

Hon Stephen Dawson; Chair; Hon Nick Goiran; Hon Martin Pritchard; Hon James Chown; Hon Kyle McGinn;
Hon Peter Collier; Hon Martin Aldridge; Hon Rick Mazza; Hon Aaron Stonehouse

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 22 October.

HON STEPHEN DAWSON (Mining and Pastoral — Minister for Environment) [5.30 pm] — in reply: Yesterday, I began the debate by thanking all members in this place for their participation in the debate thus far and commented that it had been conducted civilly and with great respect. I certainly hope that continues.

When suffering cannot be relieved, this bill provides a safe and compassionate way to access voluntary assisted dying. It does so in a way that provides a choice—a choice based on enduring consent, a choice that if faced with suffering at the end of their life, the vast majority of Western Australians have indicated they want to be able to consider. This bill would not have been possible without the diligence and thoughtful deliberations of the cross-party joint select committee, with significant input from the member for Morley as chair, and Hon Colin Holt as deputy chair. I would also like to acknowledge the remarkable work of the ministerial expert panel led by the chair, Malcolm McCusker, AC, QC, which provided the government with considered evidence-based recommendations that have mostly been incorporated into the bill. The bill differs in the requirement that the condition or illness will, on the balance of probabilities, cause death within six months, or 12 months for a neurodegenerative condition, and that two doctors must assess the person. In addition, I acknowledge the longstanding commitment of Hon Robin Chapple and Hon Alannah MacTiernan to genuine bipartisanship that has provided a foundation for this bill.

Victorian international experience of assisted dying reform has provided us with a wealth of information gathered over many years. Hon Nick Goiran's assertion that there has been an incremental extension in practice in the Netherlands, I believe, is without substance. Belgium and the Netherlands are often cited as examples of where scope creep has occurred. Access to voluntary assisted dying in these countries has never been limited to people at the end of their lives. A person needs only to be suffering. It is incorrect to describe the availability of euthanasia for mentally unwell persons in the Netherlands as eventuating as an expansion or type of slippery slope through which an initially conservative approach to euthanasia was eroded over time. Since the law was enacted, eligibility for assisted dying has included persons suffering from mental illness.

However, the WA bill is vastly different from the law in the Netherlands and Belgium. The WA bill expressly excludes access when a person has only a mental illness, and does not otherwise satisfy each of the eligibility criteria. The bill also requires decision-making capacity and precludes the use of advance directives. As the Attorney General has already explicitly stated, this government does not, and will not in the future, support a proposal to include voluntary assisted dying in an advance request for those with dementia. The Netherlands and Belgium laws are not relevant to the WA bill.

In jurisdictions with more restrictive eligibility criteria and more rigorous processes, like those in the US, there is no evidence that the scope has been informally expanded. In the 22 years that Oregon has had the Death with Dignity Act, one amendment has been made in 2019. This allows the 15-day waiting period to be waived if death is likely to occur before expiry of the waiting period. The ability to waive the waiting period in some circumstances is consistent with the legislation in Victoria, Canada and that proposed for WA in this bill.

The honourable member also asserts that members should exercise intellectual honesty and accept that there will be wrongful deaths. An assertion that wrongful deaths have occurred, or will occur, is a serious claim and therefore should be carefully assessed. It is important that if no evidence is provided for a factual claim, it should be ignored. If evidence is provided, the question then becomes: how reliable is it? A claim that wrongful deaths have occurred or will occur is a factual claim, and members should ask any claimant for that evidence. Hon Jim Chown, rightly, reminded us of the 10 per cent of suicides related to chronic or terminal conditions. He reminded us of the terrible guilt and devastation for those left behind. These are the wrongful deaths that we should all be very deeply concerned about.

The issue of coercion has been raised by a number of members in this place. It is important to consider the facts. Repeated, independent and exhaustive reviews have shown no evidence of abuse of the vulnerable overseas. Facts in this debate are very important. Information presented as fact, not based on evidence, does this Parliament no credit and the Western Australian community a disservice. Evidence from overseas demonstrates that members of vulnerable groups are no more likely to receive assistance in dying. Those who access assisted dying have competent social, economic, educational and professional advantage. Under this bill, assessment to determine whether the decision was made voluntarily and to detect coercion will form an explicit component of the mandatory training. Medical practitioners will have experience in determining that a person has not been unduly influenced by health professionals, friends or family via longstanding application of consent to treatment processes. This bill includes safeguards to ensure a person is acting freely. Clause 15(1)(e) provides that the eligibility criteria for voluntary assisted dying include the requirement that the person is acting voluntarily and without coercion. Clauses 23

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and 34 provide that the person is required to be assessed against the eligibility criteria by two independent medical practitioners. Clauses 27(2)(a) and 38(2) provide that if the medical practitioner is not satisfied that the person is acting voluntarily and without coercion, they must assess the person as ineligible. Clauses 25(3) and 36(3) provide that if the medical practitioner is unable to make a determination on this matter, they must make a referral to a person with the appropriate skills and training to make a determination.

Clause 54 requires that the medical practitioner must be satisfied that the patient is not being coerced prior to the issuing of a prescription. Clause 58(5) also requires this prior to administration in the case of practice administration. The bill provides that an application may be made to the State Administrative Tribunal for review of a decision that the person is acting voluntarily and without coercion. The process is suspended whilst the review application is determined. SAT has indicated that it would attempt to resolve the matter in an expeditious manner. Express offence provisions reflect that coercion will not be tolerated in relation to voluntary assisted dying. Severe penalties ranging from a summary conviction of three years to life imprisonment have been drafted. The bill makes it clear that the *parens patriae* jurisdiction of the Supreme Court is not excluded. The Supreme Court may, in the exercise of its *parens patriae* jurisdiction, make orders for the protection of vulnerable people such as children, the mentally ill and the elderly.

Some in this chamber have made the suggestion that voluntary assisted dying will be seen as a solution to dealing with the complex issues of ageing and dying and that there could be a temptation to avoid cost and complexity by encouraging people down this path. Hon Nick Goiran worries that these laws will result in an increase of elder abuse. The McGowan government is committed to preventing and addressing elder abuse. The government has invested funding in 2019–20 for elder abuse prevention initiatives. This includes funding for Advocare to run the elder abuse helpline, the Northern Suburbs Community Legal Centre to provide the older people's rights service and the age-friendly and dementia-friendly community grants program. Five-year service agreements for elder abuse prevention services, such as Advocare and the Northern Suburbs CLC, provide much-needed funding security to allow them to continue to provide vital on-the-ground services to older Western Australians. This bill does not address concerns relating to aged care or quality of life in older Western Australians. It sets out to provide choice for a small number of people who have a life-ending illness and are nearing the end of their life, on the timing and manner of their death.

The bill includes safeguards through stringent eligibility criteria and strict procedural requirements for accessing voluntary assisted dying. Under the eligibility criteria, a person must have decision-making capacity and be diagnosed with a terminal illness or disease that is advanced and progressive, causing intolerable suffering and will, on the balance of probabilities, cause death within six months or 12 months for a neurodegenerative condition. The bill provides for a strict assessment process by two qualified doctors working to clear guidelines set down in law. Medical practitioners must have particular qualifications and must undergo approved training before they can assess a person. The coordinating and consulting practitioners must refer for specialist advice when they are unable to confirm the condition, the prognosis, or that the person has decision-making capacity. Under clauses 25 and 36 of the bill, if the assessing doctor is unable to determine that the person is acting voluntarily and without coercion, the doctor must refer the patient to a person who has appropriate skills and training to make a determination. This may include a social worker or a police officer.

The bill contains rigorous safeguards to guard against coercion, but it is important that we also acknowledge that older people are entitled to human rights. Hon Tjorn Sibma considered this issue closely as a member of the Select Committee into Elder Abuse. The honourable member told the house —

For me, the inherent dignity and autonomy of older people is essential, and it has been an essential consideration in my evaluation of this bill. I have not met an elderly person who has felt victimised by the prospect of this Voluntary Assisted Dying Bill.

...

These are people who want to maintain their own dignity, autonomy and sense of agency over the full length of their life, however long that might be. I want to do credit to those people. I want to treat adults like adults. I want to actually defer to people who have lived on this planet twice as long as I have done. I think they have earned the right to ask for assistance in the circumstances of a terminal diagnosis or an irreversible neurodegenerative disorder.

There has also been a question as to the level of coordinating and consulting commerciality that may exist with practitioners. Based on the overseas evidence, the rates of people accessing voluntary assisted dying ranges from about 0.4 per cent in Oregon to four per cent in the Netherlands. Given that the bill is reflective of the Oregon framework—that is, a person must be dying and their death will probably occur within six months—it is more

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likely that rates of voluntary assisted dying deaths will be closer to Oregon. Given those very low rates, voluntary assisted dying will not be a commercial prospect for any health practitioner.

Some members have contended that with the best quality palliative care all suffering can be treated. This is patently untrue. Australian data from the Palliative Care Outcomes Collaboration shows that a small percentage of people—even those being cared for in the best specialist palliative care services—experience pain at end of life. Hon Alannah MacTiernan relayed to us the words of retired gynaecological oncologist Professor Ian Hammond, who told of patients he could not help—patients with severe bone or nerve root pain whose only answer was terminal sedation, which was temporally inappropriate. It is also clear that people are motivated to request voluntary assisted dying for a range of complex reasons, which are not specific to pain management only. PCOC Professor Kathy Eagar has told the ABC that when it comes to choosing euthanasia, pain does not even make it into the top five reasons. The most common reason is the person not wanting to lose their independence and autonomy.

A number of members commented that we need to do more for palliative care, especially in the regions. This government is doing more than any government in recent history and providing record levels of funding. Across the forward estimates there will be a \$224 million investment in palliative care. This level of funding stands in stark contrast to previous investments in palliative care services. Increased metropolitan palliative care services will see an additional 10 inpatient beds in the northern suburbs and expanded community services for care in the home. The McGowan government is also dedicated to expanding services in rural and regional WA to enable care closer to home with a boost to regional community-based services, provision of in-home palliative care support, and ensuring palliative care on-country visits are delivered. More than 61 full-time equivalent staff will be employed over a phased approach across regional Western Australia as part of the government's \$41 million end-of-life choices and palliative care services package, as included in the 2019–20 state budget. This will triple the staffing arrangements for palliative care support in regional Western Australia. This includes the establishment of new specialist district palliative care teams comprising medical, nursing, allied health and Aboriginal health workers across all regions. As part of the package, \$3 million will enable 24-hour support via the WA Country Health Service Telehealth hub, which will ensure staff, patients and families have access to nursing care for patients who want to die at home. There will be an additional \$2 million for the expansion of community palliative care services in regional Western Australia to better meet demand for domiciliary services, and a further \$2.5 million for enhancing rural and regional palliative care services by improving governance, consistent with the recommendations of the report of the Joint Select Committee on End of Life Choices. In addition, a further \$5 million has been allocated to progress a purpose-built 38-bed residential aged and palliative care facility in Carnarvon. This increases the total funding for that facility to \$16.6 million. Over four years, the investment for regional palliative care services builds on current service arrangements.

Hon Adele Farina in her contribution asked what the government is doing about the joint select committee recommendations. The Department of Health is currently addressing the recommendations set out by the joint select committee. As part of the program of work, five distinct work streams have been established—one on current state activities; the second on service models, patient choice, benefits and risks; a third on health profession education and awareness; a fourth on consumer education and awareness; and a fifth on needs analysis and future commissioning priorities. The first work stream has been established to assess current state activity and funding of palliative care in Western Australia. With this, information gaps in recorded activity will be identified and future initiatives to improve services systems will be identified. A statewide palliative care services plan will also be produced.

The WA Country Health Service is also working carefully to ensure equity of access across the seven regions so people can benefit from receiving high-quality palliative care regardless of where they live. I also note that the Department of Health is working closely with Palliative Care Western Australia. For example, PCWA has representation on the end-of-life and palliative care advisory committee, which advises on the development, implementation and review of effective sustainable and high-quality end-of-life and palliative care health systems and services in WA. It also provides statewide strategic direction on implementation of this strategy. PCWA has received funding from the Department of Health to facilitate advance care planning workshops since 2015 and 76 workshops have been delivered across the state in the four-year period to date. The Department of Health has agreed to continue funding for PCWA to facilitate advance care planning workshops through a grant. This will involve the delivery by PCWA of 36 two-hour advance care planning workshops in metropolitan and rural communities. Other work is underway by the Departments of Health and Justice to address all the recommendations in relation to advance health directives. The Department of Health is finalising a statewide advance care planning policy, which will ensure that when an advance health directive is provided to a hospital, it will be easily accessible and stored prominently on the patient record. The government is considering all the recommendations of the expert panel on advance directives. The Attorney General has already indicated to the Parliament interim acceptance of all recommendations except one. The government will not support advance directives for voluntary assisted dying. The Department of Health will continue to work with the Department of Justice, Palliative Care WA, WA Country Health Service and other stakeholders in end-of-life and palliative care to progress all recommendations.

