



**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

**SELECT COMMITTEE ON THE VOLUNTARY ASSISTED
DYING BILL 2023**

(Reference: [Inquiry into the Voluntary Assisted Dying Bill 2023](#))

Members:

MS S ORR (Chair)
MS L CASTLEY (Deputy Chair)
MR E COCKS
DR M PATERSON
MR A BRADDOCK

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 2 FEBRUARY 2024

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Secretary to the committee:
Ms K de Kleuver (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

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Amended 20 May 2013

The committee met at 10.09 am.

SENGSTOCK, MS ELSA, Senior Policy Officer, ACT Law Society

MORTON, MR TIMOTHY, Co-Chair, Elder Law and Succession Committee, ACT Law Society

FISCHER, MR THOMAS, Committee Member, Employment Law Committee, ACT Law Society

THE CHAIR: I would like to thank everyone for appearing today and welcome everybody to the public hearings of the Select Committee on Voluntary Assisted Dying Bill 2023 and for its inquiry into the bill. The committee will today hear from a wide range of witnesses who made submissions to the inquiry.

I would like to acknowledge that we are meeting on the land of the Ngunnawal people and pay my respects to elders past, present and emerging. The committee wishes to acknowledge and respect their continuing culture and contribution they make to the life of the city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard and will be published. Proceedings are also broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used the words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

Voluntary assisted dying is a very sensitive topic, and the secretariat have information on support organisations available for witnesses, or other people attending this public hearing, who are impacted by any of the issues raised in this hearing.

We will now move to our witnesses from the ACT Law Society. I would like to remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Mr Morton: I do.

Ms Sengstock: Yes.

Mr Fischer: I understand the statement and abide by it.

THE CHAIR: Thank you very much. We are not inviting opening statements; however, if you do have one, you are welcome to leave it with the committee secretariat and the committee can consider it in due course. So we will proceed to questions. Given that we are on quite a tight timeframe, I would remind everyone that a succinct question and a succinct answer are very good things.

Given the legal background or the legal expertise you bring to this hearing, are you satisfied with the strength of the bill's eligibility requirements given the ACT bill does

not have a time-to-death requirement that is in other bills?

Ms Sengstock: For us, we are in a position that we know this is a departure from the other jurisdictions, however, we appreciate that there have been some policy considerations that have gone into removing it. In our submission we did flag this as a departure, more for the perspective of making sure the committee was aware and could properly consider the issue. I think the way in which the ACT is trying to approach this is to try and link the definition of “advanced” to the person being at the end stages of life because we appreciate there are difficulties for doctors in accurately being able to prognosticate, I think is the word, time of death.

Mr Morton: We do not have a position. We are not here in a personal capacity. I am certainly not here in a personal capacity, though for the sake of transparency, I have been involved in a separate committee before in a personal capacity there. We should just simply be considering whether it is a necessary condition. We do not advocate one way or the other. As Elsa has identified, the definition of “advanced” seems to capture late stages of life. It is for the committee to decide, and the government to decide, the form that the bill finally takes.

MR BRADDOCK: There have been comments from other witnesses about clause 11(4)(c) which describes the last stages of life as being legally ambiguous and does not add value to that particular clause. Have you turned your mind as to whether that clause should remain in the bill or not?

Ms Sengstock: I am aware of that submission. I think that is the attempt to have a timeframe-type requirement in the act. I agree it could be open to interpretation, and that is where it will be very important that the guiding material given to practitioners and the training they are given, actually supports a less ambiguous interpretation of that provision.

MR COCKS: It sounds like that provision, as it stands without anything else there, is ambiguous.

Ms Sengstock: It could be, yes.

MR COCKS: And we could end up, without that guidance, having a practitioner interpreting things differently to what a court would.

Mr Morton: It seems likely that such a term would attract a certain amount of judicial consideration. If that were to occur, then there are the purposes of the act and the balance of the act that can be used to construe what the Legislative Assembly has put in place. It could be argued one way or the other certainly, but that is the case with many provisions as a matter of law. What it does, though, is it says that this person who is considering accessing VAD is not at a stage of health where they are going to live for a long period of time. I think that part of it is sufficiently clear.

MS CASTLEY: Paragraph 33 of your submission relates to the differences between explanatory notes talking about the board monitoring in real time, and the act which relates to a retrospective review. Can you clarify your concern, and if the overriding principle is to be consistent with other jurisdictions, do you think there should be

retrospective oversight as raised in your paragraph 35?

Ms Sengstock: I will start with that one. I think the ACT government submission has given some more clarity on what their intention is around that. Our first principle was to ask what is the intention of the board, because it was not entirely clear. It did seem to us to be more in the nature of monitoring after the fact. With other boards that have been set up in other jurisdictions, it is very clear that they have a decision-making power. So I think that information has clarified the issue somewhat for us. Jurisdictions have taken different approaches to this, and so again we do not have a position on which way is better, just that everyone is clear on what the role of the board is and in relation to oversight.

MS CASTLEY: Would a recommendation be—is it necessary that we are all a little more similar?

Ms Sengstock: I think it is hard because the jurisdictions are different in this regard. So I think there are some very core elements of VAD legislation in which there is consistency with the ACT legislation. It is important to have those core matters consistent. Where there are departures, I think it is important the policy considerations have been thoroughly worked through. On the role of the oversight board, it is essentially a policy choice as to whether or not it is getting parallel, or has a power of veto, as it were, or whether it is just there to do a compliance function for the overall scheme, which it appears to do in this case.

DR PATERSON: In the next session we are going to hear from the minister responsible for this bill which is the Human Rights Minister. So that is the starting point for this question: a human rights lens. We heard from Exit ACT yesterday very strongly that this bill is discriminatory in terms of children and young people accessing voluntary assisted dying. I note that your submission speaks to this. I was wondering if you could express your Society's views on this from a human rights lens.

Mr Morton: The consideration of access to this scheme by children attracts, without really requiring it to be said, significant ethical issues from both perspectives to be sure. The Law Society does not have a view right now except to acknowledge that there are significant ethical considerations on both sides. The complication that it will have is, if we move into that space, you will immediately attract the application of federal legislation with the best interests of the child being covered under the Family Law Act. That is a more complicated issue and appropriate that it be discussed as part of the review in three years.

MR BRADDOCK: We have had other witnesses advocating to reduce, say, the level of administrative process to accompany oversight, for example reducing the number of witnesses, reducing the number of requests. I notice in your submission you are actually suggesting some strengthening there in terms of who those witnesses should be. I am trying to balance those two competing views and I would like to hear your view as to where you think there should be appropriate oversight of the process.

Mr Morton: There is no doubt we have advocated for greater oversight or ensuring that oversight is sufficient. We have simply asked questions to ensure that this committee is able to interrogate the processes and ensure that what ultimately happens

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is a voluntary access of the voluntary assisted dying regime. To pick a particular point, that you have raised, is the witnesses. We have advocated to a degree strengthening that process by the word “certifying” carrying a little bit more weight by potentially having a qualified witness, however defined, do that certification. That way it has a degree of solemnity that can be relied upon by court or tribunal in the future. We would be concerned that anything which takes away from the safeguards may result in less voluntary deaths.

Ms Sengstock: So we very much appreciate there is a policy consideration. I know submitters have raised concerns that you may not be able to access the requisite number of witnesses. So it is balancing, I suppose, the availability of witnesses with also making sure the witnesses who are present are appropriate. The safeguards go to making sure it is free of coercion and duress, which is something the practitioners need to be certifying at that assessment stage, but also that the witnesses are doing it.

So it is a balancing act of making sure that we are—you are absolutely right—not over-bureaucratising the process but making sure that there are sufficient stages in the process, and there are sufficient safeguards around that. It is a consideration of whether or not witnesses will be in a position to attest that the person is not being coerced. Obviously, there will be obvious situations where that might be clear, but there are a lot of situations which might be open to interpretation. So we would leave it to the committee to determine whether or not overall the safeguards are sufficient as they are.

MR COCKS: We have spoken a lot in this process about conscientious objection. You have brought quite a different lens to that, particularly in paragraph 43, around the risk of facility operators taking an adverse action towards someone who holds a conscientious objection. I would really like to hear a bit more about that, if you can explain the thinking there.

Mr Fischer: Certainly. In the field of employment we have overriding federal legislation, the Fair Work Act, that kind of dominates the field in a sense. What we have sought to bring up in this submission is that some of the conscientious objection elements overlap in significant ways with the federal legislation and may be subject to interference from it. So what the conscientious objection elements of this are attempting to do is to free an individual from the ordinary principle that underlines every employment contract, of lawful direction; to say there are certain lawful directions that they can refuse. The adverse action provisions of the Fair Work Act are something slightly different. They say that somebody cannot be punished or disciplined for a characteristic that they have, which may include religious belief. So those things are not exactly aligned.

Part of what we are saying in this statement is that the operators of facilities may have very, very strict requirements to adhere to, guidelines and so on and so forth; that they may not be able to necessarily compel their staff to undertake those activities lawfully without potentially breaching the Fair Work Act. So that is what we are trying to get at: that the strictness of the deadlines that relate to facilities operators could create a situation where they feel compelled to discipline, to move people around, to their disadvantage, in order to complete the processes, and that might be a breach of the Fair Work Act.

MR COCKS: So it sounds like there is a risk that whatever the facility's position, individual conscientious objection could lead to some degree of liability or breach of this act? And that would be a step to try and prevent that occurring?

Mr Fischer: We wanted to identify it as a risk. Obviously the facilities that will be offering this kind of procedure are very significant and hopefully have a lot of backups in place. Any health facility should be able to cope with one or more staff being absent on any particular day. They all have leave, for example. However, there is a risk that if there are key members of staff in bottleneck positions that they may come under pressure, particularly if these kind of procedures are happening frequently, to be part of the process that they wish to conscientiously object to, and that could create an adverse action problem.

MR COCKS: Is that exacerbated by the strict liability provisions?

Mr Fischer: It was the view of the committee that it might be, yes. There is no opportunity for the facility to say, "We were not able to do so because x." It simply is or is not done.

THE CHAIR: Mr Fischer, in the example you just gave of not having enough staff and staff having to participate in a process they do not want to be in, my read of the bill is that the institution would then not be meeting the requirements of the individual to opt out of the process. Am I misguided in that view?

Mr Fischer: No, that is quite right. They must permit somebody, under the conscientious objection provisions within the bill to be apart from the process. There is a related issue which is about the coverage of that conscientious objection, which appears to be limited to health practitioners. So other ancillary staff may not benefit—

THE CHAIR: Yes, okay.

Mr Fischer: But yes, that is correct. The issue arises, that in doing so—there is an incentive for facilities to pressure people to be part of the processes.

THE CHAIR: If I have understood the submission—I actually have questions arising from paragraph 43 as well. If I have understood what you have written in your submission around wanting to also be cognisant of the obligations under the Fair Work Act, and the protective characteristics and attributes that come with that, is there—I am trying to find out essentially where you draw the line, for lack of a better way to put it. If you have an employee who wants to conscientiously object, that is fine. They exercise their rights under the act, but then the organisation takes adverse action as a result of that, then the Fair Work Act would come into play. That is my understanding. If someone conscientiously objects and does not meet the requirements under the act then it actually is not necessarily a work-related matter, it is a matter under the provisions of the Voluntary Assisted Dying bill as to what the consequences are—

Mr Fischer: Yes.

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THE CHAIR: So I guess, in my mind, when I was looking at it and what came to my mind when I read your submission, is that there is not necessarily a role for the employer to take any action if someone does not meet the conscientious objection requirements of the act. But if they did, they could potentially be breaching employment law. Have I broadly got that correct?

Mr Fischer: Let me consider that for a moment. Yes. I think that is right. If they do not take action against somebody, then they are not going to be in breach of the Fair Work Act. The minute they do, that person may be able to raise the adverse action.

THE CHAIR: Yes. So in your recommendation of the legislation pointing to reminding people of their obligations under the Fair Work Act and employment law, would it be fair to say that the committee, in their consideration, should also take on board the idea that you can have one set of rights under this act and one set of obligations under another, and the two are not necessarily incompatible? People just need to know how to navigate them.

Mr Fischer: Absolutely. It is the obligation to follow every set of laws that applies. The fact that they are not perfectly aligned, as long as there is no inconsistency that cannot be bridged, it does not excuse you from one set of laws.

