HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:
Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr JP Kelly MP
Mrs T Smith MP

Staff present:
Ms S Cawcutt (Inquiry Secretary)

PUBLIC HEARING—INQUIRY INTO THE ABORTION LAW REFORM (WOMEN’S RIGHT TO CHOOSE) AMENDMENT BILL AND INTO LAWS GOVERNING TERMINATION OF PREGNANCY

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 14 JULY 2016
Emerald
Committee met at 10.08 am

CHAIR: Good morning, ladies and gentlemen. Before we start could I request that mobile phones be turned off or switched to silent. I now declare open this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee’s inquiry into laws governing termination of pregnancy and the Abortion Law Reform (Women’s Right to Choose) Amendment Bill 2016. I would like to acknowledge the traditional owners of the land on which we meet this afternoon and pay my respects to elders past, present and emerging.

My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, the deputy chair and member for Caloundra; Mr Aaron Harper, the member for Thuringowa; Mr Sid Cramp, the member for Gaven; Mr Joe Kelly, the member for Greenslopes; and Mrs Tarnya Smith, the member for Mount Ommaney.

The committee’s terms of reference require the committee to consider and report on aspects of the law regulating termination of pregnancy in Queensland. The terms of reference include examination of a bill introduced by the independent member for Cairns, Mr Rob Pyne MP, which was referred to the committee on 10 May 2016. However, the committee’s terms of reference are broader than the bill.

The parliament has asked us to consider and report on aspects of the law including existing practices in Queensland concerning termination of pregnancy, existing legal principles that govern termination in Queensland, the need to modernise and clarify the law without altering current clinical practice, legislative and regulatory arrangements elsewhere in Australia, including regulating terminations based on gestational periods, and provision of counselling and support services for women. Copies of the terms of reference are available from the inquiry’s secretary.

There are a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly’s standing rules and orders. The committee will not require evidence to be given under oath, but I remind witnesses that intentionally misleading the committee is a serious offence.

Witnesses have previously been provided with a copy of schedule 3 of the standing orders, Instructions to committees regarding witnesses, and we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript to propose any necessary corrections.

While parliamentary privilege applies to these proceedings, there is nothing preventing another agency from utilising public evidence forensically to seek to gather evidence parallel to that disclosed in the committee’s inquiry. For any media present, I ask that you adhere to my directions as chair at all times. The committee’s broadcast rules are available from the inquiry’s secretary.

I remind all those attending today that these proceedings are similar to parliament to the extent that the public cannot participate. Members of the public are reminded that the public may be admitted to or excluded from the hearing at the discretion of the committee. Please also note that this is a public hearing and you may be filmed or photographed.

Before we hear from our first witness, I note that the times shown in our program may need some adjustment. We will invite each witness to make a brief opening statement then members will ask questions. I will allow up to 20 minutes for individual witnesses and longer for organisations. I ask witnesses to focus on new information. If an earlier witness has made the same point you wanted to make, it would be helpful if you could offer us new information rather than repeating earlier evidence.

STOTT, Mr Wesley, Private capacity

CHAIR: I welcome our first witness, Wesley Stott, to make some opening remarks.

Mr Stott: Good morning, ladies and gentlemen. I am not going to try to get into too many statistics or too much data, but try to speak from my own experience. I have been married to my wife, Karen, for 28 years. We have had four amazing children—Bethany, Caleb, Joshua and Abigail. Each of these are unique. For each child we have a different story surrounding their birth.
After three natural births, our last, Abigail, was a caesarean section due to Karen having placenta praevia. After 12 weeks of pregnancy we had a scan and blood tests. Karen received a call from the doctor to urgently attend the surgery. There was no information given prior to that. We were then pressured to make a decision whether to abort the pregnancy and kill the unborn child because it had been determined that Abigail had a one in five chance of being Down syndrome.

We rejected what the doctor was saying and informed the doctor that no matter what happened the child had a right to live. This resulted in what seemed like an eternity long wait. We had chromosome testing by amniocentesis at 19 weeks to determine the health and wellbeing of the baby. At that time that was the safer alternative for the unborn child.

The Abortion Law Reform (Women’s Right to Choose) Amendment Bill seeks to remove sections 224, 225 and 226 from the Criminal Code. The arguments given to promote this bill are that the laws are old, women are suffering needlessly, there is a rise in self-harm and there is always a potential for any woman or doctor to be prosecuted.

When these so-called archaic laws were written the aim was to protect one of the most vulnerable groups in society—child and mainly unborn children. As a society we, who are able, need to be a voice to speak up for those without a voice, the vulnerable. They are the elderly, the disabled and children, including unborn children. That is as per the 1989 United Nations Convention on the Rights of the Child and preceding documents declaring human rights. We need to have compassion and understanding for women facing pregnancy, wanted or unwanted. It is such a daunting task. Many face fears that come when there is no support from partners, parents, families and friends and feel there is no other choice. Provision for counselling for all women and access to alternatives means women can be supported and make informed decisions.

The second point is that to say that the current laws are causing a great hardship seems an exaggeration of the facts. There are approximately 13,000 medical abortions in Queensland each year for the past 10 years. I know that there would be lives and stories just like my story and there is to be suffering, not because of the law, but rather because of the emotions and the physical results of those medical procedures.

To announce that there is a rise in the number of women claiming that they will abort their babies themselves if they cannot get abortions safely indicates the particular point that they are struggling and not thinking clearly. Again, it is about counselling, discussion of alternatives and providing support for those alternatives. The fact that no woman or doctor has successfully been prosecuted under the current laws indicates that there is no-one really interested in prosecuting criminality. To leave the law the same gives the opportunity to prosecute doctors who do not fulfil their obligations to disclose all the risks of abortion procedures and what alternatives there are for the woman and the unborn child.

I would like to finish with one story that I did not have time to write. I said I had four children, but we actually had seven pregnancies. We started off with a miscarriage, an ectopic pregnancy which is a medical procedure. I can tell you the emotions that go through that as you live it and then for another two years after that you cannot fall pregnant. There are a lot of raw emotions that go with that. Having said that, we had three wonderful children and then we had another miscarriage. With that last miscarriage, we had a heartbeat. It was there for at least four weeks. At the very end, at 12 weeks we were told there was no heartbeat and my wife was booked in for a medical procedure to have removed the baby who had died. The day that she was going to have that procedure, she got up to have a shower. She actually let go of that baby and caught it in the shower. That was disturbing for her, and equally disturbing in some ways for me—I am just the person who supports her, but in terms of I what went through seeing a dead baby in her hand with all the pieces of the baby intact. It actually went off for genetic testing that came back and said there was nothing they could see genetically wrong to explain why the baby’s heart stopped beating, but it did.

I guess I get to the point where you say that human life is so precious, but we seem to look at it as no gift whatsoever. We treat it as something that we can dispense with. I want to be the voice that speaks up for the unborn child. That is all I have to say.

CHAIR: Thank you, Wesley, for sharing your very personal story with the committee. I appreciate it takes courage to do that in such a public setting. Thank you for that. Wesley, you started your testimony to the committee speaking about the experience with a scan that your wife had?

Mr Stott: Yes. Basically, it was a doctor giving no information but saying, ‘Come in urgently to the surgery. You are at 12 weeks now and you are coming up to 13 weeks, so you need to decide quickly because an abortion needs to happen ASAP. You only have limited time.’ Whether that was...
because of the law that he was coming from or whether he was saying that for her health it was better
to have it done earlier; he did not really say either way. He was very adamant that we needed to think
it through seriously and consider it, and make sure that it was going to happen fairly quickly.

CHAIR: Just to get to the bottom of that story, what were your feeling when the doctor
suggested that? Did you have some sense that they were pushing you? What was the issue?

Mr Stott: I guess that is what it comes back to. That was my experience. There were no
alternatives given. Because we already had our own beliefs about what we thought was right and
wrong, we said that even if it was 100 per cent that it would have Down syndrome we still would not
have gone through with it. We would have gone through the pregnancy. We still wanted to go through
the other testing to find out. We did that because we wanted to be forewarned and be able to pre-arm
ourselves and get our minds around it, and prepare for a Down syndrome child.

CHAIR: Is a key concern for you making informed decisions?

Mr Stott: Yes.

CHAIR: People should be placed in a position where they can make an informed decision?

Mr Stott: Yes.

CHAIR: You talked about counselling and you talked about the quality of information that
people are given. You have very clearly stated that human life is precious, but is it your position that
if a woman was to present with very complex circumstances—and, of course, life can be very
complex—and she has an unwanted pregnancy, not under the current regime but under the proposed
bill, she has all the options set out in front of her and she makes an informed choice that she did not
want to progress with that pregnancy, would you then say that that should be a choice provided to
women?

Mr Stott: You are trying to say whether it is the stage of life that determines whether or not it
is a life. We can go into the definition of where life starts. So many medical experts say that it is at
conception. If you do not want to accept that, where do you want to draw the line? The heart beats at
22 days. We have a heartbeat, therefore, life has begun. Do you want to start it from there? If you
want to start at when it feels pain, it starts feeling some pain at about seven weeks. We know that by
13 weeks it feels pain in most of its nerve centres. Clearly to me, given the alternatives, if a doctor is
going to say on medical reasoning why she should not proceed with it, that is their decision. I do not
agree with it, but that is where I would say that my belief system kicks in.

CHAIR: If a woman has given informed consent, if the foetus was healthy or unhealthy, are
there any circumstances where you feel that a woman should have the choice personally as to
whether she terminates? Are there ever any circumstances in which you would—

Mr Stott: At the end of the day, the woman always has the choice. I do not see that right has
ever been taken away. Again, I think that is the correct thing that should happen. I believe that life is
precious and that, therefore, we should be doing everything in our power. The alternatives we are
talking about obviously are adoption. On rates of adoption, I think someone said 46 were done in
Australia last year.

CHAIR: The reason I ask, Wesley, is because what the committee is looking at is that the
current legislation would not allow a woman to simply walk into her GP and say that the pregnancy is
unwanted. It has to be for particular reasons. The proposed legislation before the committee would
make it that a woman could walk in for a variety of reasons. That is why I was asking for your opinion.
I think your comment was that a woman could choose now.