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The premise of the bill is not, as one honourable member stated, self-interest, public expediency polls or government propaganda. The premise of this bill is choice—choice for an expected small number of people already nearing the end of their life on the timing and manner of their death. Voluntary assisted dying does not preclude or prevent palliative care. These are not either/or choices. We are considering the compassion we show to those people for whom palliative care does not relieve their suffering. The provision of voluntary assisted dying in Western Australia will be part of a continuum of end-of-life care choices available to the Western Australian public. As Hon Jacqui Boyde noted, this is not a choice between palliative care and voluntary assisted dying; this is about helping to support people throughout end of life.

A number of members on both sides of the argument told this place that they believe in the sanctity of life. But I think Hon Pierre Yang said it best when he said that his God wants us to have dignity, liberty and self-determination. Whatever your belief, individual freedom and choice is something that most of us can support.

I acknowledge the contribution of Hon Tjorn Sibma, who properly stated that the bill establishes a right for a very small number of people to ask for assistance to die when facing their inevitable, imminent and difficult death. He noted that the bill's reach is modest and the safeguards are well balanced, well drafted and appropriate.

This bill will protect vulnerable people in ways that do not exist now. Parliaments are actually arguing for the substandard status quo to remain. Decision-making capacity is required at every step of the voluntary assisted dying process. Determining whether a person is able to make a treatment decision is part of current professional healthcare practice. Doctors routinely assess decision-making capacity now: decisions made by their patients to consent to, or refuse, dialysis; decisions to consent to, or refuse, chemotherapy; decisions to consent to, or refuse, surgical interventions; and decisions to forgo treatment that may result in the person's death. Under this bill, the coordinating and consulting practitioners must refer to a relevant health practitioner, such as a psychiatrist, geriatrician or psychologist, if unable to determine capacity. This is the approach that was endorsed by the Royal Australian and New Zealand College of Psychiatrists in its submission to the Joint Select Committee on End of Life Choices. It said —

Where there is some question regarding capacity or the potential of treatable mental illness then the RANZCP WA branch would support a framework in which it is mandatory to consider psychiatric assessment.

This bill does not overturn the fundamental legal principle that an adult is presumed to have decision-making capacity. But when there is a question, when there is doubt, the practitioner must refer to specialist assessment. The coordinating practitioner must also complete a final review that certifies, by way of a signed statement, that the practitioner is satisfied that the person has decision-making capacity, is acting voluntarily and without coercion, and that the person's request is enduring. Practitioners are required to undertake mandatory training that will emphasise the importance of referral for specialist opinion when there is any concern that a mental health issue may be adversely impacting the decision a person is making to access voluntary assisted dying. GPs already conduct detailed mental health assessments of their patients for the purpose of mental healthcare plans. These are not undertaken during a short consultation but require a long appointment to enable GPs to properly assess the mental health needs of their patients.

I wanted to touch on the issue of conscientious objection. This bill provides for the ethical, moral and professional objection to voluntary assisted dying held by some medical practitioners but balances this with the need to facilitate timely and appropriate access for people who request voluntary assisted dying. Practitioners are not obliged to refer persons seeking voluntary assisted dying directly on, but it does require them to inform the patient of their refusal and give the person basic contact information about voluntary assisted dying. Faith-based hospitals and hospices are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital, care facility or home. Practitioners at those facilities remain bound by ethical and professional obligations to ensure proper care and timely transfer. However, evidence from overseas shows that most people wish to die at home.

Hon Colin de Grussa raised the issue of equity of access across the state. All of us in this chamber are aware of the challenge of delivering world-class health care across the single largest jurisdiction in the world. As the Ministerial Expert Panel on Voluntary Assisted Dying noted, Western Australia covers 2.5 million square kilometres of the Australian mainland, being the largest state in the commonwealth. Although most of the Western Australian population resides in Perth and surrounds, a significant part of the population is vastly dispersed across the state. According to the Australian Bureau of Statistics, almost 40 per cent of Western Australia's Aboriginal population lived in remote or very remote locations compared with just under five per cent for non-Indigenous populations. Apart from the challenges presented by its geographical size and location, Western Australia is also the most culturally and linguistically diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of its population.

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People across the state sometimes have to travel. Albany has perhaps the best regional palliative care service, but some residents still have to travel to Perth for heart surgeries. Some Western Australians still have to travel interstate for certain surgical procedures. This is the reality we face given our vast state and the nature of health care. This bill has been drafted in full awareness of the challenges faced by regional Western Australians and seeks to enhance accessibility through the inclusion of nurse practitioners and provisions for the appropriate use of technology for some communications. Although we acknowledge the challenge of service access equity across regional and remote WA, it is not the purpose of the Voluntary Assisted Dying Bill 2019 to address underlying issues related to access to healthcare services generally. During implementation, the government will work closely with regional stakeholders, such as the WA Country Health Service, the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the Australian College of Nurse Practitioners and other relevant stakeholders to facilitate access for regional and remote Western Australians.

Hon Simon O'Brien raised the issue of prisoners accessing voluntary assisted dying. The bill contemplates that this may occur, but the death of a prisoner will remain a reportable death to the coroner, as will all deaths of persons in care. This will be managed on a case-by-case basis with the involvement of the relevant medical team and the prison authorities and subject to the Prisons Act. A prisoner can request voluntary assisted dying and may be assessed as being eligible under the bill if they meet all the necessary requirements. The bill requires the VAD board to advise the CEO, who has administration over the corrections portfolio—presently, the director general of the Department of Justice—in circumstances in which a prisoner has been given final approval for voluntary assisted dying. The enabling clause is clause 117(c)(v). A prisoner may be on a long-term sentence or a continuing detention order.

It should also be noted that the CEO of Justice is not included in the Victorian legislation as a referral agency; however, the government views this as a necessary referral as it will ensure that proper processes, such as transfer and management of the patient, can be followed. It would be unlikely for the administration of the substance to take place in a prison setting. The patient would most likely be transferred to a hospital, and it is important that there is capacity to refer and communicate. It should be noted that a patient who is a prisoner is a person held in care and this bill provides provision for a death of a person held in care to be automatically referred to the coroner as a reportable death.

If the bill passes, Western Australia will adopt a voluntary assisted dying care navigator program, similar to Victoria. Many people will be well supported as they go through the voluntary assisted dying process by their coordinating doctor or healthcare team; however, some people will need extra support during the process. For these people, WA Health will, during the implementation phase for VAD, establish the role of voluntary assisted dying care navigators. In Western Australia, the navigator role will provide culturally appropriate advice and also include Aboriginal health workers.

Aboriginal health services will link with local health and community services to facilitate the cultural and spiritual support that is needed at end of life for people, their families and communities. We have entered into a dialogue with these services about voluntary assisted dying and during the implementation we will continue to work with Aboriginal communities and healthcare services to ensure appropriate information and access in a manner that suits Aboriginal people. I know this was an issue that was raised by a number of members, including Hon Kyle McGinn, and I think Hon Robin Scott also had something to say in this space.

I want to briefly touch on telehealth.

Sitting suspended from 6.00 to 7.00 pm

Hon STEPHEN DAWSON: Concerns have been raised about the commonwealth Criminal Code Act provisions on counselling or inciting suicide over a carriage service such as telephone, internet or video, and that they may prevent the use of telehealth for the voluntary assisted dying process. Firstly, there is nothing in the Voluntary Assisted Dying Bill 2019 that is inconsistent with the commonwealth Criminal Code Act. In fact, the bill makes it clear that it does not authorise the use of a method of communication if or to the extent that that use would be contrary to or inconsistent with commonwealth law.

We acknowledge that there may be uncertainty about whether particular communications about voluntary assisted dying will contravene the commonwealth legislation. That is why the state has engaged, and will continue to engage, with the commonwealth about this issue. Discussions have taken place at the highest level and the commonwealth has kindly offered its assistance to the Department of Health in further considering this issue. If telehealth cannot be used as a method of communicating with people for the purposes of access to voluntary assisted dying in Western Australia, the WA health department will adopt alternative implementation strategies. There are other jurisdictions that have similar restrictions, such as Victoria, and similar geographic challenges,

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such as Canada. For example, in Victoria a direction has been issued that requires the provision of information to occur face to face.

Options currently being considered for this state include a central hub that would link with networked spokes in regional and remote WA, and transport assistance to support face-to-face interactions. The hub would be able to receive requests for information on access to voluntary assisted dying and then facilitate the provision of information either by hard copy or in person. Assessments may need to be undertaken in person, with either the patient travelling to the practitioner or the practitioner travelling to the patient. If the bill passes and this is required, WA Health will provide packages to support access for regional patients where needed.

If the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act becomes operational. This time period will enable the Department of Health, in consultation with the commonwealth, to develop appropriate administrative measures to ensure compliance with state and commonwealth laws. The training for health professionals will reflect the outcome of the ongoing consultations between the state and the commonwealth. We are confident that, as in Victoria, this issue will not compromise health professionals or prevent eligible Western Australians from accessing voluntary assisted dying.

Some members, including Hon Adele Farina, have also asked about training for health practitioners. Training will be comprehensive and will address the legislation. It will cover assessing capacity, detecting coercion, assessing patients against the eligibility criteria, best clinical practice and communication with patients about end-of-life care. Consultations will include the Department of Health; key medical, nursing and allied health stakeholders and experts; palliative care and end-of-life stakeholders and experts; cultural stakeholders and advisers; and consumer and community representatives.

The Royal Australian College of General Practitioners will be involved in the development and accreditation of the training to ensure that it is both effective and meets required standards. In addition, in a submission to the Joint Select Committee on End of Life Choices, the Western Australian branch of the Royal Australian and New Zealand College of Psychiatrists noted that psychiatrists are well placed to support the upskilling of colleagues in relation to capacity assessment. The training will contain competency assessments, and a successful pass will be required for the training requirements to be met.

The bill does not require that one of the assessing doctors be a specialist in the disease. People who are terminally ill will have already consulted at least one specialist. If a GP is uncertain about the diagnosis or prognosis, they will seek further specialist input. In fact, the bill mandates that where there is uncertainty, the assessing doctors must seek a further opinion. Requiring a specialist in the disease to be an assessing doctor would be particularly onerous. That is particularly the case for regional Western Australians. This would make access very difficult if there is a limited number, if any, of such specialists in remote and regional areas, or if there is only a handful of specialists for rare diseases, for example. Of course, specialists would still provide an opinion where necessary, but would not be required to take on the role of an assessing doctor. This reflects contemporary medical practice, under which a multidisciplinary team is involved, and the care is coordinated by the GP. Further, in Australia, general practice is a medical speciality. Under the bill, assessing doctors must be either specialist doctors with at least one year's experience as a specialist, generalist doctors with 10 years' experience, or overseas-trained specialists who meet the requirements prescribed by the CEO of Health.

Another issue relates to the Victorian prohibition on health practitioners raising the topic of voluntary assisted dying. The bill does not prevent health practitioners from appropriately raising the issue of voluntary assisted dying. Victoria is the only jurisdiction in the world with this prohibition. The Joint Select Committee on End of Life Choices, and the Ministerial Expert Panel on Voluntary Assisted Dying, strongly recommended against prohibition. Conversations about all options at end of life is good clinical practice. That a patient is well informed is fundamental. There is no other law that imposes a restriction on a doctor discussing a lawful treatment option with a patient. It is an extraordinary measure, which is out of step with a patient's fundamental right to know all options available to them. This is not about a medical practitioner suggesting voluntary assisted dying to a patient. It is about appropriately informing patients about their choices, consistent with professional standards. An academic review of the Victorian provisions concluded that open and honest communication between doctor and patient represents good clinical practice, and the prohibition may lead to less optimal patient outcomes.

