

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

**INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA
TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS
REGARDING THEIR OWN END OF LIFE CHOICES**



**TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 27 FEBRUARY 2018**

SESSION FOUR

Members

**Ms A. Sanderson, MLA (Chair)
Hon Colin Holt, MLC (Deputy Chair)
Hon Robin Chapple, MLC
Hon Nick Goiran, MLC
Mr J.E. McGrath, MLA
Mr S.A. Millman, MLA
Hon Dr Sally Talbot, MLC
Mr R.R. Whitby, MLA**

Hearing commenced at 1.59 pm

Ms PAULINE MEREDYTH BAGDONAVICIUS

Public Advocate, Office of the Public Advocate, Department of Justice, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson and I am the Chair of the joint select committee. I will introduce the other committee members. We have Simon Millman; Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; Reece Whitby; and Hon Robin Chapple.

The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you may say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet.

Do you have any questions about your attendance here today?

Ms BAGDONAVICIUS: No.

The CHAIR: Before we begin with our questions, did you want to make a brief opening statement?

Ms BAGDONAVICIUS: I would like to make some opening remarks, thank you. The opening statement I would make is that I did take the opportunity to make a submission to the committee to inform you of the ways in which treatment decisions, including end-of-life decisions, are being made for adults with a decision-making disability. The Guardianship and Administration Act provides a number of options for treatment decision-making after a person has lost capacity. These range from family or friends, whose decision-making authority comes from their place in the person's hierarchy of treatment decision-makers; through to planning documents which adults can make while they have the capacity, being an advance health directive and enduring power of guardianship; and, finally, the appointment of a guardian by the State Administrative Tribunal, whether they be a family member or friend or, as the last resort, the appointment of the Public Advocate as guardian. In addition, I just wanted to highlight the importance of these vulnerable adults who lack capacity to make their own decisions being excluded from any model for voluntary assisted dying, if that becomes a recommendation to the Parliament. In my view, only adults with capacity to make their own decisions should be able to participate in such a scheme.

The CHAIR: I will just start with some questions on advance healthcare directives. Given that advance healthcare directives and substitute decision-makers have been legislated for under the Guardianship and Administration Act, can you describe how you came to an arrangement to work with the Chief Medical Officer in developing this partnership, with the Department of Health in the lead role?

Ms BAGDONAVICIUS: Sure. Community consultation in 2005 on a discussion paper, "Medical Treatment for the Dying", informed the development of the Acts Amendment (Advance Health Care Planning) Bill, which was released at that time by the Attorney General, who was also Minister for Health, in May 2005. Hon Jim McGinty, the then Minister for Health, introduced the Acts Amendment (Advance Health Care Planning) Bill 2006 into the Legislative Assembly on 21 June that year. It was later known as the Acts Amendment (Consent to Medical Treatment) Bill and, upon its

passage through the Parliament, it was proclaimed as the Acts Amendment (Consent to Medical Treatment) Act 2008. The partnership between the Office of the Public Advocate and the Department of Health developed from 2008 in preparation for the implementation of the Acts Amendment (Consent to Medical Treatment) Act. The Department of Health, through the office of the Chief Medical Officer, took the lead role with advance health directives, with their specific focus on treatment decision-making, and the Office of the Public Advocate took the lead role in relation to enduring powers of guardianship, and that covered the broader approach to personal lifestyle and treatment decision-making.

The CHAIR: The report for the statutory review into the GAA identified that the lack of registration was an area for discussion by the community. Is that still an issue for members in the community—the lack of central registration?

Ms BAGDONAVICIUS: I will just make some comments in terms of the statutory review. I was a key stakeholder, as the Public Advocate, and I was consulted in respect to the major issues that were raised in submissions to the statutory review of the Guardianship Administration Act, which was conducted by the then Department of the Attorney General for the then Attorney General. I was also consulted in respect of the development of recommendations. The report prepared by the Department of the Attorney General on the statutory review of the Guardianship Administration Act was tabled in the Parliament on 2 December, 2015. As is often the case, a number of issues were raised in submissions that were considered to be outside the terms of reference for the statutory review and the operation and effectiveness of the act.

I understand that there was, however, limited interest in the establishment of a register. It was submitted that a central registration of advance health directives and enduring powers of guardianship would reduce the risk of misuse of these documents, and the likelihood of legal action being taken against hospitals where decisions might be made in consideration of an advance health directive or a guardian's view that it had been revoked or adjusted and the updated information not being provided to the hospital. In my role of the Public Advocate, I submitted that, in relation to the registration of advance health directives, the concern for most people relates to health professionals being aware that they have made this document, and having it available at the time their treatment decisions are being made. This can be managed by the individual through ensuring that their guardian, their family members or treating health professionals or service providers have a copy of their enduring power of guardianship and/or their health directive and the names of the persons appointed. Agencies such as an aged-care facility can obtain copies of these powers from people at the time they come into their service. This provides a simple and cost-free way of information being shared with relevant parties by either the maker of the power, family members, or an appointed enduring guardian.