Mr Stott: Currently, the way it would be is that the woman does have a choice. There are
13,000 happening in Queensland and no-one has been prosecuted. I would suggest that that allows
the 13,000 people to walk free, doesn’t it?

CHAIR: So you support the current legislation remaining as is?

Mr Stott: Remaining as it is, yes. I do not even know if I agree with what is actually there, but
what is there, I think, is a safeguard for the unborn child.

Mr McARDLE: Mr Stott, thank you for your testimony today. In your commentary, you said that
you and your wife were pressured into believing termination was the only course available to you.
Can you explain to me what was done to make you feel that you were under pressure and that that
was the only response?
Mr Stott: I guess it was just the actual phone call. My wife got the call to come in. She did not know what it was about. There was no information whatsoever, other than to know that test results were back and that she needed to come in urgently. I guess it was just that urgent feeling to attend. Obviously, I went with her. It was pretty much put to us that, ‘You are at 12 weeks’. He was sort of saying, ‘You only have another week at the most and you really need to decide now, because we need to get you booked in to get a termination done’. We were both trying to say, ‘Hang on, that is not what we want to see happen’. I guess it was the fact that the discussion went on for a good half an hour before—

Mr McARDLE: So at no time in that discussion were alternatives put to you or your wife?

Mr Stott: No. We were the ones who put forth the alternatives. We said, ‘It is not going to happen’. It was again put back to us, ‘You have a one-in-five chance, which is significant’. You say, ‘Even if what you are saying is that it is a disabled child, it has the right to life, just like anyone else’. We are doing all we can now to support the rights of disabled people in society. If we do not value them, where do we stick with that? As a society, we are going backwards if we are saying that we can cut those sort of people out.

Mr McARDLE: Really it was left up to yourself and your wife to act under your own devices? You were not given help by anybody else to come to a conclusion?

Mr Stott: No. There was no counselling given. There was no offer of counselling. There were no other alternatives, other than the choice that we were making. Obviously the doctor said, ‘Well, that is your choice. I think you should think seriously about it. It is a one-in-five chance. It is very high.’ We made phone calls and did a lot of research ourselves into how they come to the conclusion that it was one in five.

Mr McARDLE: Do you feel that you were abandoned by the practitioner that you were talking to, who did not offer you fulsome advice or other alternatives?

Mr Stott: Yes.

Mr McARDLE: I have one other quick question: when do believe the foetus becomes a living human being? At what point in time, from conception to birth?

Mr Stott: For me, I would agree with at least six specialists I have read, who have written detailed books on pathology and medicine, who all detail that it is at conception. If you say it is from when the heartbeat is, was there anything before the heartbeat? Of course there was. Where can you go back to? The only place you can ever arrive back at is conception. Even on the definition of ‘foetus’, in the Latin it means ‘small child’.

Mr McARDLE: Finally, Mr Stott, if I suggested to you that other evidence seems to indicate that it is between 22 and 24 weeks respectively that a foetus can survive outside the womb of its mother, and that is medically where people look at a foetus becoming self-sustaining, would you accept that?

Mr Stott: It depends on your terminology of self-sustaining. I have heard the definitions of a pregnancy not being viable, because once it is outside the womb it is not viable. That is the whole reason that a human baby is actually in a womb, in the uterus. It is because it is protected, it is insulated, it has everything it needs. It is the perfect parasite. We know that from medical studies. In terms of saying yes, we can see them survive at 25 or 26 weeks, that is a miracle in itself. On the one hand, you have one ward where you have people who have had these early deliveries that there were unplanned and in some ways unwelcomed, but it happened and they have had to force through with it; in the next room, you have people who are trying to get rid of the exact same baby.

Mr McARDLE: Mr Stott, thank you very much, indeed. I appreciate your answers.

Mr KELLY: Thank you, Mr Stott, for sharing a very personal story. Reviewing the situation that you described and thinking about the current law, it seems to me that there are issues around not receiving counselling. Under the current law, are there any requirements for you and your wife to have received counselling?

Mr Stott: Not that I am aware of, no.

Mr KELLY: Do you think that laws that deal with abortion would require counselling to be in place or at least be offered?

Mr Stott: I would say it would be mandatory. Whether it be a single female or whether it is a couple, I think the support for that lady or that couple is paramount so whatever support mechanisms we need to have we should have. Whether it is a wanted pregnancy or an unwanted pregnancy, there should be enough support mechanisms for those people. People talk more about miscarriages and
things that go on these days than they did when we went through it. That was back in the late 1980s. Having said that, the last miscarriage was in 2003 so that was a long period. We never felt there was a great amount of counselling offered from the medical side. It was more for you to go and seek that.

I have been very fortunate. I have had a very blessed life. I have been involved heavily in a church in several towns we have lived in and we have had that support mechanism with us. We have not always had our families nearby because we have moved around Australia. I am originally from Victoria. I have lived in South Australia. We moved back to Victoria and we are in Queensland now. We had not always had family nearby. There is not much else other than the church support that we have had which has actually sustained us in those areas.

**Mr KELLY:** There has been a range of evidence that we have heard over the last few days that the legal status in Queensland is unclear and uncertain. There has been a range of evidence that that contributes to an environment where there is a culture related to the criminalisation of abortion that people do not feel the capacity to discuss abortion openly. When you and your wife were going through this difficult situation, did you feel that this was an issue that you could discuss openly in public with your family or friends or other people?

**Mr Stott:** Not in public. It is pretty hard. I would say generally, no. It was probably close friends and not even all family. We had some honest and frank discussions with my wife’s parents and they basically did not know what to say. They said, ‘It never happened to me. I had five kids and never had a miscarriage.’ We had other people say, ‘It is probably all for the best.’ That is the sort of thing you do not want to hear as a 22-year-old—‘It is probably all for the better.’ No-one wants to hear that.

**Mr KELLY:** You mentioned that you do not know why the doctor was suggesting that you go for an abortion at 12 to 13 weeks.

**Mr Stott:** I know why he was saying that.

**Mr KELLY:** You made the statement, I would have to check *Hansard*, that you felt from a legal perspective that there may have been a requirement to do it within a certain time frame.

**Mr Stott:** Yes.

**Mr KELLY:** So clearly at that stage you did not have a good understanding of the legal framework and the doctor did not explain to you the legal framework that he or she was operating under?

**Mr Stott:** No, not at all.

**Mr KELLY:** Would that suggest to you that there is a lack of understanding and clarity around the legality of abortion in Queensland as it currently stands?

**Mr Stott:** For sure. I think that you will find that that is the same in most states. In Victoria they have changed the laws so that they have late term abortions—

**Mr KELLY:** They are available in Queensland as well.

**Mr Stott:** Yes, so up to 38 weeks. I am not sure exactly what happens in Queensland, but the ones that we heard about in Victoria were the babies were born because it is the safest way for the woman. They actually have to go through a birth anyway. Because they were unwanted they were not allowed to live. They were just left crying to die basically from starvation. You would not do that to a dog.

**Mrs SMITH:** I appreciate you sharing your story this morning. You made the comment that 13,000 abortions—I think we have heard over the last couple of days it is around 10,000 or 11,000—

**Mr Stott:** I understand that people say the figures are not accurate. We only based it on the Medicare figures. It was anywhere between 14,000 down to 10,000.

**Mrs SMITH:** Over the last 10 years.

**Mr Stott:** Yes, and it goes up and down.

**Mrs SMITH:** You said that no-one has been charged or anything so it does not appear to be a problem. Is that not the issue, though? If the law is not being enforced then there is a reason to change it or is that not your view? Do you think the law should stay as it currently is?

**Mr Stott:** I would say that I think 13,000 or 10,000 abortions is a disgrace on us as a society. We put so much money and advertising into getting the death rate down for people who smoke to what we think is a better level and yet in this area the figure has been consistently at 80,000 in Australia, and probably around 10,000 to 15,000 in Queensland, and we have not changed anything. We obviously do not advertise or we do not do anything with it. We do not promote any sort of adoption
or welfare for the mothers or for the unborn child. That is where I think we are sadly missing out. I am pretty sure we know these days what the cause of pregnancy is, but we do not seem to do too much about that.

Mrs SMITH: It was your fourth child, Abigail, who was the subject of the experience with the doctor. How old is she now?

Mr Stott: She is 13. She is in year 7. She is a vibrant, happy kid. Everyone who meets her seems to fall in love with her. She is one of those kids who has a bright and happy way. She is bright academically. She has been involved in debating locally. In year 7 she was the captain of the school debating team. She won one of the rounds as well. She is a bright kid but very humble and very genuine.

Mr CRAMP: Thank you, Mr Stott, for coming in today. My question revolves around your comments about your dealings with the doctor. I want to confirm, was the doctor actually biased toward you seeking termination or was he just seeking to get you to make a decision either way? I am just trying to clarify that. Did you feel there was a bias either way?

Mr Stott: I probably would not want to comment on whether the doctor was biased. I think it was probably harder for us. We had only seen him for probably the six months leading up to that. Unless you are sick, you do not tend to see doctors or, in this case, when you are pregnant. Our previous doctor had left town. He was relatively new to us. In terms of having that other relationship, maybe a friendship, it was not there. It was purely a doctor-patient relationship.

Mr CRAMP: Once you made your decision to continue with the pregnancy, you made mention before that your main support structure was your church structure. Did you find any information outside of that, say, through websites? I guess in 2003 it would depend on whether you had that sort of access.

Mr Stott: Yes, we had websites then.

Mr CRAMP: I will tell you the reason I am asking this. I asked a witness yesterday whether he thought the government could do more in terms of providing information to help people be more informed in the decision-making process? Is there any onus on us as the regulator to ensure that that information is out there?

Mr Stott: I think for sure. I think there is a lot more that can be done. We did have websites back in those days. My wife did lots of research as well as myself. The first part was probably looking at how they determined the statistics, so the one in five. We rang up some of the people in the medical profession who do the testing and talked to researchers about how they actually come up with that. A lot of it was attributed to her age. She was 38 at the time. That was the main reason. We had people say, ‘Give up and don’t worry about going back for another one.’ If we had, we would not have Abigail. I guess that is the point. There were plenty of websites. They probably do not seem to have the push or the variety. You will tend to find most of the websites that people are pushed to are along the lines of prochoice. There is another one called child choice or something like that.