It is anticipated that a hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, there would be a central pharmacy service, potentially based at one of the tertiary hospitals, with a number of regional pharmacy hubs, such as selected regional public hospital pharmacies. The central pharmacy service would likely act as a central ordering and storage point for approved voluntary assisted dying medications. It would also be responsible for the training and certification of authorised suppliers of voluntary assisted dying medications. The central pharmacy service would also receive prescriptions, dispense medications and dispose of any unused medications for metropolitan patients. Regional pharmacy hubs with

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appropriately trained and certified pharmacists would obtain supplies of voluntary assisted dying medications from the central pharmacy service.

In relation to death certification, voluntary assisted dying will not be listed on the medical certificate, or on the public death certificate, as the cause of death. The intent of this provision is to prevent circumstances in which the information is released into the community by persons who may see the cause of death on the certificate that is provided by the medical practitioner to a person making funeral arrangements. It would not be appropriate for several communities, for cultural and faith-based reasons, for information about a patient accessing voluntary assisted dying to become more widely known. This strong sentiment was reflected through the consultation led by the ministerial expert panel and the Department of Health. Instead, when the medical practitioner reasonably believes or knows that the cause of the person's death was the administration of a voluntary assisted dying substance in accordance with this bill, they must notify the Voluntary Assisted Dying Board of the patient's death in writing on an approved form. The board will monitor that the correct process is being followed in each case of voluntary assisted dying and maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

In relation to the coroner, with the exception of the death of a person in care such as a prisoner or a person involuntarily detained under the Mental Health Act, a death pursuant to the voluntary assisted dying process is not automatically reportable to the coroner. The Voluntary Assisted Dying Board will provide the necessary oversight and monitoring of all deaths brought about by voluntary assisted dying. The board is able to refer any suspected contraventions of the bill to the appropriate investigative authorities, including the Western Australia Police Force and the coroner. An automatic investigation by the coroner is thus unnecessary and could cause significant distress to the person's family. For an expected death brought about by voluntary assisted dying, it would not be appropriate to require coronial or police investigation and questioning of families for each of these deaths, unless there is a suspicion that the proper process for accessing voluntary assisted dying was not followed.

The Voluntary Assisted Dying Bill 2019 does not restrict who may refer a matter to the coroner. A death involving voluntary assisted dying may still be a reportable death if it is not in accordance with the act or suspected of not being in accordance with the act and, therefore, is reportable to the coroner for investigation. This may be reported by the medical practitioner examining the patient's body or it may be a concern reported by a family member to the Western Australia Police Force.

Members, this is a watershed moment. It is within our power to be courageous, compassionate, decent and fair. This Voluntary Assisted Dying Bill offers a beacon of hope for those in our community who experience unnecessary suffering at end of life. It is an exemplar of safety, freedom and individual autonomy. Those who satisfy all the eligibility criteria and who undergo a stringent assessment process will be free to choose. Those who are already dying will be free to end their life in a humane and dignified manner. Freedom is one of the deepest and noblest aspirations of the human spirit. Let us have the courage and confidence to uphold freedom for the most vulnerable amongst us. Let us resolve that we, as members of this Parliament, will not abuse the trust of the community, the trust of more than 80 per cent of Western Australians. Members, I commend the bill to the house.

The PRESIDENT: Members, before I put the vote, I am going to say that this debate has been conducted in a very calm and respectful manner and I want to acknowledge that. I hope that continues as we deal with the vote that we are about to have.

Division

Question put and a division taken with the following result —

Ayes (25)

Hon Martin Aldridge	Hon Colin de Grussa	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Jacqui Boydell	Hon Sue Ellery	Hon Martin Pritchard	Hon Darren West
Hon Robin Chapple	Hon Diane Evers	Hon Samantha Rowe	Hon Alison Xamon
Hon Jim Chown	Hon Adele Farina	Hon Robin Scott	Hon Pierre Yang (<i>Teller</i>)
Hon Tim Clifford	Hon Laurie Graham	Hon Tjorn Sibma	
Hon Alanna Clohesy	Hon Colin Holt	Hon Aaron Stonehouse	
Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Matthew Swinbourn	

Noes (10)

Hon Peter Collier	Hon Rick Mazza	Hon Charles Smith	Hon Ken Baston (<i>Teller</i>)
Hon Donna Faragher	Hon Michael Mischin	Hon Dr Steve Thomas	
Hon Nick Goiran	Hon Simon O'Brien	Hon Colin Tincknell	

Question thus passed.

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Bill read a second time.

Committee

The Chair of Committees (Hon Simon O'Brien) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 1: Short title —

The CHAIR: Order, members. We are considering the Voluntary Assisted Dying Bill 2019, 139–1. I draw your attention to supplementary notice paper 139, issue 2, of today's date, Wednesday, 23 October 2019, which contains a number of proposed amendments that we will come to in due course. I also draw members' attention to a Legislative Council procedural note for members, number 1 of 2011. Members may wish to peruse that procedural note to refresh their memory about what a clause 1 debate is and what it is not. In particular, I draw members' attention to the remarks of a previous Chairman of Committees, Hon Barry House, on 16 October 1996 when he pointed out to the chamber—and I again point out to the chamber, for those of you who were not here in 1996 —

The short title debate does no more than give members the opportunity to range over the clauses of the Bill, foreshadow amendments and indicate, consistent with the policy of the Bill, how its formal content may be improved. It is not a vehicle for continuing debate on policy; rather, if members do not wish the Bill to proceed, the action they should follow is to vote to defeat clause 1 of the Bill as it stands.

With all that in mind, members, my proposition is that it is the will of the Committee of the Whole that my purpose is to facilitate the proceedings of the chamber through this stage—no more, no less. I will be upholding the rulings of previous chairmen of committees, particularly in respect of a clause 1 debate, just so we can keep it focused and this chamber can function as it should—sentiments with which I am sure everyone will agree. With that in mind, I will not be allowing too much *carte blanche* in respect of the clause 1 debate. To give members an example of what I have seen from time to time, if someone gets up during the clause 1 debate and says, "Look, I've got some concerns about clause 127", that is fine. What is not fine is for them to then say, "But while I'm on my feet, I may as well ask the minister now anyway." I will sit you down and say, "We will come to clause 127 in due course."

I say that up-front now, and these will be the standards that the deputy chairmen of committee will be following also. I make that clear now so that nobody thinks they are being limited improperly or anything like that, I would hope. With all that in mind, we come to clause 1, "Short title".

Hon NICK GOIRAN: Minister, what is a "voluntary assisted substance"?

Hon STEPHEN DAWSON: Under the definitions on page 8, the bill states —

voluntary assisted dying substance has the meaning given in section 7(2);

Proposed section 7(2) states —

A poison approved under subsection (1) is a *voluntary assisted dying substance*.

The CHAIR: Hon Nick Goiran, who is addressing clause 1, of course, not clause 7.

Hon NICK GOIRAN: Minister, that was not my question. I asked: what is a "voluntary assisted substance"?

Hon STEPHEN DAWSON: I am advised that that is a clerical error that has already been picked up by the Parliamentary Counsel's Office and will be fixed up at a later stage.

Hon NICK GOIRAN: The minister is saying that there is an error. Is the government intending to move an amendment?

Hon STEPHEN DAWSON: I am advised that it is a technical amendment, so it does not require the government to move an amendment. It will be fixed up as part of the process once the bill has passed this place.

Hon NICK GOIRAN: Minister, on whose advice is that the case?

Hon STEPHEN DAWSON: I am advised that it is on the Parliamentary Counsel's advice.

Hon NICK GOIRAN: With all due respect, minister, to the Parliamentary Counsel, it is not up to it to decide what the Clerk of the Parliament will or will not amend. Standing orders deal with clerical amendments. It is not for the Parliamentary Counsel to determine these things. Has advice been sought by the Clerk of the Parliament as to whether he is able to make the amendment that the government now recognises is an error in the bill?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: The minister has sought the advice of the Clerk of the Parliament and he has agreed that he can make an amendment to the bill for this phrase "voluntary assisted substance". Can the minister confirm that that was the case and the date upon which that advice was obtained?

Hon STEPHEN DAWSON: Yes, I am advised that advice was sought by the PCO from the Clerk. It should say "voluntary assisted dying substance", but the advice from the Clerk was that it could be fixed and an amendment

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was not needed. I do not have the information as to what date that advice was sought, but I am well aware that the clause 1 debate may well take us through this evening, so I will be able to provide the answer to that tomorrow.

Hon NICK GOIRAN: We will most certainly take that up later. Minister, what other errors have been identified in the bill?

Hon STEPHEN DAWSON: My advisers tell me that we have not noticed any other errors in the bill.

Hon NICK GOIRAN: Minister, in the debate in the other place, the Premier on 5 September said —

I understand the sentiments behind the proposed amendment ... However, in any event, we will not accept the amendment now, on the run. We will consult about what the member is proposing between here and the upper house with doctors, the health department and the like. I do not propose to amend the bill at quarter to one in the morning with some words written on a piece of paper. We will consult between here and the upper house, which I think is the right way to deal with legislation.

Minister, is the government intending to move any amendments in light of the Premier's remarks on 5 September 2019?

Hon STEPHEN DAWSON: I am advised that the government will not be moving any amendments to the bill.

Hon NICK GOIRAN: That is interesting because during the second reading debate at least one member indicated that the government would be moving some amendments, so clearly there has been some communication. I understood that the Minister for Health indicated that some amendments would be moved. I certainly look forward to exploring that further. If it is the case that the minister has misled one of the members of this place, no doubt that member will want to take that up further. At least for the time being, I think it is clear that the government says that there is no need for any amendments. It has not identified any errors. It alleges that one error can be addressed by clerical amendment and, apparently, according to the minister, we will consider that tomorrow, once he has obtained the date of the advice that he obtained from the Clerk of the house.

I turn to the 20 amendments that were moved in the other place. The Premier indicated that there would be some consultation with doctors, the health department and the like on those amendments. I am not too sure what he meant by "the like", but in any event, has there been consultation with doctors, the health department and the like on the 20 amendments that were moved in the other place?

Hon STEPHEN DAWSON: I am advised that all of those amendments have been the subject of consultation, certainly with the health department. I am also aware that conversations have taken place with the AMA in relation to amendments generally.

Hon NICK GOIRAN: I do not want to hear about consultation with people generally. We will only make good progress if we are specific. I am asking about the 20 amendments that were put in the other place. The government knows precisely what those 20 amendments were. I would like to know who the government has consulted in respect of those 20 amendments. I ask the minister to take a moment to work out when the consultation took place with respect to each and every one of those 20 amendments.

Hon STEPHEN DAWSON: It is preposterous to take a moment to go through information that I do not have before me. As I said, conversations have taken place with the health department in relation to the amendments that were proposed in the other place and numerous conversations have taken place.

Hon MARTIN PRITCHARD: I am finding it very hard to hear the minister, and it is very important. I apologise for raising it but I cannot hear.

The CHAIR: Minister, perhaps if you could project a little more, that might accommodate Hon Martin Pritchard. It is a full chamber, and that restricts us a little. I thank members, too, for keeping their conversations down. Have another go, minister.

Hon STEPHEN DAWSON: Thank you for your guidance, Mr Chairman. Certainly I will speak as loudly as I can. Often in this place I am told that I speak too loudly, so it is interesting to be told that I am not speaking loudly enough this evening.

As I was saying, conversations have taken place with the health department and the WA branch of the Australian Medical Association about amendments moved in the other place. I note that the amendments that were moved in the other place were, indeed, moved in that place and it is for this place to decide whether members in this place should be moving amendments to the bill that is before us.

Hon MARTIN PRITCHARD: I want to follow on in a similar manner. I just supported the second reading of the bill, which I was happy to do. However, that does not mean that I am particularly enamoured of all the drafting within the bill. The question I would like to ask has been asked before, but I want to ask it in a slightly different way. I understand that the minister is not proposing to move any amendments, but it has been put to me during consultations outside this chamber that any amendment, no matter how small, would make the bill fundamentally

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unworkable. Could the minister confirm whether he holds that same view or whether amendments that may improve the bill or at least satisfy some of our concerns would be acceptable? I make that point with regard to the first amendment that I will move, which is quite minor. Would that amendment be unacceptable on the basis that it would make the bill unworkable?

The CHAIR: Without debating the issue of the amendment, if the minister wants to provide a general response, that is consistent with the clause 1 debate.