I also submitted to the statutory review that registration of any powers would have significant community education and resource implications. If the provisions relating to registering advance health directives are proclaimed, there would need to be consideration of a requirement either for registration to be compulsory or, if registration is not compulsory, a provision that ensures a doctor who has searched the register would not be liable if the document was later produced and treatment had not been provided in line with the document. There would also need to be consideration of a person having only one advance health directive at any time, which would require revocation provisions and a likely administrative process, with a fee, for parties to follow in regards to revoking a document. The need for revocation provisions for all powers—enduring powers of attorney, enduring powers of guardianship, and advance health directives, which are legislated under part 9 of the Guardianship and Administration Act—is one of the recommendations of the statutory review.

Hon NICK GOIRAN: The statutory review that you mentioned—you gave a date when it was tabled. I think it was December 2015.

Ms BAGDONAVICIUS: That is right—2 December 2015.

Hon NICK GOIRAN: You mentioned that you are a key stakeholder in that review?

Ms BAGDONAVICIUS: Yes.

Hon NICK GOIRAN: And you have had an opportunity to read the report?

Ms BAGDONAVICIUS: Yes.

Hon NICK GOIRAN: Would you be in a position, either today or, if needs be, on notice, to advise the committee which of the recommendations in that review you agree with?

Ms BAGDONAVICIUS: I have made recommendations, and my deliberations have been considered as part of —

Hon NICK GOIRAN: Submissions?

Ms BAGDONAVICIUS: Yes, I made the submission, and then I was consulted in the final preparation of the recommendations for the Attorney General. That process is subject to the Attorney General announcing what recommendations are to be implemented as a result of that review, at this stage.

Hon NICK GOIRAN: Yes, I understand that. There is a report that has been tabled, and the report has got a series of recommendations. I do not know off the top of my head how many recommendations there are, but I am just interested in whether the Office of the Public Advocate agrees with all of those recommendations.

Ms BAGDONAVICIUS: At the end of the day, it is up to the Attorney General in terms of any government deliberation in terms of those recommendations.

Hon NICK GOIRAN: Is the Office of the Public Advocate an independent position?

Ms BAGDONAVICIUS: I am appointed under the act. However, I am also part of the Department of Justice; I am an executive member of the Department of Justice. I report to the Attorney General through my annual report each year.

Hon NICK GOIRAN: So, you are not in a position to advise the committee as to whether you agree with the recommendations without checking with the Attorney General first?

Ms BAGDONAVICIUS: I would agree with that comment, yes.

Hon COLIN HOLT: Just to follow up on that, are we actually still waiting for the government to respond to that report? Is that what you are saying?

Ms BAGDONAVICIUS: There is an election commitment by the current government to the implementation of that statutory review. It would be a question for you to put to the Attorney General, in terms of the implementation process.

Hon COLIN HOLT: I am just asking about the process. I understand you have got to get a response, but are we still waiting for a response?

Ms BAGDONAVICIUS: Yes, there has not been any public announcement about the government's response to the statutory review at this point.

[2.10 pm]

Hon NICK GOIRAN: Further to my questions before: at the outset, during your opening statement, I think you expressed to the committee that if there is going to be a regime for assisted suicide in this state that your view is that that should exclude people with a mental incapacity.

Ms BAGDONAVICIUS: Yes. People who do not have capacity to make their own treatment decisions.

Hon NICK GOIRAN: Is that your view or did you check that with the Attorney General first?

Ms BAGDONAVICIUS: That was the view I put forward in my submission.

Hon NICK GOIRAN: Was that submission vetted by the Attorney General?

Ms BAGDONAVICIUS: As a courtesy, I passed a copy of my submission to the Attorney General. He is aware of what comment I have made in that regard.

The CHAIR: Can I ask: what is your view of a central register for advance healthcare directives? Do you think that is a system that would have merit?

Ms BAGDONAVICIUS: I think there are complications around the development of a central register. There are issues around a central register. It does mean registration has to be compulsory. I am aware that the Department of Health had some concerns in relation to a central register because they would have to be sure that current advance health directives lodged on the register also represent current views of patients. Access to the register would have to be provided 24 hours a day and access to advance health directives being held on the register would need to be limited to appropriate members of staff within the Department of Health. There are issues probably for how someone like myself as the Public Advocate, when I am appointed, would gain access to such a register as well, depending on where the register was held. There is quite a number of issues. I think the important thing is that people really do want people to know what their treatment decision is and they can have an advance health directive with them, they can make their family members aware of their advance health directive, they can make their GPs aware and they can make their nursing home aware if and when at a later stage in life they are admitted into such a facility. At this point of time that is a preferable option.

The CHAIR: Why have the view that registration be compulsory? My understanding is that was not the intention of the original bill.

Ms BAGDONAVICIUS: To work effectively, it would be very difficult to have a register if it was not compulsory to register because then a treating team may not ask someone, "Do you have an advance healthcare directive?" They may assume that it is on the register. I think it adds a complexity if it is not—it would appear to me to be one system for doing so or not doing so.

The CHAIR: Can I talk about the advance health care plans that the health department has developed. Do you have any concerns about the use of the advance healthcare plans as developed by the department in 2012 rather than the legally binding statutory advance healthcare directive instruments, given the Department of Health's advice to us that the former do not constitute common law advance health directives and are not binding?