Mr CRAMP: So they are one way or the other? It is not just factual information that you can make a decision based on?

Mr Stott: No.

Mr CRAMP: So there could be more room for unbiased information out there?

Mr Stott: For sure. I think that is what we are leading. We had an inquiry a year or two ago relating to the babies that were taken from their parents in the 1950s to 1970s. I can see a lot of legal issues in the future. We are going to see a psychological downturn, which we are probably already seeing, of women who have been either forced to have abortions or regret having abortions years later because they feel they were not informed. We are going to have a whole series of inquiries again about why this was legislated, why did we do this.

CHAIR: Thank you, Wesley. I apologise that the time is always short in these committee hearings. I thank you for coming in today and speaking to us and answering our questions.
KIRK, Ms Olga, Private capacity

KIRK, Ms Susan, Private capacity

CHAIR: Welcome, Susan and Olga. Thank you for coming before the committee this morning. I invite each of you to make a brief opening statement and then we will open to the committee for questions. Would you like to go first, Susan?

Ms S Kirk: In relation to seeking to answer the questions raised under the terms of reference—specifically in relation to No. 3, the need to modernise and clarify the law, and No. 4, the arrangements in other Australian jurisdictions—I urge you that we must always seek to hold onto what is right and true. I know some would argue that our law is outdated when it comes to abortion being a crime under the Criminal Code. However, case law means abortion is generally regarded as lawful if performed to prevent serious damage to the woman’s physical or mental health. Maybe you have said to your children, ‘Just because everyone else is doing it, doesn’t make it right.’ I implore you to look at what is right in the abortion issue.

I have reviewed the current law and believe it should remain as a crime under the Criminal Code since the reality of abortion is that it is killing a baby or an unborn child. There is overwhelming agreement amongst the medical, biological and scientific writings that conception marks the beginning of the life of a human being that is completely separate and distinct from the mother even though for survival the baby needs to be housed in the mother’s womb. The baby’s heart begins beating usually before the mother even knows she is pregnant—about 18 days or three to four weeks.

My reason for speaking is not because I want women who have had abortions to feel judged and condemned but because I love and care deeply for women and babies. Abortion is not all that it seems. I would implore you to watch on YouTube the 2016 abortion documentary ‘Right choice or murder’. These are people who have been directly involved in the abortion industry or personally impacted and are willing to share the truth of the industry.

Carol Everett, a former independent abortion clinic owner in America, says, ‘We had a whole plan that sold abortions and it was called sex education. Breakdown their natural modesty, separate them from their parents and their values and become the sex expert in their life, so they turn to us when we would give them a low dose birth control pill that they would get pregnant on or defective condoms because we did not buy the most expensive condoms, we only bought the cheapest condoms. Our goal was three to five abortions from every girl between the ages of 13 and 18.’

Later she also shares that—

Abortion is a skilfully marketed product sold to a very frightened person in crisis. They buy that product expecting a fix and find it’s defective …

Abortion has been sold to our society as pro-choice. A woman should have the right to choose what to do with their body. My question is: what about the baby? Where is the protection for the baby? Sex education tells girls that pregnancy is just the product of conception and we can get rid of it if we want to. The facts are pregnancy is not just a cluster of cells like a wart that can be removed without any repercussions. If people would look long and hard at the information and follow up on women in two, six, nine, 12 or 18 months or three, five, 10, 15, 20, 30, 40 or 50 years later who have had abortions, it could easily be seen how much trauma most women experience at some point in their lives.

The pregnancy might be unplanned and the baby may be unwanted by the biological mother, but let us provide women with options and support to continue the pregnancy and then adopt the baby to a family that desperately wants children. Adoption law needs to be changed in Australia to make this easier for everyone. We need to provide for those babies and women. Many people are willing to adopt babies with disabilities as well. A woman should not be made to feel that killing her baby is the right choice and what is best for both her and the baby. How often is a woman encouraged to abort due to the possibility of some disability and if they choose to continue the pregnancy no such disability exists? We need to care for babies and people no matter their disability.

Abortion is advocated as a woman’s right to choose and yet in America—and I am sure it is not much different here—in 80 per cent of cases when women were asked why they had an abortion they stated, ‘I felt I had no choice.’ They felt coerced and often threatened that if they do not have an abortion then their life will be punished for it. They are told, ‘You can’t do this’, ‘It is not good for you’, ‘Your life will be ruined’, ‘You’re too young to be a mother’, or ‘You won’t be able to cope looking after a child with a disability. It’s the only kind thing to do for your child,’ et cetera. Often abortion is not about choice; it is about despair. They feel they have no choice.
Women are the victims who are coerced in crisis mode thinking that abortion will get her out of trouble. In a large majority of cases the mental health of the woman is often the justification for the abortion, but who determines the mental health of the mother seeking an abortion? Often it is those who are going to conduct the abortion and who profit from it. It is a simple matter of saying, ‘You would have problems if you carried this pregnancy to term, wouldn’t you?’ Where is the consideration for the effect that abortion has long term on the mental health of the woman? As one woman shared, ‘Rather than just go through nine months of a crisis pregnancy, I’ve gone through about 20 years of hell on earth just by exercising my right to choose.’ Allan E Parker of the Justice Foundation states—

Women have constantly said, ‘They didn’t tell me I would suffer for years from my abortion. They didn’t tell me I’d have nightmares about my baby. They didn’t tell me I would regret it so deeply that I would rather kill myself than go on living.’ ‘Nah, it’s 10 minutes and you’ll never have to think about it again.’ That’s a lie.

In reference to the fifth term of reference and the provision of counselling, this should not be done by someone who is seeking to get the business of the abortion and support services need to be thoroughly investigated and opened up as it is essential that women are given all the facts and warnings with regard to the possible short- and long-term health risks and repercussions of the decision to abort. Nothing should be covered up, and that includes not just the physical risks such as infertility, hysterectomy, damage to the intestines and possible death but the psychological effects, both short and long term, such as the post-traumatic stress, the years of nightmares about children, anxiety, anguish, tears, sleepless nights, the grief and shame, the inability to bond with living children and suicides.

In America teenagers who have had abortions are up to six times more likely to take their own lives within a year of having an abortion. Many attempt suicide in an effort to stop the pain they are feeling as a result of the abortion, even though sometimes they might not directly link it to that experience at the time. One lady shared all the guilt and shame she experienced, even though at the time she did not even know it was a baby. The reason is because inherently women know at some point that they allowed their baby to be killed and it goes against the very nature of women who are nurturers. In our society mental health problems are such a big issue. We need to ensure we do all that we can to protect and support women and babies.

CHAIR: Thank you, Susan. Olga, would you like to make an opening statement?

Ms O Kirk: Yes.

CHAIR: I will have to limit you to the time limit, which is five minutes.

Ms O Kirk: Thank you. Good morning. I respectfully make the following submission to the committee present regarding the abortion law reform bill. With regard to the third term of reference in terms of the need to modernise and clarify the law without altering current clinical practice to reflect current community attitudes and expectations, Rob Pyne MP in his explanatory notes said—

These archaic laws are dangerous and have no place in modern society where women should always have control over their own bodies.

We the modern society would agree that women should have control over their own bodies. However, the abortion or medical procedure is not performed on the mother’s body but that living body of the child she carries. This is the main reason I understand that abortion sits in the Criminal Code. The unborn baby’s life is not the mother’s life. The baby has a different DNA and different blood cells to the mother. The mother is providing nourishment and security to the new life. That is why it is deemed to be a criminal offence to abort the baby because it is a new life within the mother and it is a criminal offence under our laws to kill a person or persons.

The abortion law reform in its own words uses the terms ‘women’s right to choose’. However, the choice that is being made is to keep the child or to abort the child. This is having the power over life or death. In our society our current attitudes and expectations are to care for one another humanely and to protect the vulnerable. To reform our current abortion law is to have a double standard. We can kill our unborn child, but once the child is born they are protected under the law. My question is: where is the unborn child’s right to life? Also in his explanatory notes Mr Pyne says—

The Bill will repeal outdated laws that can criminalise women and doctors for a basic human right and a medical procedure. An abortion is not a basic human right as it interferes with the basic right of another person—the unborn child—to live. The current Queensland abortion laws make allowances for extenuating circumstances and if these are heeded to then there is no need for concern of prosecution.

This abortion law reform bill presented to parliament has no parameters. It allows abortion for any reason up to birth. There are no safeguards for either the health and wellbeing of the mother or the unborn child. However, the abortion law reform appears to be opening the door wide to a flood of
ab Abortion, as has happened in Victoria. There is also no mention in the bill of allowances for medical staff to conscientiously object to the performing or assisting in an abortion and I do not support this reform in any way or form. My last point with regard to how does it reflect our current community attitudes and expectations is that just recently an e-petition containing approximately 24,000 signatures was delivered to the Queensland parliament rejecting Mr Pyne’s abortion law reform. This e-petition gives voice to nearly 24,000 Queenslanders who currently reject the worst abortion laws in the world being put forward by Mr Pyne. In conclusion to the third term of reference, respectfully I conclude that Mr Pyne’s bill needs to be laid to rest.

With regard to the fifth term of reference relating to the provision of counselling and support services for women, I have three points. The first is adoption. I suggest that we as a community relax the adoption laws and provide another avenue for women and families to have their babies. Adoption becomes a viable option for those families unable to have children. Fewer abortions would result in more full-term babies who could be adopted into a loving family to nurture them.

With regard to community support, as a community let us be more proactive in providing practical support to women and families to enable them to experience a successful pregnancy and birth of their child. Just recently our state government gave billions of dollars to preventing domestic and family violence. Why can’t we do the same to support and enable families to keep their babies? That is not only saving precious new lives but helping mothers to avoid the detrimental effects that an abortion has on their physical, psychological and emotional health. My third point on counselling is that the current abortion law in Queensland allows for abortions under specific circumstances. Prior to and as a follow up to an abortion, compulsory counselling needs to be provided to the mother, the father and the family directly involved in the abortion process. The mother and the father need to be totally informed and made fully aware of the abortion process itself and the varying impacts—that is, physical, mental and emotional—that the abortion will have on the mother after the operation into the future. In conclusion to the fifth term of reference, there are positive alternatives to assisting women, fathers and families other than reverting to an abortion. This concludes my presentation and I thank you for your time and consideration.

