, pp 9-10.

[45] Explanatory notes, p 5.

to provide medical termination of pregnancy in the future[46] and the application of a gestational limit for prescribing a pregnancy termination medication in line with advice from the TGA.[47]

2.2.1.1 Capability of nursing and midwifery professionals

In response to questions on notice from its initial public briefing to the committee on 14 December 2023, Queensland Health advised that the additional health practitioners authorised by the proposal will include nurse practitioners, registered nurses, endorsed midwives and midwives.[48]

> Nurse practitioners and endorsed midwives will be authorised to prescribe MS-2 Step as a Schedule 4 medicine, while registered nurses and midwives will be authorised to administer or give a treatment dose of the drug under their Extended Practice Authority.
>
> Registered nurses, enrolled nurses and midwives who are not working under an Extended Practice Authority will be able to administer MS-2 Step on a prescription from an authorised prescriber (for example, a doctor, nurse practitioner or endorsed midwife). Registered nurses and midwives working under an Extended Practice Authority cannot delegate their authority to others….
>
> Nurse practitioners and endorsed midwives may be working in private practice, a non-government organisation or in Queensland Health. The Bill is most likely to apply to nurse practitioners working in sexual and reproductive health services, primary care settings or in rural and isolated practice areas. They will assess the person's suitability for early medication termination and, if assessed as suitable, provide the patient with a script for MS-2 Step to either fill privately or provide to a Queensland Health pharmacy.[49]

Some submitters, including AMAQ, Cherish Life and Australian Christian Lobby indicated concerns that some nurses and midwives were not appropriately qualified to provide end-to-end termination of pregnancy care, including treatment for any potential complication.

AMAQ objects to the proposal to permit registered nurses to provide medical termination of pregnancy. AMAQ stated that the proposal goes further than Recommendation 20 in the report of the Australian Senate Community Affairs Reference Committee released in May 2023, which sought to improve access to MS-2 Step by 'allowing registered midwives, nurse practitioners, and Aboriginal Health Workers to prescribe this medication—including pain relief where indicated'.[50]

While AMAQ supports expansion of provider authorisation to nurse practitioners and registered midwives, it opposes prescribing by registered nurses, on the basis that the potential for medical complications, the ability to accurately date pregnancies, exclude ectopic pregnancy via scan, and ensure availability of escalation pathways, can impact the safe prescription of termination of pregnancy medications in rural and remote areas, even by medical practitioners.[51]

At a public hearing, Dr Nick Yim, Vice-President of AMAQ stated:

> It is also not safe for registered nurses to administer these medicines outside of a collaborative setting with appropriate clinical oversight. This is likely the reason the Senate committee did not

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[46] Queensland Law Society, submission 34; Queensland Nurses and Midwives' Union, submission 26.

[47] Children by Choice, submission 30, p 8.

[48] Queensland Health, correspondence, 21 December 2023, p 1.

[49] Queensland Health, correspondence, 21 December 2023, p 1.

[50] Australian Senate Committee Community Affairs References Committee, May 2023, *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia,* Recommendation 20, p 78, https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000075/toc_pdf/EndingthepostcodelotteryAddressingbarrierstosexual,maternityandreproductivehealthcareinAustralia.pdf.

[51] Submission 12, p 1.

> include RNs in its recommendation for extension of authorised MS-2 Step prescribers. For those reasons, AMA Queensland urges the current committee to recommend the Queensland government only make those amendments in the bill that would enact the Australian Senate committee's recommendations. [52]

Cherish Life also focussed on the capability of nurses to provide medical termination of pregnancy, in their concern that if complications arose from the provision of a medical termination, nurses are not permitted to provide surgical intervention:

> Medical abortion is associated with higher risks of bleeding and incomplete abortion than surgical abortion. Under this Bill, health practitioners such as nurses will not be permitted to perform surgical abortions and must know how to deal with the consequences of a medical abortion.
>
> It is generally accepted that 5% of medical abortions will result in excessive or prolonged bleeding requiring a blood transfusion and/or curettage to manage this. Ongoing bleeding may be an indication of incomplete abortion and is also an important source of infection. The failure rate varies with studies, but in the PI (product information) for MS 2 Step, it is given as 7% prior to 63 days, making follow up mandatory. An incomplete medical abortion requires a surgical procedure called curettage.[53]

Regarding the safety concerns about medical abortions expressed by some submitters, Dr Catherine McDougall, Chief Medical Officer for Queensland Health advised at a public hearing:

> The evidence in the studies on MS-2 Step says the incidence of severe bleeding is less than one in 1,000. The incidence of some bleeding is very common; in fact, it is 10 per cent. When we are discussing complication and risk with the patients, there is almost like there are three groups. Firstly, it is nausea and vomiting, abdominal pain and some bleeding, and that is reasonably common—about 10 per cent. Requirement for a surgical procedure in a non-urgent setting potentially related to a D and C or because the termination was incomplete might sit at about five per cent. Infection and significant bleeding requiring transfusion in the data is less than one in 1,000.[54]

In respect of patients experiencing complications from a medical termination of pregnancy, Dr McDougall further submitted:

> The health system already deals with these issues and patient safety and care will continue to be an important priority. Patients given a termination drug will be advised about normal side effects of the medication and any side effects or complications that may require additional care, escalation or a follow-up appointment. Advice will also be available through 13HEALTH, sexual health clinics and community health settings. In the rare cases where an emergency arises, which is a rate less than one in 1,000 as per the evidence, patients would be able to attend their local hospital, multipurpose health service or primary health care centre.[55]

The proposal to permit nursing and midwifery professionals to provide medical termination of pregnancy was supported by submitters including Australian College of Midwives – Qld branch, Australian College of Nursing, Australian College of Nurse Practitioners, QNMU, RANZCOG, Children by Choice, MSI Australia, Queensland Aboriginal and Islander Health Council and ASHM Health.

Ms Karen Grace MACN, National Director of Professional Practice for the Australian College of Nursing submitted during the public hearing:

> Registered nurses, like all health professions, are well regulated. We are obligated to practise in line with a scope of practice for which we are trained, educated and competent, and that is true of

[52] Public hearing transcript, Brisbane, 1 February 2024, p 13.

[53] Submission 25, p 9.

[54] Public briefing transcript, Brisbane, 12 February 2024, p 3.

[55] Public briefing transcript, Brisbane, 12 February 2024, p 3.

> all registered nurses. Therefore, it would not be expected that all registered nurses, when this legislation comes into force, would then be able to openly prescribe any medication, including MS-2 Step, because in order to prescribe anything the nurse would have to be able to demonstrate the skills, training and competence to do so.
>
> In line with that, there is a consultation that is underway at the moment through the Australian Nursing and Midwifery Accreditation Council, which is developing standards for nurse prescribing which build on the previous and existing standards for nurse practitioners. Nurse practitioners have a fairly long and proud history of being able to work to a much broader scope of practice that has included prescribing.
>
> The consultation that is underway at the moment is proposing that we would introduce standards that would ensure registered nurses are both trained and competent in order to prescribe. There would be standards for any sort of training program that are nationally endorsed, and then only nurses who have completed a training program that is approved by AMAQ would be able to prescribe. There are a lot of regulatory protections underway before any registered nurse would be able to participate in any level of prescribing.
>
> I was actually really pleased to see registered nurses incorporated in the proposal because I feel that Queensland is futureproofing its legislation. It does not mean that any registered nurse would then be able to prescribe or be endorsed to prescribe until they had completed whatever the program is that is aligned to the final standard once it is complete. For me, the risk is minimal because nurses should never do anything that they do not feel appropriately qualified or competent to do.[56]

In its response to submissions opposing the expansion of authorised health practitioners, Queensland Health state:

> The TGA considered that State and Territory Health Departments should determine who is best placed to prescribe for their State or Territory population…
>
> Queensland Health has determined that nurses and midwives have the necessary qualifications and skills to undertake this role for the reasons set out below.
>
> To safely administer medication, all nurses and midwives undertake the following:
> - assess the patient including medication history;
> - understand the legal requirements associated with the medication and clinical situation;
> - have pharmacological knowledge of the medication; and
> - have skills and knowledge related to safe medication administration.[57]

AMAQ additionally submitted that expansion of EPAs at the present time to authorise nurses and midwives to provide medical termination of pregnancy pre-empts several Commonwealth reviews that are targeted at non-medical practitioner prescribing, including the *Nursing and Midwifery Board's Consultation Regulatory Impact Statement on registered nurse prescribing* and the Australian Government Department of Health's Scope of Practice Review.[58] AMAQ submit that amending EPAs before those reviews are finalised risks hasty implementation and inadequate patient safety controls.[59] Regarding EPAs, Queensland Health state:

> Registered nurses working under an EPA are experienced nurses with specialised clinical knowledge, skills, and qualifications. Registered nurses enabled to administer or provide a treatment dose of MS-2 Step under an EPA will predominantly be working in either sexual and

[56] Public hearing transcript, Brisbane, 1 February 2024, p 17.

[57] Queensland Health, correspondence, 23 January 2024, p 2.

[58] Submission 12, p 2.

[59] Submission 12, p 3.