THE CHAIR: Okay. I think that answers my questions.

MR COCKS: Just to be really clear, the concern though is that the incentives are there, in your words, to pressure staff to be part of the process?

Mr Fischer: Yes, that is the concern.

THE CHAIR: Yes. But on that, there is legal recourse there should that pressure be exerted? Just in the case of any risk where pressure could be exerted to do something that people are not in a position to do.

Mr Fischer: Yes, that is correct.

THE CHAIR: All right. I note we have reached time. Thank you very much for appearing today. On behalf of the committee, we are grateful for your submission and for your attendance. I do not believe any questions have been taken on notice, but you will be provided with an uncorrected proof *Hansard* for you to have a look at for any factual errors. So once again, thank you very much for coming today and for your submission.

Short suspension.

MATHEW, DR PENELOPE, President and Human Rights Commissioner, ACT Human Rights Commission

TOOHEY, MS KAREN, Discrimination, Health Services, Disability and Community Services Commissioner, ACT Human Rights Commission

GRIFFITHS-COOK, MS JODIE, Public Advocate and Children and Young People Commissioner, ACT Human Rights Commission

THE CHAIR: We are now welcoming witnesses from the ACT Human Rights Commission. I would like to remind witnesses of the protections and obligations afforded by parliamentary privilege, and draw your attention to the privilege statement—the pink cards on the table. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Dr Mathew: Yes. I do.

Ms Toohey: Yes.

Ms Griffiths-Cook: Yes.

THE CHAIR: Thank you. We are not inviting opening statements; however, if you do have one you are welcome to provide it to the committee secretariat, who will pass it onto the committee in due course. We will go straight into questions, and I am going to start with myself, just for something a bit different.

One of the biggest topics we have had come up consistently through the hearings has been the balancing of human rights, particularly the right to exercise religious belief against the right to access and make decisions over your own health care. I am interested to know if the bill has, in your view, balanced those considerations?

Dr Mathew: In short, yes. We have a lot of discussion about the bill, prior to me coming on, obviously, as Human Rights Commissioner, and we do think that a satisfactory balance has been struck.

THE CHAIR: Can you elaborate on the reasons that form that view?

Dr Mathew: It is important, when talking about health practitioners who have a conscientious objection, that they do have the right not to participate in a particular treatment. But it is also important that someone who is seeking access to what will be a lawful end-of-life option is not impeded in their access. We have drawn the conclusion that, where the bill has come down on that, it will mean that people get access to that treatment.

THE CHAIR: Just one final question on this line. One part that has been put to us is that if you have a conscientious objection even to referring someone to another person who can provide information, even if you do not, it is still participating in the scheme. And while it has been acknowledged that there is a range of different beliefs and how to apply them in conscientious objection—and what people consider is acceptable and

what is not acceptable does differ a little bit—one of the stronger versions of conscientious objection is if you are a healthcare professional you are participating by even referring someone to another person or to information under this scheme, where you would have to do that. How are your rights balanced with the right to healthcare? That is the bit I am still trying to get my head around.

Dr Mathew: Well, we take the position that it is a reasonable limitation, and I might also defer to my sister commissioner, because she can talk about the code of conduct and how that is already dealt with.

Ms Toohey: And as the Human Rights Commissioner indicated, we have been involved in these discussions for quite some time. I know some of the earlier people presenting to the committee have referred to the codes of conduct for health practitioners, all of which provide for conscientious objection, but all of which say that the person has to ensure that the patient can get access to the care they are seeking. So we think that the bill provides that adequately, both at an individual level, but also at an institutional level.

THE CHAIR: Okay. Great.

MS CASTLEY: I have a question on your views with regard to the two-day turnaround and the criminal liability. We have heard from a few people: “Yes, two days is perfect. Great. Get that done.” And then the Australian College of Nursing is sticking out in my mind saying that 48 hours in a nurse’s life is very different to any other workplace, and that is too short a timeframe, especially when we are looking at criminally charging a nurse. Can you talk to us about your thoughts on it?

Ms Toohey: We certainly had some concerns about that being too tight in those circumstances, particularly for a strict liability offence. I think the feedback that we had from the policy people was that the health practitioners were satisfied that that was sufficient timeframe. Our concern is the potentially chilling effect on people wanting to be involved in the scheme. I think we have seen in some of the other jurisdictions, where there have been technical issues with compliance, that there have been fines issued.

So I think we would suggest that there might need to be further consideration given to that, particularly given the ANMF’s comments on that. As I said, the feedback we got was that there was a degree of satisfaction with that. As you said, I think 48 hours in a nurse’s or doctor’s life is slightly different to mine, and so we do think there is room to consider that and for the committee to make further recommendations on that.

MS CASTLEY: Do you have a view on what our recommendation might be?

Ms Toohey: Not really, because I think it should be given over to the practitioners about what is practical for them. It is a small jurisdiction. No doubt there will only be a small number of people involved. And, as I said, I am concerned about the potential chilling effect on things like those particular concerns playing out with respect to how many people are going to want to step up and be involved.

DR PATERSON: Again, just on the idea of unnecessary delays, your submission

raises concerns that delays may be caused by the number of steps that need to be notified to the board. I was just wondering if you could speak to that, and why that is important—that perhaps there are too many stages that need notification, and whether reducing that is reducing a safeguard to the bill.

Dr Mathew: Well, arguably it is reducing a safeguard, and I understand the cautious approach that the government, or parliament, or Legislative Assembly is taking, in being line with other jurisdictions. I think our recommendation in our submission was that we might want to look at this at the review stage, because the experience, now that there are jurisdictions in Australia that have voluntary assisted dying, is that they are hold-ups in access to the treatment. And, again, my sister commissioner might want to comment more on that.

Ms Toohey: Yes. Again, the experience we have seen in Victoria in particular is that those additional steps for people who are at end of life, who often have limited supports, and with a limited number of practitioners available, is a barrier to accessing not just the service but access to VAD itself. As we have indicated, we think that that should be up for review at the review time, to see what the board thinks. We think that it is a valuable role for the board to be able to look at those steps to see where it is creating a barrier. I think everybody in Canberra is keen to see this implemented effectively, and any barrier that is put in the way is likely to cause people not to have access to VAD at the very time they would be looking for it, which would mean increased distress at end of life, which is the last thing we want to see.

DR PATERSON: We just heard, in the last evidence from the Law Society, that they felt there was a need to have one of the witnesses certified—some sort of certification process for a witness. Given that you already have certified medical practitioners on this side, do you think it is necessary to have extra certification of witnesses, or would that be adding extra layers and complexity?

Dr Mathew: Yes. We were listening to that evidence, and our view was, no, we think that would just add to the complexity of the process. There are already two witnesses involved as well. So, no.

DR PATERSON: Given someone is at the end stages of their life and how stressful that may be, adding that type of complexity to find witnesses that are certified might be significant.

Dr Mathew: Absolutely. Again, my Assistant Commissioner might want to talk about the experience of elderly patients that she has come across in the system who just might not have access to lots of people that they can draw on to be those witnesses. So we certainly would not be wanting to add to the complications for the person at that point.

Ms Toohey: Yes, and we did consider those issues throughout the number of submissions that we have made, but, as has been indicated, our concern is more with people needing to be involved—particularly in a small jurisdiction, sometimes with people who do not have family around them, and where people are sometimes in facilities that it is not easy to navigate bringing people into, and when people who are already in a vulnerable state—and we think the current safeguards are more than

adequate.

It would be adding complexity: who is a certified witness; where can we find them; is it a public holiday in Canberra; is it over Christmas, when there is no-one here? You know, there is a whole range of factors that go into that, particularly in a small jurisdiction.

MR BRADDOCK: A lot of witnesses were concerned that the bill does not address those who lack capacity. I wanted to understand from your perspective, the use of advanced care directives, in terms of the human rights and ethical considerations that come into play, where someone subsequently loses capacity of any application of VAD in those situations where they are unable to give their consent?

Dr Mathew: As we have said in the submission, we certainly agree that this should be looked at at the three-year review point of time. There are jurisdictions overseas that do allow for advanced care directives. It is a fraught issue for a practitioner, who, at the time, may not think that the person knows what is happening—understand that—but it should be possible to have an advanced care directive. There are parallels with not resuscitating, for example, and that is what we have pointed to in our submission.

MR BRADDOCK: So have you done any exploration of how those other jurisdictions have addressed this from an ethical or a human rights perspective?

Dr Mathew: Not in great detail. I am aware of one case where there was a prosecution in the Netherlands and the practitioner was acquitted, at the end of the day, because she was acting on the basis of an advanced care directive. And in Canada there is an ability to waive consent at that last stage. So we want to look closely at those overseas models.

MR BRADDOCK: Thank you.

MR COCKS: Throughout these hearings, it has been pretty clear, and we have heard the message, that this should not be just a bureaucratic process—that it has to involve questions of values and philosophy. It goes deeper than just what is the most efficient process to do this specific thing. The first recommended change that you have made is around increasing access for children and young people who are under 18. I wonder if you can explain the basis for that expansion.

Dr Mathew: I think our fundamental position—and I will refer to my sister commissioner who deals with children and young people—is that normally when we are dealing with access to health treatments, Gillick-competent or mature minors would get access to that treatment. So there is an issue here, really, of age discrimination. Having read the explanatory memorandum I can understand that there is a desire to make sure there are adequate safeguards in place, particularly if perhaps there was a dispute between a young person and carers or between the carers. So I understand the caution there, but we will always, as the commission, raise questions about whether children and young people who have the capacity to have their views taken into account, are being listened to and are having their autonomy respected.

Ms Griffiths-Cook: I would probably just add that, assuming that the bill passes and

this becomes one of the range of treatment options that are available to persons in the ACT, the question then comes: why shouldn't a mature minor who is deemed to have the capacity to understand the nature and circumstances of what they are seeking, not be able to access the same range of treatment options as an adult in the same circumstances?

Again, as the Human Rights Commissioner has mentioned, we would obviously be looking to ensure appropriate safeguards. But the concept of Gillick competency is a long-established concept in respect of healthcare matters involving mature minors, that has long been applied by health practitioners to determine when a young person is capable of making decisions for themselves in respect of their own healthcare.

MR COCKS: I will come back to Gillick competence in a minute, but, to summarise, it sounds as if you do not think there should be a specific age limit, but that a test like Gillick competence should be what should be used instead.

Ms Griffiths-Cook: It is already used. So, yes, to change the basis on which current decision making occurs when it comes to treatment of mature minors and their ability to make decisions in their own right, I cannot see why we would change an already-established precedent and something that health practitioners are already usefully applying in treatment decision making.

MR COCKS: Gillick competence was originally developed in the context of prescribing contraceptives to young people around the age of 15, who are likely to already be, or who are about to be, engaging in sexual activity, as a harm minimisation approach. Since that time, there have been a range of decisions around the use of Gillick competence, including at least one I am aware of where Gillick competence was not regarded as applicable in all circumstances, in particular those that are going to cause potential harm and be entirely irreversible. Is there no risk with using that type of test for a life-ending decision?

Dr Mathew: I guess there are a couple of points to make. First, the nature of voluntary assisted dying as this bill sets it up, is about a young person who is unfortunately already in the last stages of their life. I do not know which case law you are talking about. You might be talking about Marion's case, where initially it is about sterilisation for a young person with a disability. Initially the concern is that that child did not have capacity.

I take your point; there are some wrinkles here around how Gillick competence would be applied. And certainly the young person would have to understand the permanence of the decision that they are making. And, again, I would say it is important to look at the jurisdictions where young people do have access to voluntary assisted dying and think about what the practitioners are telling us about competence in those cases.

I notice that there was a submission by Mary Porter, who had done some of the study tours and talked with some of the practitioners. She was talking about a practitioner who was saying that young people with a terminal illness are often very, very much aware of what is happening to them. They do have competence to make those decisions, simply because to the circumstances they are in. I hope that answers—

MR COCKS: Of course, from a scientific point of view, the brain is not fully developed until some years into adulthood, but you would be taking the view that the principle of young people making decisions for themselves would override that perspective.

Dr Mathew: I am not sure that it overrides. I think what we are saying is that it is a young person at a particularly unfortunate time in life, facing death, who knows they are suffering—they are aware of that—and whether they have the ability to exercise autonomy around that. I fully take your point about the brain not being fully developed, but this is a very unfortunate circumstances that I, certainly, as a parent would never want to be in with my child. But I think I would want my child to have those options if they were in unbearable pain and already facing death.