CHAIR: Thank you, Susan and Olga, for your opening comments.

Mr HARPER: Good morning, Susan and Olga, and I thank you for your submission today. In fact, I thank everyone who is here in Emerald for taking the time to deal with what is an ethnically and morally challenging bill that is before us. As parliamentarians we have to take the view that we respect all views and part of our role is to listen to the community on this difficult subject, and I realise that it did raise some emotions there, Susan. In your submission you say that women might find themselves in situations where they have an unplanned pregnancy and need to face the truth about the life of the unborn child. I am trying to find balance in my mind. If I can paint a scenario and I ask you to give your opinion on that. An 18-year-old first-year nurse is out running one evening and is raped but hides that event for a number of weeks but falls pregnant. Do you believe that this young professional who wants to get on with her life should have the right to choose and it would solve and fix all of their problems. ‘Where is the option to do something to assist the person?’ I understand what you are saying about the rape and it would be horrific, but what about the life within? Where is that person that stands for that life that is there? As Susan said, it was not their fault that it happened and they have been brought into existence. Who stands for that life within? I honestly do not have an answer and I just really appreciate what you are doing—it is very difficult—but I still would say no because of mental anguish.

Ms S Kirk: No, I do not. It is not the child’s fault and nine months is not long. It might seem like a long time, but the opportunity there is to give the child up. Abortion is very final and, while they have been told that it is their right to choose and it is going to solve all of their problems, women are now speaking up about what has happened. They are living a hell on earth because of the decision that was made that they thought was their right to choose and it would solve and fix all of their problems. I have read testimonies of women who have been the victims of rape and who have chosen to go through and give life and keep that child. Children that have been the product of rape that have been given up for adoption are so glad that their mother chose life. You have to look at the big scheme of things—nine months. If they were given the support and help, there would be a lot more healing. They need to heal from the rape, but if you add an abortion to it it is just opening up another whole area of mental anguish.

Mr HARPER: Olga, did you want to put any views to that?

Ms O Kirk: Just talking from my perspective, I would agree with Susan, but I have never had that happen. It seems to me that people are all so ready to say, ‘Let’s abort the life because of this, this or this.’ Where is the option to do something to assist the person? I understand what you are saying about the rape and it would be horrific, but what about the life within? Where is that person that stands for the life that is there? As Susan said, it was not their fault that it happened and they have been brought into existence. Who stands for that life within? I honestly do not have an answer and I just really appreciate what you are doing—it is very difficult—but I still would say no because of
where I stand. Unless I can come to some other understanding, I would have to say no. I would appreciate that it would be very difficult for the young lady and that she would need every support to get through the situation to bring the child into the world.

Mr Harper: I respect your views and thank you very much.

Mrs Smith: Thank you, ladies, for coming along today to present. You might be interested to know that over the last couple of days we have heard a range of views from ethical, legal and medical professionals, including psychiatrists as well, because we have not only the bill to look at but the parliament has asked us to look at the five other points. Yesterday when one of the submitters was presenting I asked a question about reflecting the community’s views. I put to them the fact that we have had a number of submitters saying that they oppose any change to the current law and various people have come along and expressed that. What I did learn was that at the end of the day there still is not a lot of information out there with regard to women terminating pregnancies. Whether it is a late gestation period right through to the morning after pill, there are still a lot of unknowns out there with regard to it. At the end of the day I guess it does come down to what is the community’s expectations or what is reflected by the community. In your view or position, have you got a sense in the Emerald community, for example, of what their position or view is for us to get a better understanding?

Ms O Kirk: I think that is probably reasonably difficult to answer because your personal position in the community would depend on your standing in the community, who you have contact with, who you are influenced by or who you influence, who you mix with, where you work, where you mix socially. All of that will impact an individual on their concept, and it is what you hear. I hear your question, but from my personal view what I hear is that, no, it is not good. People are quite distressed about it and people have been talking about it saying, ‘Who’s going? Who’s going to talk? Are you going to the inquiry? Are you going to listen or are you going to present something?’ People have said, ‘I’m not going to present anything because I’ve already done something by putting a submission in.’ The ones that I have any connection with are all of the same mind. They are very distressed about the change in the bill.

On the other side they are also distressed that there is not enough done for women and fathers. An abortion will often happen and the father does not know or he is not involved, but sometimes they are of course. From a family perspective, families are impacted by an abortion. I do have some personal issues, not possibly of my own but of my family and friends who have had experiences like the first gentleman where the doctor told them certain things and they have never really been informed properly, never offered counselling and come away highly distressed and the community or their friends or whoever is around them have to pick up the pieces and support them through that. It really would be great to have that support in the community that everybody was aware of, that there is a place you could go and get some support and not be told, ‘You need to have the abortion because this is wrong and that is wrong.’ It is like going to counselling. You tell them all about your problem. They do not try to influence you one way or the other. They lay it out before you to the best of their ability like a counsellor. I am a counsellor and a social worker—I am retired now, but I still do a bit of counselling—so I understand the problems that people encounter with abortion and so on. It really is not an easy road for those who are looking at an abortion because they are finding it difficult to have the child. Sometimes all they need is someone to provide support and encourage them through.

Mrs Smith: I have one other question that I also asked the previous witness. In the current law there are exceptions to the rule with regard to women seeking terminations and in Queensland last year there were over 10,000 abortions. I guess that comes back to the question of that award modernisation or changing the current practice. If no-one has been charged under the Criminal Code and there have been over 10,000 abortions in the last year, should the law reflect the practice that abortions are occurring but nobody has been charged, or do you see the current laws as a safeguard?

Ms S Kirk: I think I addressed that already in my statement that we need to do what is right and true. Even though all the other states or whatever have changed the law, abortion is killing a baby—a person—so I think it should remain in the Criminal Code.

Mrs Smith: Thank you.

Mr Kelly: Thank you, Susan and Olga, for taking the time to make submissions and appear this morning. I want to step away from the moral argument or discussions that we seem to be having. I am a registered nurse and I want to think about this issue from a public health perspective. We have heard in this committee evidence this week that strong research suggests that criminalising abortion has no impact on reducing the rates of abortions or terminations and also that decriminalising abortion has no impact on increasing the rates of abortion, and I am aware from my own reading in that area
that I believe that to be the case. We have also had credible evidence I believe—and I have read it myself elsewhere—that where abortion is criminalised women seek unsafe abortion procedures. In fact, I think the World Health Organization lists unsafe abortion as one of the top 4 health issues for women. My question to you is that from a public health perspective we would be trying to minimise the harms. I am not going to get into what those harms are and who those harms are to, but I think all reasonable people would agree that we would all like abortion to be rare. If criminalising abortion is a one-policy option and it is having absolutely no impact on the rates of abortion, what is the policy objective of maintaining the current status quo here in Queensland from a public health perspective?

Ms O Kirk: If what you are saying is correct—I have not heard it before, but I accept what you are saying—in that if we change the law and decriminalise it it will not alter the number of abortions and that it would neither decrease or increase; is that what you are presenting?

Mr KELLY: That is correct.

Ms O Kirk: I do not know what the actual law says as far as the details of those rulings or boundaries of where the law of an abortion is legal. I do understand some of it just by the little bit that I received. If we say that it is not going to make any difference and then on the other side we are looking at the health of women and in the community there maybe abortions going on elsewhere, which does happen—I am not aware of it, but I do understand that—which are not done in the hospital under a doctor’s care, are the restrictions under the current law not sufficient for people to have an abortion under those circumstances? What are we looking at if we broaden the law and, say, decriminalise it? What are the parameters? That bill says nothing. All we have is what we have now. That bill that was presented did not have any boundaries. It is just going to remove it. That is probably what you are doing anyway looking at it, but again I cannot really comment because I do not know if we take it off—decriminalise it—what are the parameters for abortions in a clinical setting?

Ms S Kirk: I do not really understand your question in that what is the purpose? Are you saying it will not make any difference, so why not just leave it as it is?

Mr KELLY: No, I am not saying it will not make any difference. I am saying that if you decriminalise it there is no increase in abortions. If you criminalise it there is no decrease in abortions. It does not change the rate of abortion. If our objective from a public health perspective is to decrease abortions, how does criminalising help?

Ms S Kirk: I do not think women are being harmed because they think it is a crime. As you have heard, people are readily pressured into abortions. I personally know people who have had abortions and it is often a decision that they feel pressured even by the doctors to go ahead and do, so it is not like it is illegal. In places where it is legal, these women have these mental health problems not because it is not legal. It is legal, but it is inherent within us that at some point they realise that they have killed a baby.

CHAIR: Thank you. Our time has expired. Susan and Olga, I again thank you for coming before the committee.
GRIERSON, Mrs Noela, Private capacity

GRIERSON, Mr Robert, Cherish Life

CHAIR: Good morning, Noela and Robert. Thank you for coming before the committee today. I invite you to make a brief opening statement and then we will open up to questions.

Mrs Grierson: Good morning, everybody. I am a mother, a grandmother and a great-grandmother. I would like to refer to the bill presented by Mr Rob Pyne, the Cairns Independent, which removes sections 224, 225 and 226 from the Criminal Code, these being attempts to procure an abortion, the woman self-aborting and procuring drugs to abort.

The bill that Mr Pyne would like to change has stood for over 100 years and is now termed outdated, archaic and has no place in a modern liberal society. We will just pause for a moment to look at the meaning of these words. Liberal: willing to respect or accept behaviour or opinions different from one’s own, even if you know they are wrong. Archaic: old fashioned, outdated, no longer useful or accepted. When this bill was introduced, the population of Australia was about 3 ½ million. Unborn babies were protected in the mother’s womb. Slowly this protected haven has deteriorated over the past 110 years or so. I was 44 when I fell pregnant with my last child. I was asked if I wanted to go through with it by my doctor. I declined.