Hon STEPHEN DAWSON: Thank you, Mr Chair. I am not aware of those statements having been made. Any amendment would have to be considered on the basis of that amendment, and we would make a decision at that stage, depending on what the amendment is, as to the effect it might have on the bill and its implementation in the future.

Hon MARTIN PRITCHARD: Just for clarification, it was not a member of the government who made that comment; it was someone outside the chamber who suggested that any amendment should be rejected on the basis that it would have unintended consequences. Is the government open to amendments so long as they are not directed at making the bill unworkable, even if they will not necessarily improve the bill but will satisfy some of the concerns that have been raised in this chamber?

Hon STEPHEN DAWSON: Honourable member, we are dealing with the clause 1 debate. At this stage, there are no amendments before us. I am not in a position to say yes or no to any amendment until any debate happens at a particular clause.

Hon JIM CHOWN: Obviously, medical practitioners are integral to the process of voluntary assisted dying, as stated in the bill. St John of God Health Care has six hospitals in this state. It is a well-known and well-respected institution that has hospitals in Bunbury, Geraldton, Midland, Mt Lawley, Murdoch and Subiaco. They are part of our health system. St John of God Health Care has medical practitioner by-laws on healthcare requirements that medical practitioners have to abide by. I am wondering how the Voluntary Assisted Dying Bill will be able to be upheld and complied with, certainly in regional areas, especially when we understand that St John of God Health Care employs 71 per cent of Western Australia's doctors.

Hon STEPHEN DAWSON: Faith-based hospitals are obviously able to object to participating in the voluntary assisted dying process for any reason, including but not limited to conscientious objection. There are faith-based organisations in operation in Victoria, including in regional Victoria, and the scheme is able to operate in that state. These questions are for the implementation phase of the scheme, if I can call it that. I alluded to this in my second reading reply: if this bill passes Parliament, there will be an approximately 18-month implementation phase during which all these issues will be worked out. I cannot confirm or deny the figure the honourable member used; that is, that 71 per cent of doctors work for that organisation —

Hon Jim Chown: Either wholly or partially, yes.

Hon STEPHEN DAWSON: I am not aware of that, so I cannot comment on that. We are confident that regardless of faith-based organisations and their opposition to voluntary assisted dying, voluntary assisted dying can operate in Western Australia and in regional Western Australia, and there is a commitment to ensuring that regional Western Australians can access voluntary assisted dying.

Hon JIM CHOWN: Thank you for that, minister. Seventy-one per cent is a large percentage of doctors in this state who are partially or wholly employed by St John of God Health Care. According to its 2017–18 annual report, it employs about 2 500 doctors, and they have signed St John's by-law arrangement and agreement that they will not participate in such things as sterilisation, termination of pregnancy, or physician-assisted suicide and euthanasia. If we take 71 per cent of this state's qualified medical practitioners and specialists out of the equation, we are left with a very small number of doctors who are able to assist or give advice in regard to the bill before us today. Regional Western Australia, as I said during a motion earlier today, has a large number—almost 60 per cent—of overseas-trained doctors, who actually do not understand the processes and are challenged culturally in the words of the English language. This concerns me greatly, minister, even though I supported the second reading of this bill. The minister's response to date has not been adequate, in my opinion, in how the state is going to implement the Voluntary Assisted Dying Bill, when only about 30 per cent of doctors across the whole state of Western Australia are free to do so.

Hon STEPHEN DAWSON: The honourable member is, of course, entitled to his opinion and to express his views; obviously he has expressed those. This bill has been drafted in full awareness of the challenges faced by regional Western Australians. It seeks to enhance accessibility through the inclusion of nurse practitioners and provisions for the appropriate use of technology, when appropriate.

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In my second reading reply, I also alluded to the fact that the voluntary assisted dying scheme in Western Australia will be similar to that in Oregon in terms of the numbers—0.4 per cent of deaths in Oregon relate to voluntary assisted dying. We anticipate a similar number in Western Australia. We are talking about, I guess, fewer than 150 people accessing voluntary assisted dying annually. Of course, there are thousands of doctors in Western Australia. I am well aware that not all doctors will participate in this, but during the implementation phase it is our intention to work closely with regional stakeholders such as the WA Country Health Service, the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the Australian College of Nurse Practitioners, and other relevant stakeholders to facilitate access for rural and remote Western Australians.

Hon JIM CHOWN: The minister is still not answering the question to my satisfaction. I am a supporter of this bill. My concern is that if we take out 70 per cent of trained doctors, especially in regional Western Australia, we will be left with a very small cohort that people can access.

I will read to the minister part of St John of God Health Care's by-laws, which very clearly state —

the Medical Practitioner has provided Health Care Services (whether at SJGHC or elsewhere) in a manner that demonstrates a lack of commitment to SJGHC's Mission ...

I have already outlined that mission statement. In effect, these doctors, 70 per cent of whom are actually working at St John's, would put their employment in jeopardy under the provisions of the by-laws that they sign up to if they addressed voluntary assisted dying or helped somebody to accomplish that outcome. The minister has already stated that the government will not put through any amendments on this bill, which I find most disturbing. The Legislative Council can put through amendments that would override St John's by-laws and put it in black-letter law.

Hon KYLE MCGINN: In respect to the implementation stage, I raised Indigenous navigators in my contribution to the second reading debate and I notice that the minister touched on that in his second reading response. I want to understand further what that will look like with respect to each area. Who will be guiding that conversation? Will all Indigenous stakeholders be invited?

Hon STEPHEN DAWSON: Honourable member, it is intended that during the 18-month implementation period there will be extensive and detailed work done with Aboriginal communities and health services. The implementation phase will enable the development of appropriate models of cultural, spiritual and practical support for Aboriginal people and their families who choose to seek information about or access to voluntary assisted dying. The Department of Health will build on the consultation already undertaken by the ministerial expert panel and work closely with a range of stakeholders, including the Aboriginal Health Council of Western Australia, Aboriginal health services, the WA Country Health Service, other health services and the WA Primary Health Alliance. As recommended by the Aboriginal Health Council of WA in its submission to the ministerial expert panel, the navigator program will be planned, designed and implemented in a culturally appropriate way, and suitable training and ongoing support will be provided to care navigators. Community awareness and communication programs about voluntary assisted dying will also be developed to ensure that everyone in the community, including Aboriginal people, has accurate and appropriate information about this choice. That is our intention and, certainly, the detail of that will be fleshed out during that 18-month implementation phase. The commitment is to work in partnership with Aboriginal organisations to make this work culturally for those people.

Hon KYLE MCGINN: I appreciate that, minister. I suppose there has been some commentary outside of these walls on the navigator role pushing people through the process, which is not the intent of what I have said and I believe not the intent of the government's response. Correct me if I am wrong, but the navigator role is there to ensure that people understand the process they are going through, as the minister said, culturally as well. It is simply to ensure that people do not misunderstand the process and fall through a gap. I want to clarify that the intent is to assist people who want to go through the process, not to coerce people into the process.

Hon STEPHEN DAWSON: That is certainly the intent, honourable member. As was alluded to in the second reading phase of the bill, Aboriginal people are not a homogenous group. We will certainly ensure that several different approaches are developed to ensure that needs are met across different Aboriginal communities, because what may work in one community may not work in another. Indeed, what may work with one family group may not work with another. For some people, care navigation may be provided by Aboriginal health services or health workers in their community. In other circumstances, dependent on the patient's preference, or when services or workers in the community are not able to provide a care navigator service, other options will be made available. Those options need to be developed in collaboration and consultation with Aboriginal communities to ensure that the patient and the family receive culturally appropriate support. It is about providing an option. It is certainly not about pushing people.

The CHAIR: A number of members are seeking the call and, one way or another, everyone will get a go. We can stay here for as long as you like. Members are deferring to Hon Kyle McGinn.

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Hon KYLE MCGINN: That gives me some peace of mind. One of the key things that seems could happen is that people will come from another area, having completed cultural competency courses—someone from Perth, for example—and that is deemed to be appropriate culturally out in areas such as communities, of which there are plenty in my electorate. I want to know that these discussions will be based around ensuring that they are as local and close to culturally appropriate as possible, rather than just saying that someone who is culturally competent will be brought from Perth to fill a gap. If there is a gap in people being able to fill the navigator role locally, will the government ensure training is done to ensure that the most appropriate and culturally respectful person in that area will be able to perform that role?

Hon STEPHEN DAWSON: We are certainly committed to ensuring that culturally appropriate services are available to people who want to access this scheme. Some people, including Aboriginal people, may not want to access services locally and indeed may not want to have local people providing assistance or helping them navigate the process. It is a difficult area. We cannot say we absolutely will give people a local person to help them get through the process because some people might not want that. Our commitment is to make sure that during that implementation phase we work through all options to ensure that the service provided is appropriate for the people in that community who want to access the service.

Hon PETER COLLIER: I did not intend to talk at this early stage of the proceedings, but I picked up on something the minister said about amendments. Can I clarify something? I did not support the second reading, but I respect the will of the house in that regard. I said in my contribution to the second reading debate that should the bill pass the second reading stage, I would like to do whatever I could to improve what I felt were areas of deficiency in the legislation. In the other place, the Minister for Health made it quite clear he was not going to countenance any amendments whatsoever. Some very legitimate amendments were moved in the other place. Again, that was the will of the house and I respect that. However, we have now got to this point and we are at this stage. Probably every person in this chamber has gone out and done an enormous amount of research on this legislation. As I said earlier today, this bill essentially changes the fundamental fabric and a tenet of our society, so I would like to think we can ensure that we get it right. With that in mind, I note that I have personally accessed the views of a vast array of groups in the community that are directly involved in this area and will be impacted by this legislation, as have probably most other people in this room. Can the minister clarify—I guess it is a simple yes or no answer; it is up to the minister of course—that the government will not countenance any amendments whatsoever to this legislation in its transition, potentially, to the third reading?

Hon STEPHEN DAWSON: I did not say that. What I said was that there are no amendments before us at clause 1, and there are no amendments lodged in my name on any supplementary notice paper.

Hon PETER COLLIER: I am conscious of that. My question was not whether the minister is going to move any amendments. I am asking whether the government will countenance or consider any amendments, or is this pretty much a fruitless exercise, as far as the government is concerned?

Hon STEPHEN DAWSON: I think we will take each clause as it comes and we will consider whatever is put before us at each clause.

Hon PETER COLLIER: Without divulging too much here, I have been led to believe that some considerations have been put to the Minister for Health and he has been quite receptive to that. With all due respect to the minister, I will take him at his word, and of course the minister in his representative capacity will do likewise. Is the minister aware of whether the Minister for Health is considering any amendments to the legislation at this stage?

Hon STEPHEN DAWSON: I understand that conversations are taking place between, I think, members of this place and the minister's office, and indeed outside organisations and the minister's office, but I say again that there are no amendments at clause 1, and if amendments are moved by honourable members in this place as we progress through the bill, they will be considered at that time.

Hon PETER COLLIER: I am mildly comforted by that. I know that the minister cannot say too much at this stage. Suffice to say, I was a little perturbed at what I thought I heard, which I obviously heard incorrectly, which was that no amendments would be countenanced, because, as I said, that is certainly contrary to what I have been informed and what I would like to think will occur.

Hon Stephen Dawson: That was not what I said.

Hon PETER COLLIER: That is great. I cannot go out there now and say that the government is not going to countenance any amendments, because what will happen, as I understand it, as with any piece of legislation, is that if amendments are put on the supplementary notice paper, the government will consider those amendments and will not flatly reject them.

Hon Stephen Dawson: Amendments will be considered on their merit.

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Hon PETER COLLIER: And not flatly rejected?

Hon Stephen Dawson: No.

Hon MARTIN ALDRIDGE: Clause 9 of the bill refers to the conscientious objection of a health practitioner. I do not want to ask this specifically about clause 9, but do any provisions in the bill relate to institutional objection? While the minister is considering that, I want to put to the minister my concern about the way in which the private sector has become more involved in the delivery of health care in our country. We have a number of public hospitals that are run by private entities; namely Peel Health Campus, Joondalup Health Campus and Midland Public Hospital, as well as, for example, the palliative care unit run by St John of God Health Care in Geraldton. Are there any provisions within the bill that provide for institutions to object to their participation in the regime? I understand, for example, that public–private hospitals have a contractual protection that prevents them from being forced to provide services such as termination services, but when those contracts were executed it was not anticipated that a regime like this would come into play; therefore, they are not specifically protected by their contract with the state from being obliged to provide these services.