Ms BAGDONAVICIUS: As I mentioned earlier, the Office of the Public Advocate has worked closely with the Department of Health in relation to providing information to community members and service providers about advance health directives and other aspects of the Guardianship and Administration Act as it relates to the future decision-making planning tools available to people. As I mentioned before, the Department of Health has had the lead role in promoting advance health directives, particularly to the health professionals. During that working partnership that we had with the rollout of the consent to medical treatment act implementation, we did a lot of intensive community education, sometimes jointly, sometimes independently. We, through that process, became very well aware of the advance care planning process that the Department of Health is undertaking and is encouraging people to do as part of their preparing for the future. This is something that is not just happening here in Western Australia; it is happening across Australia. The important thing is that the advance care plan goes much further than an advance health directive.

The advance health directive will be more specific around specific treatment decisions. I appreciate that the advance care plan is a very holistic document in terms of talking about people's wishes, but it does not have that status in terms of being an automatic recognition because it is not in the form of the advance health directive. To be an advance health directive, it must primarily be in the form of the advance health directive as it is actually being done in the regulations of the Guardianship and Administration Act. The benefit of people still doing an advance care plan is that it is still very useful and rich information for anyone who, at any point down the track, has to make decisions on behalf of a person. If I as the guardian am aware of what is contained within an advance care plan and a person has not made an advance health directive, and they have not appointed an enduring guardian and I still have a copy of their advance care plan, that is nevertheless very useful information to me as the guardian because as the guardian I am bound to make decisions in accordance with section 51 of the Guardianship and Administration Act and make decisions in the best interests of the represented person. The most critical issue in that is that I am taking into account the views and wishes of the person as they were known; to give effect to those views and wishes, to the extent that that is possible and to the extent that I can also do that in a culturally appropriate way as well. It is very rich information nevertheless, even though it does not have the same status as an advance health directive.

The CHAIR: When you say it goes a lot further than an advance healthcare directive, can you elaborate on that?

Ms BAGDONAVICIUS: The documents are actually readily available, I am sure, to the committee. I will have a look at one. I think I have a copy of one.

Actually, I did not put it into this document. It will talk about what sorts of things you want considered such as, "Where would you like to live?" It even will encourage people to talk about what they may eat; what sorts of things they like to eat, and other wishes. I am sorry, I do not have a copy in front of me.

Hon Dr SALLY TALBOT: I have actually got it open on my screen, and I have had for the extent of the hearings. If I can just explain —

Ms BAGDONAVICIUS: Yes, that would be good.

Hon Dr SALLY TALBOT: — and you can tell me whether I am right. The directive is simply about treatment decisions.

Ms BAGDONAVICIUS: The advance health directive is only treatment?

Hon Dr SALLY TALBOT: Yes.

Ms BAGDONAVICIUS: It makes treatment-specific decisions.

Hon Dr SALLY TALBOT: There is essentially only one part of the form that is repeated over and over again. It just says under "Treatment decision", "In the following circumstances:"—blank—"I consent/refuse consent ... to the following treatment:"—blank. It is just that repeated down the form.

Ms BAGDONAVICIUS: That is the advance health directive but —

Hon Dr SALLY TALBOT: Whereas presumably an advance care plan would talk about, "This is where I would like to live and this is who I would like to look after me."

Ms BAGDONAVICIUS: Yes. Those sorts of things, yes.

Hon Dr SALLY TALBOT: Does that assist?

Ms BAGDONAVICIUS: Yes. Thank you.

The CHAIR: Do you think people understand the difference when they are filling out an advance healthcare plan as opposed to a health care directive—that one is more enforceable than the other?

Ms BAGDONAVICIUS: In our community education we make that point and I know the Department of Health do, and a range of other agencies such as Palliative Care Network also do as part of the ongoing community education around the use of these instruments.

The CHAIR: In relation to the Criminal Code, are you able to expand on why the relevant Criminal Code provisions were not included in the review?

Ms BAGDONAVICIUS: Section 14 of the acts amendment did actually talk about having a statutory review of the operation and effectiveness of the Guardianship and Administration Act and the Criminal Code to be undertaken within three years of commencement of the amendment act. As I am sure the committee is aware, but I will just touch on it: the Acts Amendment (Consent to Medical Treatment) Act amended sections 259, 265 and 275 of the Criminal Code. The amendments to those sections clarified the term “treatment” used in the three sections included palliative care, and in addition a new subsection (2) was added to section 259 which deals with surgical and medical treatment liability to provide that —

A person is not criminally responsible for not administering or ceasing to administer, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.

[2.20 pm]

I am aware that prior to developing the draft terms of reference the then Department of the Attorney General did consult with a range of key stakeholders, including the Department of Health, to determine what issues had arisen since the enactment of the consent to medical treatment act in respect to the interpretation of the amended legislation. It was determined there were no issues in respect to the operational effectiveness of the amendments to the Criminal Code. There had also been a judgement in the Supreme Court by the Chief Justice in relation to section 259 and 262 of the Criminal Code, as you may be aware from the Brightwater submission.

The CHAIR: The Brightwater v Rossiter case?

Ms BAGDONAVICIUS: Yes. The terms of reference for the statutory review, as approved by the then Attorney General, Hon Michael Misichin stated the following would be examined. That was in terms of the Guardianship and Administration Act—the operational effectiveness of that act; the need for amendments to ensure that the act provides for effective guardianship of adults who need assistance in their personal affairs due to a decision-making disability; provides for effective administration of the estates of people who need assistance in their financial affairs due to a decision-making disability; to enable the State Administrative Tribunal to operate efficiently and effectively in respect of guardianship and administration matters and supports the effective operation of enduring powers of attorney, enduring powers of guardianship and advance health directives; the making of treatment decisions and the making of decisions relating to medical research. I am also advised by the Department of Justice that no issues were raised in the submissions to the statutory review in respect of the operational effectiveness of those particular sections of the Criminal Code.