Deputy Premier Jackie Trad is reported as saying it is time state law treats pregnancy termination as a health issue, not a criminal issue. I say to Jackie Trad, they got it right in 1899. Killing a baby is a criminal offence. Abortion was added to the Criminal Code because back then the nation was entrenched in biblical values. These are the values that are being termed outdated and archaic. What a woman decides to do with her body is her choice; this is true. However, then there is the small body of the child. These small children need protection and so do the mothers. If the bill is passed, the babies suffer and so do the parents, in different ways. More needs to be done in educating the young men and women or boys and girls, as it is, and early teens regarding saving sex for marriage or safe sex.

In 2015, only 209 children were adopted, with a large amount of parents waiting and wanting to adopt. If the adoption procedure could be made easier, the unwanted babies would find homes. There are many couples wanting to adopt, but not enough babies and lots of red tape. In closing, ideally any law that is passed should be virtuous, just, necessary and useful. If the 1899 act is changed by parliament, it will not be any of these. Thank you.

CHAIR: Robert, would you like to make any opening comments?

Mr Grierson: Thank you. My name is Robert Grierson. I am here as part of Cherish Life. I would like to address terms of reference No. 3, the need to modernise and clarify the law. We are altering current clinical practice to reflect current community attitudes and expectations. Cherish Life is an organisation that believes that all life begins at conception and is to be protected until its end due to natural causes. Queensland law must remain as a guardian of the silent innocence of the unborn.

I will be referring to a Galaxy poll completed in May 2016 titled, ‘What Queenslanders really think about abortion’. I am not sure if you have seen that; you probably have. The decriminalisation of abortion in Queensland would mean abortion would be legal for any reason at all effectively until the moment of birth, yet there is clear evidence that 85 per cent of voters are opposed to late-term abortion, after 20 weeks.

A friend of mine drew my attention to an article in the local paper. It is only a tiny section in the paper. I quote from a Central Queensland News article dated 17 June 2016, titled ‘Failed abortions’. This should have been a headline. It states—

REVELATIONS made in the Queensland parliament have revealed that 27 Queensland babies were born live and then left to die after failed late-term abortions. Revelations were made by the Minister for Health Cameron Dick in response to a question on notice from Dr Mark Robinson. Mr Dick revealed last year that 27 Queensland babies were born alive after late-term abortions and allowed to die.

This is utterly shameful. That one child a fortnight has been left to perish puts this into perspective. As a father and as a Queensland man, I feel our sons and daughters are left to die. It sounds like a battlefield and maybe it is. Life is to be valued and protected. As adults, we need to be the voice of the voiceless. Unborn babies at every stage of development are valued.

The law of the land is often the moral compass for the people of society. Often people will say, ‘If it is legal, then it is okay’. The existing law protects women from being pressured into abortion by those around them. They are protected by the law and empowered by the law to say, ‘You cannot tell
me to do something that is against the law. Not all Queenslanders are aware that 10,000-plus abortions occur in Queensland ever year. Does the community know the effect an abortion has on our society? The term ‘one dead, one wounded’ is often used.

However, it is more than that. Abortion is a social issue that concerns everyone. Eighty-four per cent of voters say abortion is hurting women. I say, abortion is hurting all parts of our society. Other statistics that are in this poll: 53 per cent of voters say we do not need to change the laws at all; they are strong enough and, if anything, they should be strengthened. Cherish Life is proactive in informing the community about the stages of birth and that life of a person begins at conception. Abortionists, members of parliament and members of the community should be encouraged to attend education programs on human life before birth to make all people aware of the progress of a baby as it grows. For my part, it is miraculous and amazing, and should be valued.

We all want change, so let us change. Our job is to change the culture of Queensland, not the law. The law is here to protect us and our most vulnerable. We need to change the way we think about humanity and that our life is precious. We need to fall in love with the unborn. Thank you very much.

CHAIR: Robert, thank you very much for those considered comments. Thank you, Noela, as well. I open now to the deputy chair to ask questions.

Mr McARDLE: Thank you very much for your time today, Noela and Robert. Noela, you made the comment that the Criminal Code goes back to 1899, that is, well over 100 years now. In that time, there have been very few prosecutions of a doctor, a woman or other person under the code. I do not think there have been any convictions. There were 10,000 abortions that occurred last year at least in this state. Would you say that the fact that the code has existed for that long, that the abortion numbers are still at 10,000 per year and that there are no convictions indicate that the code is working?

Mrs Grierson: It is there as a safeguard, as I see it. They are still having abortions; as you say, 10,000 a year. Do you think that it is good for the nation for all these babies to die? Do you think it is a benefit in any way to keep it going? Cannot we just start educating our young people, instead of—I could go on to another subject here, but I will not. You probably know what I am talking about. Instead of giving them all this sex stuff at school, why cannot they just ring them up and tell them the right thing to do, without titillating them with all these other things that are going on. It all starts at the home. People need to know what the basis of—

Mr McARDLE: A value system?

Mrs Grierson: Values, yes.

Mr McARDLE: Based upon what, Noela?

Mrs Grierson: Values based on Christian living. That is the bottom line. If you are building on that, you will not have a smooth path but you will have something to fall back on. If you are going on those values, it is not going to be plain sailing; it will be rocky, too. However, you have support. People who are willy-nilly doing this, that and the other thing have no support.

Mr McARDLE: Do you envisage a set of circumstances where a woman could have an abortion or termination?

Mrs Grierson: I would have to say no, because of my values. I have seen young girls who have been in dire straits. I have talked to them. Some have not had an abortion. I do know that some went ahead and had it, but they deeply regretted it later. Each case is individual.

Mr McARDLE: Would you envisage any set of circumstances where a woman could have an abortion?

Mrs Grierson: No, not knowingly. They are saying with the pill that you might have been pregnant.

Mr McARDLE: The morning after pill?

Mrs Grierson: No, I am talking about the birth control pill. Some say that you could have been pregnant; each month, you might have been pregnant. That is another thought that has come through lately.

Mr McARDLE: What do you say to the comment that has been made to this committee on many occasions that it is the woman’s right to choose?

Mrs Grierson: To choose?

Mr McARDLE: To have or not have a termination?
Mrs Grierson: It is her own body, but she has to choose what is right for the baby.

Mr McARDLE: What would happen if the woman’s life is in danger because of this?

Mrs Grierson: That would have to be the doctor’s decision. If the woman’s life is in danger, it does not happen very often. There is a statistic about that. It is very, very—

Mr McARDLE: But in those circumstances, would you say a termination could occur?

Mrs Grierson: Is it one for another?

Mr McARDLE: No, it is just a question.

Mrs Grierson: No, it cannot be. Are you saying the baby or the mother? No. You would have to do everything you could to save both of them.

Mr McARDLE: Thank you very much, indeed.

Mr KELLY: Thank you, Noela and Robert, for your submissions and for your appearance here today. Robert, in regards to the 27 late-term abortions that you referred to, I too read the response from the health minister in which he talked about the fact that palliative care practices were put in place in each of those instances. Clearly you are operating off some information garnered from the media. How much do you know about each of those 27 cases and the decision-making that occurred leading up to the decision to perform those abortions?

Mrs Grierson: I do not know anything at all about them. The fact is that there was minimal noise in the media. I, like many other people in Queensland, would be of the same mind. We need to know more.

Mr KELLY: If we went through those 27 cases one by one could you in your own mind see that there may be instances where a mother and the clinicians have had to make an extremely difficult decision about whether or not to continue a pregnancy?

Mrs Grierson: You are saying that these sorts of things just had to happen because people need to have an abortion because it is important to end a life. Is that what you are saying?

Mr KELLY: No, I am saying if we went through those 27 cases would you be able to envisage a situation whereby a clinician and a mother might have to make a very difficult decision about whether or not to continue a pregnancy?

Mrs Grierson: I am sure people have make decisions about all sorts of things, but when you have a situation where it is someone else’s right to choose one life over another then all of a sudden a right is negated because you are choosing your life over that of another person. That person has a right to live regardless of what you think.

Mr KELLY: What if we had a situation where, say, at 21 weeks a woman was advised by a team, involving obstetricians and gynaecologists, neonatal intensivists, paediatricians, that the unborn child that she was carrying had absolutely no chance of living beyond birth or any quality of life as they saw it or even sustaining life for any great period of time. Could you see that a mother might make a decision in that instance that rather than continue to carry that baby for a further 18 weeks they forego that pain and make a very difficult decision?

Mrs Grierson: I hear what you are saying. You are also saying that this baby is still alive and will live to full term, is that correct?

Mr KELLY: I am saying that once the baby is delivered, whether it is at 21 weeks or 39 weeks, it would have very limited chance of continuing on.

Mrs Grierson: But it is still alive, is it not?

Mr KELLY: Indeed it is.

Mrs Grierson: I am glad for your question. I have been addressed by a lady who delivered, as I am aware, two babies that were destined to die. I am not too sure of the medical term, but it is a situation where the baby is born without a skull due to a lack of something within the mother. She made the decision to go full term and deliver these two children. This was on two separate occasions. The result was that one lived for not much less than a day and the other lived for a week. Her words were that for the entire life of this child it was held in loving arms. She was able to give that baby a funeral and name the child. She speaks around the world about her experience. That is a tremendous testimony to her, rather than, ‘I do not know the name of the child and whatever else may have occurred.’

Mrs SMITH: I was hoping that you might be able to table that document. I actually referred to that document yesterday. I was hoping that the survey could be tabled.
Mr Grierson: I have a copy for each member.

Mrs SMITH: I wanted to be clear on your view on the current bill that the member for Cairns has introduced. You referred to the fact that with the Criminal Code provisions being removed there would be no safeguards. Do you see the current bill being adequate even though we talk about the bill coming up to today’s standards.

Mrs Grierson: I see Queensland a long way ahead of Victoria in safeguarding the unborn. Victoria is no holds barred on abortion. Babies are left to die if they are born alive after attempted abortions. They are left with nil by mouth above them. If we take away the safeguard that we have got that is what is going to happen in Queensland. They say it will not, but I see it happening.

In Victoria they have had this since 2008 or a bit later. There have been a lot of terrible things happen. A lot of doctors have been deregistered and nurses have left. They cannot handle it. I do not think I could handle it either. I am sure I could not. I cannot even kill a fly.

I cannot understand how they can be saving a little 22-week-old baby here and dismembering one there. It does not make sense. This is a baby. This is a foetus. It does not make sense to me. I think it is a protection. Queensland has that protection. Even though it might be a bit waiving it is there.