> reproductive health services or in rural and isolated practice settings. These registered nurses apply advanced and expert clinical specialty knowledge, skills, and judgement relevant to the position.
>
> A health service or facility which allows registered nurses to work under an EPA must develop a health management protocol for the activities permitted under the EPA. A health management protocol details the clinical use of medicines that may be administered or given as a treatment dose by a registered nurse under the EPA and must include the recommended medicine for the relevant clinical problem and detailed medicine information, procedures for clinical assessment, management, follow up of patients and when to refer to a higher level of care. A health management protocol must be reviewed and endorsed by an inter-disciplinary health team comprising, at a minimum, a medical practitioner, registered nurse and pharmacist, and may include other relevant health professionals. The health management protocol must be approved by the chief executive of a Hospital and Health Service (HHS) or the chief executive officer of a non-Queensland Health facility or organisation.
>
> Midwives working under an EPA must have access to, and refer to, the relevant Queensland Clinical Guidelines. The Queensland Clinical Guidelines for termination of pregnancy will be updated as part of the implementation process for the Bill. Clinical Guidelines and health management protocols assist midwives to gather information, inform consultation and choose an appropriate course of action. They incorporate information about when to consult with, or seek advice from, a senior colleague or a medical officer.

The requirement for training for nursing and midwifery professionals was indicated by numerous submitters, including Children by Choice who note that appropriate information and resources will be required to support health practitioners and consumers.[60] A study published in the Australian Journal of Advanced Nursing in 2020 indicated that barriers to nurse-led medical termination of pregnancy in Victoria include a lack of nurse training opportunities, funding, and professional support.[61] At a public hearing, Ms Sarah Beaman, QNMU State Secretary submitted:

> We would like the committee to consider providing greater clarity and certainty around the following issues: firstly, developing additional education and training resources to support health professionals in their role in providing termination-of-pregnancy care and a plan for education for the community; developing a statewide health management plan to establish a level of clinical governance and standardised processes across the sector within Queensland; ensuring any of the additional health practitioners authorised to provide termination-of-pregnancy services are suitable and qualified, with sufficient regard to confidentiality, expertise and continuity of care required.[62]

In response to submissions about training and resourcing for additional authorised health practitioners, Queensland Health stated:

> If the Bill is passed, there will be an implementation period before additional health practitioners are permitted to perform medical terminations of pregnancy. Queensland Health has commenced work, which will be completed during this implementation period, to ensure the existing regulatory; education and training; clinical pathways; and safety and quality monitoring processes are updated to ensure that nurses, midwives, nurse practitioners and endorsed midwives can safely prescribe, administer or give a treatment dose of MS-2 Step within an appropriately supported environment…
>
> Queensland Health has undertaken a gap-analysis to identify elements of the framework that need to be enhanced or strengthened to ensure that additional health practitioners can safety perform early medical terminations of pregnancy. The gap-analysis considered what support and resources

[60] Submission 30, p 4.

[61] Identifying barriers and facilitators of full service nurse-led early medication abortion provision: qualitative findings from a Delphi study. (2021). *AJAN - The Australian Journal of Advanced Nursing*, *38*(1). https://doi.org/10.37464/2020.381.144

[62] Public hearing transcript, Brisbane, 1 February 2024, p 24.

> are needed for the workforce delivering termination of pregnancy care, as well as information for consumers. The gap analysis identified that there is a need for education and training resources on the provision of medical termination of pregnancy using MS-2 Step that encompass pre- and post-termination of pregnancy care, recognising that the provision of this healthcare is more than just prescribing the medication. The development of education and training resources will be in alignment with the Queensland Clinical Guideline for termination of pregnancy.
>
> The gap analysis also identified the need for a clinical pathway for medical termination of pregnancy using MS-2 Step. As outlined above, this pathway would include guidance on appropriately diagnosing and confirming pregnancy including gestation, escalation pathways to a medical practitioner at any stage if there are contraindications or if complications arise, requirements for access to emergency care, guidance on the provision of culturally appropriate care for First Nations pregnant people, pre- and post- assessment, screening, care and counselling.[63]

2.2.1.2 Willingness of nurses and midwives to provide medical termination of pregnancy

Cherish Life submitted that nurses may not want to provide medical termination of pregnancy:

> Presumably [nurses and midwives] will be required to work under the Termination of Pregnancy Act which requires them to report an inability to provide abortion on the grounds of conscience, and to refer to another whom they believe will do so. To whom do they report? In rural, remote and isolated areas, there are fewer other staff members to call upon, less who will be qualified to replace them, even if they wished to place the responsibility upon fellow staff members. In larger centres, there are more staff, and less onus is placed on the individual nurse/midwife or practitioner to comply with a request.[64]

Australian Christian Lobby submitted that health practitioners - including nurses and midwives if the Bill is passed - have inadequate rights of conscientious objection to administering abortion drugs.[65]

Section 8 of the Termination of Pregnancy Act currently provides that health practitioners with a conscientious objection to provision of termination of pregnancy must disclose that to the person who has requested assistance and then must refer the person onto another health practitioner who, to the knowledge of the objecting practitioner, does not hold a conscientious objection. In its response to submissions, Queensland Health advised:

> No changes to the provision for health practitioners or students to conscientiously object are proposed to the legislation. The rights of health practitioners and students to conscientiously object to performing or assisting to perform a termination on a pregnant person will be maintained in the legislation.[66]

Regarding their members' willingness to provide medical termination of pregnancy, Dr Belinda Maier, QNMU's Strategic Midwifery Research and Policy Officer submitted at a public hearing:

> Over 80 per cent of our members support women's access to early-termination-of-pregnancy services. About 40 and 50 per cent would be prepared to undertake it themselves. We are not going to have a rush of nurses and midwives wanting to provide early-termination-of-pregnancy services for a range of reasons. It will just come through community health settings in rural and remote areas more so where the women will approach the nurses or the midwives they know to talk about their options around early termination of pregnancy.[67]

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[63] Queensland Health, correspondence, 23 January 2024, pp 3-4.

[64] Submission 25, p 10.

[65] Submission 28, p 2.

[66] Queensland Health, correspondence, 23 January 2024, p 3.

[67] Public hearing transcript, Brisbane, 1 February 2024, p 25.

Ms Shelley Nowlan, Chief Nursing and Midwifery Officer for Queensland Health advised during a public hearing:

> The nurses who work in our rural and isolated practice environments tend to want to work to their optimal scope. They are very dedicated to meet all of the needs of their community and, in many cases, have already undertaken broad depths of knowledge and education in anything that is experienced in a rural community. Many of our nurses whom I have worked with advocate very strongly for women's health and for sexual health in that regard. If a nurse did not feel that they were wanting to work in this environment, or get this extra education, we do have processes around conscientious objection and support for them.[68]

2.2.1.3 Consistency across Australian jurisdictions

AMAQ submits this proposal is inconsistent with authorised provider arrangements in other Australian jurisdictions. AMAQ submits it is imperative that prescribing and use of all medications, including MS-2 Step, is consistent across jurisdictions and between state and federal agencies, because of the potential professional, legal and insurance risks to health practitioners. [69] The explanatory notes state:

> The amendments to allow additional health practitioners to perform medical terminations of pregnancy align with recent changes approved by the Therapeutic Goods Administration regarding the prescribing and dispensing of MS-2 Step.
>
> The amendments are also consistent with legislation and amendments being made in certain other States and Territories.
>
> - Western Australia – On 21 September 2023, the Abortion Legislation Reform Bill 2023 (WA Bill) was passed by the Western Australian Parliament. The Bill will allow medical practitioners, other *prescribing practitioners*, and certain other registered health practitioners to perform medical terminations on a person not more than 23 weeks' pregnant. Nurse practitioners and endorsed midwives will be *prescribing practitioners* and able to prescribe termination drugs. Registered health practitioners will be prescribed by regulation and will be able to perform medical terminations under the direction of a directing practitioner, which is either a medical practitioner or a *prescribing practitioner*.
>
> - South Australia – The *Termination of Pregnancy Act 2021* (SA) allows for registered medical practitioners and certain other registered health practitioners to perform early medical terminations in certain circumstances. A registered health practitioner may perform a termination by administering a prescription drug or by prescribing a drug provided that the registered health practitioner is acting within their scope of practice and the registered health practitioner is authorised to prescribe the drug under section 18 of the *Controlled Substances Act 1984* (SA).[70]

As at the date of reporting, the substantive parts of the *Abortion Legislation Reform Act 2023* (WA) (WA Act) passed in September 2023 have not yet commenced. Once commenced, the WA Act will allow certain registered health practitioners to perform a medical abortion if they are authorised under the *Medicines and Poisons Act 2014* (WA) (WA MP Act) to prescribe an abortion drug which is prescribed by regulation. At present the WA MP Act allows the regulation to prescribe a class of health professional that can administer, possess, prescribe or supply certain types of medicine, and the Medicines and Poisons Regulations 2016 (WA) (current from 1 July 2023) authorises nurses practitioners and endorsed midwives to prescribe Schedule 4 poisons/medicines. However, the Public Health Regulations 2017 (WA) do not presently contain the prescription required to allow other registered health practitioners (such as registered nurses) to perform medical terminations under the direction of a directing practitioner.

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[68] Public briefing transcript, Brisbane, 12 February 2024, p 4.

[69] Submission 12, p 3.

[70] Explanatory notes, p 18.