Hon STEPHEN DAWSON: No, there are no clauses in the bill that relate to institutional objection, if I can call it that, as the bill is directed towards practitioners and not institutions.

Hon MARTIN ALDRIDGE: A situation could arise, then, in which a practitioner working for a private operator is willing to participate in the voluntary assisted dying regime, but the institution objects to such participation, or a circumstance in which the state requires an institution, by enforcing a contract, to participate in the regime. Are those two scenarios possible, as the bill stands, and how does the government intend to deal with those situations?

Hon STEPHEN DAWSON: Clause 113 gives legal protection for a person acting in accordance with the legislation.

Hon MARTIN PRITCHARD: The minister said in his second reading response that, if this bill were to pass, he believed that it would be best practice for the doctor to be able to discuss a range of treatment options, including voluntary assisted dying. I want to confirm that there is nothing in the bill that requires a doctor to raise this with their patient.

Hon STEPHEN DAWSON: There is no obligation in the bill for a doctor to raise this with their patient, but I am advised, bearing in mind that I am not a doctor, that good clinical practice would be that a doctor would discuss a range of options in relation to a person's health with the patient.

Hon MARTIN PRITCHARD: Given the issue raised by Hon Jim Chown, and adding to that doctors with their own conscientious objection, or doctors who just do not wish to be involved, it would seem to me, on the surface, that there may be many doctors who will not raise voluntary assisted dying with their patients, even if the bill is passed. Does the department have some plan to make people aware of their entitlement to access voluntary assisted dying?

Hon STEPHEN DAWSON: Although there is no obligation, for the successful implementation of this bill there will need to be a high level of community awareness. The department is adept at advising the community and communicating with the community about any such changes, as it does with other services or changes to its policy. Should this bill pass, we anticipate that we will work with the various professional organisations, whether they be the Australian Medical Association or the royal colleges, to advise people of the legislation. Obviously, there is no obligation, and the member is correct—there may well be hundreds, if not thousands, of doctors in Western Australia who may not want to participate in voluntary assisted dying; that is their right, and they are entitled to have a conscientious objection. There will also be hundreds, if not thousands, of doctors in Western Australia who will want to provide this option to their patients, or at least have conversations with their patients that this option is available, bearing in mind that we anticipate the number of people who may well access such a scheme would be around 150. We are confident that even though many doctors may object, there will be others who will participate, and we are confident that the Department of Health will be able to alert the community and ensure that there is a high level of awareness of voluntary assisted dying, should the bill pass.

Hon MARTIN PRITCHARD: I raised that matter because when I had discussions with people from the department about an amendment, which I will not go into, regarding doctors not being restricted from raising voluntary assisted dying, the argument that was put to me was that people may not be aware of it—for instance, people in faith-based hostels and such. I would be quite interested to know what sort of public awareness campaign the department will run now and into the future. I would have thought that this topic would be well known to most people in the community at the moment, but it might not be so well known in the future. I would be interested to know about the plans the department has for such awareness programs.

Hon STEPHEN DAWSON: We have not considered this issue in detail. The same processes would be followed as are followed with any other policy that Health is involved in. We will also learn from the work that has been

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undertaken in places like Victoria on how they have advised the community in that state. The member is correct: I suspect that there is a heightened level of awareness of this issue in the community at the moment based on this debate. However, it is certainly the government's intention that the Department of Health ensures that there is a high level of awareness of the policy if the bill passes.

Hon MARTIN PRITCHARD: I will not labour the point, but it does seem that if the department is confident that there will be an ongoing program of awareness, opposition to my amendment concerning doctors being restricted from raising the issue should not be so heightened. If there is a general awareness of voluntary assisted dying, one would imagine that a patient would be aware of it and could raise the issue. Of course, nothing in my amendment would restrict a doctor from having a discussion with their patient; it is just a restriction on them raising it in the first instance. I am not asking for a comment. We can deal with that when we get to my amendment.

Hon NICK GOIRAN: The minister has not responded to my earlier questions; we will get back to that in a minute. However, in the interim, there has been some interesting discussion between the minister and members. In particular, I note that in response to Hon Jim Chown, the minister mentioned, I think, in accordance with my notes, that the government anticipates 0.4 per cent of deaths will be due to voluntary assisted dying, and it says so on the basis of data from Oregon. Can the minister confirm that is the case?

Hon STEPHEN DAWSON: I certainly did allude to Oregon, where a similar scheme is in operation and where the figure for those accessing voluntary assisted dying is approximately 0.4 per cent. But we have to be careful, because the scheme in Oregon is different from the scheme in Western Australia, and the landscape is different too. However, we anticipate the figure to be around that same number. It would be very inaccurate to say at this stage that we could arrive at an evidence-based estimation of the number of deaths in this state that will be attributable to voluntary assisted dying. When we use an international jurisdiction on a comparative basis, there will be many varying factors, such as differences in eligibility criteria, cultural and geographic characteristics and healthcare systems. That makes it very difficult to make an accurate prediction. Certainly, the statistics from Oregon could be used to widely infer that number, given that its eligibility criteria are most similar to those proposed for WA.

Hon NICK GOIRAN: The minister has said that the Oregon scheme is similar but different. What are the differences?

Hon STEPHEN DAWSON: Oregon is different from Western Australia; the culture is different, the geography is different and the health system is different. Certainly, the 0.4 per cent rate is from Oregon. In my second reading reply, I mentioned the rate of four per cent in the Netherlands, which has a very different voluntary dying process from the one outlined in this bill. We believe that our scheme is closer to that in Oregon than it is to the one in the Netherlands. The rate of 0.4 per cent is the one that we are using as a comparative basis.

Hon NICK GOIRAN: The minister has indicated that the differences are in culture, geography and health, but how is the scheme in Oregon different from the scheme that the government proposes for Western Australia?

Hon STEPHEN DAWSON: I draw the member's attention to the final report of the Ministerial Expert Panel on Voluntary Assisted Dying. Appendix 5 relates to voluntary assisted dying in other jurisdictions. Pages 132 to 135 list the differences between the schemes in Victoria, Canada, Oregon, Washington State, Vermont, California, Belgium and the Netherlands. The differences are listed there.

Hon NICK GOIRAN: No, minister; that is unacceptable. My question was: what are the differences between the Oregon scheme and the Western Australian scheme? There is no point in referring me to the ministerial expert panel's report when we both know that the ministerial expert panel did not have a copy of the bill when it prepared the final report. I go back to my original question: what are the differences between the Oregon scheme and the Western Australian scheme?

Hon STEPHEN DAWSON: I am advised that the key difference is with self-administration. The Oregon laws require self-administration. There would be other minor differences, but the key one would be the self-administration issue.

Hon NICK GOIRAN: What period of time is required in Oregon for the prognosis of death?

Hon STEPHEN DAWSON: It is six months.

Hon NICK GOIRAN: What is the period of time under the Western Australian scheme?

Hon STEPHEN DAWSON: It is six months, or 12 months for a neurodegenerative disease.

Hon NICK GOIRAN: Is 12 months for a neurodegenerative disease a minor difference?

Hon STEPHEN DAWSON: With the greatest of respect, we are talking about the Western Australian legislation that is before us now. I indicated that the main difference relates to self-administration. I also suggested that there were other differences between the two bills. We are dealing with the Western Australian legislation, not the Oregon

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legislation. The member may point out a range of differences in that legislation or, indeed, legislation in other states or jurisdictions around the world. There are differences, of course, but the legislation that we are dealing with this evening is the Western Australian legislation. I would urge us all to focus on the legislation before us.

Hon NICK GOIRAN: The minister introduced the Oregon scheme this evening—not me. In response to Hon Jim Chown, the minister indicated that the WA government anticipates that 0.4 per cent of deaths in our state would result from the bill that is before the chamber that the government has introduced and that the minister has responsibility for in this place, and he based that on the Oregon data. I did not introduce that concept; the minister introduced it under clause 1 in response to a question from Hon Jim Chown. I am testing the veracity of the minister’s statement that the government anticipates that 0.4 per cent of deaths would result from this bill. So far, the minister has indicated to me that there are some differences in the scheme. The minister has indicated that self-administration is one, and I will get to that in a moment. The second thing he said is that there are other minor differences. It is interesting that the criteria being extended from a six to 12-month terminal prognosis is something that the minister and his government would describe as minor, or merely a matter of categorisation. I would have thought that was a major difference between the Oregon scheme and the Western Australian scheme, because, quite plainly, we are going to have an extra cohort of individuals who would not qualify under the Oregon scheme because they have a prognosis of more than six months to death. Nevertheless, the minister indicated that self-administration is one of the key differences. I take that to mean that practitioner administration is not permissible under the Oregon scheme. Can the minister clarify that?

Hon STEPHEN DAWSON: It is permissible when the patient is unable to physically administer.

Hon NICK GOIRAN: How many deaths occur annually in Oregon as a result of practitioner administration?

Hon STEPHEN DAWSON: I beg the member’s pardon; I have misled the chamber there. In Oregon, a doctor cannot administer. The only option is for people to self-administer.

Hon NICK GOIRAN: I thank the minister for the correction. Practitioner administration is not permitted under the Oregon scheme. Would it be permissible under the Western Australian scheme; and, if so, under which clause?

Hon STEPHEN DAWSON: It is under clause 58.

Hon NICK GOIRAN: What number of deaths does the government anticipate would arise under clause 58?

Hon STEPHEN DAWSON: Sorry, would the member mind asking that question again?

Hon NICK GOIRAN: What number of deaths does the government anticipate under clause 58?

Hon STEPHEN DAWSON: We do not have a figure, and it would be inaccurate at this stage to say that we could arrive at an evidence-based estimation of deaths attributable to this category of voluntary assisted dying in this state. Again, I make the point that it is difficult to use international jurisdictions as a comparative basis, because there is a great number of varying factors such as differences in eligibility criteria, cultural and geographic characteristics and healthcare systems. Therefore, it is very difficult to make an accurate prediction. What I suggested is that the scheme in Oregon is most similar, or certainly the eligibility criteria in Oregon are certainly most similar, to the scheme that is proposed for Western Australia, but obviously there are differences. Some widely inferred numbers have been given for Western Australia, but I am not aware; I cannot give this chamber a number. It would be very difficult for anybody to accurately suggest or project the number of people who may access voluntary assisted dying in this state.

Hon NICK GOIRAN: What is the government’s anticipated additional number of deaths as a result of its decision to extend, in certain circumstances, the period of time for death from six months to 12 months?

Hon STEPHEN DAWSON: We cannot anticipate that.

Hon MARTIN PRITCHARD: I did not wish to interrupt the honourable member, but I thought some other members might want some answers. I am interested in the skills required in order for a general practitioner to be a coordinating practitioner. Clause 25(1) provides that the coordinating practitioner is able to refer. It states —

Subsection (2) applies if the coordinating practitioner is unable to determine whether ...

It then lists a number of things for which the coordinating practitioner is able to refer to another practitioner. Is there anything other than skill or training—when it says “unable”—that the minister would contemplate?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Honourable member, I just bring your attention to the comments that were made by Hon Simon O’Brien a little earlier that debate on specific clauses must for the most part be restricted to those specific clauses. I will allow you a little bit of leeway at the start, but if you are going to delve into specific clauses in detail, I will ask you to hold that debate until we get to those specific clauses, unless you are looking at a more general debate early on.

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Hon MARTIN PRITCHARD: I am. I have a concern about what skills general practitioners will bring to this. It affects a number of areas within the bill. I am just trying to determine whether I can be satisfied that for referring it, I will not necessarily need to move my proposed amendments.

The DEPUTY CHAIR: I am going to cut you a little slack at the beginning of the process.

Hon MARTIN PRITCHARD: Thank you very much.

The DEPUTY CHAIR: The minister is yet to reply.

Hon STEPHEN DAWSON: Sorry, member. I am not clear on the question.

Hon MARTIN PRITCHARD: I believe that the reason a general practitioner would refer to somebody else—I would say a specialist, but it may be another person equally as able—is that they do not have the appropriate skill or training. I want to confirm whether that is the only reason for which a referral would be made.

Hon STEPHEN DAWSON: Another reason would be if they were unable to do it—if they would be unavailable, essentially, at that time and place; so, in that case, they could refer.

Hon MARTIN PRITCHARD: Would it not invalidate them from being a coordinating practitioner if they could not fulfil those requirements?