Mr Grierson: I was going to say one thing on that point. What we know or understand is that late-term abortions have increased sixfold in Victoria since they have changed the rules. It would be the same trend in Queensland, and we do not want that at all.

Mrs SMITH: With modern science we have seen over the last 20 or 30 years babies can survive at 24 weeks. I imagine that in years to come that could be earlier. This is where you are saying a baby can survive. When you have opportunities to have late-term terminations that is where the problems occur because a baby can survive at that stage. Is that where you were going before?

Mr Grierson: No. Sometimes I think we need to change the language we use. In modern day society we have had to change our language in terms of the way we deal with many things. As I have referred to, it is part of a change of culture. We have changed the culture around smoking but yet we still have the same view on abortion. It is a foetus. It is a termination. Let us say it is a baby and we are killing it.

If the truth be known, we need to change the culture in our country, this great country. We have plenty in our country. We are not broke by any stretch of the imagination. We can well afford to support at least 10,000 more children. If it is like that in every state we can support them. We do not need to be terminating or killing our babies.

CHAIR: The time for questions has expired. I thank you Robert and Noela for appearing before the committee.
CHAIR: Thank you very much for your submission to the committee and for appearing today. Belinda, would you like to make some opening comments and then we will open up to questions.

Ms Lindel: I am the manager representing the Women’s Health Centre Rockhampton and I am also a social worker of 15 years. The Women’s Health Centre Rockhampton strongly supports this bill and the decriminalisation of abortion in Queensland by amending the Criminal Code to omit abortion in sections 224, 225 and 226. It is the position of the centre that these laws are outdated, do not support gender equality and do not acknowledge the basic human right for a female to have a choice over her own body.

The Women’s Health Centre Rockhampton was established in 1991, is governed by a board of directors and is funded by the Department of Communities, Child Safety and Disability Services. The centre services Rockhampton, Mount Morgan and the Capricorn Coast. In saying this, however, we regularly receive phone calls from women throughout Central Queensland and Western Queensland and provide information, support and counselling as needed.

We are a community based, not-for-profit organisation committed to providing an environment that supports and facilitates the empowerment of all women. The staff work from a strength based perspective to enhance women’s wellbeing by acknowledging the physical and cultural factors which affect women’s health.

We have two programs. The first is the sexual assault support service, which is a support and information and counselling program for women, men and adolescents from 12 years of age who have experienced historical or recent sexual assault or who are supporting someone who has been sexually assaulted. We also provide an excellent advocacy service for clients throughout the judicial system.

The Women’s Health Service provides counselling, information and support to women, young women and their families, with a focus on providing services to women from disadvantaged backgrounds including Aboriginal and Torres Strait Islander women, immigrant and refugee women, women experiencing homelessness, women who have a disability, including mental illness, lesbian and bisexual women and women living in rural, regional and remote areas. From 2015 to 2016 we have provided counselling to 176 Aboriginal and Torres Strait Islander women and 95 culturally and linguistically diverse women. Of the 500 individuals who accessed our sexual assault support service 485 were females. There were 806 women accessing our services for various women’s wellbeing issues such as depression, low self-esteem, a lack of confidence, relationship breakdowns, bullying, workplace issues, anxiety and other mental health concerns.

Due to the confusion in sections 224, 225 and 226 of the Criminal Code we do not keep statistics on how many women we have assisted in procuring an abortion. However, I can estimate it would be approximately one to two a month.

As this is a regional parliamentary committee hearing, I would like to draw your attention to some of the barriers that women from regional, rural and remote areas face. One is a lack of access. In many small towns, there are only a very few number of services or perhaps services are only outreach on certain days in that town and in certain places, whereby anyone and everyone knows who is going where and for what.

Another barrier is the lack of support services or support for family and friends. Isolation in rural and regional settings can have devastating impacts on a person. Then, when an unplanned pregnancy occurs, support systems can be very limited. For example, a 16-year-old female lives on a rural property west of Rockhampton with her father. She is raped almost daily by a worker on the property for a period of three months. She realises she is pregnant and when she tells her father, he kicks her out of home. She is unable to access an abortion because of the significant financial cost. A family member adopts the baby. However, as a repercussion, this woman is retraumatised and reminded of her violent rape every time she sees the child. This woman has been diagnosed with PTSD, post-traumatic stress disorder.

The third barrier is stigma. Many women have stated that they need to justify why they are seeking an abortion. We assisted a young woman to procure an abortion and she came into the centre as she wanted to meet me. She had her head down and started to explain her situation and how she became pregnant in a very soft voice. I gently stopped her and said that she did not have to justify to me or anyone else why she chose to have an abortion. I stated that I believed in her decision.
and she looked very shocked. I said that it was her choice. I then went on to explain that when she had the abortion, we have counselling at the centre and if she wished to speak to someone it was free; however, it was her decision and her choice.

Another barrier is people’s sense of morality. It is our belief that everyone has the right to their own opinion. However, under no circumstance should it be okay to force your beliefs and values onto someone else. Who gives you the right to be the enforcer, make judgement or be the jury on another human being’s decision? Women do not make this difficult decision lightly. It is my experience that women seek information and support before making this major decision. I know of regular protestors who stand outside a private clinic in Central Queensland to intimidate and attempt to force women to change their minds to abort the foetus, without knowing of the women’s stories behind this.

In one case of historical sexual abuse, a 55-year-old woman tells her story of being a 15 year old with a mild intellectual disability. Her adoptive father is sexually abusive, as well as physically, emotionally and verbally abusive. He has been raping her since she was six years of age. At 14 years old, she becomes pregnant and asks to have an abortion. However, she is denied this right as the adoptive parents do not agree with abortion due to religious beliefs. She has no money and no access to money, so she carries the baby to term. The baby subsequently dies at eight months from cot death. The woman was still being raped by her adoptive father when she was 40 and has vicious nightmares and many flashbacks of the rapes when she was a child.

Another barrier is the financial cost. The AMA says that wealth should not dictate health. However, it appears that, due to geographical location, costs skyrocket for women seeking assistance to have an abortion. An example was when a 17-year-old female who was violently raped and tortured was unable to have an abortion as she had no income. At 23, she was referred to the centre by the mental health service. She is suffering severe depression and anxiety. She has major psychological issues and compounding stressors, one of which is the child from the rape repeatedly questioning their paternity. She says that when she looks at the child, traumatic memories surface and replay in her head about her violent rape.

Time delay is another barrier. A woman residing in a regional, remote or rural area has a considerable time delay when travelling from a property to town may take a day. Consideration of all the factors from the property, such as when is the best time for her to get to town, when can she get into the doctors and when can she access support and counselling with her decision, et cetera, lengthens the gestational age of the foetus, increasing the cost of an abortion rapidly.

A significant consequence to these barriers is women at risk of self abortion. Many times we have been told that if a woman cannot access abortion, she will attempt to carry out the abortion herself through self abortion. Overdosing on medication, sticking foreign objects into their vagina and throwing themselves down staircases are only a few ways reported. A 36-year-old female with an intellectual disability is brutally raped by her uncle and her elderly mother does not have the money for a termination, so she tries to terminate the pregnancy herself. The woman is taken to hospital and an emergency hysterectomy is performed to save her life, with reproductive consequences for the rest of her life.

Our comments on terms of reference No. 1 are that from January to December last year, 571 women accessed abortion in the clinic in Central Queensland; in January to June this year, 244 women have accessed an abortion. Those costs start at $700 under the medical rebate. On a surgical day, only one out of approximately 100 will get to the clinic and change her mind. This is anecdotal evidence on the certainty and importance based on a woman’s mindset when making this difficult decision. I will skip through to the recommendations.

CHAIR: Be, if they are contained in your submission, we have all read your submission. We can open it up to questions and I will give you an opportunity to make further comments.

Ms Lindel: I think the only difference that we put was to allow conscientious objection, allowing doctors to have a say in their practice and providing mandatory training.

CHAIR: Thank you for your opening comments in support of the submission that you have made. I have a question in regard to the written submission. Quite compelling were some of the comments that you made about women who find themselves in violent relationships and what they experience. Can you talk briefly about that? The reason that I ask about that specifically is that a submitter made a comment to me that the Criminal Code may provide protections for women in these sorts of situations because of fear of prosecution, but you are presenting a different argument. Can you talk to that?
Ms Lindel: I know of several occasions where women are in domestic and family violence relationships, so sexual violence and inter-partner violence occurs. It is one control that the male asserts through birth control cohesion, condom negotiation. Because of the grey area in the law, the woman will not access an abortion because she is scared of being prosecuted. If it was brought into a health act and out of the Criminal Code, the decision could be made, giving the woman information, so it makes the choice easier for her, once that hold is broken, to get out of the violent relationship.

CHAIR: Am I correct that you are saying some perpetrators may use a pregnancy as an ongoing tie?

Ms Lindel: Absolutely, as a form of control over the woman.

CHAIR: That was my next question. Your submission talks about women who may need to access an abortion in a violent relationship. Of course, the outcome we would like is that the relationship was not violent and, if it is going to continue, that she be removed from that relationship. You are saying that you are obviously working towards that with the women who come to see you, but that this is being used as an additional tool to tie—

Ms Lindel: I actually have an example, if you would like me to read it out.

CHAIR: Is it a short example? Time is always our issue. It is okay, Belinda. It is quite clear in your submission.

Ms Utting: The research evidence around the co-occurrence of domestic violence and abortion is extremely compelling and international. It is likely that in those 10,000 abortions that happened in Queensland, at least a quarter of them will involve stories and situations of violence and sexual violence.

CHAIR: With regard to women who present to you, have they gone to a GP? How are they coming to you and raising the issue that they want an abortion? Tell me a bit about the process for how women come to your centre?

Ms Lindel: Women come to us for a variety of things. We work quite closely with several sister women’s organisations. It is quite well-known that we are pro-choice in Central and Western Queensland. I am also part of several networks. Women get referred through Children by Choice in Brisbane, some GP providers—

CHAIR: When they come to you, what are some of the considerations that women weigh up when making a decision? Are they coming to you with a clear decision that they want to move forward or do you find that there is ambivalence and it is a real process? Is it a very traumatic process for them with their considerations? Tell us a bit about what you see when women do come to you who are considering termination?