In South Australia, early medical terminations of pregnancy are available up to 9 weeks gestation since the commencement of the SA Termination of Pregnancy Act in July 2022. Section 18(1) of the *Controlled Substances Act 1984* (SA) presently stipulates that nurse practitioners can prescribe a prescription drug if authorised by the regulations, however the Controlled Substances (Poisons) Regulations 2011 (SA) do not presently authorise nurse practitioners to prescribe the relevant drugs. Advice from SA Health indicates that while the class of registered health practitioners that could provide early medical termination of pregnancy 'could include nurses, nurse practitioners and midwives in the first instance (t)here are currently other legislative and policy barriers to this part of the Act, and so this part of the Act has not yet commenced'.[71]

In Victoria, section 6 of the *Abortion Law Reform Act 2008* (Vic) commenced in July 2012. It provides that a registered nurse who is authorised under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) (VIC DPCS Act) to supply a drug or drugs may administer or supply drugs to cause a medical abortion. However, currently there are only authorisations under the VIC DPCS Act and the Drugs, Poisons and Controlled Substances Regulations 2017 (Vic) for: nurse practitioners (for all Schedule 4 drugs), midwives (for the drug misoprostol but only in emergencies and during birth, not in relation to terminations), and rural and isolated practice nurses working within specific rural health services (for the drug misoprostol in certain circumstances, but not in relation to terminations).

2.2.1.4 Compatibility with human rights

Because this amendment makes changes to laws regulating the termination of pregnancy, it has the potential to engage with the right to life, protected by section 16 of the Human Rights Act, the right to freedom of thought, conscience, religion and belief, protected by section 20 of the Human Rights Act, and the right to access health care services, protected by section 37 of the Human Rights Act. Section 8 of the Termination of Pregnancy Act provides for rights of conscientious objection.

The purpose of this amendment is to remove barriers to accessing health care for people who are pregnant seeking early medical terminations of pregnancy. This purpose aligns with the right to access health care protected by section 37 of the Human Rights Act.

Committee comment

While noting that this proposal does include a wider class of health practitioners as providers of medical termination of pregnancy than that envisaged by the May 2023 Senate Community Affairs Reference Committee report, Queensland Health have provided sufficient policy justification for the proposal to permit some nurses and midwives to provide medical termination of pregnancy once those personnel have obtained appropriate qualifications and training. Such personnel will participate voluntarily and will be covered by existing conscientious objection provisions. We also note the advice from the TGA that MS-2 Step can now be prescribed by any healthcare practitioner with appropriate qualifications and training. Importantly, the TGA decision only requires practitioners to have appropriate qualifications and training – it does not specify which practitioners this should be.

It appears to us that Queensland Health's development of the clinical pathway for medical termination of pregnancy using MS 2-Step will be a critical step in the implementation of this proposal, and we encourage Queensland Health to continue work on this pathway to ensure a timely implementation, especially given the apparent experience of other Australian jurisdictions which have sustained lengthy delays in commencing similar legislative provisions. Presently, nurse practitioners and endorsed midwives are legally able to provide medical termination of pregnancy only in Victoria.

[71] SA Health, *Abortion legislation reform and the new Termination of Pregnancy Act 2021,* https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Conditions/Abortions/Abortion+legislation+reform+and+the+new+Termination+of+Pregnancy+Act+2021.

Regarding the impact on human rights of this proposal, we believe it strikes a fair balance between the public benefit of improving equality of access to health care services and protecting and promoting other important rights including the right to freedom of thought, conscience, religion and belief. By expanding the range of health practitioners able to perform early medical terminations, the Bill will allow pregnant people living in regional, rural and remote areas to have increased access to reproductive healthcare services without facing excessive barriers of cost or distance. The Bill also applies the existing conscientious objections provisions to the new practitioners, which recognises that these health practitioners have, and may exercise, the right to freedom of thought, conscience, religion and belief. Any impacts on human rights are reasonable and demonstrably justifiable in accordance with section 13 of the Human Rights Act.

2.2.2 Regulation making power

Clause 22 of the Bill proposes the insertion of a regulation making power into the Termination of Pregnancy Act to prescribe other registered health practitioners who may perform medical terminations.[72] For example, in the future, Aboriginal and Torres Strait Island Health Practitioners may be prescribed to perform medical terminations.[73]

The QNMU submission specifically opposes the potential for such a regulation making power to permit pharmacists to provide medical termination of pregnancy:

> We raise concerns regarding the suitability of women seeking access to early medical termination services from pharmacists. The provision of termination services is complex and nuanced, requiring appropriately trained and qualified health practitioners to provide thorough patient consultations, obtaining patient history and examinations before going ahead with a medical termination. Consultations should cover the physical, mental, and pharmacological effects of the medication. Pharmacists do not have this training. Further concerns include that pharmacists are not able to order ultrasounds or blood tests when they are deemed necessary, nor do they have access to the Medicare Benefits Schedule or Pharmaceutical Benefits Schedule.
>
> A busy retail pharmacy setting does not provide the optimal environment for complex diagnostic reasoning, appropriate consultation, or the necessary environment to maintain confidentiality when discussing women's private health issues. Consideration needs to be given to ensuring that multidisciplinary clinics are appropriately resourced and supported to provide information about this service in a respectful, qualified, and confidential manner.[74]

2.2.2.1 Compliance with fundamental legal principles

Whether a Bill has sufficient regard to the institution of Parliament depends on whether, for example, the Bill allows the delegation of legislative power only in appropriate cases and to appropriate persons.[75] The Bill provides for a regulation making power. The QLS have raised reservations about this proposal from a legislative drafting perspective.[76] It submits 'the inclusion of additional health practitioners should be the subject of appropriate stakeholder consultation as well as sufficient scrutiny by the Legislative Assembly'.[77] QLS President, Ms Rebecca Fogerty, told a public hearing that while the QLS acknowledge the flexibility provided by this regulation making power proposal:

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[72] Bill, cl 22 (*Termination of Pregnancy Act 2018*, new s 6A(1)(c)).

[73] Explanatory notes, p 13.

[74] Submission 26, pp 7-8.

[75] *Legislative Standards Act 1992*, s 4(4)(a).

[76] Public hearing transcript, Brisbane, 1 February 2024, p 30.

[77] Submission 34, p 6.

> There are different views among submitters about what range of health professionals should be granted the extended power. We say that it underscores the importance of stakeholder consultation because it is not unanimous among concerned parties.[78]

The explanatory notes state:

> This delegation of legislative power is considered justified and necessary to ensure the legislation is sufficiently flexible to allow increased access to medical terminations of pregnancy in the future, once the capability and training of a new category of health practitioners has been assessed as sufficient. The amendment will allow Queensland Health to be responsive to community needs for access to reproductive healthcare. It is appropriate for these matters to be dealt with in subordinate legislation, which must be made by the Governor in Council, tabled in Parliament and subject to disallowance and Parliamentary oversight.[79]

Committee comment

We note that even if a registered health practitioner is prescribed in a future regulation, the practitioner would only be able to perform a medical termination if the practitioner is authorised under the Medicines and Poisons Act or its instruments to carry out the activity. For example, EPAs set out the qualifications or training required to deal with regulated medicine. EPAs generally undergo several stages of approvals, including health management protocols endorsed by an interdisciplinary health team. In other words, any future class of health practitioner who may be prescribed by regulation to provide medical termination of pregnancy would be subject to significant clinical assessment and regulatory oversight.

While a regulation is oversighted by Parliament, it is subject to less scrutiny than a Bill. It could be argued that the registered health practitioners who are allowed to perform medical terminations should be set out in a Bill. However, a regulation would provide more flexibility to respond quickly to changing circumstances, and any regulation prescribing a registered health practitioner who may perform a termination would be subject to a level of scrutiny by Parliament through tabling and disallowance. We note the comments from Ms Karen Grace MACN, National Director of Professional Practice for the Australian College of Nursing in terms of Queensland futureproofing its legislation with the proposal to extend the class of authorised health practitioners who may provide medical termination of pregnancy.

We are satisfied that this proposal is an appropriate case to delegate legislative power and as a result has sufficient regard to the institution of Parliament. We are satisfied that the provisions are justified in the circumstances which have been described above.

2.2.3 Replace gendered language with gender-neutral language

Schedule 1 of the Bill sets out amendments to section 313 of the Criminal Code and schedule 2, section 11 of the Powers of Attorney Act to use gender-neutral language when referring to a person who is pregnant. The Bill also sets out amendments to the Termination of Pregnancy Act to replace gendered language with gender-neutral language.

The explanatory notes state:

> These amendments will ensure the provisions apply equally and without discrimination with regard to all pregnant persons in Queensland. The changes are also intended to ensure the terminology

[78] Public hearing transcript, Brisbane, 1 February 2024, p 31.

[79] Explanatory notes, p 13.