Hon STEPHEN DAWSON: I will answer that question in this way, honourable member, bearing in mind clause 25: general practice is a speciality in which the person is considered as a whole—body, mind and spirit—in the context of their family and community. Specialists in a particular disease may prognosticate about the disease, but it is the GP who considers this information in the context of the whole person and the likely comorbidities that impact on their prognosis, and is better placed to be an assessor in the context of VAD. The referral clauses in the bill, clauses 25 and 36, enshrine good clinical practice into legislation. This requirement ensures that the quality of the assessment is not compromised. It is well within a medical practitioner's current scope and practice to make a referral when they feel there is a need to do so in a particular case.

Hon MARTIN PRITCHARD: Clause 25(4) states —

If the coordinating practitioner makes a referral under subsection (2) or (3), the coordinating practitioner may adopt the determination ...

I want to know why it is “may” and not “will”.

Hon STEPHEN DAWSON: With the greatest respect, I am happy to answer the honourable member's questions at clause 25. This essentially refers to amendments that he has on the notice paper at clause 25. Given the detail he is requesting about clause 25, I prefer that the issue be dealt with then.

The DEPUTY CHAIR: Hon Martin Pritchard, taking that on board, if you have a more general question, I will accept it.

Hon MARTIN PRITCHARD: As a correction, I think my amendment is at clause 16, which comes before clause 25. If I were satisfied at clause 25, I would not necessarily need to move my amendment at clause 16. That is the reason I raised it. I am happy if the minister is happy for me to raise the amendments, even if they are not required.

Hon STEPHEN DAWSON: I am advised that it is not appropriate to require that the coordinating practitioner must adopt the determination of the assessing practitioner. It is the assessing practitioner who must make the final determination on consideration of all materials before him or her, and to require otherwise would be to set aside good clinical practice.

Hon MARTIN PRITCHARD: I understand that. Clause 28(3)(i) states —

if the patient was referred under section 25(2) or (3), the outcome of the referral;

Would it not be more accurate to say “outcome of all referrals”?

Hon STEPHEN DAWSON: I am sorry; we are still discussing the last point. Can the honourable member ask that again?

Hon MARTIN PRITCHARD: Keeping in mind that I think the minister's response is that the general practitioner is best placed to take in all the information—a number of referrals possibly—it is my understanding that they have to report those to the board. Would it be more appropriate if clause 28(3)(i) said, “if the patient was referred under section 25(2) or (3), the outcome of all referrals;”? Would that be more accurate?

Hon STEPHEN DAWSON: I am told that “the outcome of the referral” encompasses everything because it refers to sections 25(2) and (3).

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Hon RICK MAZZA: I have a few questions about the safety aspects of this bill. It has been much heralded that this will be a very safe procedure. My understanding is that there will be a coordinating medical practitioner and a consulting medical practitioner, and a contact person can be appointed by the patient, who can acquire the prescribed substance from an authorised supplier. From what I can understand, the contact person can then take that home to the patient. Can the minister explain how that will be monitored? I would imagine that the substance will be sitting around the patient's home. If the patient changes their mind, what is there to prevent coercion by the contact person? Will the contact person be able to be a family member or somebody who may benefit financially from the person's passing? I would like to get a general sense of how this bill will provide safety around those matters.

Hon STEPHEN DAWSON: Clause 64 sets out how the patient is to appoint a contact person. A patient who is the subject of a self-administration decision must appoint a person as their contact person. The appointment of a contact person only places a new responsibility on a person who consents to undertaking the role. The role of the contact person is set out under clause 66. The intent of appointing a contact person is to ensure that once supplied, a voluntary assisted dying substance can be monitored and safely retrieved and disposed of if unused or there is any remaining. Clearly identifying who will be responsible for returning the unused substance to the authorised disposer will be another safeguard in the process of accessing VAD in this state. In agreeing to take on the role, the contact person agrees to take on the responsibility for any voluntary assisted dying substance that is unused when the person dies. The contact person must return any unused or remaining substance within 14 days after the day of the patient's death. The contact person must also inform the coordinating practitioner if the person dies, and provides a clear contact point for the VAD board.

I refer to eligibility requirements of the contact person. The bill sets out that the contact person must be at least 18 years of age and may be the patient's coordinating or consulting practitioner or another registered health practitioner. The patient is able to choose a family member or another person to be their contact person as long as they are 18 years old. In practice, the contact person will need to be a person who maintains close involvement with the patient to enable them to effectively undertake the role. It is likely that the contact person will be a close and trusted carer, family member or friend of the patient and will have been involved in discussions with the coordinating practitioner and the pharmacist, including instructions about storing the voluntary assisted dying substance in a safe manner. The coordinating practitioner has an important role to play in guiding the patient through the process. From that perspective, it is reasonable to expect that they would want to make sure that the contact person is able to function under the act. Accordingly, the practitioner will discuss the requirements of the contact person with the patient so that an appropriate person can be chosen. Should they have concerns, it is also possible for the coordinating practitioner to take on the role of contact person.

It should be noted that no evidence has been found elsewhere in the world of misuse associated with voluntary assisted dying medication, but if there is a breach by the contact person and they decide to retain the prescribed substance or mislead authorities about how much was used, they will be in breach of the act and will be subject to severe penalties. As well as the requirements of clause 104, there are very strict laws, including the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1981, that relate to unauthorised possession of drugs and poisons.

Hon RICK MAZZA: I thank the minister for that. There appears to me to be quite a lot of trust around the possession of the prescribed substance as far as the contact person is concerned and how long it may take before the substance is actually used by the patient. If there is an unused portion or if the substance is not used—for argument's sake, the patient passes away without taking the substance—I know there are some pretty harsh penalties if it is not returned within 14 days; I think it is 12 months' imprisonment. Is there any follow-up by any of the practitioners in relation to the return of the substance?

Hon STEPHEN DAWSON: The board is the follow-up. The board is advised when the patient passes away. I make the point that it would be inappropriate to put on a patient a time constraint within which they must keep or take the medication. Stipulating such a time frame could potentially risk coercing the patient into taking the substance sooner than they would otherwise choose to. The legislation includes all the existing safeguards in the Medicines and Poisons Act 2014 for the safe and secure storage of the substance, and also provides for closed-loop safe and appropriate prescription, supply, storage and disposal of any unused voluntary assisted dying substances.

Hon MARTIN ALDRIDGE: I want to take the minister back to my earlier questions around institutional objection. The minister referred me to clause 113 of the bill, which does not assist me much. I think clause 113 provides protection for a person who acts in good faith under this legislation. My issue went to the right of an institution to object to participation in voluntary assisted dying. I cited examples such as a public-private hospital and the potential for the state government to enforce an existing contract; or, indeed, what happens when it comes to the renewal or execution of an option under a new contract. As I understand it, there are no protections in the bill for an institution to object; it is centred around the health practitioner. I want to understand the view of the state government on private organisations or companies providing public services.

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Hon STEPHEN DAWSON: There is no reference to institutions in the bill because institutions are not obliged to do anything under the legislation. The state's best interests are in ensuring that the individual gets the best care. It may not be in that person's best interests to force anyone to do anything. I am not sure if this is where the member is going, but in terms of future contracts, when a contract with St John of God Health Care or another institution expires, would the state seek to renegotiate or not sign again, based on voluntary assisted dying? I cannot answer that question. Certainly, under this legislation, individuals can conscientiously object. Faith-based hospitals are able to object to participating in the processes for any reason, including, but not limited to, conscientious objection. But the bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility. That may be the case, for example, for a person who is living in a nursing home that is run by a faith-based institution. There may well be a requirement for that patient to be transferred to a hospital, a home or somewhere else to enable them to access voluntary assisted dying. But in relation to future contracts, I am not in a position to answer yes or no, contracts will be negotiated, renegotiated or not signed again. We anticipate that people in faith-based hospitals may want to access voluntary assisted dying upon passage of the bill, and the likelihood is that they will need to be transferred elsewhere, whether it is to a house or another facility, to enable that access to take place.

Hon MARTIN ALDRIDGE: I want to confirm what the minister has said to me. Let me use St John of God Midland Public Hospital as an example, because that is the most recent one that has been done in my time. At the time, its contract specifically excluded termination services. I recall it quite well because I remember at the time, the Labor opposition made quite some noise about it in this very chamber. The hospital is not excluded from providing voluntary assisted dying services specifically under its contract. Can I take it from what the minister just told me that the state will not seek to enforce St John of God Midland from providing a voluntary assisted dying service, despite the fact that its contract does not specifically exclude it from such a provision?

Hon STEPHEN DAWSON: If I can answer it this way: it is not in the state's interest to force any faith-based adviser or indeed anybody to participate in this process. We have allowed for the conscientious objection of doctors, and we do not believe it is in the patient's best interests to force any faith-based organisation, hospital or otherwise, to participate in this process, so I will answer it that way.

Hon MARTIN ALDRIDGE: That reassurance is welcome, minister; that the government will not seek to exploit aspects of contracts with private organisations and may not protect them from providing services that the organisations may, on various grounds, object to. I do not think that provides any protection for those organisations in terms of future contractual negotiations, because from what I have heard there is certainly no guarantee that they may be discriminated against in a future contractual process by being excluded if they were to object to providing such services.

If an aged-care provider objects to having any interaction with voluntary assisted dying, would it be liable for prosecution under any civil or criminal code with respect to, say, discrimination? Is there any protection, or is there any possibility that it could be pursued if it were to object to having one of its patients participate in voluntary assisted dying?

Hon STEPHEN DAWSON: An institution cannot object to a patient participating in the voluntary assisted dying process. The likelihood is that it would not happen at that facility. It is likely that the patient would be moved to their home or to another care facility where the voluntary assisted dying process would be undertaken.

Hon NICK GOIRAN: I wish to follow up on this line of questioning by Hon Martin Aldridge. I know that another member wants to ask some questions. Eventually, I will take the minister back to those anticipated death counts.

With respect to what Hon Martin Aldridge is pursuing at the moment, I want to clarify what the minister has said. When the minister responded to Hon Jim Chown, he said that faith-based organisations can object. In response to Hon Martin Aldridge, the minister indicated that there is no need to have an institutional conscientious objection as no obligations have been imposed. Further, he indicated that, in essence, a patient wanting to access voluntary assisted dying would need to be transferred from the institution. Obviously, that transfer process requires individuals to do something, as the minister quite rightly pointed out. It is not like the institution or the organisation itself can uplift the person and transfer them; it requires individuals within the institutions to do things. I will give the minister a practical example. What happens if the individuals within the institution have grave concerns that the person is being coerced, which I know this government does not want to occur and is why it is one of the principles in the bill? What capacity does the institution have to address those concerns or is it simply obliged to transfer the patient?

Hon STEPHEN DAWSON: The facility could tell the coordinating doctor of its concerns. It could approach the VAD board with its concerns. If it reasonably suspects that coercion is taking place, it could also report that to the police.

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In relation to the transfer, I am advised that the transfer is a necessity of good clinical practice.

Hon NICK GOIRAN: The minister says that the individuals within the institution can approach the VAD board or the police, and, of course, that relates to my example of a patient requesting a transfer but the individuals within the institution are concerned that there has been coercion. What can the VAD board do in those circumstances?

Hon STEPHEN DAWSON: I am told the board can alert the coordinating doctor. The board can look into the case, it can alert the CEO of the department and it can also advise the police. Those options are all available.

Hon JIM CHOWN: I would like to go back to the statement I made some time ago on faith-based institutions employing by far the majority of doctors in this state—almost three-quarters of them—and their protection from liability under the bill. Hon Martin Aldridge addressed the issue, but I do not think the minister has actually responded to the question to my satisfaction.

Hon Stephen Dawson: Honourable member, I do not have the figures in front of me in relation to that.

Hon JIM CHOWN: My figures are derived from the Australian Medical Association, so I assume they are correct.

Hon Stephen Dawson: Is the member suggesting 71 per cent of doctors in Western Australia are employed by —

Hon JIM CHOWN: They are employed either wholly or partially.

Hon Stephen Dawson: I actually think you are wrong.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Minister, take your seat for a minute. I am going to give the call to one person at a time. Hold on, Hon Jim Chown. Unless the interjection is taken, I am going to let Hon Jim Chown finish what he is saying. Minister, I will give you a chance after that.

Hon JIM CHOWN: Let us settle on something like a majority or a large proportion of doctors in this state are employed by faith-based organisations.

Hon Stephen Dawson: Ask the question. I can't even agree to that.