Ms Lindel: It is a very complex and difficult decision. The majority of women have already made the decision to have an abortion. It is then talking about the morality around the issue, what other people will think, that sort of thing, and also the women’s health. It is really complex.

CHAIR: Are they accessing information to assist them in that?

Ms Lindel: Yes. I have five really well-trained counsellors who provide information to the women, the clients. If we need further information, we refer onwards or get an organisation such as Children by Choice on the phone, which has highly trained counsellors to answer the women’s questions if we cannot.

CHAIR: If a woman presented to you and you provided all the information that you do and she made a decision to keep that child, what would your view be?

Ms Lindel: We support the woman. It is the woman’s choice. There is no moral ground for us. As trained counsellors, we have no judgement.

Ms Utting: There is the Women’s Health Services Alliance Queensland and ongoing midwifery support is available through telehealth, which provides a women’s health Queensland-wide service, across the whole of Queensland.

CHAIR: Essentially, you support choice, but informed choice?

Ms Utting: Absolutely.

Ms Lindel: And ongoing support.

Mr McARDLE: Thank you very much for being here today. It is much appreciated. You have five counsellors, Belinda?

Ms Lindel: Yes.
Mr McARDLE: Are they social workers or certificate 3 or certificate 4 counsellors?

Ms Lindel: They are a mixed bunch, but the majority are social workers. One has a master of counselling, one has a diploma with 10 years experience.

Mr McARDLE: Outside of that, is there a visiting psychologist or a psychiatrist? Yes. Let us say that a lady comes to your office and says, ‘I want to have an abortion’. The law in this state requires that there will be a reason for that outside of simply saying, ‘I want to have an abortion’. There needs to be a mental health concern of some determination or a physical concern in relation to the mother. What do you do to determine the mental health issue that triggers the right for termination in this state?

Ms Lindel: I do not make a determination at all. If a woman comes to us and says that she wants an abortion, we provide her with factual information on where she can procure an abortion.

Mr McARDLE: When you make the comment that it is the woman’s choice, I accept your comment. You do not go that extra step, shall I say, to satisfy yourself as to whether or not the requirements are met under state legislation?

Ms Utting: Section 282 only allows the defence for doctors and the doctor is defined in the Criminal Code as the only person who can make that assessment of a physical or mental health reason for why a woman needs an abortion. It is not within our legal scope of practice.

Mr McARDLE: That is fine. You refer the lady on to a practitioner or a clinic, I suppose in Rockhampton?

Ms Lindel: Yes, the Marie Stopes clinic.

Mr McARDLE: Do you know whether at that clinic that questioning takes place prior to termination occurring?

Ms Lindel: I am not in a position to answer what happens in their clinic.

Mr McARDLE: Selina, you mentioned that up to one-quarter of terminations—

Ms Utting: The frequency of violence, yes.

Mr McARDLE: —occur because of domestic violence scenarios. Do you have a citation for that article?

Ms Utting: The key work done in that area in Australia is done by Angela Taft from Victoria.

Mr McARDLE: Her statement is that one-quarter of terminations occur because of a domestic violence situation?

Ms Utting: She studied women who presented at termination clinics, their health history and their reasons for terminating. I am not sure of the exact per cent figure, but it is in that order of one quarter. Also, I will read you the finding of the World Health Organisation, UN Women—

Women who have been physically or sexually abused by their partners are more than twice as likely to have an abortion, almost twice as likely to experience depression, and in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.

Mr McARDLE: Each year in this state there is a requirement for certain types of clinics to report to the Chief Health Officer statistics in relation to terminations that occur. Last year, 10,000 terminations occurred at clinics, in relation to admitting patients. Those reports are not made publicly available. Would you think it would be important to understand the question of termination for those reports to be made publicly available, or at least to this committee, to understand gestational periods, reasons for termination and that sort of information?

Ms Utting: That kind of information would be useful. The most relevant documentation the committee could obtain right now would be the South Australian report on maternal outcomes. There is no reason to believe that Queensland is different in terms of the rate that women choose abortion versus continuing the pregnancy, the age patterns, the gestation patterns, the outcomes of stillbirths and that kind of stuff. It is a very detailed report that extends over the past 20 years of data. That is the most accurate source that you could currently get.

Mr McARDLE: Would you agree that, while data is relevant to South Australia, as we are now looking at the legislation in Queensland data in this state would be equally important?

Ms Utting: It would be really useful, but I do not think from the Medicare number that that information is going to be valuable to you, as that Medicare item number also covers D&Cs and other procedures relating to termination, and not just a woman choosing with a doctor to terminate.
Mr McARDLE: A lot of your submission deals with the issues around regional health concerns, which is absolutely correct, whether it is termination, vaccination, simple GP practices. In regional Queensland, it is very difficult to get the bulk that you get in the south-east corner. How does changing the law and removing the sections from the Criminal Code facilitate greater access in regional Queensland or are there two separate questions here? There is changing the Criminal Code and then providing better access, or do you think Rockhampton Hospital may come online? Very few terminations occur within the public hospital system; in fact, they are mainly beyond 23 or 24 weeks.

Ms Lindel: In Queensland, 99 per cent of abortions are performed in private settings and one per cent in public. If the Criminal Code was changed and maybe sat in the Health Act or something like that, Department of Health hospitals could offer an alternative. Women would not need to feel the pressure to fly out or come up with the finances. Rather than flying from Winton to Rockhampton or Brisbane to access an abortion, they might be able to go to Longreach or OB/GYN might go out there. It would shift the culture and the way that people think about access to abortion, as well.

Ms Utting: I think also in this last year the centre had a meeting with doctors who we could try to encourage to be able to prescribe medical termination. At the moment, to our knowledge, there are no doctors prescribing medical termination in the whole of Central Queensland. The abortion clinic in Rockhampton does not have a paediatric licence, so there is no termination in Rockhampton happening for any young woman under 14.

Mr McARDLE: My final question is this: the committee has been told that whether you criminalise or decriminalise, there is no difference or little difference in the number of abortions. What do you ‘gain’ by decriminalising abortion if there is no difference in the number of abortions?

Ms Lindel: This is also about choice, giving the woman choice, allowing her to freely talk to a doctor and allowing the doctor to understand the implications for her and also where it sits in the law. Being under a health act, it will give more information and better access to women.

Mr McARDLE: Thank you very much ladies. It is much appreciated.

Ms Utting: Possibly you could also consider the decision theory. Where a woman is given the option to make a decision for her own mind, whether to continue or not to continue, her commitment to either of those paths will increase. Even if you want to continue the pregnancy, if it is raised with you, ‘Are you sure you want to continue the pregnancy?’, even being able to consider openly that you do or do not want to continue creates an environment where women’s decisions are more solid and psychologically framed.

Mr HARPER: Belinda and Selina, thank you very much for your contribution here today. You have driven a long way to share some compelling stories. There is no doubt about that. I have a 25-year history with the ambulance in northern Australia or parts thereof. You have highlighted some cases that show we have challenges in rural and remote locations. They were pretty tough stories to hear. I think you raised some valid arguments that, if the bill was passed, medical officers could medically terminate and the burden of access would be reduced for the woman. No doubt, there is an array of circumstances and challenges to access that. I think there is some validity in the point that you have raised.

I wanted to get your thoughts on gestational periods, if we look at the terms of reference under item No. 4. Could you share your opinions and viewpoints on gestational periods, which seems to have come up a fair bit over the past few days?

Ms Lindel: The current private clinic in Rockhampton only provides treatment up to 17 weeks. We are concerned that having a gestational limit below 24 weeks would disadvantage regional women, where delays are regularly experienced within the system.

Ms Utting: If I can talk to one case that I have been told of, a woman realised she was pregnant through a home test. She waited a week to get into her own doctor, who knew her. The doctor referred her for an ultrasound, which took another week. Then she went back to her doctor. They had a very long discussion. She had several children already. At that point, she decided that she did want to go with the termination. She tried to get into the clinic in Rockhampton, which is operated on a fly in, fly out one-day-a-week basis. Over the course of making a very thoughtful and supported decision, it took her over a month. That is what it is really like for people in the regions.

Reducing the gestational limits has the risk of reducing all of that time period and consultation that a woman can make. To reduce it any lower than Victoria, at the 24-week mark, would create enormous problems for the regions. The main scan in a wanted pregnancy is at 18 weeks gestation. It is fairly often that a regional woman would have to wait to 21 weeks to have that routine scan done.
There are lots of delays within the public health system. She might not get the diagnosis that a woman in Brisbane would get. Genetic counselling such as is available through the Mater Hospital would not even be offered and known that she needs it until 21 weeks. Obviously, if the gestation is very low her timing is reduced. What will really happen is that if she still wants to go with a termination or if the scan leads her to that decision, if she has money she will fly to Victoria or South Australia or New Zealand or India or the USA. If she has no money, she will need to continue the pregnancy.

Mr HARPER: Thank you very much.

Mr CRAMP: Thank you for your attendance today and your input so far. I have a couple of questions around when women present to your clinic. I take on board what you said that they do not need to explain their decision-making process to you. Currently, as the deputy chair stated, there are criteria around seeking a termination. If we were to change the laws, from your experience in the clinic, do you think there should be any criteria set to seek termination?

Ms Lindel: Do you mean ‘seek’ as seeking information or going ahead with the abortion once the decision has been made?

Mr CRAMP: Correct. We are seeking a termination currently on the mother’s health status, on severe deformities, the questionable life status of the child and psychological issues. Should those criteria remain in the new legislation, should we have no criteria or should there be other criteria, from your experience?

Ms Utting: Within the different jurisdictions in Australia, there are several variations. Those options are available to the committee and to the parliament to decide. The fact that we are talking about removing it from the Criminal Code is the significant issue here. There are still extensive regulations, codes of practice and licensing for all private clinics operating in Queensland, for all doctors, and professional standards for social workers. Social work’s code of practice embodies non-directional counselling. All of those professional standards are a method of regulating abortion.

Mr CRAMP: Currently, when ladies come to your service seeking your assistance, do you explain to them the criteria that currently exist for termination or do you accept that they understand that already? How do they find that out?