> used in the legislation is contemporary and appropriately acknowledges trans and gender-diverse people.[80]

The explanatory notes additionally state:

> There was considerable variation in views about updating the terminology within the Termination of Pregnancy Act and Criminal Code to reflect Queensland's gender-diverse community….
>
> Although consulted stakeholders supported the provisions applying equally with regard to all pregnant persons, several stakeholders expressed a strong conviction that references to 'woman' and 'women' should be retained in the legislation. Some of these stakeholders maintained that retaining specific references to 'women' carries cultural significance and is important in the provision of reproductive healthcare.
>
> The intent of the amendments is to ensure the legislation applies equally and without discrimination to all pregnant persons in Queensland. This is best achieved by using language that is gender-neutral. The use of gender-neutral language also aligns with current legislative drafting practices and the amendments introduced in the *Births, Deaths and Marriages Registration Act 2023* to strengthen legal recognition of trans and gender-diverse people, which were passed by the Queensland Parliament on 14 June 2023. Use of gender-neutral language in the legislation does not impact on health practitioners using a person's preferred gender descriptors when providing treatment and care to the person.[81]

2.2.3.1 Submitter support

Submitters including Australian College of Nursing, Human Rights Law Centre, Australian College of Nurse Practitioners, Children by Choice, QLS, RANZCOG, MSI Australia and Max Heers supported this proposal. At a public hearing, Children by Choice submitted:

> We are also supportive of updating the proposed legislation to align with non-gendered and inclusive language. Currently the Termination of Pregnancy Act 2018 does not align with inclusive language adopted in similar legislation in the ACT, New South Wales, South Australia and New South Wales. This change would also align with other recent Queensland legislation which removes unnecessary gendering to ensure public information meets the needs of groups requiring plain language.[82]

Max Heers, who has lived experience as a trans masculine person who can experience pregnancy, submitted:

> Currently trans and gender diverse Queenslanders face systemic barriers in accessing comprehensive reproductive health and abortion services. Experiences of pregnancy and abortion are not unique to cisgender women. People with a uterus, if engaged in certain sex acts, may experience an unintended pregnancy. Even testosterone-bodied, trans masculine people (who have been on hormone replacement therapy for years and present male), can become pregnant and require safe access to pregnancy options and abortion care….
>
> If doctors, nurses and pharmacists don't know people other than cis-women can experience; menstruation, lactation, pregnancy and abortion, how are they to provide safe or appropriate sexual health care? (ie: Trans guys need contraception too). The QLD ToP act currently mentions women 56 times, with no information or disclaimers that people other than women are also legally entitled to access these services. Legal and medical frameworks inform how societies act, changing the ToP legislation to use inclusive language is the start of working toward reproductive justice in QLD for trans and gender diverse people capable of becoming pregnant.[83]

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[80] Explanatory notes, p 28.

[81] Explanatory notes, p 16.

[82] Public hearing transcript, Brisbane, 1 February 2024, p 10.

[83] Submission 33, p 1.

2.2.3.2 Submitter opposition

Other submitters opposed this proposal, including Queensland Aboriginal and Islander Health Council (QAIHC), Australian College of Midwives – Qld Branch, Associate Professor Karleen Gribble, QNMU, IWD Meanjin Brisbane and Women's Forum Australia.

2.2.3.2.1 Impact on First Nations and culturally and linguistically diverse people

QAIHC does not support replacing references to woman with person. QAIHC submitted:

> While QAIHC accepts proposed amendments for inclusive language to acknowledge trans and gender diverse people are well-intentioned, it does not support achieving inclusivity by simply replacing 'woman' with 'person' in legislation.
>
> Historically, Indigenous cultures around the world have supported diverse identities that do not conform to traditional Western understandings of gender. In Australia, Sistergirls (Sistagirls) and Brotherboys (Brothaboy) are inclusive terms used to describe trans and non-binary Aboriginal and Torres Strait Islander peoples in some communities
>
> These terms are used with affection and appreciation of the contribution that transgender and non-binary people make to their communities.
>
> However, for many Aboriginal and Torres Strait Islander peoples including trans and non-binary people, part of their cultural identity is linked to sex, gender and stages of life. Babies grow into girls, culturally learn Women's Business, and grow into women, as boys grow into men with Men's Business. This identification as woman or man is fundamental and has strong cultural significance for many Aboriginal and Torres Strait Islander people.
>
> For this reason, the proposed amendment, intended to be inclusionary in a Western cultural context, may have the unintended consequence of excluding Aboriginal and Torres Strait Islander women and trans and gender diverse people who have a different concept of what it means to be a woman.
>
> QAIHC recommends that the term woman is retained in recognition of the cultural significance that this word has for Aboriginal and Torres Strait Islander peoples. To enable inclusion for those who may identify differently to the sex they were assigned at birth, QAIHC recommended that legislation be amended to refer to "a woman or person who is pregnant but does not identify as a woman"…
>
> QAIHC accepts that this construction will not comply with best practice drafting principles – which generally require gender neutral language - but believes if this legislation is to be truly inclusive, it is an appropriate compromise that balances Western constructs of gender and inclusivity with Aboriginal and Torres Strait Islander cultural considerations and notes that drafting principles are not always strictly observed. Here, the Bill's aim of inclusivity would be better achieved by departing from drafting principles.
>
> Alternatively, the definition of woman, for the relevant parts of the Acts, could be amended to expressly include all people who identify as a woman including those who are transgender, intersex, gender diverse or gender fluid. This approach would be consistent with the Queensland Women and Girls' Health Strategy. However, QAIHC recognises that not all people who are pregnant identify as a woman and, for this reason, recommends that legislation refer to "a woman or person who is pregnant but does not identify as a woman".[84]

At the public hearing, Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives—Queensland Branch expressed support for the submission from QAIHC that the proposed amendment, intended to be inclusionary in a western cultural context, may have the unintended consequence of excluding Aboriginal and Torres Strait Islander women. Ms Weatherstone submitted:

> ACM believes that the same could be said for many women who do not apply the concept of gender identity to themselves, including those from diverse cultural and linguistic backgrounds. ACM is

[84] Submission 5, p 2.

> concerned that, if legislation related to female reproduction in Queensland is desexed through the removal of the term 'woman', it will encourage similar changes in health contexts, including health promotion. Public health interventions utilising desexed language are predicted to create barriers for marginalised individuals with lower health literacy. An example of this is evident in the public health intervention for cervical screening inviting 'anyone with a cervix' for screening rather than 'women'. Women with low literacy, low health literacy or low English language skills are at risk of not understanding that such interventions are directed at them. This example demonstrates potential real-world negative impacts of desexed language, further disadvantaging marginalised groups. Alternatives for 'woman', like 'anyone with a cervix', that refer to women by bodily organs, processes or diseases are also dehumanising and unacceptable.
>
> ACM would like to draw to the attention of the committee the importance of accurate data collection on sex and the need for recognition of this in legislation and policy. Data collection relies on specific categorisations in language. Accurate recognition of and recording of sex is vital to safe healthcare provision, including for transgender and gender-diverse people, and also in relation to pregnancy. Data collection on sex is critical to closing the female data gap that results in poor health outcomes for women. Removal of the word 'woman' from legislation addressing female reproduction, making invisible the sex of those whose rights are central to the legislation, constitutes a marginalisation of women through language. In contrast, using the word 'woman' demonstrates a firm commitment by government to women, their rights and health care. ACM highlights that there are multiple strategies that are focused on women, including the Queensland Health women's health strategy and the national women's Centacare strategy, and we note that the Queensland government has a Minister for Women, and we therefore consider it appropriate that this legislation would contain the word 'woman'.[85]

In response to submitter concerns about this proposal, Queensland Health stated it acknowledged that:

> for Aboriginal and Torres Strait Islander peoples, including transgender and non-binary people, cultural identity is deeply linked to sex, gender and stages of life. Identification as a 'woman' or 'man' holds strong cultural significance. Embracing broader, more inclusive language in legislation does not overlook the cultural significance of gender identity in First Nations communities.
>
> The Bill will facilitate legal access to termination of pregnancy care for all Queenslanders by ensuring pregnant people and practitioners are not committing crimes under termination of pregnancy legislation. Importantly, Queensland Health will continue to include references to women and pregnant people in all materials, guidelines, websites, documents and clinical settings, where possible and appropriate. It will also use culturally appropriate language with First Nations people to ensure culturally safe and appropriate care.[86]

At a public hearing, Mr James Liddy, Legislative Policy Unit Manager for Queensland Health advised:

> We definitely consulted on the bill with Aboriginal and Torres Strait Islander groups and that is where we got the information from QAIHC about their concerns. They provided those representations. We did consider those carefully. A number of different ways of framing the provision were considered and discussed. We did look at alternatives. Unfortunately, the laws have to be drafted for the statute book as a whole. We cannot have special provisions just in health legislation because it then casts doubt on provisions elsewhere across the statute book about their interpretation. In this case, the advice was that the simplest legally effective way to do this was to use 'person' as the gender-neutral term and that is consistent with other legislative changes that have been made recently….
>
> Quite a few of our stakeholders made suggestions during the consultation process about alternative formulations and they were all considered. They were all considered very carefully. What we are going to do, though, is ensure that when care is provided to people in practice—this is about the wording that is in the act. All of the materials and all of the information that is provided

[85] Public hearing transcript, Brisbane, 1 February 2024, p 21.

[86] Queensland Health, correspondence, 23 January 2024, p 5.