MS CASTLEY: Most of our specialist paediatric services happen in Sydney. How would that work if we are opening this up to younger people who would definitely be in those paediatric services? Would it be the intention that, because they have not residence in New South Wales, that access should still be allowed, or would you be wanting to move them home? We have heard that that is quite problematic. Just wondering if you could expand on that.

Dr Mathew: I might defer to my sister commissioner. I think the evidence suggests that people do return home when facing death.

Ms Toohey: Yes. We do not deal with every transfer of a patient between Sydney and Canberra, but, certainly, we are aware of a number of matters where, at the end of life, the child has come back to Canberra to be with friends, to be with family, and maybe to spend a couple of last days at school even. I guess that is why it is in tranche 2—it is subject to review and it is not in this first round because it is complicated.

We certainly think that it should be a broader consideration than just on an age basis, but people are in very different circumstances. Not all of the paediatric services occur in Sydney. As I said, we are involved in a number of matters where young people have gone backwards and forwards between Sydney and Canberra, and appreciate that there are cross-border issues with how the law will operate. But we do think that that should be resolved in the second consideration of the bill.

DR PATERSON: Yesterday, we heard from Exit ACT, who made an argument about a young child—like a child who is three years old, who cannot give consent—who might be experiencing intolerable pain and end of life. They likened it to a situation where a parent would make decisions about their medical care—like whether they have a transplant or those type of things—and said that parents should be able to consent to voluntary assisted dying for children that young. Just hearing you talk now, it sounds as if the bounds of your argument are for older, consenting young people. I wonder, is there scope, do you think, in the ACT, to ever go down the path of this sort of service for young children?

Ms Toohey: I think the issue is that it is a service that is part of a continuum of health treatments. Young children are already accessing palliative care services, so this is another service on that continuum. So should we deny it to them? It is not my call to make, obviously, but I think we need to look at it in that context, as opposed to

“Here’s a parent making a decision about VAD,” because that child will already be accessing those other services.

Dr Mathew: But it is true that our focus has been on Gillick competence, and the idea of the mature minor. There are examples of jurisdictions overseas that go for an age limit. In the Netherlands I think it starts at 12. Colombia has taken it as young as six. So in the review stage you could certainly have a look at those other jurisdictions and what is happening there, but our focus has been on Gillick competence.

DR PATERSON: From a human rights perspective, yesterday we discussed whether the bill was discriminatory because it did not include children, or people under the age of 18. So could the argument be made that an age limit, no matter what it is, is discriminatory?

Dr Mathew: Potentially; except that I think the way the bill is framed—and I welcome comments from my fellow commissioners here—it is about voluntary assisted dying, and at the moment it is about having capacity. A very young child simply does not have that capacity. So I do not think we are at risk of getting into an argument about discrimination, unless it is about a mature minor at this point in time.

THE CHAIR: Is there is anything that you would like to add, briefly? We might actually just like to wrap up a couple of minutes early.

Dr Mathew: That is perfectly acceptable to us.

THE CHAIR: Thank you. I take it that there is nothing further you would like to add, and no-one has any further questions. If they do, they can put them on notice, anyway. There were no questions taken on notice, so we will not need to follow up with those. But I would like to thank you today for your submission, and the time you have taken to appear before the committee. We are very grateful. You will be sent an uncorrected proof *Hansard*, for you to check for any factual errors. The committee secretariat will be in touch. Thank you again, and thank you for accommodating our request to finish a little bit early.

Dr Mathew: Thank you.

Short suspension.

CHEYNE, MS TARA MLA, Minister for the Arts, Culture and the Creative Economy, Minister for City Services, Minister for Government Services and Regulatory Reform and Minister for Human Rights

ZAGARI, MS JANET, Deputy Chief Executive Officer, Canberra Health Services

NG, MR DANIEL, Executive Group Manager, Legislation Policy Programs, Justice and Community Safety Directorate

CROSS, MS REBECCA, Director-General, ACT Health

BROWNE, MS TANIA, Acting Executive Branch Manager, ACT Health

RAD, MS CHADIA, Senior Director, End of Life Policy, ACT Health

THE CHAIR: Thank you. I would like to welcome Ms Tara Cheyne MLA, Minister for Human Rights, and officials from the ACT government. I would like to remind all witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement, which is on the pink cards on the desk.

Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Can I please get you, once you have had a chance to look at the statement and you feel comfortable with it, to confirm that you understand the implications of the statement and that you agree to comply with it. I do need you to say yes so that Hansard can record it.

Witnesses: Yes.

THE CHAIR: We are not inviting opening statements. We are just going to jump straight into questions. If you do have an opening statement, you are welcome to provide it to the committee secretariat who will pass it on to the committee in due course.

MR COCKS: I want to start with the considerations around children and young people. Minister, you have made various statements around the progress of this bill; where you started from; and where this bill has ended up. I am interested to understand, firstly, why you made the decision to not include children and young people; and, secondly, given that, why it is included in the review process.

Ms Cheyne: Thank you, Mr Cocks. I will speak to that. As you have heard from the Human Rights Commission, this is something other jurisdictions have also looked at, and at whether a mature minor—someone with decision-making capacity, Gillick competence—should be able to have access to voluntary assisted dying, especially because there are some examples overseas but also due to the principle nature of human rights and the Discrimination Act, so I will not repeat all the evidence that you have just heard.

It is why we did actively consult on that question, and it is why we took seriously the fact that we have heard from the community about it. During our consultation, we did hear some strong support for this, and I think the view that was generally put forward as a theme was that an age as a limit is arbitrary, and it really should be about someone's decision-making capacity. However, we also heard of the significant policy complexities of implementing something like this. So from a principle point of view, yes; and from a human rights point of view, yes, it ticks those boxes for a

mature minor. However, we would be the first jurisdiction in Australia. It would require significant safeguards, frameworks, guidelines. There is a question about autonomy. So should there also then be another layer of approval or acquiescence, I suppose, from a parent or guardian?

There are many questions to work through in terms of how it would operate—that, combined with the reality in a clinical perspective that it is not mature minors who usually die. I think we can probably go to Ms Zagari in a moment about this, but you will also hear evidence, if you have spoken to any VAD practitioners or even oncologists, that teenagers of decision-making capacity who have not reached 18 generally do not die of a terminal illness. That is the experience worldwide, and so even with countries elsewhere that have implemented this, we have basically transposed their data. For us, on a crude guess, it would be applicable to one mature minor every 50 years. So balancing the practicalities of all of the time and extra effort it would take to get to that point—and that it would likely seriously delay the implementation of this scheme—and given that we have heard from the community that they have waited long enough, in addition to the fact that it would not practically help many people, we have decided not to go with it now.

That said, there are many states—all states—that now have voluntary assisted dying that is operating. So we have included it in the review because we are taking a principle approach—a human rights approach—and thinking of safeguards and consideration of this issue, particularly in the states where it is operational at the moment. In states where they are beginning their own review processes, like Victoria is right now, they might emerge with more evidence, more mechanisms, more safeguards that we could take into account. So that is why it is for consideration in that review, but it is not a certainty that that would review would then result in its being legislated.

MR COCKS: There are a couple of threads there. To try and tie those together, you have said that from your principles approach, and from a human rights approach, it would be a yes, but there are complexities in how you would do it. So it sounds like that review would look to whether those complexities could be overcome, and, if so, then it sounds like you would be looking to expand into the group?

Ms Cheyne: I certainly would not comment on the hypothetical in that way, Mr Cocks. I appreciate what you are after here, but we do not know what we do not know, in the future. We do not know what is going to happen in three years' time, after it has been operational. We do not know what the sentiment will be in the community. But we have taken seriously human rights obligations, and we have also taken seriously what we have heard from the community—that there is some strong support—but neither of those things necessarily means that those barriers or obstacles could necessarily be overcome, and sentiment may change.

MR COCKS: To be clear, it sounds like you are not ruling it out?

Ms Cheyne: I am not ruling it in or out.

MS CASTLEY: A supplementary question. You talked about consultation, and some people said yes, it would be great to include kids. Have you heard much from families

about that younger group? It must be extremely hard to be a parent in that position. So I am just wondering what you heard.

Ms Cheyne: Absolutely. Ms Castley, I think it probably points a little to the point I made before. I am trying to be delicate here, so I may ask for some assistance from a clinical perspective, but the reality is that it is not mature teenagers who are at that point of their lives. So, yes, we have heard from some families where a young person has died in their early twenties, but when it was diagnosed as a teenager. And certainly, we do know that there are some illnesses that really do affect very young children, but in that age range that we are talking about for mature minors, there are not a lot.

MR BRADDOCK: Clause 11(4)(c) talks about individuals at the last stages of their life. There has been a lot of criticism from witnesses that it is legally ambiguous and potentially duplicative of other parts of the legislation. So I would like to get your perspective as to what unique contribution that clause is making, and how you might deal with any legal ambiguity about its phrasing.

Ms Cheyne: Thank you, Mr Braddock. Certainly, we take very seriously the fact that there are numerous submissions, especially from experienced practitioners—Mr Perrin, as well as academics—about the definition here. It is something that we will go away and consider, especially when we have gone through all of the evidence, and depending on, of course, the recommendations of the committee.

But the fact that numerous respected persons in this field, across a range of different experiences, have brought this to our attention meant that it is something that we were already going to take a closer look at. So the intent of our approach was to avoid the challenges the practitioners from all the states have shared with us, as well as individuals and their families, that a diagnosis where you have a timeframe within which you will die is very, very challenging.

Illnesses have trajectories that are pretty hard to predict because it can be based on a person's condition or health—whatever it might be. For example, in my own personal case, my father was told he may have 12 months to live, and he died in 11 weeks. So it is highly inaccurate, and there are plenty of stories like that from right across the system. I am not saying that my father wanted voluntary assisted dying—I will never know—but I think that is illustrative of how it is not a science; it is a guess. So it has been difficult with a six-month timeframe. Indeed, most bills across Australia, when they were first considered, had no timeframe to death. It has largely been, especially in Victoria, through political machinations to get the bill passed, that a timeframe has been inserted.

But what that means in a practical reality is that it is very difficult for practitioners to engage with. We have heard that from every single jurisdiction. That is why we have removed it, but we were also wanting, with that definition, to balance the fact that voluntary assisted dying is an end-of-life choice to help end intolerable suffering for an individual whose condition is terminal and is progressing—it is progressive—and that it is at an advanced stage; not on immediate diagnosis. That is in some cases. There are plenty of other cases where people just do not realise that something is gravely wrong with them and then they get their diagnosis. So that is the intent.

Whether the policy intent has been met through that definition is something that we will take a closer look at.

MR BRADDOCK: Thank you.

DR PATERSON: We have heard lots of evidence this week around the logistics of getting health practitioners across the legalities of the bill once it is implemented and the education and public awareness that this is an available end-of-life option. All these things have come up in submissions and evidence. I am just wondering if you can speak to what the implementation of this bill may look like, and the timeframes, and what the government proposes to do in terms of education and awareness.

Ms Cheyne: Absolutely. I will start and then I will hand over to our colleagues who will be doing the implementation. They can correct anything I say that might be wrong. The intention is to have an 18-month timeframe. This is consistent with the other states. I think there would be a contention that if other states have done it, and you are second-last of the jurisdictions, why couldn't it be quicker? But for us, because we do have some differences from what is considered to be the Australian model, we think 18 months is probably quite right for us.

There is going to be considerable training, and, as you know, nurse practitioners are also intended to be part of our scheme. That will be tailored, and there will be quite a lot of work, I think, in establishing the governance arrangements for the board as well as the care navigator service. I might hand over to Ms Cross, who can expand.

Ms Cross: Thank you. The Health Directorate will be leading the implementation, working very closely with Canberra Health Service, and, of course, JACS when we need to. There are probably about 10 major elements of implementation that have to be worked through. The minister has referred to governance, training, and the care navigator. There are a number of other elements which we can run through if you are interested, but, basically, we want to do it in a way so that all of the people involved in the scheme are not just trained, but have all of the information that they need, that for the public it is easy to understand and easy to access, and that all of the guidelines are very tight in the background. We can go through it in more detail if you would like.

DR PATERSON: Sure.

