Senate Community Affairs Committee – Children Born Alive Protection Bill 2022

8 June 2023 hearing - Questions on notice

Senator CANAVAN: *On that point, the data before us—I'm happy for you to take it on notice if there's different data—is that 10 per cent of late-term abortions end in the baby born alive in Victoria, and 28 per cent in Queensland. You wouldn't call that uncommon. That's quite common.*

Response from Associate Professor Paddy Moore AM

Senator Canavan stated that the data provided to the Senate Community Affairs Committee (through a number of committee submissions) shows that in Victoria, 10 percent of late term abortions end in a baby "born alive" or, in his words, a "failed abortion".

I understand, the data being referred to comes from the Mothers Babies and Children 2020 report produced by the Victorian Consultative Council on Perinatal Morbidity and Mortality (COPPM).

As I stated at the 8 June hearing, I am familiar with such reports and indeed, I am obligated to report case outcomes to COPPM. I further stated that my interrogation of the data does not support the conclusion made. I was asked on notice to supply my rationale.

In preparation for this response, I have now read all submissions to the enquiry and the transcripts of the hearing on 8 June. As a result, I have gained further insight and believe this is an issue of data interpretation.

I make two contextual comments which I hope may help to explain the difference in understanding of the data.

Firstly, I note the submissions which cite historical cases and recollections of health workers (in some cases dating back decades) where gestation was wrongly assessed, resulting in a distressed, and potentially viable fetus, being delivered and then left unattended, neither resuscitated nor palliated. These examples do not reflect current practice and these assumptions and conclusions cannot be reached by merely looking at the data. For example, the COPPM data set as presented is a summary sheet and contains none of the detail practitioners are obliged to report. Reportable data includes gestational age and, in the case of a live birth, the time of death. The descriptors in the flow chart (page 70 of the Mothers Babies and Children 2020 report) provides no information to understand the gestational age nor the viability of the fetus in each case.

Secondly, when interpreting the data summary sheet from the report, it is important to understand the definitions of terms used in a perinatal data base such as the Victorian one cited. "Live birth" is defined within the profession of obstetrics with reference to the World Health Organisation's declaration, which defines "live birth" as being when a fetus exits the mother with a sign/s of life. For example, limb movement or pulsation of the umbilical cord prior to expulsion of the placenta would be recorded as a "live birth". This term is used regardless of the gestational age of the fetus (ie. the capacity of the fetus to survive outside of the uterus). Further, the term is used regardless of the length of time the sign/s of life are present. While viability is not absolutely correlated with gestational age, 24 weeks is a general estimate of expected viability. Therefore, given the above definition, a "live birth" may occur at earlier gestations such as between 20 and 21 weeks completed gestation. Thus, neither a heartbeat at delivery nor an audible cry is a necessary criterion of the definition of "live birth". I suggest this is qualitatively very different from the term "born alive" with its implicit assumption of potential for survival and sensory experiences typical of a full-term infant.

Therefore, while I acknowledge the data referred to by multiple witnesses and Senator Canavan, my position stands that the data provided by COPPM does not indicate gestational age, other than greater than 20 completed weeks, nor does it provide any information of the neonatal course, including time to death or what actions were taken.

We simply do not know from this data how many of these live births occurred at a viable gestation, nor what the signs of life were and for how long they were present. Further, there is clearly nothing in the data to indicate the repeated assertions that these very premature and non-viable infants were not palliated or cared for. My clinical experience and knowledge of submitted case numbers for Victoria suggest that a very large proportion of these cases would be at early, pre-viable gestations when feticide may not have been clinically appropriate, sign/s of life would be fleeting, and resuscitation would not be a feasible option. To characterise such cases as “failed abortions “is incorrect.

I believe the submissions detailing historic cases assume the issues raised represent current practice and seek to assert that palliation and comfort is not supplied as a part of routine care. The data does not provide any evidence to support this assertion. Rather, I can confirm, that as a clinician practising in this area in Victoria during the years covered in the cited reports the decade covered in the cited report, that comfort and palliation are routine components of the patient centred care offered.

My argument remains that unless the committee were to specifically request a further break down of this data from COPPM, it is not appropriate to use this data to draw the conclusions made by many who support this bill.

Yours sincerely

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June 23rd 2023