> to people can use different terminology. It can use broader terminology like 'women' and 'pregnant people' et cetera. Queensland Health's intention is to adopt broader language for all of our materials, our websites and our guidance for people so that it is inclusive. [87]

2.2.3.2.2 Distinguishing concepts of sex and gender

Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives—Queensland Branch submitted at a public hearing:

> It is important to understand that sex, a reproductive category; gender, a societal role; and gender identity, an inner sense of self, are not synonymous. The word 'woman' can have a sexed or gender identity-based meaning. The legislation being amended makes it clear that 'woman' is used in its sexed meaning to refer to female people. Given the inherently sexed nature of pregnancy, this is entirely appropriate. However, the explanatory notes and statement of compatibility for the bill indicate that the word 'woman' should be understood in a gender identity-based meaning to refer to people who have a gender identity of woman. The removal of 'woman' from the legislation is therefore not the common understanding and as such appears flawed.
>
> The use of the word 'woman' in its sexed meaning rather than from a gender identity use must be understood by all decision-makers here today, including the unintended consequences of removing sexed language from legislation. Keeping 'woman' in legislation is crucial for acknowledging and safeguarding the specific rights and experiences of women as a group encompassing all female people. 'Woman' in its sexed meaning in legislation ensures that legal frameworks recognise the unique challenges and needs faced by women, ensuring targeted protection against discrimination and the promotion of gender equality. Preserving the term 'woman' in the legislation specifically under consideration accurately reflects the reproductive rights held by those who can and do become pregnant, while removing this word obscures who it is that this legislation applies to.[88]

IWD Meanjin Brisbane submitted:

> The Government argues 'transmen' must be included in the legislation. They already are, 'transmen are women and girls. There are only two sexes: women and men. 'Transman' and 'transwoman' are based on identity not sex. Pregnancy, whether it is wanted or unwanted, occurs because of biology not 'identity'. It matters for nought that many different 'gender identities' are being created, women who campaign for women's rights don't really care how many gender identities the Qld Government believes in because gender and gender 'identity' are different from biological sex.[89]

Associate Professor Karleen Gribble from Western Sydney University submitted:

> Neither the Explanatory Notes nor the Statement of Compatibility provide an explanation for why 'woman' should be interpreted in the new gendered meaning. The Statement of Compatibility inaccurately describes replacing 'woman' with 'people' as making the legislation 'gender-neutral' when in fact that change desexes the legislation. While it is undoubtably true that not everyone who is female has a gender identity of 'woman,' only females can become pregnant and may seek a pregnancy termination. In fact, gender identity is not relevant to pregnancy and I cannot see any justification to gender pregnancy. Rather sexed language should be maintained.[90]

While not specifically addressing submitter issues regarding the proposal's potential confusion between sex and gender, in its response to submissions Queensland Health stated:

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[87] Public briefing transcript, Brisbane, 12 February 2024, p 7.

[88] Public hearing transcript, Brisbane, 1 February 2024, p 20.

[89] Submission 31, p 1.

[90] Submission 23, p 3.

> Removing gendered language from Queensland legislation is an objective of the Queensland Government. Removing gendered language from the Termination of Pregnancy Act and Criminal Code is also consistent with recent changes to the *Birth Deaths and Marriages Registration Act 2003* for greater legal recognition of transgender and gender diverse people…
>
> Performing an unauthorised termination of pregnancy is a crime in Queensland under the Criminal Code. Updating references to 'woman' with 'person' in the Termination of Pregnancy Act and Criminal Code also protects Queensland health practitioners who provide termination of pregnancy services to transgender and gender diverse individuals.[91]

2.2.3.2.3 Impact on women's rights

The QNMU submitted that retaining the term 'woman' in the Termination of Pregnancy Act is important to safeguard the specific rights and experiences of women:

> We caution against the potential adverse consequences of desexed language when referring to sexual and reproductive health services.
>
> The terms women, woman and women and babies provide essential language that supports a human-centered philosophy of midwifery care that empowers and protects all women and persons who are accessing their care. Women continue to experience discrimination based on sex and harmful gendered stereotypes associated with being female.
>
> The removal of the term 'woman' in legislation that is targeted at a population level has the potential unintended consequence of making biological sex less visible and more difficult to clearly explain in healthcare education.[92]

In its response to public submissions about the effect of this proposal on women's rights and experiences, Queensland Health advised:

> Queensland Health recognises there are differing and strongly held views about this issue.
>
> Queensland Health understands the important role women play in our community and that the experiences of women, especially in the context of reproduction, are unique and significant. The Queensland Women's Strategy 2022-27 (Strategy) outlines how the Queensland Government is ensuring women and girls are safe, valued, and able to freely participate in economic, social and cultural opportunities. A key principle underpinning the Strategy is that gender equality is inclusive. The Strategy recognises everyone who identifies as a woman and acknowledges that Queensland women and girls with diverse backgrounds and experiences have the right to be safe and be provided with the same opportunities as everyone else.
>
> To support women and girls achieve their full health potential, Queensland Health is developing a Queensland Women and Girls' Health Strategy (QWGH Strategy) as a priority commitment under the Queensland Women's Strategy 2022-27. The QWGH Strategy will respond to the specific health needs of women, address the social determinants of women's health and promote women's health and wellbeing. It will also consider the health needs of priority communities of women and girls who experience increased health inequity and additional barriers to accessing healthcare. Ongoing public consultation to inform the QWGH Strategy has been underway since late 2022, including more than 10,000 responses to an online survey to hear the views and experiences of Queenslanders.
>
> Updating references to 'woman' with 'person' in the Termination of Pregnancy Act and Criminal Code ensures equal access to termination of pregnancy services in Queensland by removing a legal barrier for people who may be pregnant, but not a woman — for example, a transgender man or

[91] Queensland Health, correspondence, 23 January 2024, pp 4-5.

[92] Submission 26, p 8.

> non-binary person. The recognition of other gender identities does not detract from the experiences of women; rather, it extends the same dignity and rights to all persons.[93]

2.2.3.3 Comparison with other Australian jurisdictions

The following jurisdictions use the term woman in relevant termination of pregnancy legislation:

- Victoria – *Abortion Law Reform Act 2008* (Vic)
- Tasmania – *Reproductive Health (Access to Terminations) Act 2013* (Tas)
- Northern Territory – *Termination of Pregnancy Law Reform Act 2017* (NT).

The following jurisdictions use the term person in their relevant legislation:

- New South Wales – *Abortion Law Reform Act 2019* (NSW)
- South Australia – *Termination of Pregnancy Act 2021* (SA)
- Western Australia – *Abortion Legislation Reform Act 2023* (WA)
- Australian Capital Territory – *Health Act 1993* (ACT).

The legislation in New South Wales, South Australia and Western Australia contained the term person when the legislation was introduced. The Australian Capital Territory amended their legislation in 2018 to adopt inclusive language.

Committee comment

We note the advice from Queensland Health that it consulted with First Nations representatives regarding concerns about this proposal, but that to draft this amendment consistently with the statute book, the word person has been utilised as a gender-neutral term. We also note the undertaking by Queensland Health to use suitable terminology like 'women' and 'pregnant person' in health promotion materials which support this legislative change.

The need to draft consistently with the statute book also responds to concerns expressed by some submitters that the amendment, given the inherently sexed nature of pregnancy, fails to distinguish between sex, a reproductive category; gender, a societal role; and gender identity, an inner sense of self.

2.3 Amendments to the *Mental Health Act 2016*

2.3.1 Admissibility of evidence and transcripts in criminal proceedings

Clauses 15 and 16 of the Bill amends section 157 and 157A of the Mental Health Act to allow that an expert's report and transcript of Mental Health Court proceedings are admissible at the trial, or in Magistrates Court proceedings, of the person for any offence. The proposal is to also include transcripts from Mental Health Court proceedings within the remit of sections 157 and 157A.

The Bill would extend the admissibility of expert's reports by providing they are also admissible at the trial of the person for any other offence alleged to have been committed by the person, to inform a criminal court's consideration of a person's soundness of mind or fitness for trial, or for the purpose of sentencing a person. The explanatory notes state:

> Expert reports related to a different offence may still be of relevance for a criminally charged person. For example, a person may wish to have the criminal court consider an expert's opinion as to their psychiatric health and history. Limiting the admissibility and use of such evidence therefore deprives an individual of the ability to have their personal mental condition accounted for during trials.[94]

[93] Queensland Health, correspondence, 23 January 2024, p 4.

[94] Explanatory notes, p 6.