Hon JIM CHOWN: What protection is available in this bill for the future contractual arrangements of these doctors if they implement a VAD consultation or VAD itself? How will they be protected from not being re-employed under future contracts? I refer the minister to a press release of 2012, some time ago, about a doctor at St John of God Health Care who became unemployed when he breached the contractual arrangements under its by-laws by carrying out a vasectomy, which is a lawful operation. What protection is there in this bill for medical practitioners who are employed by faith-based organisations when their contractual arrangements come up for renewal?

Hon STEPHEN DAWSON: That issue really is outside the scope of this bill. Clause 113, "Protections for persons acting in accordance with the Act", states —

- (1) This section applies if a person, in good faith, does a thing —
 - (a) in accordance with this Act; or
 - (b) believing on reasonable grounds that the thing is done in accordance with this Act.
- (2) The person does not incur any civil liability, or any criminal liability under this Act, for doing the thing.
- (3) The doing of the thing is not to be regarded as —
 - (a) a breach of professional ethics or standards or any principles of conduct applicable to the person's employment; or
 - (b) professional misconduct or unprofessional conduct.

That relates to someone in a contract. Nothing in the bill precludes an organisation from not renewing an expired contract based on their actions, but that is really outside the bill. I cannot give the member industrial relations advice on whether that person may have a case to go to the Western Australian Industrial Relations Commission or the Fair Work Commission, depending on what area they are working in, but certainly for someone who is employed, clause 113 answers that question.

Hon JIM CHOWN: Surely, this is a deficit in this bill, because in reality, this bill will not work unless we have medical practitioners who are able to carry out the recommendations and the process in the bill. The minister was in the house earlier today when we had a motion on health in regional Western Australia, and we understand that this state is likely to have a decline in the number of general practitioners especially. The minister is saying the government has not addressed in the bill contractual arrangements with faith-based organisations when they come up for renewal. These are doctors with families and mortgages et cetera. Does the minister really think that in order to exercise the voluntary assisted dying process, they will jeopardise their future, their profession and their income without some protection in regard to their contractual arrangements at some stage in the future? If my figure from

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the Australian Medical Association is correct and these faith-based institutions employ 71 per cent of the state's doctors, we have a serious issue in that the bill is deficient on this matter. Whether it is 71 per cent or 40 per cent, it is still an issue that needs to be addressed.

Hon Alannah MacTiernan: How would you address it, member?

Hon JIM CHOWN: I am not talking to you.

Several members interjected.

The DEPUTY CHAIR: Order, members!

Hon Peter Collier interjected.

The DEPUTY CHAIR: Order! The minister has the call.

Hon STEPHEN DAWSON: Members, the debate has been civil thus far, so it is probably good to keep it at that level.

Hon Jim Chown: I did not interject.

Hon STEPHEN DAWSON: I am just generally suggesting that we should keep it civil. I am happy to answer the member's question. This is an important debate, as we would all agree. In response to the member's question about the 71 per cent, my advice is that I am not able to get a guaranteed number of how many doctors work for St John of God hospitals in Western Australia, but certainly the annual report states that there are 2 839 accredited doctors. We do not know whether this is FTE or headcount or whether doctors are registered at more than one hospital.

Hon Jim Chown: It is a large number.

Hon STEPHEN DAWSON: I am aware from the medical board that there are approximately 11 000 doctors registered in WA and about 6 500 are generalists or specialists. The figure would be much less than that 71 per cent.

Hon Jim Chown: I am happy to accept that, but 2 800 is a large cohort.

Hon STEPHEN DAWSON: I am happy, for the purposes of debate, to seek that information and provide it at a later stage so that it is on the record. In relation to doctors who have a contract, I have read from clause 113, which refers to protections for persons acting in accordance with the act.

Hon Jim Chown: Is that clause 113?

Hon STEPHEN DAWSON: Yes. My reading of that is that it is for people who have a contract. There is nothing in this legislation to make that organisation employ people who have a different ethos from that institution. Nothing in the legislation provides that upon the cessation of a contract, there is a protection to ensure that that person needs to be re-employed or given a new contract. Obviously, from time to time, contracts expire and organisations do not renew them. Certainly for those who are employed, there is a protection in there and clause 113(3) alludes to that.

As I said, I am happy to get those numbers for the member and provide them at a later stage. I do not believe that the bill warrants an amendment to do what the member is suggesting. Hundreds and probably thousands of doctors will not want to participate in voluntary assisted dying in Western Australia, and many will conscientiously object. Others will participate and, upon the passage of this bill, the Department of Health is committed to working with those professional organisations in the implementation phase to talk to doctors, to train doctors and to encourage more doctors to participate in this bill. Certainly, others can object, if they so want to.

Hon JIM CHOWN: The minister is saying that the state is not prepared to include a future clause to give some protection to doctors who work in faith-based institutions across the state in regard to their future contractual arrangements. In my opinion, regardless of the figures, we have a large cohort—2 800 or 3 000 or whatever the figure is—of medical practitioners in this state who will more than likely not exercise their right to help people who apply or ask them about the VAD bill in front of us and how they can go about it, get advice, or even specialist advice, for their future treatment. I will say again, minister, that I think this is a fault in the bill that needs to be addressed by the government.

Hon STEPHEN DAWSON: I hear what the honourable member is saying. The institution cannot be compelled to renew someone's contract. Certainly, I do not propose to move an amendment in the bill before us to deal with this issue.

Hon PETER COLLIER: I am following on from the point that I raised earlier about potential amendments—I am speculating, I guess, to a degree—and following on from Hon Jim Chown. If I can play the devil's advocate, let me say that the bill goes through the committee stage and some amendments get the approval of the chamber. We come out of committee, the report is adopted, and the third reading is then approved. At this stage, thinking pragmatically, if we go full hog at this—it will take a fair amount of time in the committee stage, I would imagine—the Legislative Council will sit beyond the Legislative Assembly. Will the Legislative Assembly return and accept any amendments that are approved by this chamber?

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Hon STEPHEN DAWSON: Honourable member, I cannot answer that question. If there is a need for the Legislative Assembly to return following the passage of this bill, I am sure the Legislative Assembly will, but I am not in a position to countenance or second-guess what amendments may pass this place. If the Assembly needed to sit again post the passage of the bill, I am sure the Assembly would sit.

Hon PETER COLLIER: I will just finish on this, and the minister does not need to respond. I raise that point because based upon the comments of Hon Jim Chown, there will be a considerable amount of appraisal of this legislation, and so there should be; that is what I said in my second reading contribution. It is very important that we give this legislation the scrutiny and respect that it deserves.

With that in mind, as I said earlier, I am at pains to point out that I am disappointed that the government did not countenance any amendments in the other place. I think it would have been in the better interests of not only the legislation, but also the government having a more seamless process for this piece of legislation had it considered some very legitimate amendments in the other place. Having said that, we cannot unscramble an egg, so we are here now on the assumption that potentially there will be amendments. We heard ad infinitum from the Premier, along with some other somewhat intemperate comments, that he wants this legislation passed by Christmas. I will accept the will of this chamber, as I have done with the second reading, and that of the other place, but I will be very disappointed if we go to all that trouble and the bill comes out at the other end with amendments based upon the will of this chamber only to find that the Premier then says, “Sorry, but we’re not coming back until February”, because that would put paid to the sincerity of getting this piece of legislation through. That is fine; I take the minister at his word.

Hon Stephen Dawson: There is a commitment from government to get this bill finalised by the end of the year—by Christmas. I did say that if amendments are made in this place that require the Assembly to sit again, I am sure that the Assembly will sit.

Hon PETER COLLIER: That is good. I accept that. If there are amendments, the bill will be passed by this chamber and go to the Legislative Assembly and the Legislative Assembly will sit again beyond its scheduled rising at the end of November.

Hon Stephen Dawson: To consider the amendments.

Hon PETER COLLIER: That is correct—to consider the amendments. If it does not accept them, of course, it is game on again.

Hon NICK GOIRAN: Further to this line of questioning from Hon Peter Collier, does the government have in its possession drafts of any amendments?

Hon STEPHEN DAWSON: I have no amendments, and any government amendments would be in my name. I have no amendments to this bill. There are not any at this stage. Could there be? As I said earlier, we will deal with the bill on a clause-by-clause basis and we will deal with each amendment at that time as well.

Hon NICK GOIRAN: Minister, let us be clear: the government does not have in its possession any draft amendments. I am not asking whether the minister has amendments on the supplementary notice paper. I can read; I can see that there are none in his name. I am asking whether there are any draft amendments in the possession of anybody in government. I am not asking whether there are any in the name of this minister; I am asking whether there are any in the possession of government. The minister must know whether parliamentary counsel has been briefed on any amendments.

Several members interjected.

Hon NICK GOIRAN: With all due respect, Leader of the House, you do not have carriage of this bill, so I suggest you stay out of it!

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, please direct your comments to the Chair, not to other members in the chamber.

Hon STEPHEN DAWSON: I have the same answer: I do not have any amendments to this bill.

Hon Nick Goiran: That was not my question.

Hon STEPHEN DAWSON: That is the answer I am giving the member. I do not have any amendments to this bill. Any amendments to this bill that would be moved by the government would be in my name. No amendments have been provided to me, if they do exist.

Hon NICK GOIRAN: The minister has advisers at his disposal. He can also defer and ask for a recess to get this information. It is important for the chamber; if we are to range over possible amendments on clause 1, we need to know what the government is up to. I do not know whether any of the minister’s advisers have any role within the Parliamentary Counsel’s Office. I am simply making the observation that it is impossible for the government not

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to know whether it has briefed parliamentary counsel on amendments. I know that the minister does not have any in his name. I am simply asking him a very basic question. Has the government briefed parliamentary counsel on any amendments to this bill?

Hon STEPHEN DAWSON: The government has had conversations with parliamentary counsel about amendments that have been foreshadowed by the Australian Medical Association and others. Conversations have happened, but I am not at liberty to suggest what those amendments are and I do not have any amendments.

Hon NICK GOIRAN: The minister said that there have been conversations with Parliamentary Counsel. Does the government have any draft amendments in its possession as a result of those conversations?

The DEPUTY CHAIR: Member, you have asked that question four times, to my recollection. The standing orders of this chamber refer to tedious repetition. It is tedious repetition to ask the same question four times, with the minister answering the question but not giving you the answer that you want. Perhaps you might rephrase the question and not ask it in that manner. Of course, the minister is entitled to answer if he chooses.

Hon NICK GOIRAN: Mr Deputy Chair, I am happy for *Hansard* to be checked. The question that I have just asked the minister I have never asked before this evening. I simply asked if the government has in its possession any draft amendments as a result of the conversations that we have just learnt for the first time that the government has had with Parliamentary Counsel. I am asking whether any draft amendments have been provided to government as a result of those conversations.

Hon STEPHEN DAWSON: I am advised that the government has some draft amendments in its possession. It is beginning to discuss those draft amendments with interested members.

Hon NICK GOIRAN: Will the minister table those draft amendments?

Hon STEPHEN DAWSON: No. I do not have the draft amendments, but, no, I will not table them. I have been told that they are being discussed with interested members.

Hon AARON STONEHOUSE: I have a couple of questions on the interaction with the Medicines and Poisons Act. Before I get to that, I would like to reflect on the conversation that seemed to lead towards discussion around compelling organisations to continue their contracts with medical practitioners who offer voluntary assisted dying, and a concern raised by Hon Jim Chown about the accessibility of voluntary assisted dying, if there are no protections for practitioners who offer such a thing to have their contracts renewed. I might just express my concern. I raised in my second reading contribution the importance of protecting conscientious objectors, which I think this bill does somewhat well, although it is deficient in other areas. I have an amendment to address that, but we can discuss that at a later time when we get to that clause. On protections for conscientious objectors, I bring to members' attention clause 4(1)(j) under division 2. This principle of this legislation is stated as —

all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

I feel that applies not only to frontline practitioners who may be conscientious objectors to voluntary assisted dying, but also to the organisations that employ those practitioners, such as faith-based private hospitals.

I think it is important that we do not lose sight of that. As I said in my second reading contribution, we cannot extend freedom to one class of people at the expense of another. Freedom should be applied broadly to all people. We should not be in the business of compelling people with strongly held moral objections to voluntary assisted dying to participate in a scheme that is counter to their own moral values. With that said, I wonder whether the minister could advise about the interaction with the Medicines and Poisons Act. Earlier, Hon Rick Mazza gave a scenario in which a patient who had been given a voluntary assisted dying substance did not use all of that substance. What measures are in place to recover that substance? How would recovery of that substance be done? Will the bill grant any powers to the Voluntary Assisted Dying Board to recover such a substance?

