General Comments:

It is my personal opinion that the ACT is altogether unnecessary. It creates needless red tape within the industry, disparity in practices between states and containins discriminatory elements for some patients. My suggestion would be to remove the ACT altogether, adhere to NHMRC and RTAC guidelines as per Tasmania, QLD and the ACT.

In the likely scenario that this will not happen, my suggestions for amendments are as follows:

- **Research and experimentation on gametes**

  National legislation of research involving gametes and embryos is sufficient and the need for state based legislation is unnecessary. If possible, remove this or at least bring in to line with NHMRC requirements as is stipulated by any human research ethics committee (HREC) already established within WA. Current practices to perform research in WA first require approval from a HREC based within a hospital or university (sometimes both), followed by approval from the RTC. This process as is stands, takes months, and for many small-scale research projects, it is an unnecessary tick-box, where they already have ethics approval from hospitals and/or universities, which require research to adhere to NHMRC guidelines, all prior to RTC application.

  I would also like to recommend that this suggestion extends to the application for innovative procedures.

- **Genetic testing of embryos, savior sibling, mitochondrial donation and gene editing technology**.

  Once again, refer to national guidelines or at the very least, bring into line with other states legislation. Significant advances in technology now mean that PGS and PGD have become routine testing procedures worldwide, and the WA legislation is grossly inadequate and outdated in this regard.

  Specific suggestions include the following:

  PGS: Remove the rules for eligibility. For a patient with a good ovarian reserve and the high likelihood of multiple good quality embryos, transferring a known, chromosomally normal embryo first, would give the highest chance of pregnancy, with a decreased chance of miscarriage and potentially a faster time to live birth. Miscarriage, while common, is a traumatic experience for many patients. For patients who are already seeking assistance to conceive, PGS provides the greatest ability to reduce the risk of miscarriage and subsequent embryo transfers.

  PGD: Remove the need to seek RTC approval prior to the commencement of every PGD cycle. The process of requiring PGD is stressful and emotionally/financially draining for the patients. The extra time to wait for treatment only contributes further to this stress.

Remove or increase the number of embryos allowed in storage before the commencement of another IVF cycle. Batching of embryos for biopsy and testing for PGS/PGD is commonplace and often necessary for women with a reduced ovarian reserve. It reduces the cost and time to treatment for the patient and the need to apply to the RTC every time you wish to have more than two embryos in storage is arduous and unnecessary.

In regards to mitochondrial donation and gene editing technology, I do not believe we are currently at a point where these technologies should be available routinely. However, given the speed with which they are advancing and becoming increasingly accurate, I would ask that when considering the decision to legislate either for or against them, that we be mindful that their potential to treat/eradicate genetic diseases is profound, with their potential to be routinely performed elsewhere in the world and other Australian states. I believe decisions regarding these technologies should lie with RTAC and the NHMRC.

- **The posthumous collection, storage and use of gametes and embryos.**
  Refer to national legislation and patient consent.

- **The rights to storage of gametes and embryos in complicated relationships and mental incapacity.**
  Refer to national legislation and patient consent.

- **The storage of gametes, eggs in the process of fertilisations and embryos (including the duration of storage and procedures for extension of storage periods)**

  The 10 and 15 year limit on the storage of gametes and embryos needs to be increased and the 5-year renewal removed. Five years is grossly inadequate for a timeframe involving storage of gametes and the continued need to update storage consents is unnecessary. Gametes and embryos stored, particularly in younger, oncofertility patients, means they will likely be in storage for more than 10-15 years. I do believe a limit is necessary to prevent clinics being required to keep materials in storage for decades to come. Perhaps 30 years, or allow clinics to perform their own audit of materials and discard after a certain period and after exhausting all methods to contact the patient.

- **Current licensing requirement, fees, data reporting etc.**
  WA is the only state where legislative licensing is required. Clinics already have to comply with RTAC and NATA accreditation. Bring into line with other states requirements.

  In regards to data reporting:

  The requirement for data reporting to the RTC should be removed entirely. Annual reporting of treatment outcomes are already submitted to the ANZARD NPESU, where they are managed effectively and national data reports produced in a timely fashion. If this requirement must stay, removing the quarterly reporting requirement and bring the annual report into line with the ANZARD data dictionary.

- **The effectiveness of the operation of the Council and committees of the Council**

  As the council stands, there is no representative from an Embryologist in the industry. There is representation as a deputy member of the council; however, I believe there should ALWAYS be a council member elected from practicing scientists in WA clinics, on the main council and all relevant sub committees. This could involve the current representative being elevated to the main council or a nomination through the Scientists in Reproductive Technology (SIRT) WA membership.

Other considerations:

Bring the legislation regarding the import of gametes and embryos from overseas donors and the donor family limit, into line with other states requirements to enable a more streamlined procedure for embryo/gamete import and export between states.

Conditions involving reciprocal IVF are gender discriminatory. In a female same sex relationship, one partner may not wish to become pregnant or cannot carry a pregnancy, but may wish to use their gametes in the relationship, similar to a male partner providing the sperm in a heterosexual relationship. The legislation requires review in regards to same sex couples donating gametes to their partners.

Thank you for your consideration.

With Kind Regards,

Dr Melanie Walls, Scientific Director

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]