Ms Lindel: We are usually one of the first ports of call when they find out that they are pregnant and it is usually through sexually violent means. When they come in and ask what their options are, we talk about abortion, adoption and the whole gamut of the options that they have. We can talk through more with them. If they want some further information and ask questions that we do not understand we refer them on to organisations like Children by Choice which can then give them more detailed information. Generally, the woman might go away and think about it and then return to the centre. We then plan what she wants to do. We completely support her choice and her decision through information that is thorough and that she feels supported with.

Mr CRAMP: If the information is thorough, do the legal aspects of termination ever come into the conversation, via verbal or documented information, with those ladies coming into your centre?

Ms Lindel: I cannot talk to what information the Marie Stopes clinic gives in Rockhampton. We are around decision-making—

Mr CRAMP: You are saying they will be passed onto them?

Ms Lindel: Absolutely.

Mr CRAMP: Should termination be a crime under any circumstance if the legislation were to change? Currently, as you know, it technically is. Although we have not had any charges, as such, over a very long period of time, with an exception as we know in North Queensland, I wonder about that question. You are two people who have real world experience of dealing with women in incredibly distressing situations. I am trying to get a feel and an understanding from you. I am seeking your wisdom in this regard. Do you think there are circumstances where termination is not necessary and there should be a penalty associated with that termination?

Ms Lindel: It is my belief that it should not sit in the Criminal Code whatsoever. Other states have it sitting in different legislation like health acts. I think that we should support women and give women a choice. It is a basic human right.

Mr KELLY: Several witnesses over the last few days have given evidence that the criminalisation of abortion creates a cultural construct in Queensland whereby abortion is not something that is easily discussed in anyway in society. What is your experience in relation to that? How does that affect women that you deal with?
Ms Lindel: Women that we deal with come to this very difficult and complex decision. There is a lot of shame and guilt attached to it as well. By working through some of the issues we help and support the women through this difficult decision that they are making.

Ms Utting: I think the stigma and the culture that is indicative of having criminalised abortion in Queensland is that the committee is not hearing from one woman today her story of her abortion and her experience of abortion and the fear that women have around being judged. That to me is the key.

Mr KELLY: There is a submission—and I am sorry I cannot reach the number; it is in there somewhere—from a sexual health clinic run by Queensland Health where a medical practitioner is performing or conducting medical abortions in significant numbers. There was evidence given that over a 10-year period the number of terminations has decreased markedly because she has had the capacity to build relationships with women at a point where she can influence their behaviour. I know that is not the right way to put it. She can provide education, support and guidance around relationships, sexuality and birth control. Have you had similar experiences in the environment that you deal with whereby taking a non-judgemental approach to women seeking a termination actually helps you to have a more holistic discussion with women about their situation?

Ms Lindel: I am not quite sure of your question because it was really long.

Mr KELLY: Do you want me to shorten it?

Ms Lindel: Please.

Mr KELLY: There is a doctor who has been performing terminations and through that process has actually seen the number of terminations decrease and that doctor obviously supports the decriminalisation of abortion. What has been your experience? You deal with people who are seeking a termination or are probably seeking a whole range of support. Would you believe that the decriminalisation of abortion would have an impact on the rates of termination and being able to deal with things like contraception, sexual education and those sorts of things?

Ms Lindel: We deal with contraception and sex education all the time. That is part of our funding as well. I cannot talk about whether it would change or not. What I do think is that it would remove the shame and the stigma associated with general conversations around abortion and judgemental people and people imposing their view. It would free up more women to feel easier about coming and seeking information about their choices.

We do not use biased questions or relationships to change anyone’s mind about topics that we do counselling and support with. It is about providing that information. The woman then goes away and makes her own decision and comes back if she needs more counselling and support.

Mr KELLY: Finally, in your submission you talk about the number of GPs who offer abortions in Central Queensland. You said that there are many who have expressed an interest but do not do it. We have heard a lot of evidence about access issues across the board, but particularly for women in regional and rural Queensland. In your view, how important is a change in the law to improving access for women in rural and regional areas?

Ms Lindel: It is highly important. If GPs felt with a really clear conscious that they could talk with a woman about providing Mifepristone and RU486 to them without fear of incarceration or reprisal that would mean that there would be no lack of access and there would not be travel to get under the nine-week gestational period. It would open up a whole wealth of access for women that has not been seen before, rather than women self-aborting and relationships breaking down.

I have an example of a woman who was beaten in the abdomen with a bat by her so-called partner because she was too scared to tell him she was pregnant and she did not have any money. She could access her GP quite easily and get the drugs without his knowledge if there were more access. There is another lady who committed suicide because her husband was financially controlling and would not give her any money. She already had seven children. I think that sums up the lack of access.

Ms Utting: One of the critical things in making medical abortion more available is the secure environment for GPs. In terms of women experiencing domestic violence, medical abortion is extremely safe for them because it will mimic a natural miscarriage in its presentation. That makes her decision completely confidential towards the violent partner.

Mrs SMITH: You said something about conscientious objections. What were your thoughts or views on that issue?
Ms Lindel: We support conscientious objections. Health professionals who hold a conscientious objection to abortion need to make a woman aware of their objection to abortion and make a referral to a doctor who does not have this objection thus providing the woman with the information and support she is seeking.

Mrs SMITH: We were talking yesterday about the requirements on doctors. I think Victoria went down the path where they insisted the doctor still had to provide a referral, which is probably at odds with what actual medical ethics state. Where does that sit then with regard to somewhere like the Mater Mothers’ Hospital that has a clear ethical belief that it goes against the grain to provide terminations? Where do you sit in terms of hospitals or individual doctors being able to say, ‘No, I am not going to assist you with providing you that option.’?

Ms Lindel: It is our position that doctors would have to refer on. It is okay for them to hold those values, but that should not be a barrier to a woman seeking an abortion. You are quite within your rights to have your own values. I have my own values, but I will not stop someone from seeking A, B or C. For a GP to say, ‘No, I do not believe in that so off you go,’ is not equitable and fair to the woman. If the law were changed so they could refer on to another GP if they had a conscientious objection I would say that it would happen quite rapidly. They would know other GPs that they could then refer onto and could easily say, ‘I do not believe in this or I am a conscientious objector, but you can go and see Dr Selina down the road and she will assist you with your support.’

Mrs SMITH: Where does that fall with the actual hospitals?

Ms Utting: I think the hospitals would be the same under the therapeutic termination of pregnancy guidelines. The person doing the assessment of whether the abortion can be provided in the hospital would be required to disclose that they cannot do that. For example, if you are a doctor in an emergency department or the Mater Hospital you would have to disclose that. I would assume that it would be put up at the Mater Hospital in very large letters that termination is not available in their hospital. Women in that catchment would be able to access another public hospital in the region where that was not the case.

Mrs SMITH: Where does that fall with regard to late-term terminations? There was the issue raised yesterday with regard to the case in Melbourne of the late-term termination at 31 weeks and the way the law was framed. There were issues with the doctor who objected to not necessarily terminations but the length of time for a termination. We are getting into a whole grey area there. Where is the doctor’s obligation to say, ‘I do not do it but so-and-so down the road does.’? We are getting into a very grey area there.

Ms Utting: That is probably outside our scope to comment. This centre has the position that we expect our counsellors to be pro-choice even if they believe that they would not have an abortion themselves under any circumstances. We have current and past counsellors who hold that position themselves. They would refer on to a colleague.

Mrs SMITH: I know it may not be in your area, but you raised that you had a position with regard to conscientious objectors. That is why I wanted to explore that a little bit more.

Ms Utting: In terms of access, we believe that it is very necessary for doctors to refer, particularly in regional and remote areas where the numbers of options that they could refer to are much lower. It makes it even more critical that the woman is quickly aware that she will not get that support from that doctor, but it is available to her from someone else.

CHAIR: My colleague the member for Mount Ommaney was talking about conscientious objection. I absolutely appreciate what you were talking about in terms of the tyranny of distance and the time that can elapse. Would you not think potentially a conscientious objector may then be being forced by proxy to support something that they do not support by being forced to refer to a doctor that they know will give them an approval? What would you say to that?

Ms Utting: I would say by referring to a colleague who does not hold that position in no way implies that that colleague would convince the woman to seek an abortion. That colleague that they are referring to is then responsible and has a clear duty of care to evaluate the woman, her physical and mental health, within their framework and not including abortion is not on the table.

CHAIR: Could a central register get around the concerns that are being raised by the conscientious objectors and your understandable concerns about timing—that is, where somebody can still access that information but it may not place a conscientious objector or medical professional in a position where they feel compromised?
Ms Lindel: I think I have a sense of what you are asking. If it were passed and taken out of the Criminal Code and then conscientious objectors were noted and the AMA had a list I would see that the information would be passed on to centres such as ours so that if someone comes to us we can say this doctor will see you. We would not say that this one does not or this one does not. It is about giving them the information and access to where they could go and get it.

CHAIR: Yes, the example is theoretical under the bill that we are looking at. Do you ever see a need to balance the interests of the autonomy of the woman and the interests of a foetus in decision-making?

Ms Lindel: It is our position that the woman has a basic human right to make a choice over her body?

CHAIR: Does that ever change depending on the gestational age of the foetus? I appreciate you deal with very complex situations and women in violent situations. I would like a broader type of example of when women present to you.

Ms Utting: I would not say there was a definite gestational limit. Certainly under our practice and the guidelines of ASW and other professional bodies our duty of care is towards the woman who is the living client then and there. A foetus cannot be our client. They cannot be involved in the decision. I would also raise that parents have the responsibility of deciding medical and life or death decisions for children until they are 18. That parental right to decide for the child, including life or death decisions, is recognised under the law until a child is 18.

CHAIR: You are talking about life and death situations for a children—

Ms Utting: Life threatening—

Mr KELLY: That is not always the case, is it?

Ms Utting: Yes, and then they go to the courts for a decision.

CHAIR: Our time for questions has expired. A draft transcript of proceedings will be sent to witnesses for any necessary corrections. I would like to thank everyone, both in the gallery and those who have appeared before the committee today, for their attendance. As my colleague the member for Thuringowa said, this is a very vexed and complex issue. We appreciate the very divergent views that are held across Queensland. I declare this public hearing closed.

Committee adjourned at 12.33 pm