Hon NICK GOIRAN: No submissions raised issues with regard to the relevant provisions of the Criminal Code. When submissions were requested, would the submitters have been provided the terms of reference given by the Attorney General?

Ms BAGDONAVICIUS: Yes.

Hon NICK GOIRAN: Which made no mention of the provisions of the Criminal Code.

Ms BAGDONAVICIUS: No, but often —

Hon NICK GOIRAN: I submit they could well have had no idea that they were to put in issues with regard to the Criminal Code because the Attorney General of the day decided not to include that in the terms of reference.

Ms BAGDONAVICIUS: The only other comment I would make in response is that people often do go outside the terms of reference and make additional comments if they so wish.

Hon NICK GOIRAN: Sure. Is it possible that the mandated statutory review of the relevant provisions of the Criminal Code is still outstanding?

Ms BAGDONAVICIUS: At the end of the day, the statutory review has been undertaken certainly in terms of the Guardianship and Administration Act.

Hon NICK GOIRAN: Yes, the first part.

Ms BAGDONAVICIUS: As I have indicated, their focus was not on the Criminal Code at that time in terms of the terms of reference that were developed for the review of the act.

Hon NICK GOIRAN: In terms of me pursuing this further, is this something that falls under the remit of the Office of the Public Advocate?

Ms BAGDONAVICIUS: No.

Hon NICK GOIRAN: Who should I be directing my question to?

Ms BAGDONAVICIUS: The Attorney General.

The CHAIR: We will move to treatment decisions and those that you have authorisation for. Can you tell us how many people for whom you are authorised to make treatment decisions are in palliative care?

Ms BAGDONAVICIUS: To clarify for the benefit of the committee, in making decisions on palliative care my decision is actually always recorded on the represented person's file, both electronic and hard-paper file. Since April 2015, I have collected those decisions centrally. So from that basis, because I have had to go back to my central file, it is not something I can easily gather from individual files. I have examined the decisions made for people since April 2015. There are currently 41 represented persons for whom I have given consent to palliative care.

The CHAIR: In your position statement on palliative care, you state that all decisions regarding palliative care are authorised by you. Can you advise how many such decisions were made in 2016–17?

Ms BAGDONAVICIUS: I can advise that in terms of 94 represented persons, I made a palliative care decision for people in 2016–17.

The CHAIR: Thank you. Would it be correct to assume that generally you would consent only to non-resuscitation in instances where a medical professional adjudges it to be futile, but you would not consent to non-resuscitation otherwise?

Ms BAGDONAVICIUS: The Public Advocate—I say the Public Advocate because sometimes other people are acting in my job—is always guided by the medical professional; the treating doctor. We are not a medical person; we are a person standing in the shoes of the represented person. It is the doctor's recommendation about these matters that we take into account, just as an ordinary person would in making a decision around consent to “not for resuscitation”.

The CHAIR: Given that paid carers are excluded from the hierarchy of decision-makers, are you able to take into account the views of paid carers when making treatment decisions?

Ms BAGDONAVICIUS: Yes, we do. You would be aware that section 110ZD(5) of the Guardianship and Administration Act excludes a person from being a person responsible to make a treatment decision where their contact is of a professional or business nature.

The CHAIR: Yes.

Ms BAGDONAVICIUS: However, in making a treatment decision the Public Advocate will routinely seek the views of paid carers who are interested parties and have a long-term relationship with represented persons. Those carers have contemporary knowledge of that person. They are seeing them day to day and can provide us with very good information in terms of what the person's wishes are and how they are responding. I will give you an example. We have a number of people for whom I am appointed as the Public Advocate who have very profound disabilities and who have been living long term in accommodation provided by the Department of Communities, Disability Services or funded through the now National Disability Insurance Agency. In many cases for the people for whom I am appointed, families have ceased to have contact; often it is because their parents have died or their parents are now very elderly and not in a position to take on an active role in terms of decision-making. In those cases we are very much routinely talking to those carers because they know the person well, and so they are able to help inform us as we make those decisions—as I make those decisions.

The CHAIR: In relation to other palliative care practices, are you able to advise if you would authorise any of the following: a refusal of life-sustaining medical treatment, other than when assessed by a medical professional as futile?

Ms BAGDONAVICIUS: I would prefer to answer these particular categories as a group, if that works for the committee.

The CHAIR: That is fine.

Ms BAGDONAVICIUS: I wondered if it might be helpful for you to have an example from me of how I have made a palliative care decision in the past just an example of my role in doing that.

The CHAIR: Yes please; feel free.