Professor John Allan, Mental Health, Alcohol and Other Drugs Branch Executive Director for Queensland Health, provided additional clarification about the proposal at a public hearing:

> When a person goes to the Mental Health Court, a lot of the work is done by having expert opinions given for them. They will see a psychiatrist who will provide a report to the court. That might be one or two reports, depending on the nature of the offence, its complexity and so on. The court uses those things, along with other evidence, to make a decision and they are assisted by two psychiatrists. They are really good reports. There are really good things about the patients, it talks about their life, about their outcomes and can be very helpful. If the matter does not proceed in the Mental Health Court and has to go off to a criminal court, there has been a holdup in releasing those reports and it is only about the offence that took them to the Mental Health Court, but they might have a lot of other offences for which this is relevant.
>
> The idea is that, to assist that person, those reports would be available to the criminal court, and I will go through the process in a minute, and can only be used for three things: to determine if a person was of unsound mind, if they were not fit for trial or to assist in the sentencing—so to use that material to help in the sentencing. It is the report and the transcript that make the context of the discussion of the report important. It is really to try to help people to get that assistance in other matters that they might have. It has not been used a lot but, as I say, there is material there that could help the person.
>
> There was a bit of debate about whether the person needed to consent but the issue is that in the Mental Health Court they are represented, they have a lawyer, so the court has to make a decision about sending that. Then the criminal court has to decide whether it would accept that evidence and, again, representations can be made to that court to do that but it is limited. Remember, these are mental health interviews; they are not records of interview like the police would have. It is not about whether the facts are there; it is about the diagnosis and the care of the person.[95]

The explanatory notes report that stakeholders were 'generally supportive' of this proposed amendment. The President of the Mental Health Court provided feedback that leave of the Court should continue to be required for any expert report to be made available for use in proceedings in a criminal court and that transcripts may only be admissible for extremely limited purposes.[96]

Submitters who were generally supportive of this proposal include QLS and Aged and Disability Advocacy Australia. QLS is supportive based on the benefit of transcripts being admissible in certain circumstances and importantly, noting the discretion of the Courts to admit evidence in this regard.[97]

The Public Advocate and Mental Health Lived Experience Peak Queensland (MHLEPQ) responded extensively to this proposal. The Public Advocate, Dr John Chesterman, indicted in principle support, but recommended further safeguards to ensure that only the person who is the subject of the report consent to the use of relevant materials.[98]

> For example, during sentencing for an unrelated offence, the prosecution may wish to admit a past report where the person has stated some negative intentions towards a particular group of people that the unrelated offence has some connection to, potentially aggravating the person's culpability. Even though the person's statement was never intended to be used for anything other than the assessment of the person's mental state at the time and may have even been a reflection of a mental illness, the report could then potentially be used to seek a harsher sentence than the person would have otherwise received for that offence.
>
> Another example is if the person has been charged with an unrelated offence and is attempting to rely on a Criminal Code defence of unsoundness of mind or diminished responsibility. If there is no

[95] Public briefing transcript, Brisbane, 12 February 2024, pp 6-7.

[96] Explanatory notes, p 17.

[97] Submission 34, p 3.

[98] Public hearing transcript, Brisbane, 1 February 2024, p 2.

> restriction on who can admit previous reports into evidence, the prosecution could tender an old report that the person was not of unsound mind at the time of a previous offence, which may be contradictory to a more contemporaneous report. This could confuse a jury, who should generally be relying upon the more recent report.[99]

While noting the discretion of the Courts to determine admission of evidence, Dr Chesterman stated at the public hearing:

> I think giving the person that opportunity is an important potential safeguard, to make sure that if the person, for instance, is objecting then the court takes that into account in making a determination.[100]

Dr Chesterman also submitted that only those parts of a transcript that record evidence by experts should be admissible.[101] 'The whole transcript of a proceeding should not be admissible in other proceedings, as it will contain information irrelevant to the person's condition. It would contain submissions made by various parties, and potentially information from witnesses who were examined.'[102]

Mental Health Lived Experience Peak Queensland (MHLEPQ) submitted:

> We agree with this existing reasoning in relation to both the use of expert reports and transcripts. A person before a court on a criminal matter should have access to any evidence that can mitigate or defend the person as freely as is practicable and possible. It also makes sense that if a person has engaged in the development of a report concerning their mental health and or a court procedure that they can consent to use such assessments and records for other purposes.
>
> The MHLEPQ is concerned that the proposed change prima facie goes further than this. It allows any relevant party to use this information for any criminal matters in court proceedings for eternity with or without the consent of the person with whom they concern.
>
> In our advice to the Queensland Health Strategy, Policy, and Reform Division in September 2023 we recommended…that any change to the use of expert reports in unrelated criminal matters specifically be limited in the legislation to the defendant having the right to use such reports, and further that no detriment should be inferred on a defendant for choosing not to do so.[103]

Regarding submitter views that the person the subject of Mental Health Court reports and transcripts should consent to the use of those reports in other proceedings, Dr Catherine McDougall, Chief Medical Officer for Queensland Health advised at a public hearing:

> The department does not consider this necessary or appropriate as other safeguards and considerations apply. Firstly, leave of the Mental Health Court is required before any release or use of an expert report or transcript in a criminal proceeding. This process ensures all parties, including the person the subject of the report, can make submissions about whether the report should be able to be used and to suggest conditions the Mental Health Court should place on the use of the material.
>
> Secondly, criminal courts will have discretion about whether to admit the material into evidence. Again, the defendant would be able to make submissions to the court about whether the material should be admissible. The criminal court would need to consider the relevance of the clinical opinions, including how recently the report was prepared and its relevance to proceedings. Thirdly, if material is admitted into evidence, a criminal court may only use it to consider a person's

[99] Submission 5, p 2.

[100] Public hearing transcript, Brisbane, 1 February 2024, p 3.

[101] Submission 5, p 2.

[102] Submission 5, p 4.

[103] Submission 19, p 3.

> unsoundness of mind, fitness for trial or in sentencing. Evidence of a person's mental illness or intellectual disability may be considered relevant as a mitigating factor in a criminal case; for example, it may reduce the severity of a person's sentence.
>
> Under the current provisions the use of the expert reports or transcripts by prosecutors in criminal proceedings is exceptionally rare and it is expected this will continue to be the case. However, it is the prosecutor's role to act in the interests of justice, so it is important to have a legislative mechanism available to ensure criminal courts have all relevant information available to decide a matter. Ultimately, the criminal court will have discretion about whether to admit the material and the weight given to it. The defendant's ability to make submissions about both the admissibility of the evidence and how it is used in the proceedings is considered a sufficient safeguard to appropriately balance the interests of justice for all parties.[104]

2.3.1.1 Compatibility with human rights

Given the sensitive nature of the information contained in mental health related expert reports and transcripts, this proposal has the potential to limit the right to privacy and reputation protected by section 25 of the Human Rights Act, as it requires a greater number of interested parties having access to reports and transcripts which may include sensitive and personal information about a person. Section 25 of the Human Rights Act protects the right of a person not to have his or her 'privacy, family, home or correspondence unlawfully or arbitrarily interfered with' and not to have their personal reputation unlawfully attacked.

Committee comment

We note submitter recommendations that the person who is the subject of Mental Health Court reports and transcripts should have a say in whether such documents should be admitted into evidence in other proceedings, and are satisfied with the explanation provided by Queensland Health that current provisions in the Mental Health Act provide for sufficient input by the person concerned when applications for leave to admit such documents as evidence are considered by the various Courts.

Regarding the potential impact of this proposal on human rights to privacy and reputation, on balance, the rights enhancing purpose of these proposed amendments outweigh any potential limitation on the rights to privacy and reputation with respect to a person whose personal information is shared as a result of these new provisions. The proposed amendments will be introduced to a legislative regime that includes multiple safeguards against the misuse or disclosure of confidential personal information and preserves the powers of the Courts to make decisions about the admissibility of evidence adduced in criminal proceedings. The proposed amendments also continue to protect the freedom from self-incrimination. As a result, any limitations on the right to privacy and reputation appear to be within the scope of justifiable limitations as set out in section 13 of the Human Rights Act.

2.3.2 Use of expert reports prior to a Mental Health Court hearing

At present, the Mental Health Act does not release or allow the use of expert reports that have been filed with the Court but not yet received in evidence at a Mental Health Court hearing. The explanatory notes provide various reasons why expert reports might need to be used and disclosed:

- to plan or deliver treatment and care, and manage any risk, for existing patients or persons who are not existing patients of mental health services
- to support the provision of further expert opinions to the Court
- to allow parties to undertake their functions to assist the Court

[104] Public briefing transcript, Brisbane, 12 February 2024, p 1-2.

- to enable parties to a matter to use an expert report filed with the Court but not yet received in evidence for another purpose.[105]

Clause 17 of the Bill would amend section 160 of the Mental Health Act by allowing access to expert reports (early reports) filed with the Mental Health Court registry, provided leave of the Court is obtained. The amendment would mean that authorised mental health service clinicians could access expert reports to provide treatment and care prior to a Mental Health Court hearing, by an expert report (obtained with leave of the Court) being included on a person's Consumer Integrated Mental Health and Addiction (CIMHA) health record.[106]

QLS submitted this proposal should more clearly articulate the circumstances for which leave is required and on what basis a report may be released. It also suggested ensuring the provision be extended to cover reports tendered during a proceeding that are not filed in the registry. It notes section 160(4) of the Mental Health Act appears to allow an expert report received in evidence to be released to the listed entities without leave of the Mental Health Court.[107]

The Public Advocate expressed concern that this proposal does not specify who can admit such reports into evidence, and so recommends amending the proposal so that it should only occur with the consent of the person who is the subject of the report.[108] Further:

> It should be noted that there does not appear to be an equivalent provision in the Mental Health Act to section 130 of the Evidence Act 1977. Section 130 of the Evidence Act clearly states that nothing in that Act derogates from the power of the court to exclude evidence if it is unfair to the person charged. Therefore, allowing broad admissibility under the Mental Health Act in section 157 may force a court to admit the evidence even though it may violate a person's right to a fair trial.[109]

In its response to submissions, Queensland Health noted:

> The proposed amendment to section 160 will continue an existing ability for giving expert reports received in evidence to limited entities without leave of the Mental Health Court. The entities are limited to services responsible for providing a person with treatment and care, including to the relevant authorised mental health service or forensic disability service, and the Mental Health Review Tribunal. This is essential to ensure these entitles can perform their required functions under the Mental Health Act of providing appropriate treatment and care to a person whose involuntary order they are responsible for, or in the case of the Tribunal, undertaking the independent review of a person's involuntary treatment and care which is its core function.
>
> The normal rules of evidence, including those contained in the Evidence Act, will continue to apply to the use of expert reports and transcripts, so that criminal courts can decide if a particular transcript or report should be admitted into evidence. The amendments are intended to make clear that transcripts and expert reports can be tendered in evidence for any offence. However, criminal courts will retain their ability to exercise discretion in deciding whether to admit evidence.[110]

While the MHLEPQ was not supportive of the proposal to allow the early use of expert reports, it submitted that any release of material submitted to the court registrar only be made with leave of the court and that the court has the power to impose any conditions on such release it finds

[105] Explanatory notes, p 6.