Ms Rad: As Rebecca said, there are almost 10 components, if not more, which is what other jurisdictions have experienced. And some of those key elements and deliverables that need to be progressed are: care and referral pathways across the health system, the establishment of a care navigation and pharmacy service, clinical guidelines, and workforce training and accreditation. As Rebecca said, there will be lots of communications and engagements, as well, with various stakeholders and community organisations, and the establishment of the VAD oversight board. There will be other elements that we will need to progress through. So, yes, it is similar to other jurisdictions. Most of them would have had, or have had, about an 18-month implementation period.

DR PATERSON: Thank you.

Ms Zagari: I might add to that, if that is all right.

DR PATERSON: Yes. Sure.

Ms Zagari: The experience in other jurisdictions, in particular, has been around the availability of workforce to participate in voluntary assisted dying, and ensuring that there is a sufficient uptake of practitioners, where if somebody identifies that this is the right decision for them, there is a workforce available to meet their needs. And that needs a period of time for people to work through whether, morally and ethically, it is the right decision for them to participate as healthcare practitioners, and to access that additional layer of education. So certainly, the experience—and I have had direct experience of implementation in another jurisdiction—is that there is a bit of a groundswell later on, and that you need enough time for people to develop a level of comfort around the way that things are going to be implemented, and to be part of the design of the implementation itself, to then be willing to participate as practitioners.

DR PATERSON: We heard evidence from Victoria that there was a really low uptake in practitioners. So what will we be doing here to ensure that that is not the case?

Ms Cheyne: There are a few things I can start with. First of all, as more states have joined or created their own scheme, there has really developed, now, a community of practice. So there is a lot of information sharing, and Go Gentle Australia has obviously played a coordination role, but in the third quarter of last year, Voluntary Assisted Dying Australia and New Zealand launched. So it is the peak body representing the VAD practitioners.

I am not sure if they are appearing, but I would highly recommend you talk to them, because the president is Dr Cam McLaren, who is from Victoria and is an oncologist, and supported the decision we made about mature minors, for the reasons I was explaining. He is excellent, and a great communicator, and his lead in that work and the sharing and coming together, I think, is very important. The first conference—the inaugural VADANZ Go Gentle conference—was in September last year. There were more than 200 people there—plenty of practitioners and academics, but also dying with dignity organisations. I was there for just one of the two days, but it was incredibly enlightening and helpful to hear stories from other jurisdictions.

So that is one thing. I think the point I really wish to underline is that bringing the clinical community along on the journey has been an objective of mine from the beginning. We wanted the health profession to have confidence in the bill that we were proposing. That is why we have taken so seriously the lessons learned from other jurisdictions where practitioners say, “This is resulting in perverse outcomes for whatever reason,” and why we are also making sure that we are consulting. We established a clinical reference group from the beginning.

I think, perhaps, even if you do everything right, as Ms Zagari said, it still takes time to build that groundswell. But it is even harder if the health community is being asked to participate in something that they did not help design. I think probably the best example of that is New South Wales, in that it was a private member’s bill. Mr

Greenwich took an approach where he did consult, absolutely, but, from what I understand, not with anyone who would be a practitioner in his bill. He consulted with the nursing and midwifery association, with the community and with his MPs to get the bill across the line, but the clinical community was not necessarily brought along. It probably would have been quite difficult with him not doing it through a government process. So I commend New South Wales and I commend Mr Greenwich's work. I think it was absolutely critical, and it may not have passed—we will never know—if it was any other process, but it has meant that New South Wales, even though it is the most recent to have operationalised its voluntary assisted dying scheme, is considered by most of the VAD community practice to be behind. And even Mr Greenwich, at the time of introduction said, "This is a conservative bill."

Victoria is considered the most conservative in the world, and there has been progressive consideration of what is working and what is not. Queensland's is now accepted across the community as working the best, and that was our starting point, whereas for New South Wales, Victoria was their starting point.

DR PATERSON: How much of an advantage are we at, having had other jurisdictions go through this process before us?

Ms Cheyne: At a huge advantage, I think. Probably the only silver lining of territory rights taking such a long time to be restored is that Victoria did pass in 2017, that it was operational 18 months later, and that, to everyone's surprise, I think, WA followed soon after—which was fantastic to see—and then Tasmania, South Australia, Queensland, then New South Wales.

Everyone has learnt a little bit more from each other, and I really commend Queensland for taking that seriously. They also had an enormously iterative process, again, bringing the community at large along but also bringing the clinical community along as well. My understanding—unless I am wrong—is that Queensland actually has had a reasonably good uptake from health practitioners, and it has been operating just over a year now.

MR COCKS: That conference you refer to as being the basis, was that the Go Gentle conference?

Ms Cheyne: Yes; and VADANZ.

MR COCKS: At that conference there was a particular group there. Would it be unreasonable to say that that conference was predominantly people who are strongly in favour of and often involved in advocacy for assisted dying?

Ms Cheyne: It was a voluntary assisted-dying conference; so, yes.

MR COCKS: What I am getting at is it was a particular perspective.

Ms Cheyne: Sure, because it was a voluntary assisted-dying conference; it was not a "do-we or don't we like voluntary assisted dying?". It was: "Voluntary assisted dying is operating in five states and about to be six and the ACT is going to be legislating for it." They had a day that was really focussed on the clinical community and then a

day that was more open. That was the day that I attended and spoke at. But, yes, it was a supportive room, because these are people who are engaged with voluntary assisted dying, not fundamentally opposed to it.

MR COCKS: So, just to be clear, that means the perspectives you would have been getting, when you talk about conservative jurisdictions, would have been coming from organisations like Exit and Go Gentle, who have a perspective which is at the very progressive end?

Ms Cheyne: What I would say, Mr Cocks, is that everyone there is engaging with voluntary assisted dying in some way. Mr Perrin, the former Northern Territory Chief Minister and the first person to bring in a Voluntary Assisted Dying Bill was there. It was intended to be—and I will read this: “A growing community of voluntary assisted dying health professionals, policymakers, peak bodies and health advocacy organisations” discussing the future of end-of-life care in Australia and New Zealand. When we talk about some states having more conservative bills, it is those practitioners that we have heard from—those practitioners in that room—who we have been learning from.

When I announced that we would not be having a time frame to death, there was spontaneous applause from the whole room. That is pretty powerful, to me, given we did have people there who have been operating—especially in the case of Victoria and WA—for a longer time in this space, with their conservative models, and they are saying, “This is the thing we need to change.” You would have heard, I am sure, from Dying With Dignity Victoria in their oral submission and in their written submission, that they are really hoping that the review that Victoria is conducting will look at this closely, because the six-month time frame to death, as I said, was never based on evidence; it was a political move to get the bill passed.

MR COCKS: Thank you.

MS CASTLEY: I have so many questions. Let us start with the ACT jurisdiction. I have asked a few people this. We are an island in New South Wales. Can you talk to me about the practicalities? I know if you live in New South Wales you can access it if you work here et cetera. But what about doctors living across the border? Could you just unpack a little bit about those considerations, with the differences in the bill compared to New South Wales?

Ms Cheyne: I will not rehash the evidence I have just given about how the New South Wales bill came to be and how ours came to be. Our bill is superior—there is no doubt about it—because of the consultation process we undertook and because we have had the advantage of being in government and being able to work across government and with our broader community. So, if anything, I would be hoping that, when New South Wales reviews theirs, that they then align closer with us. As you have heard, having things like time frame to death is roundly criticised by practitioners. So it would be silly for us to try to align with New South Wales when we know that the practitioners participating in that hate it.

MS CASTLEY: I get that. What about doctors living in New South Wales? How does that work?

Ms Cheyne: I probably need you to expand on what you mean by doctors living in New South Wales. Do you mean living in New South Wales and working in the ACT?

THE CHAIR: Yes, I think that is the scenario we are going with. We have had questions put to us about doctors who might work across both jurisdictions—so who might practise in New South Wales and the ACT—and meeting the requirements of two different schemes, how that works in practice and how realistic it is.

Ms Cheyne: That is something we are absolutely alive to, and there are a number of issues. I will first talk to the positive, which you picked up on, is the residency requirement. New South Wales and Queensland do have that exemption, as we intend to as well. So that is for the person. In terms of our clinical community and people who might be working in both schemes, that is something that we absolutely have to tackle and provide training in. My understanding is that, if a clinical professional wants to participate in voluntary assisted dying in the ACT and already operates in New South Wales, they would have to go through the ACT's training. But there is no reason that they could not be then accredited in both. Ms Cross, go on.

Ms Cross: The only other thing I would add is that, under the legislation, the entire procedure has to occur in a single state. So, even if you practise across borders, if you are dealing with it in New South Wales, the entire procedure has to occur in New South Wales.

MS CASTLEY: Yes; I understand. Thank you. That is helpful.

THE CHAIR: Just picking up there, you mentioned the training. This is one thing that has come up with the committee. We have had a number of witnesses say that it is important to make sure that there is training, and certainly learning from the Queensland example. We had some witnesses yesterday who said that they are just having introductory models. We heard from the Pharmacy Guild and the speech pathologists that there is a level of anxiousness, for lack of a better word—that they are just not quite sure where the boundaries. I think one of them put it to us that they do not want to inadvertently do something wrong or unintentionally do something wrong. I am quite interested—and I think other members of the committee are too—to actually understand what kind of training will be in place so that all health practitioners are comfortable with administering the scheme from day 1.

Ms Cheyne: First of all, again, the benefit of going second-last is that there are training schemes that have already been established. Certainly, Professors White and Wilmot, who I think you heard from yesterday, have been heavily involved in developing several of those, and I think that has added a lot of credence to them. Our training will absolutely be based on our scheme, and our scheme will have some key differences and those other things that we do need to stress to people as well. But I guess my message to those organisations who have a level of anxiety, which we absolutely appreciate, is that training has been undertaken in other jurisdictions very successfully and those schemes have been operating very successfully, and with little to no prosecution, except perhaps in Dr Carr's case. I think everyone wants to do the right thing here, and the care navigator service, I think, will play a central role in that

as will the board. But I will hand over to Ms Cross.

Ms Cross: I was just going to note that that is one of the elements that the implementation team will be looking at over the 18 months after the legislation passes. Once we have developed the training material, which will be done in consultation with all of the relevant people, it will then be mandated, so you will know that everyone has undertaken the training as part of being accredited to participate.

THE CHAIR: When we say “everyone”, that could mean different things to different people.

Ms Cross: The people who are VAD practitioners will have to undertake mandatory training. Even if they have done it in another state, they will still have to undertake the mandatory ACT training.

THE CHAIR: The evidence that was put to the committee that raises the question was around the situation where you are not a practitioner but you are a healthcare professional. Again, I look to the pharmacists, where they said they provide a lot of support to people who are receiving end-of-life palliative care and have a very trusted relationship with a lot of people who might be starting to come up against these questions. Their position was that they are an obvious first point of contact but may not necessarily be considered a practitioner under the bill, and their discomfort was just not having any guidance. I guess the scenario I am going to is not so much the practitioners but the rest of the healthcare profession.

Ms Cheyne: Ms Orr, I have an answer to that. Sections 125 and 126 make it abundantly clear that, as long as a person is acting honestly and without recklessness, that person is not criminally or civilly liable for conduct under the bill, including conduct that assists an individual to access voluntary assisted dying in accordance with the bill. That is deliberately a broad protraction that includes health professionals but also family, friends and carers, to the extent that they are performing a statutory function.

THE CHAIR: I think that sentiment goes to an aspect of the concern the Guild had. We also heard from the speech pathologists. They also provided quite a bit of information around this. Correct me if anyone else had a different interpretation of the evidence, but I think it was more saying, “Can we just get some guidance, so we know how to approach this?” My question comes back to the training. We have got training, but will there be, say, a general training on the scheme that can be available to health—

Ms Cheyne: I will pass to Chadia.

Ms Rad: This will all form part of our implementation planning. We are hoping to obviously progress with communications materials, guidance et cetera. We will be working closely with a range of health professionals and organisations like, for example, community pharmacists, and doing consultation throughout the implementation period to ensure that everyone is quite comfortable with any materials or information that we do develop and are aware of their expectations.

Ms Cross: There will be certain expectations. If you are talking to someone about VAD, you also talk about treatment options and palliative care. All of that will be made clear in the material. As I said at the beginning, we want to make sure that is really simple, so that people have an easy basis of understanding their obligations.