Hon STEPHEN DAWSON: I thank the member. Disposal of unused medication will be controlled and reported back to the board; that is in clauses 75 and 77. For self-administered voluntary assisted dying medications, the proposed electronic approval and notification system will show when any unused medication is disposed of by the authorised disposer when it is received from the contact person. The board will receive the authorised disposal form from the authorised disposer. For any unused practitioner-administered voluntary assisted dying medications, the proposed electronic approval and notification system will identify any unused voluntary assisted dying medications that have been disposed of by the administering practitioner, and the board will receive the practitioner disposal form.

In relation to the return of medication, I want to make the point that it should be noted that no evidence of misuse associated with voluntary assisted dying medication has been found elsewhere in the world. A person undertakes to adhere to certain obligations when they consent to taking on the role of contact person. If the contact person were to retain the prescribed substance or mislead authorities about how much was used, they would be in breach

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of the requirements of clause 104 of the bill. Both the contact person and the patient's agent will also be subject to very strict laws, including under the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1981, that relate to unauthorised possession of drugs and poison.

In relation to the return of medication by others, under the bill, the contact person, not the patient or agent, will be legally required to give the authorised disposer any prescribed substance that is unused or remains. There will be nothing to stop the patient from returning it to an authorised disposer, but the contact person will be the person responsible under the act and will bear the responsibility.

Hon AARON STONEHOUSE: Can the minister point me to the offences in the bill—if they exist—for refusing to dispose of either a practitioner-administered or self-administered voluntary assisted dying substance?

Hon STEPHEN DAWSON: It is in clause 104, "Contact person to give unused or remaining substance to authorised disposer". The penalty for an offence under subclause (1) is imprisonment for 12 months.

Hon MARTIN PRITCHARD: I want to turn the minister's mind to clause 6 and the concept of decision-making capacity. I must say that I have a different view with regard to decision-making capacity. It seems that this clause talks more about understanding. I can imagine a doctor saying, "Do you understand that if you take this poison, you are going to die?", and the person says that yes, they understand.

I note also that at clause 9(2), a person is not excised from the use of voluntary assisted dying just for the sake of having a mental illness. With regard to a patient having a mental illness that impacts on their decision to access VAD, how is it coped with in the bill?

Hon STEPHEN DAWSON: A person who has a disability or a mental health condition would still be eligible for voluntary assisted dying as long as they met all the eligibility criteria, including decision-making capacity. Having a disability or mental health condition does not exclude someone from accessing voluntary assisted dying, but they are not able to access voluntary assisted dying only on the basis of disability or mental illness, and that is in clause 15(2).

Hon MARTIN PRITCHARD: I understand the two concepts, but I am saying that a person may end up with clinical depression, obviously because they have just been told they have six months to live. I am concerned because the bill seems to suggest that decision-making capacity is understanding, and I understand that. What part of the bill would require the two medical practitioners to determine whether a decision is impacted upon by a mental illness or depression, for instance?

Hon STEPHEN DAWSON: When the coordinating practitioner cannot determine whether the patient's disease, illness or medical condition meets the eligibility criteria or whether the patient has decision-making capacity in relation to voluntary assisted dying under the eligibility criteria, the coordinating practitioner must refer the patient to a registered health practitioner with the appropriate skills and training to make that determination. The appropriate registered health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate.

The DEPUTY CHAIR: Minister, sorry to interrupt you, but I think the member might be struggling to hear a little bit. Perhaps a bit more audibly would be helpful.

Hon STEPHEN DAWSON: Let us do that again.

Hon Martin Pritchard: No; I —

Hon STEPHEN DAWSON: I would be grateful if perhaps someone in the chamber could make sure the microphones are turned up.

If the coordinating practitioner cannot determine whether the patient's disease, illness or medical condition meets the eligibility criteria or whether the patient has decision-making capacity in relation to voluntary assisted dying under the eligibility criteria, the coordinating practitioner must refer the patient to a registered health practitioner with the appropriate skills and training to make that determination. The appropriate registered health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate. If the concern is decline due to ageing, a geriatrician may be preferable. The ability to refer the patient to a specialist is consistent with the joint select committee's legislation framework.

Hon MARTIN PRITCHARD: If I understand the minister correctly, there will be two main bases for referral—I am not trying to limit it. One is whether the practitioner can determine whether the underlying illness meets the criteria. The other is whether the patient has decision-making capacity. I am inferring that decision-making capacity is about understanding. A person may have decision-making capacity as referred to in the bill, but still have a mental illness that can impact on the decision. What the minister suggested—that is, sending the patient to a psychiatrist if there is a mental illness—may not be a bad thing, but I cannot see that under the two prescribed

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reasons the minister indicated. One is about the illness and the other is about decision-making capacity. I do not think the decision-making capacity, as stated in the bill, has anything to do with mental illness. I would be happy if I were wrong.

Hon STEPHEN DAWSON: Clause 6 of the bill refers to decision-making capacity. It states —

(1) In this section —

voluntary assisted dying decision means —

- (a) a request for access to voluntary assisted dying; or
- (b) a decision to access voluntary assisted dying.

(2) For the purposes of this Act, a patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to —

- (a) understand any information or advice about a voluntary assisted dying decision that is required under this Act to be provided to the patient; and
- (b) understand the matters involved in a voluntary assisted dying decision; and
- (c) understand the effect of a voluntary assisted dying decision; and
- (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purposes of making a voluntary assisted dying decision; ...

Hon MARTIN PRITCHARD: Is the minister indicating that paragraph (d) is the one?

Hon Stephen Dawson: Paragraph (d) is the one.

Hon JIM CHOWN: I have just been checking some figures in my previous statement about employment and faith-based institutions. The St John of God Health Care annual report 2017–18 states that it fully or partially employs 2 500 doctors. That includes general practitioners and specialists. The Department of Health’s “General practice workforce supply and training in Western Australia” report from 2018 states that our general practitioner ratio in this state is 81.5 per 100 000 people. We have a population of 2.72 million people in the state, so 2 216 GPs are employed in Western Australia, excluding specialists. I believe my statement about the 71 per cent is pretty close to the number of doctors employed by faith-based health institutions. I would be happy to have this figure corrected by the volume of people in the health department. If that is the case, there is a massive fault in this bill with having VAD exercised by medical professionals across the breadth and width of this state. The minister cannot tell me that a professional doctor employed by a faith-based institution, regardless of those who object to voluntary assisted dying, would jeopardise their future employment without some indemnity in this field to allow them to do so—to exercise VAD. My question is: how is the government going to address this?

Hon STEPHEN DAWSON: As I said, honourable member, I do not propose to move an amendment on this issue. In relation to the member’s earlier comments about the numbers, as I have indicated to the member, I still have a difference of opinion in relation to the numbers and that 71 per cent figure. As I indicated to the member previously—I again make this commitment—I have committed to seeking advice on the numbers and placing them on the record, but I still believe the member’s figure of 71 per cent is inaccurate. Nonetheless, that is a moot point. There will be a significant number of doctors in Western Australia who are employed by faith-based institutions. I have already pointed to clause 113 of the bill, which talks about protection for those who are employed and who have contracts. I do not propose to move an amendment in relation to those whose contracts cease and the agency, for whatever reason, does not employ them again.

Hon AARON STONEHOUSE: I have some more questions around the interaction with the Medicines and Poisons Act, if it is not unruly to ask them now, as I am not sure where they appear in the bill, or whether they appear in the bill at all, but it seems to be relevant. What is the normal penalty for someone in possession of a schedule 8 poison without otherwise having some exemption?

Hon STEPHEN DAWSON: I am advised that the penalty is a fine of \$45 000 and imprisonment for three years. Those penalties are under the general penalties in section 115 of the Medicines and Poisons Act 2014. The offence falls under section 14(4) of the Medicines and Poisons Act 2014, but the penalties are a fine of \$45 000 and imprisonment for three years.

Hon AARON STONEHOUSE: Can the minister clarify whether someone who fails to return a voluntary assisted dying substance within the 14-day window, as is outlined in proposed section 104 of the Voluntary Assisted Dying Bill, would be liable for prosecution by the CEO for 12 months’ imprisonment? Would they also be liable to penalties under the Medicines and Poisons Act? Is that correct?

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Hon STEPHEN DAWSON: For possession, the penalty of a fine of \$45 000 and three years' imprisonment is the same.

Hon AARON STONEHOUSE: All right. What I am getting at is a scenario in which someone is in possession of a VAD substance and they exceed the standard 14-day window to return the substance to an authorised disposer. They would be in breach of the penalty in proposed section 104 of the VAD bill and also in breach of the Medicines and Poisons Act; therefore, they would be liable to both penalties. Is that correct?

Hon STEPHEN DAWSON: It can be both.

Hon AARON STONEHOUSE: It can be both, assuming there is not some defence or other circumstance that might exempt them from the penalties of the MPA. Under the VAD bill, the CEO can commence prosecution. The CEO is responsible for the enforcement of the penalties under proposed section 104. Who is responsible for the enforcement of the MPA? That would be the Department of Health, but would it be the CEO, or is there some other delegated sub-agent or authority that would be responsible for enforcing the provisions of the MPA?

Hon STEPHEN DAWSON: It is the CEO and any person he authorises.

Hon AARON STONEHOUSE: It is the same person, at least, and they can apply those penalties when they think appropriate. Are there powers in either the VAD bill or the Medicines and Poisons Act that facilitate the recovery of a schedule 8 poison such as the VAD substance? There are penalties for being in possession, but what powers exist to allow the CEO to investigate someone in possession of a VAD substance? For instance, someone has a substance and they fail to return it. It turns out that, maybe, they sold it or gave it away or lost it—who knows? Is it now a matter for the police, or does that still rest with the CEO of the Department of Health?

Hon STEPHEN DAWSON: Part 7 of the Voluntary Assisted Dying Bill relates to enforcement. It sets out the application of the Medicines and Poisons Act 2014 and factors relating to the enforcement of this issue. I am told that the MP act enables police or investigators appointed by the CEO to investigate, and they also have powers of seizure.

Hon AARON STONEHOUSE: I might have some more detailed questions around how that will work at a later stage.

If there is a concern that someone lawfully in possession of a VAD substance, with their prescription and exemption, may be misusing that substance—giving it away, selling it, cutting it or whatever—will the board be empowered to notify the CEO to recover that substance, assuming that it is within that 14-day period and there is no obligation on them to dispose of the substance but concerns are raised that they have acquired a substance, they do not intend to use it, they may be misusing it or they may intend to use it for some nefarious purpose or who knows what?

Hon STEPHEN DAWSON: The board has the power to advise the CEO and the police. The likelihood is that the board would refer the issue to the police.

Hon RICK MAZZA: I want to pick up on a couple of questions asked by Hon Martin Pritchard around mental capacity and the eligibility criteria. I gathered from the minister's answer earlier that three parts of the clause on decision-making capacity had to be met—paragraphs (a), (b) and (c)—but the patient also had to be able to weigh up those factors. There is a whole list of things under the eligibility criteria—the patient has to be over 18 years of age and a permanent resident of Australia et cetera. One of those criterion is that they have to have decision-making capacity. Am I right in saying that if, for argument's sake, somebody has advanced dementia and then develops another illness or disease, which means they will die in, say, six months, but the coordinating medical practitioner and consulting medical practitioner cannot establish decision-making capacity, that person will be ineligible to access VAD?

Hon STEPHEN DAWSON: The short answer is yes. Advanced dementia means that a person would likely not have capacity.

Hon RICK MAZZA: If the coordinating and consulting medical practitioners cannot establish decision-making capacity and they are concerned about the condition of this person, are they able to access a consulting psychiatric assessment to try to establish that?

Hon STEPHEN DAWSON: In that instance, they must refer a person. I want to place on the record—this probably goes back to Hon Martin Pritchard's comment—that decision-making capacity is a different concept from mental illness. Doctors are skilled at ascertaining whether a person has decision-making capacity. It is standard clinical practice when they are ascertaining whether a person consents to treatment, and they must refer if they are uncertain. Decision-making capacity is not just about understanding; it is also about properly weighing all the options and factors to reach a decision.

Progress reported and leave granted to sit again, pursuant to standing orders.