[106] Explanatory notes, p 26.

[107] Submission 34.

[108] Submission 5, p 2.

[109] Submission 5, p 2.

[110] Queensland Health, correspondence, 23 January 2024, p 7.

appropriate.[111] It also submitted this requirement should also apply to records obtained by the Chief Psychiatrist as a party to the proceedings (that is, so it can only be used in clinical settings with leave of the Mental Health Court).

Queensland Health stated in response:

> The circumstances in which release and leave for use of an expert report may be sought from the Mental Health Court are varied. Accordingly, the proposed amendments to section 160 provide the Mental Health Court with broad powers to ensure its ability to release reports in circumstances, and for purposes, which it considers appropriate. Reports tendered by parties during proceedings are captured by the proposed amendment to section 160 by virtue of being received in evidence by the Mental Health Court constituted to hear those proceedings.[112]

2.3.2.1 Allowing early reports to be provided to QCAT

Aged and Disability Advocacy Australia submit that the proposal be amended to include the Queensland Civil and Administrative Tribunal (QCAT) Registry as an entity that is recognised by the Mental Health Court Registry for the purpose of being provided a requested expert's report.[113]

> Oftentimes a person who is the subject of an order or who is receiving treatment under the Mental Health Act is also exposed to a guardianship and administration application or review before QCAT. Such an application (whether initiated by the individual, or by their mental health treating team) may seek to rely on a report which has been lodged with the Mental Health Court Registry.
>
> Expedient access to these reports as appropriately requested by the QCAT Registry would improve transparency and access to a person's own documents in relation to a guardianship and administration application or review.[114]

The QLS agreed with Aged and Disability Advocacy Australia regarding the use of expert reports from the Mental Health Court in related QCAT matters where simultaneous guardianship matters are on foot and capacity is an issue. 'Applications for guardianship and administration can also have a flow on impact to other legal proceedings including child protection and dangerous prisoner matters. Access to reports in these circumstances are often pertinent to ensuring these matters can progress.'[115]

In response, Queensland Health stated:

> This issue is outside the scope of the Bill, which is limited to the use of expert reports and transcripts in criminal proceedings.
>
> The use of expert reports and transcripts in civil proceedings would require further detailed consideration and consultation with affected stakeholders. In relation to their use in guardianship matters, consideration will also need to be given to the recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
>
> Queensland Health will monitor the implications of the proposed amendments in the Bill regarding the use of expert reports and transcripts in criminal proceedings and give consideration to whether this should be expanded to other legal proceedings in future.[116]

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[111] Submission 19, p 4.

[112] Queensland Health, correspondence, 23 January 2024, p 8.

[113] Submission 37, p 2.

[114] Submission 37, p 2.

[115] Queensland Law Society, correspondence, 8 February 2024.

[116] Queensland Health, correspondence, 23 January 2024, p 8.

2.3.2.2 Security of personal data stored on Consumer Integrated Mental Health and Addiction (CIMHA) electronic record

Some submitters expressed concern that, once the Court has given leave, allowing access to early reports via CIMHA could raise privacy issues. The Australian College of Nursing recommended including in the proposal measures to ensure the protection of personal data.[117] QLS noted that to protect privacy, the Court could impose limitations on access while granting leave.

In response Queensland Health noted:

> The proposed amendments only relate to the CIMHA application, which is the electronic record used by Queensland Health Mental Health Alcohol and Other Drug Services for patient records and would not apply to other medical record storage programs, such as those administered by the Australian Government, including My Health Record.
>
> The Bill only allows for the disclosure and use of expert reports with the leave of the Mental Health Court and subject to any conditions the Court considers appropriate. If an expert report is released for use by an authorised mental health service, the report is required to be stored in CIMHA as the designated health record for the purpose of the Mental Health Act.
>
> A person's CIMHA record is only accessible by authorised and approved Queensland Health staff who require access for the purpose of providing a person with treatment and care. This may include staff from different authorised mental health services accessing the material at the same time (for example, if a person is transitioning between services and it is required to support their treatment continuity). The CIMHA application also has a range of capabilities for monitoring and limiting access to sensitive information. For example, CIMHA has secure modules which are only visible and accessible by users with a specified type of access to the CIMHA application. Queensland Health applies this functionality to ensure access is only provided to staff who require access to specific types of information to fulfil their role. Importantly, CIMHA users who access confidential health information stored in the CIMHA application owe duties of confidentiality under both the Mental Health Act and the HHB Act which regulate the use and disclosure of confidential information. Both Acts include penalties for misuse or unauthorised disclosure of confidential information.[118]

2.3.2.3 Compatibility with human rights

Given the sensitive nature of the information contained in mental health related expert reports, this proposal has the potential to limit the right to privacy and reputation protected by section 25 of the Human Rights Act, as it requires a greater number of interested parties having access to early reports received by the Mental Health Court Registry which may include sensitive and personal information about a person.

Committee comment

This amendment is designed to ensure key decision-making bodies have access to timely, expert information about the mental health status of people subject to Mental Health Court references and/or subsequent criminal proceedings to ensure the person receives access to adequate health care, and to facilitate improved decision-making about their fitness to stand trial, or their appropriate sentence following criminal proceedings. It therefore enhances the right to access to health care protected by section 37 of the Human Rights Act. The proposed amendments are tightly prescribed and accompanied by a range of safeguards against the misuse or disclosure of confidential personal information and preserves the powers of the Courts to make decisions about the admissibility of evidence adduced in criminal proceedings. As a result, any limitations on the right to privacy and

[117] Submission 7, p 4.

[118] Queensland Health, correspondence, 23 January 2024, p 7.

reputation appear to be within the scope of justifiable limitations as set out in section 13 of the Human Rights Act.

2.4 Amendments to the *Public Health Act 2005*

The Bill amends the Public Health Act to exempt medical practitioners from requirements to report instances of dust lung diseases to the Queensland Notifiable Dust Lung Disease Register where they have notified the National Occupational Respiratory Disease Registry.

In June 2023, the Australian Government introduced legislation to establish a National Occupational Respiratory Disease Registry (National Registry). The legislation will duplicate reporting requirements for Queensland practitioners, who would need to report to both the Queensland Register and the National Registry. The amendments would exempt medical practitioners from the duplication of reporting.

Information in the National Registry will be shared with state and territory health agencies. According to the explanatory notes Queensland Health will retain access to data needed to detect threats to the health of workers, to contribute to early intervention and prevention activities to reduce worker exposure and disease, and to plan, deliver and promote health services for occupational dust lung diseases.[119]

We received no substantive submissions regarding this proposal.

[119] Explanatory notes, p 10.

Appendix A – Submitters

Sub #	Submitter
1	Paul Creighton
2	James William Jenkins
3	ASHM Health
4	Queensland Aboriginal and Islander Health Council
5	Public Advocate
6	Australian College of Midwives - QLD branch
7	Australian College of Nursing
8	Name Withheld
9	Human Rights Law Centre
10	Timothy Coyle
11	Owen Hitchings
12	Australian Medical Association Queensland and supplementary
13	Australian College of Nurse Practitioners
14	Australian College of Midwives
15	Name Withheld
16	Name Withheld
17	Merike Johnson
18	Nerissa Pace
19	Mental Health Lived Experience Peak Queensland
20	Crime and Corruption Commission Queensland
21	Confidential
22	Name Withheld
23	Karleen Gribble
24	Anne Coyle
25	Cherish Life

26	Queensland Nurses and Midwives' Union
27	Paul Swan
28	Australian Christian Lobby
29	Paul Barry
30	Children by Choice
31	IWD Meanjin Brisbane
32	Women's Forum Australia
33	Max Heers
34	Queensland Law Society
35	Office of the Health Ombudsman
36	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
37	Aged and Disability Advocacy Australia
38	MSI Australia

Appendix B – Officials at public departmental briefings

Brisbane, 14 December 2023

Queensland Health

- Kirstine Sketcher-Baker, A/Deputy Director-General, Clinical Excellence Queensland
- Deborah Miller, A/Chief Nursing and Midwifery Officer, Clinical Excellence Queensland
- Dr John Reilly, A/Executive Director, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland
- James Liddy, Manager, Legislative Policy Unit, Strategy Policy and Reform