THE CHAIR: That is for the practitioners who, under the bill, will be able to implement the system. The part I am getting to are the health professionals who are not practitioners under the bill administering the system. It is just a gap that we sort of see.

Ms Cheyne: The point to stress is that, unlike other jurisdictions, our bill is clear that any health professional can initiate a conversation about voluntary assisted dying. That is recognising that stopping clinical discussions about lawful end-of-life options limits an individual's ability to make important end-of-life choices. We think that is really part of—

THE CHAIR: Okay. I think this is where the confusion from the Pharmacy Guild was coming in, though. They said, “Will we—

Ms Cheyne: Are they a health professional or not?

THE CHAIR: Yes; are they health professionals or not? Will they be included? Obviously, if you are a health professional, there is a whole suite of training and information that you are going to have to undertake. I am probably not going to press the point; I think we have made the point.

Ms Cheyne: I think maybe Janet could talk from a clinical perspective.

Ms Zagari: Whilst it is subject to implementation, planning and development, clearly there are multiple layers of education that will be produced, which will include that fundamental level which will be accessible by more than just a clinical workforce within a nook within the hospital, for example, or by medical staff, and will be suitable for what we term “health professionals”, and I would include pharmacists in that term—but people working in health—and layers of how expansive that education needs to be, according to the role that somebody elects to play within the voluntary assisted-dying spectrum of roles. So, absolutely, a base-level of education would be available to all people working in health, with the greatest breadth of description, is what we would anticipate.

Ms Cheyne: To clarify—and I appreciate I am probably jumbling things a little—there are health professionals that someone who is dying will have a closer relationship with. In those circumstances, where that person raises voluntary assisted dying or the health professional raises it then there are minimum standards that they have to follow. So they have a higher threshold because of the unique relationship that they have with that patient.

Then we have someone who is more ancillary to the patient's case, such as potentially a pharmacist—and, again, this is subject to implementation and may depend. I know that speech pathologists have raised some pertinent points, which we will look at. But if they do not have that quite unique, close relationship with the patient, they will not

be subject to the same minimum standards of information they need to provide.

THE CHAIR: I think it is fair to say that the hesitation was not so much for initiating conversations—because I think it is fair to say that health professionals will not do that unless they feel adequately trained. It was more if someone approaches them and just having the information at hand. But I do feel we have pressed this point, and I think we have made the point, and I am comfortable with where we are at.

MR COCKS: You have suggested any health professional. I have had concerns raised with me from doctors that it would not be appropriate for any health professional to initiate discussions and indeed that doctors without sufficient experience are not appropriately and fully equipped to have a conversation of this sort, where you are initiating a discussion. Do you see no risk?

Ms Cheyne: I could initiate a discussion with you today. Think about it that way. The same restrictions are not applied to general people. So my mother could have a conversation with me about it today and initiate a discussion with me, and she is not subject to those minimum standards. Initiating the conversation is very different from someone starting the process. I think that is the point that needs to be made.

MR COCKS: The big concern about the health practitioner relationship is that it is, by its nature, one of a power imbalance—a very significant power imbalance—particularly when someone is in a vulnerable situation. The idea that you could visit an osteopath who sees your health condition and the pain you might be in and says, “Have you thought about assisted dying?” is a concern, and it escalates the further up the scope of practice professions you move.

Ms Cheyne: Mr Cocks, I think there are many safeguards that then follow a discussion. First of all, a person who considers what has been raised with them then needs to be acting voluntarily. They need to meet all of the eligibility criteria, not just one. They need to make repeated requests. There needs to be a coordinating and a consulting practitioner who both need to independently verify that this person does not feel coerced or whatever it may be. There are significant penalties for coercing someone to participate in voluntary assisted dying. I think all of these protections really do mitigate the risk that you are talking about.

MR COCKS: So you do not think that there is any limit that should apply to which practitioners—

Ms Cheyne: Can you give an example of what the limit would look like?

MR COCKS: Well, should a massage therapist be able to initiate that discussion?

Mr Ng: Mr Cocks, probably the contribution I would make to that discussion is that the risk that you are articulating and the special relationship with trust are dealt with in the bill by a couple of directly correlated safeguards about the minimum requirements for the initiation of conversations. So medical practitioners and nurse practitioners who initiate discussions on VAD are required to ensure that the person also knows treatment and palliative care options available to the person and also the likely outcomes.

There is a second tier of practitioner, which is dealt with via another safeguard. Those are registered health practitioners. That term takes a meaning across a few different statutes. But, essentially, they must be registered with a statutory professional body. So it does not mean everyone who considers themselves to be a health practitioner. There are particular health practitioners that are registered under the Australian Health Practitioner National Law. Those practitioners, including social workers and counsellors, can initiate conversations about VAD. But they must ensure that the person knows about palliative care options available and that the person should discuss these options with their treating doctors. That kind of gives you that triaging set of safeguards, depending on what category of health practitioner you are.

MR COCKS: Okay. But the ACT has fewer safeguards than other jurisdictions in this bill.

Ms Cheyne: Like what?

MR COCKS: For example, the safeguard of a prognosis period, which we have discussed.

Ms Cheyne: That is not a safeguard.

MR COCKS: That is your position.

Ms Cheyne: It certainly is.

MR COCKS: However, a number of people have put to us that that would be a helpful safeguard. This bill goes further in a number of respects than other jurisdictions, and it seems to me that a restriction on who is able to initiate those conversations and what qualifications and experience they should have would be a reasonable step.

Mr Ng: Yes, Mr Cocks, and that is what I was intending to articulate, and it exists currently in the bill. Depending on which category of health practitioner you are, whether you be a medical practitioner or a registered health practitioner, what would be the act would set out minimum requirements for the form of the initiation of the conversation and the content of that conversation with respect to advice about either treatment options, palliative care treatment options, or suggestions about discussions with treating medical practitioners. So to the extent that you were talking about the existence of minimum requirements for practitioners who engage in this activity about initiating conversations, that is what the bill intends to achieve.

MR COCKS: So the bill currently does not specify anything to do with how the conversation would have to occur in terms of the form of how you would put the option to someone?

Mr Ng: No, Mr Cocks. It does not go down to the level of the particular constitution of sentences or does not provide a script and the like, if that is what you are alluding to. What it does is generally prescribe the content of what the conversation must include. The remit of what sits around that is up to the practitioner's discretion to

some extent. But, as the minister referred to, there is also the strong protections by way of criminal offence on coercion and dishonest procuring, if you will, of people to engage in a voluntary assisted-dying process. What I would say about the framework is that those different parts must be seen together in terms of the safeguards that you are alluding to.

MR COCKS: Okay. Thank you.

THE CHAIR: We have had some concerns put to us that the bill as written does not adequately safeguard against a person with a disability being coerced into accessing VAD as an alternative to other supports. I am interested to hear from you how you see the protections and the safeguards for people with disability working within the bill and particularly how you see them preventing coercion.

Ms Cheyne: Thank you, Ms Orr. If I may, I will take this as an opportunity to perhaps correct some of the evidence you heard earlier this week that said that the consultation was flawed with our disability community. The bill does contain a number of safeguards, which I will go to shortly. But I do want to stress that Advocacy for Inclusion, in particular was regularly briefed and feedback was sought from them, and through the Disability Reference Group, and we offered Advocacy for Inclusion the opportunity to review a draft of the bill, which they declined. I hope that is useful context in terms of some of the evidence that you have heard this week.

I think the most important thing I can draw your attention to is that very early on in the bill, having a disability or a mental illness alone is not an eligible condition for accessing voluntary assisted dying. I do not think there could be any clearer safeguard than disability is not an eligible condition. A person must meet all of the eligibility criteria, including if they have a disability or mental illness. They need to have a condition from which they are dying and it is terminal, progressive and advanced. I think that is very clear and it is referenced throughout the bill but apparent in one of the early clauses.

THE CHAIR: Can I get your interpretation on the application? The scenario that was put to us was that there are disabilities that will be terminal—that will result in death—and could have a significant impact on an individual, particularly if they were not provided with adequate supports to live a comfortable life, that it was the nature of the disability to therefore cause death to have a significant impact and cause suffering that suddenly opened up voluntary assisted dying to that person as an option and that, without the time limit, the time frame to death, they could access that at quite an early point in their medical journey. That was the proposition that was put to us. I am interested to know if you would agree that that review had consideration of that perspective.

Ms Cheyne: We have. The starting point is that the person needs to be dying from the condition and that it is advanced and progressive. Someone may have a condition where they know their life will be shorter than otherwise for someone else, but that alone would not make someone eligible. I might see if Ms Zagari can expand on this, especially given her role in implementation and understanding.

Ms Zagari: Thanks, Minister. I would be keen not to get into specific disease

conditions, particularly if the bill does not go there. It really does come down to that advanced and progressive nature. It is the combination of criteria. Merely having a life-limiting disease that is associated with a considerable lifespan remaining does not then meet the criteria around “advanced” as is currently framed. It does talk about last stages of life. Whilst appreciating the concerns that have been raised around the wording—and, as the minister has indicated, that will be for review—the importance of that concept is around this is an end-of-life provision. So it is not enough in and of itself to have a life-limiting condition to therefore be eligible to access voluntary assisted dying. It is about an end-of-life decision with that combination of factors that lead to that eligibility and as assessed by the practitioner.

THE CHAIR: In the application of the clause it says disability is not a reason to access the scheme, and you have got the combined criteria. How do the two interact when the condition that might be life limiting and leading to the end of your life and be advanced and be progressive is a disability?

Ms Zagari: I am not quite sure how to frame an answer to that because there will be certain conditions that might be considered a disability and are at end-of-life.

THE CHAIR: That is exactly the point I am getting to—when they are the same thing, yes.

Ms Zagari: There will be a need for a clinician assessment to determine whether that is at a sufficient stage. I could not comment further than that—whether we need to take something on notice but it would be difficult to frame.

THE CHAIR: If you could consider that and take it on notice, that would be helpful.

Ms Cheyne: It is why we have tried to define what we mean by “advanced”. Again, underlining what Ms Zagari said, we appreciate there are some concerns with that. But, if “last stages of life” remained, then that certainly speaks to what we are talking about here. The person potentially then would become eligible if they were assessed as being in the last stages of their life. And, remember it is by several people, and they have to be acting voluntarily, with no coercion.

We do not want to talk about specific conditions, because it can depend on a range of factors. But I would not include lack of support or economic factors as being anywhere near part of a consideration for a practitioner. That just would not be able a layer.

THE CHAIR: As well as disability, we have had people raise instances of elder abuse and people being coerced through that. But, moving away from coercion, the other part that has been put to us is people who may just feel that they are a burden. So it is not something that has external influence; it is something that they internally are working through. In this situation, I would be interested to know how you see the scheme working for identifying what might be something where a person needs support rather than necessarily an option for voluntary assisted dying.

Ms Cheyne: Again, the most important factor to stress here is that all eligibility criteria must be met. It is not one or the others; you have to tick all boxes. Feeling like

you are a burden, feeling like you may not be contributing much in this moment, is not enough. You must have a condition that is limiting your life and is terminal and is progressive.

THE CHAIR: In the assessment process for determining whether someone has the decision-making capacity to access the scheme, is this something that would be considered as part of that process by clinicians, by psychologists and health professionals?

Ms Cheyne: Could you reframe that question?

THE CHAIR: Yes. In determining whether someone has the decision-making capability to access voluntary assisted dying, in a circumstance where their main motivation might be because they do feel that they are a burden, is there something within the process to assess whether they have the decision-making capability that would essentially tease out that their motivation is not life limiting but is actually from a point of not feeling comfortable in the circumstances that they are in?

Ms Cheyne: I think it is less about decision-making capacity—which is one of the eligibility criteria—and more about whether they have the condition.

THE CHAIR: So I guess my question then is: how is that assessed to make sure that it is excluded?

Ms Cheyne: It would not be an eligible condition. The condition has to be life-limiting.

THE CHAIR: I understand that. I think the nuance that we are missing here is that circumstance where someone might have a condition that would count as life limiting. We have just discussed various conditions. There are disabilities that we will accept. So it is where it would meet that criteria.

Ms Cheyne: If they are dying from something and then feel like a burden—

THE CHAIR: Yes.