Ms BAGDONAVICIUS: It helps put a context around where I get to in terms of my answer. I was appointed the guardian for a man who was admitted to hospital in March 2016. That man had a range of medical issues but he was still living at home alone and having some support. At the time of his admission to hospital, he had Alzheimer's dementia, he had prostate cancer, he had heart disease, chronic back pain and some other heart-related issues, as well as starting to have some hearing loss. The reason for his entry into hospital was because he had a fall so he needed treatment. It became obvious to the treating staff that they thought he did not have capacity. They made an application through their social work department to the State Administrative Tribunal for the appointment of a guardian to make those decisions and to also make decisions about where he may live in the future because their assessment was that he should not be returning home to live by himself as he had been. The State Administrative Tribunal then appointed the Public Advocate as guardian of last resort as family members were not very much engaged with this man and did not want to be seen to be making a decision which he may resist, which was that it looked to all intents and purposes that he would need to move into residential care. So the Public Advocate was appointed to make that decision as well as to make treatment decisions into the future. The decision was made and he move into residential care. He moved into residential care in May 2016. Obviously, during that time he was still being treated for his various medical conditions. A year later, the nursing

home contacted us because they were keen to progress a referral to the Metropolitan Palliative Care Consultancy Service because they felt that he was deteriorating. He was certainly progressing; he was now a full hoist transfer and could not walk or talk.

He had special chairs during the day and he was sometimes groggy. So they were wondering about what his care pathway should be in the event that he should deteriorate either rapidly or just very gradually over a long period of time. The treating general practitioner endorsed that referral and the team came back and assessed it. The palliative care team gave a recommendation back to the general practitioner, who then endorsed it. The facility staff agreed with that assessment and they advised that with all of his comorbidities, his frailty and his rapid decline his prognosis was very poor, and so their view was that his life expectancy was in terms of months, not years, and a palliative approach would be appropriate. At that point the palliative decision did not stand because my office—then the delegated guardian—consulted and got in contact with his family members and sought their views on it. They were supportive of him having humane treatment; they did not want him having unnecessary treatment and were happy for him to have a palliative approach as recommended by the doctor. On the basis of all that information I was then able to make a decision that this man should have palliative care.

[2.30 pm]

That decision was made back in August. He has not automatically been treated with intensity in terms of a palliative pathway until more recently. More recently, the nursing home staff, through their general practitioner, came back to us to suggest that they would have a further assessment by the palliative care team. I had signed off previously, in terms of making my palliative care decision, that he could only be transferred to hospital for injury management or severe symptoms that the staff could not manage in the facility, that he was not to be for resuscitation, in the case of pneumonia he would be treated with oral antibiotics in the facility and that he would receive pain relief and comfort measures at the appropriate time with the support of the Metropolitan Palliative Care Consultancy Service. That decision was made back in September. More recently in February, as I said, the nursing home has come back to let us know he is now advancing in terms of the level of care and support he needs in terms of the palliative approach. We have talked more recently about the fact that he is now having medication for pain, medications for agitation, medication for nausea and vomiting and medication for hypersecretion. We have consented to that, but essentially the palliative care decision was made back in September.

In terms of the sorts of categories that are put here, as I have said earlier, I, as a Public Advocate, am making decisions for people's treatment based on the treating doctor's recommendation. So I am taking into account what we know of the person's wishes, as well as the wishes of their family, the facility and anyone else who has a close personal relationship with this person. In reaching a decision regarding palliative care measures, which might include nutrition, hydration or sedation, I am very much guided by what the medical teams say to us about what that should be. Where possible, we do go and seek consensus from everyone about that approach. It is very important that we can achieve that to the extent we can. Sometimes where there is conflict and differing views we will go and seek a second medical opinion, so that then the decision is made taking into account the second medical decision.

Mr J.E. McGRATH: In this case you were just talking about, this person does have family and you have been able to —

Ms BAGDONAVICIUS: Yes.

Mr J.E. McGRATH: What do you do in a case where someone does not have family?

Ms BAGDONAVICIUS: In that case I make the decision. One of the things we do routinely in the office is we do try to find out whether there are other family members available, even if they are not making contact to a facility. Sometimes people stay in nursing home care and it is very difficult for family to visit—they might be interstate or whatever—but we would still be trying to contact those people by phone to talk about their represented person's situation.

Hon ROBIN CHAPPLE: If I may, two questions arise out of that; thank you. Did I hear you rightly? Were you saying that there was a decision not to resuscitate?

Ms BAGDONAVICIUS: No, it was a decision that he was not for resuscitation.

Hon ROBIN CHAPPLE: Do you in your role make those decisions?

Ms BAGDONAVICIUS: Only on the recommendation of a treating doctor.

Hon ROBIN CHAPPLE: Would the treating doctor in a situation like that, with the patient if they were available, be availed of that information? Is that information their decision or the doctor's through you?

Ms BAGDONAVICIUS: We would not be at the bedside with the patient, so it is very dependent on the doctors talking to the patient and making a judgement as to what the patient can also understand in that particular situation at that particular time, and similarly with the nursing home staff if the person is not in a hospital; for instance, in an aged-care facility.

Hon ROBIN CHAPPLE: That information that is provided to you comes from medical professionals and they actually advise you that they have had discussions with the patient?

Ms BAGDONAVICIUS: It varies. It is not always that case. When the Public Advocate is appointed, a guardian will go out and try to visit a person for whom I am appointed and gather information to the extent that that is possible. For those in the metropolitan area that is easier to do more quickly than it is for those in regional areas, where we tend to do regional visits in a scheduled way. We will talk to the people and have a sense of what their wishes would be into the future. That is why things like if someone has done an enduring power of guardianship where they have given some indication of how they wish to be treated into the future—given some direction—that is helpful. Similarly, advance care plans; again, they have some other information for us. Sometimes people have left other accounts which give us an indication of what their wishes were.