Brisbane, 12 February 2024

Queensland Health

- Dr Catherine McDougall, Chief Medical Officer, Clinical Excellence Queensland
- Shelley Nowlan, Chief Nursing and Midwifery Officer, Clinical Excellence Queensland
- Kirstine Sketcher-Baker, Executive Director, Patient Safety and Quality, Clinical Excellence Queensland
- Associate Professor John Allan, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Clinical Excellence Queensland
- James Liddy, Manager, Legislative Policy Unit

Appendix C – Witnesses at public hearing

Brisbane, 1 February 2024

Public Advocate

- Dr John Chesterman, Public Advocate

Cherish Life Queensland

- Dr Donna Purcell, President
- Alan Baker, Vice President

Children by Choice

- Christy Fischer, Senior Team Leader
- Dr Kari Vallury, Senior Research Officer

Australian Medical Association Queensland

- Dr Nick Yim, Queensland Vice President

Australian College of Nursing

- Karen Grace, MACN, National Director of Professional Practice

Australian College of Midwives – Queensland branch

- Michelle Warriner, Chair, Queensland Branch
- Alison Weatherstone, Chief Midwife
- Karleen Gribble, Adjunct Associate Professor, School of Nursing and Midwifery

Queensland Nurses and Midwives' Union

- Sarah Beaman, Secretary
- Dr Belinda Maier, Strategic Midwifery Research and Policy Officer
- Ashleigh Pawsey, Research and Policy Officer

Office of the Health Ombudsman

- Dr Lynne Coulson Barr OAM, Health Ombudsman
- Scott McLean, Executive Director Legal Services

Queensland Law Society

- Rebecca Fogerty, President
- Claire Bassingthwaighte, Deputy Chair, QLS Health and Disability Law Committee

Australian Christian Lobby

- Rob Norman, State Director, Queensland

Statements of reservation

STATEMENT OF RESERVATION

As Opposition Members of the Committee, we would like to place on record our Statement of Reservation in relation to the *Health and Other Legislation Amendment Bill (No. 2) 2023*. In particular, we highlight stakeholder concerns in relation to changes this legislation makes to the *Termination of Pregnancy Act 2018*.

At the outset, we wish to acknowledge the highly sensitive nature of this issue. Queenslanders hold different views in relation to termination of pregnancy. Irrespective of what those views may be, it is important for any discussion on this matter to be conducted in a respectful and dignified way.

We acknowledge the concerns raised by different groups and individuals around patient safety and access to care. This legislation deviates from the Australian Senate Community Affairs Reference Committee's recommendations, a point highlighted by a number of stakeholders who provided evidence to the Committee.

It was clear that during the Committee's deliberations there were several stakeholders from across the health sector who hold differing views about which clinicians should have the authority to prescribe, administer or give a treatment dose. The Committee was also provided with evidence which raised concerns around how women in regional, rural and remote Queensland would access appropriate care in the rare event of complications arising from the treatment being provided.

The Opposition believes the Australian Medical Association of Queensland (AMAQ) raised an important point with regard to clinicians, regardless of their discipline, being trained and resourced appropriately.

The AMAQ's submission stated:

"Prescribers must be able to accurately date pregnancies, exclude ectopic pregnancy via a pelvic scan, determine if patients are at risk due to other existing conditions and ensure escalation pathways are available".

The response to this concern from Queensland Health - they will "consider what further education or targeted training may be needed" - does not address the AMAQ's point about better access to equipment, such as ultrasounds, to safely administer the drug by determining which stage the patient is at in their pregnancy.

These stakeholder concerns about women who may be in these situations are legitimate. The Palaszczuk-Miles Labor Government has openly admitted to having great difficultly appropriately resourcing and staffing facilities in regional, rural and remote Queensland.

We also note concerns raised by stakeholders around the consultation process undertaken by the Palaszczuk-Miles Labor Government on this Bill. The changes being proposed are not insignificant, so to learn some stakeholders were given around a week to consider the changes is disappointing.

Consultation should not be a secretive and selective process. Parliamentary committees should be run openly and transparently. They should do all they can to ensure every interested stakeholder has the time to form an opinion of the legislation and for those views to heard and considered.

These proposed changes cannot be viewed in isolation from the issues many women face in regional and remote communities due to the State Government's failure to effectively operate and maintain services in regional and rural Queensland.

It is still the case that hospitals like Chinchilla, Biloela, Cooktown are on maternity bypass. Many services in North and Far North Queensland have also been placed on intermittent bypass in recent times – including facilities in Ingham, Atherton and Innisfail. Despite the Premier promising to open the Weipa maternity service when he was the Minister for Health, local women still cannot give birth there nearly five years after the commitment was given.

Another aspect of this Bill which received significant feedback was the proposal to replace the term 'woman' with 'person'. With all the issues facing Queenslanders due to the Queensland Health Crisis, we do not believe this should be a priority for the Government. Stakeholders including the Queensland Nurses and Midwives Union, the Australian College of Midwives (QLD Branch), Queensland Aboriginal and Islander Health Council and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists raised reservations with this amendment.

Andrew Powell MP
Member for Glass House

Sam O'Connor MP
Member for Bonney

STATEMENT OF RESERVATION

Stephen Andrew, MP

Once passed, the Health and Other Legislation Amendment Bill (No. 2) 2023, will make Queensland the first jurisdiction in the country, to allow nurses and midwives to prescribe, supply and administer medical abortion drugs.

The changes in the bill go beyond that in other jurisdictions and do not appear to be in keeping with Therapeutic Goods Administration (TGA) controls on these drugs as Schedule 4 (Prescription Only Medicines).

Currently, abortion drugs like MS-2 Step, mifepristone and misoprostol, are only available via a doctor.

According to the AMA Queensland's submission, these medicines carry serious risks for patients, including uncontrolled bleeding.

AMAQ's submission states that:

"*Prescribers must be able to accurately date pregnancies, exclude ectopic pregnancy via a pelvic scan, determine if patients are at risk due to other existing conditions and ensure escalation pathways are available, including access to local emergency health care (usually within 2 hours' drive). Unfortunately, it is often the case in rural and remote areas that patients do not have this access and even medical practitioners cannot safely prescribe MToP medicines. Extending prescribing authority to RNs in this context would not result in increased access and could put patients at risk.*"

This raises a number of questions and concerns, including:

- What measures will be taken to offset the risks involved in administering these drugs WITHOUT an ultrasound?
- How will the exact gestational age be determined in situations where a pelvic ultrasound has not been carried out before a medical abortion?
- How will it be ascertained whether a pregnancy is ectopic or not, particularly given many women in rural and remote areas may have no access to ultrasounds.
- What access to pain management would these patients have, presuming that nurses and midwives will not be able to write prescriptions for strong pain medication following a procedure?
- What measures, if any, would 'nurses and midwives' be authorised or able to take in cases where there are complications, such as the rupture of an ectopic pregnancy or the need for a blood transfusion and/or curettage?

AMA Queensland (AMAQ) expressed dissatisfaction with Queensland Health's response to its specific safety concerns, saying it considered the response to be "*inadequate and concerning as it does not directly address the patient safety concerns ... about RNs specifically and implies the amendments will be progressed on the basis of the views of a majority of stakeholders rather than on careful consideration of clinical risks.*"

The Bill includes a regulation-making power that the Minister said when introducing the Bill, will allow "*additional types of registered health practitioners" to administer these termination of pregnancy drugs in the future*".

According to the Minister this regulatory power will: *"allow flexibility to adjust the legislation over time to extend access to termination of pregnancy services as other cohorts of health practitioners become suitably trained, qualified and experienced to perform medical terminations of pregnancy such as Aboriginal and Torres Strait Islander health practitioners".*

I have serious reservations over this planned expansion beyond 'nurses and midwives' to other "health practitioners" for performing these medical abortions, particularly given the number of life-threatening complications associated with the use of these drugs.

I also believe there is a danger here of creating a 'two tier' medical system, which would put patients in the regions at much greater safety risk when undergoing these procedures.

Other concerns include:

- The bill goes beyond that recommended by the Senate Community Affairs Reference Committee.

- The bill pre-empts several Commonwealth reviews on the risks involved in non-medical prescribing by health practitioners, including the:

    - Nursing and Midwifery Board's Consultation Regulatory Impact Statement on RN prescribing; and
    - Federal Department of Health's Scope of Practice Review.

- The telephone support services provided by MSI Australia were recently ceased and so, to allow for non-medical prescribing of MS-2 Step without these supports, poses an unacceptable risk to patient safety.

- The Bill's changes could expose nurses and midwives to professional, legal and insurance risks, for which they are not appropriately remunerated for.

According to AMAQ, the government gave "targeted government and external stakeholders" just one working week to provide a response on the bill's consultation paper.

"*It is unacceptable that Queensland Health persists with this targeted and secretive approach to legislative amendments and does not act with transparency and accountability by publishing all such proposals*," AMAQ said in its submission.

Once again it feels as though important bills are being fasttracked through Queensland Parliament with very little discussion or debate, despite the bill containing some pretty radical and controversial changes to Queensland law.

It is a risky and undemocratic approach to law-making, in my view.

Stephen Andrew MP
Member for Mirani