Ms Cheyne: and that is their motivation for requesting. Again, that is where we have two practitioners who both need to make the assessment. A person's request needs to be repeated and enduring. They have to make it three times, including in writing. We do hear, especially in Australian jurisdictions, that there are people who are at the end stages of their life and may be at a point where they wish to have the option, even if they do not take it. Having control over the end of their life by being eligible, going through the process and receiving the substance is enough and gives them the satisfaction and almost a palliative effect that they have choice. I think we really do need to be not underestimating the role of our health practitioners in being able to assess a person. I guess self-coercion is within that.

Mr Ng: Minister, I might just add to your evidence there. The bill does seek to prescribe this well. The minister has described these various points of the process where health practitioners are making these assessments about capacity, which much

be enduring the whole way along. I would refer the committee to clause 12 of the bill, which sets out the meaning of “decision-making capacity”. That prescribes the relative considerations that health practitioners will need to go through when deciding whether decision-making capacity is present for the particular patient.

Those things include understanding the facts that relate to the decision about accessing voluntary assisted dying, understanding the main choices available to them in relation to the decision and weighing up the consequences of the main choices, amongst other things. We see a range of different applications of decision-making process assessments across a range of different statutory frameworks. In this context, given the gravity of the decision that is being made, the bill seeks to spell out and prescribe how that decision-making capacity is actually assessed by health practitioners.

MR COCKS: One of our jobs, as I have said before, is to test the edge cases. We do have to get into hypotheticals sometimes and we do have to get into specific conditions sometimes. In this instance, one of the fears that has been put to me is that it is not necessarily about coercion but about influence, particularly for people in vulnerable situations. It has been in the scenario of someone in a domestic violence circumstance who is diagnosed with an illness which will eventually lead to death, but they have the potential of a good life between the two points, and the partner in that instance gets frustrated with needing to care for the person and says, “You may as well kill yourself.” I would hate to think that could happen, but it could. How does this protect against those situations, because it is more than just about bureaucracy?

Ms Cheyne: Of course. Absolutely, Mr Cocks. To begin with, there is a serious penalty. What you are talking about is coercion. That would certainly fall under that definition. I believe coercing someone to engage in the process attracts a maximum of seven years imprisonment, and coercing someone to take the substance attracts life imprisonment. Those are very serious penalties in the first place.

Throughout the process, in every request that the person makes, they have to be acting voluntarily and acting without the influence of coercion. There are very significant penalties. It has to occur throughout and they need to have a witness. That is a further protection that is offered. Of course, they can choose who that witness might be. I think those factors combined together make a really strong protection for the person.

I appreciate you testing the edges, but what we have heard, and we have provided for this in the bill, is what is more common. Dr McLaren has used the term “reverse coercion”. A family member may say, “I’m in pain. I would like to die. I want to participate in this process,” and family members may say, “No. We won’t let you. We need as much time with you as possible,” or whatever it may be. That is also considered in the bill, but the penalties are much, much less where that occurs. That is way more common than the coercion that you are talking about.

MS CASTLEY: On reverse coercion, we heard from the multicultural community. They raised it, if I am remembering correctly. I am wondering what considerations you have with regard to the multicultural community.

Ms Cheyne: We have engaged with the multicultural community. They also put in a

submission, and we have heard from them, which is fantastic. I understand several practitioners put in submissions, but you have not had a witness who is a practitioner. I think it would be quite powerful for you to hear from someone like Dr McLaren, who has considerable experience and can give you real examples of what it is like in a practical sense. I appreciate today is your last day, but I think it would be useful for the committee to understand what actually happens and have the voice of a practitioner.

THE CHAIR: We will take that on board. Going back to the question—

MS CASTLEY: Going forward, what consideration will you be giving—and this is possibly to you, Ms Rad—to communicating with the multicultural community to avoid reverse coercion? That was quite a concern—

THE CHAIR: That was the example they gave—

MS CASTLEY: That was the example they gave—everyone—

THE CHAIR: Everyone you go to can make the decision.

MS CASTLEY: In the Indian community, one gentleman said they refer home.

Ms Cross: As we said, during the 18-month implementation period, we will be consulting with all stakeholders and making sure that information about the scheme, including that you cannot have reverse coercion, is available in a simple way. For the multicultural community, that will be in a way that is suitable for that community. It may be that we provide some of that information through trusted leaders of the community rather than just social media. We have that 18-month implementation period to work through that, and the aim is to make sure that it is all culturally appropriate and simple.

THE CHAIR: Dr Paterson.

DR PATERSON: My question is with respect to the health practitioners, outlining for the committee their experience and expertise in dealing every day with people who have significant disease or disability or experience family violence and come into their care—reiterating for the committee their expertise in this matter.

Ms Cheyne: Sorry—can you say that again? I missed the beginning.

THE CHAIR: I think Ms Zagari was nodding her head, so she might have an answer to this.

Ms Zagari: I am happy to take that. Thanks, Dr Paterson. We have a community of very skilled practitioners, and, regarding the spectrum of health practitioners that would be part of this, we would anticipate the involvement of general practitioners and hospital specialists—a real continuum of expertise and people who, every day, deal with diagnosis and assessment of terminal illness, how advanced it is, and whether the conditions will cause death by whatever means. It is phrased that they are the last stages of a person's life. All those criteria need to be met. But they may also

deal with people in situations of domestic violence and where coercion may exist—being able to understand and assess the motivation for making a request and whether somebody feels that they are a burden; giving consideration to that in reaching a determination around whether somebody would actually be eligible under the legislation, and that the request that they make is truly voluntary at each stage. I would provide assurance that we have included practitioners of many disciplines.

THE CHAIR: On this train of questioning around the family, the carers and the communities of people who might access voluntary assisted dying, we had Carers ACT appear—and it has been raised in other submissions as well—and they questioned what supports are in place for them. I think it is fair to say that we have heard from the families of people who have experience in their own life, and they have said it has been quite traumatic as well. I am particularly keen to know whether, under the bill, it is the care navigation system or whether additional supports would be provided to the family. That also might go part of the way to working through this reverse coercion issue.

Ms Cheyne: To start with, within the 18-month implementation period, we will explore some of the key functions of the pharmacy service, such as providing education and providing support about the approved substances, especially to the person who is accessing them, their family members and the administering practitioner. That is a critical point for people to understand and be supported on. There will be work taking place during the implementation period as well about what sorts of supports people need in those circumstances. Again, we can draw from evidence that we have had from other jurisdictions, but Ms Rad might be able to—

Ms Rad: Janet, do you want to—

Ms Zagari: CHS would be delivering the care navigation service, and the pharmacy service should at least go forward. In the implementation phase, we have already given consideration to the requirement to include psychological supports and for that to continue for a period to families, carers and loved ones of the individual after death, as well as support for them through the process. I cannot give you specific details on what that will be. Clearly, we need to design a service and—

THE CHAIR: Pointing to the Carers Recognition Act, Carers ACT also raised making sure that any response from the voluntary assisted dying system and approach also meets the requirements of that particular act. I will just throw that out as a consideration. The other part that was put forward from, I think, Carers ACT was that, when you are at the point in your life where voluntary assisted dying is something you are considering, you are most likely going to have a carer, and the carer may not be of the same view. You need to reconcile those issues. We need to talk about the psychology and the supports. Will that be a consideration where there is conflict and conflict resolution? It was put to us that it would not be beneficial for anyone to have conflict between carers and individuals on people's death beds.

Ms Zagari: Just as a general observation, I do not think this is unique to the ACT. As the minister said at the beginning, we have the advantage that we can talk to our interstate counterparts and find out what has been working in the administration of their schemes. That is certainly something that we would want to look at: drawing on

what is working in other jurisdictions.

THE CHAIR: That is good. The point I am going to, though, is wanting to get a sound understanding, because it has been raised with us that there is no clarity.

Ms Cheyne: Is there going to be a conflict resolution service?

THE CHAIR: No—not so much that. What has been put to the committee is that these issues, on the face of it, do not appear to have been considered. What I am seeking is reassurance that they will be considered and through what avenues they would be considered.

Ms Cheyne: The care navigator service is that central point. It will be able to provide generalised support and explanations and will assist people to understand the process, as well as provide individualised support to people. That will include providing support to carers about what they need to do to support their person through the process.

Ms Zagari: I could add to what the minister said. Those things will be considered during the implementation process. Having seen the submission from Carers ACT, we certainly have included it on the list of things to consider. We will need to design a service and include that.

THE CHAIR: At the heart of my question is: has something been determined or is it still to be determined?

Ms Cheyne: It will be part of it. That is a certainty. In terms of exactly what it looks like, that is something that we would be looking to essentially co-design with affected organisations.

THE CHAIR: It is a project for the next 18 months.

Ms Zagari: Correct. The consultation and inclusion of Carers ACT, among others, has already been identified and included in the plan for how the design phase would be undertaken.

THE CHAIR: Thank you. Mr Cocks, I might throw to you for a substantive if no-one has supplementaries.

MR COCKS: I do have something on this line.

THE CHAIR: I will give you one question, because you have had a lot of questions, and then I am going to go to Mr Braddock.

MR COCKS: I was going to say I do not mind. If you consider this—

Ms Cheyne: We have been through five substantives.

MR COCKS: I want to go back to the start of that line of questions.

Ms Cheyne: You will have to remind me what it was.

MR COCKS: You brought up the issue of this thing called “reverse coercion”. In my opinion, I am not sure coercion has a direction.

Ms Cheyne: It is an informal term, but it is effectively the opposite of coercion.

MR COCKS: I understand. Where a lot of the concerns were coming from, and I am not sure we got to this in that line of questioning, was that, for carers, the multicultural community and a number of individuals who provided submissions around their experiences, assisted dying is not just an individual matter. It is not just a personal choice. It has impacts and generally involves people more broadly. This thing you have called “reverse coercion” applies to persuading someone to rescind an order around assisted dying. Is that correct? Is there not a risk that we are criminalising persuading someone to live?

Ms Cheyne: Mr Cocks, there are a few things there. It is about balancing that, when a person is dying, it affects more than just them. It is also about recognising their rights, including the right to autonomy and to make decisions for yourself, and, yes, there can be very difficult repercussions. I would point out that the penalties for coercing someone not to go ahead with it are much lower and, therefore, proportionate. Again, drawing on the broad protection I was talking about before—sections 125 and 126—as long as a person is acting honestly and without recklessness, they are not criminally or civilly liable. So, to the extent that a family member or a carer or a friend is performing their statutory functions under the act, they would not be found liable if they were not behaving recklessly or dishonestly.

MR COCKS: That recklessness and dishonesty test seems to still be somewhat less than clear—exactly what could or could not be considered in that space. It seems that there could still be a risk.

Ms Cheyne: I am pretty sure recklessness has a legislative definition—

THE CHAIR: Mr Braddock.

MR BRADDOCK: You talked about the responsibility of facility operators.

Ms Cheyne: Yes. I thought we would never get there!

MR BRADDOCK: I agree with you! We received a wide variety of perspectives. I just want to check: some submitters were of the view that there was the possibility, under the legislation as drafted, for facilities to obstruct access to VAD, where they make what is reasonably a practicable assessment. They actually suggested that we move closer to the Queensland model in terms of allowing access to VAD. I want to check with you whether you had consideration of that.

Ms Cheyne: Yes. Absolutely. An individual’s conscientious objection and a facility’s obligations under the act are covered in parts 6 and 7. An important distinction to make in the first instance is that I do not believe the evidence that Professors White and Willmott gave was about—and perhaps I am wrong—the residency, because in

Queensland that is proving quite complex. There is a different set of rules for someone who is a permanent resident and someone who is not a permanent resident. We do not have that distinction here. I believe it was about the test that a facility operator needs to think through or apply in deciding whether reasonable access should not be hindered or that a person be taken to another place. We are taking seriously the suggestions that Professors White and Willmott put forward in terms of that language, but we do not have a view on it as yet.

MR BRADDOCK: It was broader than just those two. I believe the Clem Jones Group was advocating for that as well.

Ms Cheyne: Sure.

MR BRADDOCK: Secondly, there were also arguments about requiring people to potentially leave the home that they have known for a considerable length of time, going through the pain, discomfort and whatever else of the move. Is that a reasonable requirement that legislation puts in order to allow protection for the operator?