Hon ROBIN CHAPPLE: If there is no advance health care directive and there are relatives and your discussion with the relatives deals with prognosis and what may happen, do you test whether there is any pecuniary interest or interest on behalf of those family members associated with the outcome?

Ms BAGDONAVICIUS: What, in terms of whether or not they are going to benefit through the estate?

Hon ROBIN CHAPPLE: Yes.

Ms BAGDONAVICIUS: No, but we have information available to us through applications made to the State Administrative Tribunal around the background of the family. That is often a helpful source of information, giving some indication if there does appear to be any conflict of interest. If there was someone who was a family member, the tribunal would be beholden on appointing that person as guardian if that person was available and willing. If they determine that that person was not suitable for whatever reason, then that is when I would be appointed instead of that person. We would get that sort of information through the tribunal process.

Mr S.A. MILLMAN: What is the extent of the information that is provided to you by the SAT? Is it the SAT file? Is it the whole file that comes across or is it a summary of the file?

Ms BAGDONAVICIUS: It depends on the Public Advocate's role in the proceedings. I am a party to all proceedings in the State Administrative Tribunal on guardianship administration matters. The tribunal issues the directions order where they want the Public Advocate to be involved in investigating any circumstances. Sometimes they simply want us to attend because they identify there is a likelihood of the Public Advocate being appointed as the guardian. In other situations they want us to make some more investigation, make some more inquiries, particularly in terms of what the views and wishes are of the person about whom the orders are proposed. Then they might ask us to make some other inquiries as well.

Mr S.A. MILLMAN: But as a party to the proceedings, you would have access to all of the materials in the file?

Ms BAGDONAVICIUS: We have access then to those applications. All the documentation that is provided automatically comes to us when we had a direction which has referred the matter to us to be involved in some way.

Mr S.A. MILLMAN: Your access to the material does not come by virtue of the provision in the legislation that says the SAT can transmit the information to the Public Advocate; your access to the information is by virtue of you being a party to the proceedings?

Ms BAGDONAVICIUS: Yes, but I can also, like anyone else, apply to go back to the tribunal if I do not have sufficient information, and there have sometimes been, historically, matters dealt with in the tribunal before the Public Advocate's appointment or Public Advocate's involvement in an investigation phase prior to the Public Advocate's appointment as guardian. I can go back and apply to seek access to documents, which we do at times.

[2.40 pm]

Hon COLIN HOLT: I have another question based on some of that. Has there been a time when you have been appointed as a guardian by the SAT and then not been appointed or been removed from being appointed as a guardian?

Ms BAGDONAVICIUS: Absolutely.

Hon COLIN HOLT: What sort of circumstances has that involved?

Ms BAGDONAVICIUS: For example, if in the case that I just gave to you the only function that I had been given had been to make the decision around where the person would live after leaving, in terms of his future accommodation, and his family member would not need to be appointed to be treatment decision-maker and there was a family member who could make those treatment decisions on his behalf who was available and willing to make those treatment decisions on his behalf, after this particular person had been placed in the nursing home and things are settled in terms of accommodation, the guardian—meaning my delegated guardian—would make an application to the State Administrative Tribunal to seek a revocation of the appointment of the Public Advocate as guardian, because the function for which I was appointed has been fulfilled; and if there does not appear to be a need, there is no need for a guardian. We do go back routinely to the tribunal with such matters.

Hon COLIN HOLT: I understood in that example that you were appointed because of some concerns about his capacity for decision-making.

Ms BAGDONAVICIUS: Yes.

Hon COLIN HOLT: Does it ever happen that you get appointed because of the capacity of decision-making, and it gets removed because they now have more capacity to make decisions, down the track?

Ms BAGDONAVICIUS: That does happen. It happens, for instance, with people with some mental health issues.

Hon COLIN HOLT: How does that happen? The first application comes from some treating physicians. So how does the removal come—from your office?

Ms BAGDONAVICIUS: The first application is not always from a treating physician; it could be from a service provider or another family member.

Hon COLIN HOLT: But externally, anyway.

Ms BAGDONAVICIUS: Yes; anyway—so it is made by an external party. It is because with treatment, people with mental health issues do recover. If they are well and able to make their own decisions, we would then seek medical evidence to support that, and the psychiatrist undoubtedly will be in such a situation very happy to provide evidence that supports the fact that this person now has capacity.

Hon COLIN HOLT: Who instigates that—the treating psychiatrist or the treating physician?

Ms BAGDONAVICIUS: In most cases, in that sort of scenario, I imagine it comes out of discussions between our office, the delegated guardian and the treating team—around that sort of approach.

The CHAIR: Are there any palliative care measures that you would not agree to, regardless of a medical practitioner's recommendations—under the standard palliative care measures, those listed there?

Ms BAGDONAVICIUS: If I had any concerns about a palliative care measure that was being recommended to me by a treating doctor, I would seek a second opinion.

The CHAIR: Do you think if capacity assessments made under the GAA provided for supported decision-making, that decisions by represented persons may be different in palliative care cases?