Ms Cheyne: Yes. That is exactly where our policy intent is, Mr Braddock. It is that a person should only be transported away from the facility when the circumstances really do require it. It is not in terms of someone gaining access and qualifying et cetera, and there are no barriers to access. It should not be a case of either/or. That is not the circumstance we are thinking of. Let's say you are living in Uriarra and there is a nursing home there. That is as far away as I can think of. Let's say you are in a nursing home and you would like to access voluntary assisted dying, but there is no one at that facility who is qualified or can provide the necessary supports, and the only way is that you come to a place closer to Canberra. That is a pretty weird hypothetical. That is where there would be no way to get access into the facility, because there is no support there. I think I am jumbling it up now. I am sure someone has a better example.

MR BRADDOCK: That is all right. I will ask a follow-up question. Given the market concentration of faith based organisations in the aged-care sector in the ACT, is it likely that the option will be readily available for people to seek a place to transfer to?

Ms Cheyne: Yes. That is through part 7. Operators must provide reasonable access to the person wishing to access voluntary assisted dying so that they do have equitable access to services, no matter where they are accommodated or what the religious association might be of that organisation. We know that this is sensitive and complex. We have certainly heard from and will consider some of the evidence that Calvary put forward, but I would note that, for people who want to access voluntary assisted dying, it does not discriminate, and it does not discriminate on the basis of religion either. For some people, it really might, but for some others—and you would have heard from Christians who support voluntary assisted dying—faith does not necessarily interfere. Also, someone might be in a faith based facility and think they would never expect to have access to VAD and then be in a situation where they decide, “Actually, no—I really do want to have access.” We want to make sure that we are being equitable. Moving someone who is in the last stages of their life—and often people only apply for voluntary assisted dying when they have come to terms with the fact that they are dying, and that can be quite late in the piece for them—and having to

move them when they might be barely able to would potentially be hindering access. But it depends on the circumstances, and again I am botching this.

Mr Ng: Minister, I could—

Ms Cheyne: Please do. That would be great.

Mr Ng: Mr Braddock, there is the kind of circumstance you are describing, as well as an individual finding themselves in the circumstance where they are in a particular facility and are not able to access voluntary assisted dying processes. One feature, and it is a forward-information feature which appears in other discrimination laws as well, is the obligation to have some public transparency about the manner in which facilities will comply with their obligations.

I refer to the committee to clause 103 of the bill. Facilities will have a policy which articulates how they comply with their obligation. Regarding the minimum standards that we are talking about—providing reasonable access and the like, and facilitating transfer where reasonable access cannot be provided—the facility operator will be obliged to have a policy which articulates how they will go about doing that. The intention is that the policy will inform decision-making around which facilities people find themselves in, appreciating that there is a range of factors which impact on those decisions. I just wanted to draw the committee’s attention to that clause, which sits together with those general facility obligations.

DR PATERSON: I have a substantive.

THE CHAIR: I will ask my supplementary and then we will move to your substantive. It has been put to us that, should a facility not have the capacity to offer voluntary assisted dying, or should the facility, though conscientious objection, choose to not offer voluntary assisted dying—and I appreciate that is problematic, but we will just take that for what it is at the moment—as long as they are transparent in making that clear to someone, the opportunity for the person to choose an alternative facility is enough to meet the requirements of the bill. I would like to get your view on that, and the real-world reality of how many alternative options are out there.

Ms Cheyne: Thank you, Ms Orr. I think that is a good point to stress. Yes, especially in the ACT, many of our aged-care facilities are faith based. If that approach were taken, that would immediately limit a person’s ability to have equitable access to voluntary assisted dying. And, yes, I can absolutely see a circumstance where someone reads that and says, “I still want to live there. That will be fine. It will never affect me,” and then they get to a point in their life where they are intolerably suffering, do want to have that access and might not be able to leave the premises. Again, it is about equitable access and providing for a range of circumstances. As I said, death does not discriminate and nor does someone’s desire for voluntary assisted dying.

THE CHAIR: Is it fair to say, in your consideration of this issue, that, while in theory it is possible to have alternative places and to rely on that, in practice it is a bit more complicated and would not necessarily meet—

Ms Cheyne: Absolutely. That is part of the challenge that we have seen in Queensland as well, with their distinction between permanent and non-permanent residents. Having a different approach is confusing—it is hard for people to get their head around—compared to having a straightforward approach that achieves the objectives of providing equitable access. That is what we have intended to do in the crafting of this bill.

THE CHAIR: Dr Paterson, you have a substantive question.

DR PATERSON: We have talked for a week now about a substance. Is it a substance, or is it a dose of an existing medication? How is it regulated? What is it?

Ms Zagari: I think the advice is that we take the question on notice around the substance, is it not?

Ms Cheyne: We can go to some parts of that question. Not all.

THE CHAIR: Can I ask why we cannot go to all? Is it just because you do not have all the information, or is because there are sensitivities around providing the information publicly?

Ms Zagari: Certainly, there are sensitivities around providing the information publicly, which would not permit us to go to that level of detail.

THE CHAIR: Dr Paterson, would you be comfortable taking the question on notice, and the committee can consider the answer in confidence?

Ms Cheyne: I can certainly talk openly about the oversight of the substance.

DR PATERSON: Yes. I guess that is my main concern. What is the oversight of the substance? Does it have adverse consequences—is it a quick death? What is it?

Ms Cheyne: All right. Let me talk about governance oversight, and then let me—

THE CHAIR: Sorry, Minister. Just to interrupt: the other thing we can do, is to go in camera.

Ms Cheyne: I do not think it is necessary.

THE CHAIR: Okay.

Ms Cheyne: Just bear with my answer and then we can decide.

THE CHAIR: Sure.

Ms Cheyne: There are safeguards built into the bill around the dispensing, supplying, possession and disposal of approved substances. That is a very live issue. As I have mentioned before, there are many other people in other states who gain access to a voluntary assisted dying substance but never use it, so then that substance obviously needs to be disposed of. I think there was a situation in Queensland where it was not,

and that was obviously taken incredibly seriously, and there are penalties.

So ensuring that this is as robust as possible will be a matter for the implementation period, but some of the issues that we have been focusing on already are that mainly the approved substance will only be able to be dispensed from the authorised pharmacy service, and they will need to maintain a register about supply, possession and disposal of approved substances. They will need to know when substances are about to expire or when the approved substance needs to be returned for disposal, and they can and will be able to take proactive action to ensure that persons who are in that possession are fulfilling their legal obligations.

There will also be a voluntary assisted dying oversight board, which will receive reports each time an approved substance is prescribed, dispensed and disposed. To go to your question about what it is like, I would really underline, again, to speak to a practitioner who can talk you through the process, perhaps in camera. But also there are countless public stories out there from family members who have experienced it, and I think that should be what the committee draws evidence from; not my explanation.

DR PATERSON: Is it regulated by the Therapeutic Goods Administration?

Ms Cheyne: Yes.

DR PATERSON: Is it approved through them? Is it the same substance that is used across Australia?

Ms Zagari: Yes. By them.

Ms Cheyne: I think so.

Ms Zagari: So we really do have to take questions on notice about the very specifics of the substance. We are restricted in what we are able to say publicly. We will say it is absolutely governed by the same safeguards that exist around other medications and that there will, during the implementation period, need to be some consideration by the Chief Pharmacist. One of the working groups will be around pharmaceuticals, the substance specifically, and any changes that are required to the legislation in the ACT to deal with this substance specifically, as have been required in other jurisdictions.

Ms Rad: Just to add to Ms Zagari's response, the pharmacy protocols developed throughout the implementation period are similar to what other jurisdictions have done—so, comprehensive protocols.

Ms Cheyne: And to the act that regulates it, it is the Medicines, Poisons and Therapeutic Goods Act.

THE CHAIR: Ms Castley has a supplementary question, but I will just jump in there. Maybe, if it is not too burdensome, would you be able to provide on notice to the committee just what things will be considered during the implementation phase? We have already heard about the carers' supports, and we have now heard this. I think it would just give the committee a good oversight of what was coming next.

Ms Cheyne: I think we can absolutely do that.

MS CASTLEY: I think my supplementary question has been answered. The concern from the pharmacy groups was what the impact would be to them with regard to storing, registers and things like that. I think you just answered that. Over the implementation phase, I would assume you will liaise with them and look at other practices?

Ms Zagari: If I might, Ms Castley, the sole pharmacy supply would be through CHS. It is a designated pharmacy only.

Ms Cheyne: Yes. So one authorised pharmacy, with CHS.

MS CASTLEY: Sure.

MR COCKS: I have a supplementary question on that. I am just trying to make sure we have the best possible legislation here. The concern that has been raised with me, including by advocates for assisted dying, is around the handling of the substance after someone dies, in particular in the instances where an individual dies without using the substance, and the speed with which it is imperative that that substance is retrieved to avoid the situation that I believe occurred in Queensland, where we saw someone suiciding using their partner's VAD substance. Can you tell me: how quickly are we looking at getting the substance back, and exactly through what mechanisms?

Ms Cheyne: That goes a little bit to what I said before. They will be able to compel a person to fulfil the legal obligations, but also the pharmacy has obligations on it. And remember, it is the one pharmacy service, so they will be skilled within that. They need to notify the board the moment the substance is returned, and, again, there is that central register, and the information is going to be communicated about someone if they have died and there is an unused substance.

So if there is an unused substance and it has not been returned, my understanding is that the board will know and if the pharmacy service has done everything they can, then I think the board has further powers.

MR COCKS: I am really keen to understand the timeframe. How long? What is the maximum that this could actually be in someone's home and presenting a risk?

Ms Zagari: Mr Cocks, if I can just jump in. The bill, section 65(2) and 67(2), refers to this. But it is 14 days where the pharmacists will do a proactive follow-up—14 days after the person's death they will do a follow-up.

MR COCKS: Thank you. And that does seem to be a long time. It has been put to me that, really, this stuff should be back within 48 hours to offset the risk to the community, and the risk of suicides associated with it.

Ms Cheyne: I think, Mr Cocks, our approach has been to draw from other jurisdictions, and of course, where the committee has made recommendations for

disposal. I would say that losing a loved one, whether you know they are about to die or not, is incredibly traumatic.

MR COCKS: Absolutely.

Ms Cheyne: I understand the point that I think you are trying to make, but I also think there is a point where we need to balance the burden on families who are also navigating funerals, broader family engagements, wills, changing all of the ephemera that you have to change. All of that takes a toll, and so I think there is a balance to be struck about the requirement. But I certainly take your point that the longer it is, the riskier it is.

MR COCKS: Thank you.

THE CHAIR: Mr Cocks, I am going to end it there. Ms Castley and I have substantive questions, and then in the last 10 minutes we will move to final questions.

MS CASTLEY: I think I have asked nearly every group this question about conscientious objection, the two-day turnaround and criminal liability. We have heard from the College of Nurses, who said that 48 hours in any medical practitioner's life is unlike any other person's world and that that is potentially too short. They are not the only ones that said two days is too short. Of course, we have people on the other side that they want it sooner if possible. But, in light of the criminal liability, I am just wondering how we got to the point where, for the ACT bill, we are going to proceed with charges after a two-day period.

Ms Cheyne: It is a great question, Ms Castley, and I am happy to speak to it before I might throw to others. We absolutely support a conscientious objector's rights to their beliefs insofar as they do not interfere with a person's other beliefs or their autonomy. That is what we are trying to balance here with this referral.

I think we have heard through this valuable evidence that two days seems very difficult for some health professionals—perhaps all. It is something that we are open to having a closer look at and seeing what the balance is that we might need here. Again, stressing that, often when a person comes to terms with the fact that they are dying, it is in the final stages, so a time frame that is a bit too long can have some pretty serious consequences.

MS CASTLEY: Of course, and you have to balance both. I completely understand. I would hate people to get criminally charged because they just could not turn it around.

Ms Cheyne: I think that point is absolutely valid, as is the point that you have heard in evidence, especially if there was good intent and simply work gets in the way. I think we can all understand those circumstances. It is something that we will look at. As I said, this is all about trying not to exacerbate a person's suffering—because, if they are seeking to be part of this, they are intolerably suffering. We recognise there is a balance here.

We can look at the cooling-off period in Victoria of nine days. I think it is in the document that I have here. I can table it. It is a worthwhile document. There was a

review of the first 334 patients. During the cooling-off period no-one changed their mind and those who withdrew, withdrew because they died.

MR COCKS: I do have a very, very quick question.

THE CHAIR: You can have a very quick one, Mr Cocks, because you are very good at supplementaries and you have had a lot of them.

MR COCKS: Indeed. The other half of those requirements is the strict liability. That is the other concern. I am interested in why you made the decision to have strict liability on those offences.

Mr Ng: Mr Cocks, in the ACT, decisions about the categorisation of criminal offences are guided by a policy document called *The guide for framing offences*. That sets out some general criteria about when offences are characterised as strict liability and the obligation to explicitly say so is in the legislation. In this circumstance—and probably just vis-a-vis the general policy principles—they are generally amenable in circumstances where individuals who will be subject to the offence should know or ought to know their obligations in this space and they are applicable in circumstances such as where it is necessary to ensure the integrity of a regulatory scheme, for example. Here we are talking about a context where it is a highly regulated affair, the entire process of voluntary assisted dying, and the strict liability offences in large part apply to those who have professional obligations to operate in this space. So, having regard to that policy document, it was considered that these offences were amenable to strict liability.

MR COCKS: Did you consider that these offences are in the space of people who are conscientiously objecting and people who are dealing with things that are not just bureaucratic in nature.

Mr Ng: Yes, it was understood. What was considered was the clarity and understanding of what the obligations would be which would trigger, or non-compliance would trigger the offence as well. In circumstances where strict liability offences are being considered, it is really important that the behaviours—or non-behaviours, if you will—that individuals are obliged to comply with are really clear and capable of simple execution or otherwise.

MR COCKS: Thank you.

THE CHAIR: Is it fair to say that the strict liability approach taken in the bill is more towards the wilful non-participation in the scheme as opposed to if you are busy on the ward and could not get to respond within two days?

Ms Cheyne: It is about providing certainty to everyone. When you are making these sorts of requests, you are in a vulnerable state that is exacerbated by making the request. To make a request and then for the person to in their absolute right to object but to still be obligated to refer you and then not do that only exacerbates their vulnerability and the distress when someone is at that stage of their life. That is the balance we were looking to strike there. But, again, the time frame is something we will take a closer look at.

THE CHAIR: We have had a number of witnesses raise issues around palliative care. I think it is fair to say that it has been put to the committee that there is a view that we do not want this turning into a “you must choose one or the other” and it must be seen as the two are both available. A number of people have also said it is not clear within the bill the role that palliative care has. What role do you see palliative care having in the end-of-life process and do you see any opportunity for better articulating that within the bill?

Ms Cheyne: First of all, there is no evidence in Australia that palliative care funding has been withdrawn or that bucket has gone to pay for voluntary assisted dying. I think Ms Toohey described palliative care and where it is as part of the continuum of care, that it is not either/or; they absolutely exists together; and there are many, many circumstances where palliative care will be enough. We are talking about a person who is at the level of intolerable suffering even with all of the palliative care in the world.

You may know that there has been a pretty significant investment in palliative care recently as well as annually. There is a significant investment each year in non-clinical palliative care services. You might recall that Cleo’s Place was established as a trial and now is a permanent place for respite, and there is funding to expand the capacity at Clare Holland House. All of that is still certainly on the table. I believe—please correct me if I am wrong—that Dr Chapman, who is the palliative care head at CHS, is also engaging in voluntary assisted-dying research and about how the two co-exist.

THE CHAIR: My question was less about the funding—although I acknowledge that has been raised; so thank you for addressing it—and more that there is a perception that we have heard from a number of witnesses that, if voluntary assisted dying is enacted, people will start to see that it does become an either/or and that they will not necessarily understand that the two can be administered together and that people who want to access voluntary assisted dying might not also be aware that they can get palliative care to assist on their journey. The question I have got is: how are we ensuring within the system that we are providing all the options for people?

Ms Cheyne: This is absolutely explicit in the bill, in that—

THE CHAIR: These are the sections, 151 or 152, where it says in the conversations?

Ms Cheyne: Yes. Remember we were talking about the minimum standards, depending on who the professional is and their relationship to a person? Social workers and health professionals at a particular level need to not only have that conversation but also share all the other options available to a person and what those options might mean. That is explicit in the bill, and that is an important part of it. It is a safeguard for us as well. I would also draw from the evidence in all the other states that the either/or fear has not eventuated.

THE CHAIR: Palliative Care ACT recommended that those sections where it says, “Take all reasonable steps to ensure” be changed to “ensures”. Can I please get from you the basis for the wording and whether a change in wording would legally work?

You might need to take that one on notice.

Mr Ng: We might do.

Ms Cheyne: Just to clarify, at the moment it says to “take all reasonable steps to ensure”, and they are saying to take out “reasonable steps”?

THE CHAIR: They want it to say “ensures”. It is a small change, but it has quite a lot of legal ramifications, and I am interested to get your view on whether that changes or does not change anything.

Ms Cheyne: I think we might take that on notice, Ms Orr.

THE CHAIR: Thank you. I have more questions. I am happy to put some of these on notice. How many more questions do members have? You are not all jumping in, so I am going to keep going. We have had a number of people raising the review clause, saying that having specific things outlined is making them a fait accompli. We have also heard from other people that, just because something is in there, it does not necessarily mean it has a predetermined outcome. Is there any scope to making it clearer that there is not a predetermined outcome in considering it?

Ms Cheyne: The clause in the bill is pretty clear in that it says they will be considered in the review, not that the review will consider how to implement them. We are at a point in time where we know that there is community support for mature minors and there is overwhelming community support for advanced care directives, but both are inherently complex. For the reasons that you heard a little earlier in response to Mr Cocks, our bill is, in my view, the best in Australia. There are people out there who are suffering and dying right now and, if this were available, we would be able to relieve their suffering. To delay it further, after we have waited so long for our rights to be restored, would not be viewed terribly favourably.

Also, these matters could take some time to work through, if we got to a point where we thought they were barriers that we could overcome. That is not necessarily the case. I think it is really important to stress that we are focused on advanced care directives and mature minors, but perhaps the most critical one overall is residency requirements. Three years after the operation of the bill, it is likely that everywhere in Australia will have voluntary assisted dying and will have schemes that are slightly different. One of the most important things we need to consider is the interoperability of our schemes, depending on whether you are a resident or not.

You might have seen the case of Ros Williams, for example, who would have been eligible to go to Queensland, because Queensland has a residency requirement exemption, but she had no connection whatsoever to Queensland. That is where the reality starts to hit for some people. Again, that changes if we all have voluntary assisted dying, but, if there are different thresholds, eligibility criteria, operability or availability of clinicians, it is something that we will need to think about. Ms Cross spoke earlier about a provision that, in some ways, is quite important at this point in time, which is that the whole process of voluntary assisted dying needs to be undertaken in a jurisdiction. You could imagine that a resident of New South Wales who gets their medical care in the ACT could apply for an exemption from the

residency requirement, and I would expect that would be granted, but every step of the voluntary assisted dying process would then have to be undertaken in the ACT, from application to dying. That is where you can see that residency requirements are probably the most critical of all those matters, and there will be live issues that we will be contending with, I suspect. We wanted to put them in the review to make sure that we tackled them—at least considered them, even if we did not solve them—if they had not already been resolved.

THE CHAIR: Minister, what I take from that is that, by highlighting those, it is based on high community interest—

Ms Cheyne: Absolutely.

THE CHAIR: and wanting to provide a level of certainty to those who have been advocating for these parts, but it is not a commitment either way, to do it or not do it.

Ms Cheyne: Yes. We are being respectful of the consultation process that we undertook—that there are two major elements that people expressed support for, and that, in the time frame that we were working to, we simply could not tackle those issues. But, as time goes on, understanding evolves and the community of practice evolves. That is why they are in there—to reflect the respect that we have given to what we have heard—but that is not to say that, when we get to that point, they will not be insurmountable. They could be completely insurmountable.

THE CHAIR: I am going to wrap up. I have one more question and then I am going to pass to Dr Paterson, because she says she has a final question too. You are welcome to take this on notice or, if you are happy to stay around for a little bit longer, we could go over time.

Ms Cheyne: If we could have a bathroom break!

THE CHAIR: I think we all understand. Are members of the committee happy to take a quick bathroom break and come back until quarter past or so? Does that work? No. All right. We will quickly go to the questions. My question is about the review board. A few of the witnesses put forward that it is not clear whether it is prospective or retrospective or how it is going to operate. I am happy for you to take this on notice. Can you provide to the committee a clearer understanding of when the board will come?

Ms Cheyne: Yes. It is absolutely in the bill that the board needs to receive information after each step.

THE CHAIR: When we say it happens in real time, it is in unison with the decision-making process; it is not a case of the case will come before them for review once it is complete?

Ms Cheyne: No. A voluntary assisted dying application does not need to go to them before the substance is provided to the person. It serves as a review function rather than an approval function.

THE CHAIR: Okay. This is the issue that has been raised, because, in other jurisdictions, I believe there is an approval factor. Can I get a bit more rationale as to why that has changed? We had concerns raised that it takes away one of the checks and balances of the process.

Ms Cheyne: I know I sound like a broken record, but I would draw from practitioners' experiences and how it actually operates in practice. Remember that we are talking about a person who is dying and is in the last stages of life. Timeliness does matter.

Mr Ng: All I would say on the different perspectives of the gateway review, as opposed to the retrospective one, is there is the additional time it would take and the additional layer of bureaucracy. There has been a range of contributions about the stages of what is characterised as "bureaucracy" through the process, as the government's bill has constructed it. The approval process, as a gateway to proceeding further down the line, would be an additional initial step to comply with, which would have an additional time implication for individuals, at potentially a time-critical point in their life.

THE CHAIR: Could I clarify the time in the review process. Information will go to the board after every step of the process, but they will not review the full case until after the death of an individual?

Ms Cheyne: Let me check.

Ms Rad: It is after the reports have been submitted by the practitioner.

THE CHAIR: So, if there are any concerns, the review will have an opportunity to raise them prior?

Ms Rad: Prior to the substance?

THE CHAIR: Prior to the substance being administered—yes.

Ms Rad: No. They are frequently reviewing the applications, particularly during the early operation of the VAD, and then they will be tracking the applications and undertaking reviews of the reports following submission.

THE CHAIR: Okay. If I have any more questions, I will put them on notice. Dr Paterson.

Ms Zagari: I might just say that not all jurisdictions have a prospective review process. There are other boards that operate in a retrospective manner and review the cases after the administration of the substance.

DR PATERSON: Very quickly, why is it so important that Canberrans have a choice to die with dignity?

Ms Cheyne: We have choice at every other stage of our lives. This is the most important thing to stress: we have talked about voluntariness and we have talked

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about coercion, but it is ultimately a person's choice. We have waited a long time to be given this opportunity. I reflect on people who have died and wanted to see the day it is introduced—the day it passed. There are people like Gina Pinkas, who was with me in the Senate when the bill passed. She was with me, with Andrew Denton, with the Chief Minister and with Marshall Perron. She is not here now. She was dying. Every day, there are people out there who would like to have some choice and some control over what happens at the end of their life. As I said, there are benefits to voluntary assisted dying that are not necessarily associated with the substance being taken; it is simply about knowing that you have the choice if you get to a point.

I would encourage all committee members to read some of the personal experiences that have been shared, if they have not already, and to perhaps look to the two community members who spoke on day 2 of the conference, including one woman whose professional clinical husband had glioblastoma. Voluntary assisted dying was not yet operational but was about to be. Their story is quite remarkable. I do not know how anyone can listen to that story and feel that choice should not be available.

DR PATERSON: Thank you.

THE CHAIR: We might have to leave it there because we are now officially over time and we have not had toilet breaks. We conclude our final public hearing for the inquiry into the Voluntary Assisted Dying Bill 2023. On behalf of the committee, I would like to thank you all for appearing today and for the effort you have put into the submission that we received. I believe that four questions were taken on notice. The committee secretariat will be able to follow up if you have any questions regarding that. You will be sent an uncorrected proof of the *Hansard*. We will require the questions taken on notice to be responded to within five days of that uncorrected proof being provided to you. If members have any other questions, you are welcome to put those on notice. Please upload those as soon as practicable and no later than five business days after the hearing. Minister, I would note that you were going to table a document and you have not tabled it, so could we have it tabled?

Ms Cheyne: Yes. Consider it tabled.

THE CHAIR: We note for the record that the minister has tabled a document from Dr McLaren.

Ms Cheyne: And, for the final time, I say that talking to him would be valuable.

THE CHAIR: With that, we will wrap up. I thank everyone very much for appearing.

The committee adjourned at 1.05 pm.