Ms BAGDONAVICIUS: In terms of this, I have outlined already to you how the Public Advocate makes decisions. I mean, it is very difficult to hypothesise whether or not any decisions made under a supported decision-making legislative regime would work any differently. In terms of both approaches, as I understand supported decision-making, I mean, at the end of the day we are both seeking to work within a framework, which is about taking and working with the person's wishes to the extent that that is possible in the circumstances. It is probably a stronger position in terms of supported decision-making, in terms of following a person's wills and preference. But in terms of being a substitute decision-maker, the best-interest principle comes into play very clearly, and I can make a decision which is in the person's best interests but which may not be entirely what they want.

The CHAIR: That leads to my next question, which is around that difference between best interest versus substituted judgement. Do you think if the standard adopted by substitute decision-makers was one of substituted judgement, that those decisions may be different from the ones that are currently made?

Ms BAGDONAVICIUS: I would just at this point say that both approaches give consideration to the views and wishes of the patient as far as it is possible to do so, and decisions would be based on the advice of the health professions in the particular circumstances of the individual.

Mr S.A. MILLMAN: I take on board your comments in respect of the difficulties around a register of advance health directives and advance care plans. There was some discussion earlier that if one were minded to require a central registry of these, that your office might be an appropriate office to be responsible for that. I have my own views about the intermingling of an office that is an advocate with an administrative function and some concerns around that. I have had a look at the

act and your objects under the act. What would your view be if it was suggested that perhaps the OPA would be the place that is responsible for holding this registry of health care directives?

Ms BAGDONAVICIUS: I think that would be a misplaced view. At the end of the day, if there is any central registry in relation to advance health directives, they need to be where the medical records are. My office has very limited access to medical records, unless I have a clear function under the act.

The CHAIR: Can you elaborate why, in your view, assisted dying requires the consent of a competent person but it is not required in cases for refusal of medical treatment, palliated sedation or treatment in which the doctrine of double effect may apply?

Ms BAGDONAVICIUS: I think the decision to actively end life should be made only by the person concerned, if there is a voluntary assisted dying scheme, and only where people have the capacity to make an informed decision to request an assisted death. If a person who lacks decision-making capacity were to be permitted to participate in such a scheme, there is a great potential for that person to be coerced into making that decision. I think the critical factor is that treating professionals would have to determine if the person is competent to make their own decision about their treatment. As you are aware, the treatment hierarchy provided in the Guardianship and Administration Act applies if the person is unable to make a treatment decision if they lack capacity to do so. Substitute decision-makers are involved in cases where they are required to make decisions where medical professionals administer drugs to a represented person that provide relief from distressing and debilitating symptoms and there may be times where this might shorten the life of the patient. I understand that is what can be described as the doctrine of double effect. However, the substitute decision-maker will be making the treatment decision in the best interests of the represented person based on medical advice. This is not the same as enabling a substitute decision-maker to make a decision that will actively and prematurely end the life of a person who lacks capacity. That is my view, so this option should not be contemplated in terms of a person who lacks capacity to make that decision for themselves.

The CHAIR: In relation to substitute decision-making, there are a number of proposals, and we have heard in a submission from some academics who have done a lot of work in this space. They have made some recommendations regarding substitute judgement versus best interest and supported decision-making around palliative care and the practice for capacity assessment. Do you have any comments on their recommendations?

Ms BAGDONAVICIUS: I would just come back to what we already have operating within the Guardianship and Administration Act, just to make sure the committee have the context around that. As I have highlighted, best interest is applied only as a last resort. The principles in the act very clearly provide that the primary concern of the State Administrative Tribunal shall be the best interests of any represented person or of a person in respect of whom an application is made. Every person is presumed to be capable of looking after his own health and safety; making reasonable judgements in respect of matters relating to his person; managing his own affairs; and making reasonable judgements in respect of matters relating to his state. The tribunal is not to make an order if the needs of the person in respect of whom an application for an order is made could be met by any other means less restrictive of the person's freedom of decision and action.

[2.50 pm]

The current approach also encourages exploration of informal decision-making supports which a person may have, which could provide an alternative to the appointment of a guardian. A guardianship order will only be made for specific areas in which there is a need for decision to be made. This leaves people with the opportunity to continue to make decisions about themselves now

without undue interference in many areas of their life even if a guardian is appointed, for instance, just to make treatment decisions. In practice, when the Public Advocate is appointed as guardian, as I highlighted earlier, the delegated guardian consults as far as possible with the represented person to ascertain their views and wishes, and works with family members, carers, friends, service providers and other agencies wherever possible to ensure the represented person is included in the decision-making approach. Regardless of the approach, whether it is in the represented person's best interest approach or a supported decision-making approach, guardians should not have the power—I just come back to this—make decisions regarding assisted dying on behalf of the represented person.

Hon NICK GOIRAN: I am interested in the topic of the time delay between a person needing a Public Advocate and when a Public Advocate is appointed. The context is that the Public Advocate is appointed instantaneously at that moment in time when the person loses capacity. Is there any research or data held in your office, or can you direct the committee to where we might find it, on this issue about the time delay?

Ms BAGDONAVICIUS: I just make a comment in terms of the State Administrative Tribunal. If they have sufficient information that suggests a hearing should be heard urgently, they will hold an urgent hearing. We provide an on-call after hours service on urgent guardianship matters, and the on-call guardian would then liaise with the State Administrative Tribunal, and myself or the senior manager of the office who is on-call would be contacted about that. The tribunal does hold after hours hearings, so decisions are made and Public Advocate can be appointed within hours of an application being made to the tribunal. It really depends on the circumstances.

Hon NICK GOIRAN: Maybe other committee members will correct me if I am wrong, but I have a funny feeling that in a previous hearing last year we might have been told that it has known to have been done within a matter of three hours or something like that. So obviously there is that type of delay—given that three hours is exceptional, so I do not say “delay” in the negative sense—with respect to the process. I am also probably even more interested in the delay in getting to the process. Is there a body of evidence that can tell us how long it takes before someone has identified that there is a need for this and starts the process?

Ms BAGDONAVICIUS: You mean someone who has been sitting in a hospital bed and whether or not the need is being identified?

Hon NICK GOIRAN: The individual themselves is not going to identify, one would think, so it has got to be some other third party, whether it is the general practitioner, a family member or someone in the community who says, “Hang on, we’ve got a concern here.”

Ms BAGDONAVICIUS: Look, nothing comes to mind. I will keep it in mind and let Dr Purdy know if something does come to mind about it. I guess at the end of the day it is very reliant on people around someone to identify the need when someone has lost capacity and to make an application on their behalf. There are some represented persons who do make their own application; it is very rare, but it has happened.

Hon NICK GOIRAN: In the same vein, is there any body of evidence that we can go to that tells us about the circumstances of an individual who needed a Public Advocate but it never happened?

Ms BAGDONAVICIUS: Meaning a Public Advocate was never appointed?

Hon NICK GOIRAN: Yes.

The CHAIR: But they applied?

Ms BAGDONAVICIUS: But nothing happened?

Hon NICK GOIRAN: The process did not even start; it did not even get to that point. No-one knew about it.

Ms BAGDONAVICIUS: No; I am sorry, but nothing comes to mind at the moment.

The CHAIR: In terms of assessing capacity, can you talk through what the process is when someone is identified as needing a Public Advocate? What is the process for assessing capacity?

Ms BAGDONAVICIUS: The assessment of capacity in the first instance will come from a medical practitioner, because when an application is made to the State Administrative Tribunal for a guardianship or administration order, they require medical evidence to support that the person does not have capacity to make certain decisions, so there is actually a medical form on the SAT website as well. The treating doctor will be the one who makes a determination around capacity and provides that evidence to the tribunal. Often, in a hospital situation for instance, the social work staff are the ones coordinating the application. They obtain that evidence from the doctors.

The CHAIR: When you say “medical practitioner”, can you be a bit more specific? Is that the GP who is treating or the specialist?

Ms BAGDONAVICIUS: It could be the GP. It could be any one of those in terms of a doctor needs to complete the form. It is required to be completed by a doctor—or some other evidence or some other form of report provided that makes it clear.

The CHAIR: Is it just one doctor?

Ms BAGDONAVICIUS: It can be just one doctor, yes.

The CHAIR: So under the act, it just requires one doctor?

Ms BAGDONAVICIUS: The tribunal in hearing the matter has to be satisfied that the person’s capacity has been displaced through whatever evidence is put to them. Sometimes there are additional reports such as neuropsychiatric reports, psychology reports that have been done, particularly, say, for people with intellectual disabilities. Over the years there are many assessments of someone’s capacity, so we use some of those historical reports as well and put those before the tribunal when they are available when they are considering the matter as to whether or not someone has a decision-making disability.

The CHAIR: In the example in which someone with a profound intellectual disability is in a palliative care setting in a residential disability home and they are entering the terminal phase of their illness and they are highly agitated and the doctor has recommended high levels of sedation, which would obviously hasten the death, but would make them more comfortable, if you like, does that specific treatment require approval from the Public Advocate if that person has an advocate appointed? What is the process there?

Ms BAGDONAVICIUS: It would depend on the depth of the palliative care plan—what has been outlined in the palliative care plan that has been submitted.

The CHAIR: So you could approve, say, terminal sedation early on at some point in a palliative care plan and they would not need to pick up the phone, for example, or contact the Public Advocate?

Ms BAGDONAVICIUS: Yes, if I have approved the fact that somebody is on a palliative pathway, and then as things progressed, like in the example I gave you, we were contacted again in terms of the medications that were then being put in place. It really comes back to a partnership and how people contact us at the appropriate times around those medical treatment decisions.

The CHAIR: If someone took a very quick turn, for example, or had some sort of catastrophic event, and they needed to contact the Public Advocate, is there someone always available—those service providers?

Ms BAGDONAVICIUS: We have an on-call guardian for after hours. That is a contact through a paging service. In fairness to the on-call guardian, we have one person on the roster to cover the out-of-work hours. It would really depend on how quickly they can be contacted and how many calls are coming through. It can sometimes be very busy, and at other times it can be quiet, so there will be a variation in terms of how quickly they have contact with us. The important thing under the Guardianship and Administration Act is that any treating team, a medical team, can provide urgent treatment as they deem necessary, so they do not actually need to contact the Public Advocate to get consent for an urgent treatment decision. The treating team can use their clinical judgement and do that.

Hon ROBIN CHAPPLE: I am sorry to do this to you, and it is a bit of a hypothetical. Assume that voluntary assisted dying legislation has come to pass. What would your view be around the protections necessary to ensure that the patient's wishes are genuinely protected rather than the family interest, which may or may not be of value to the patient? I want to try to figure out whether there is a point at which your office would get involved because it was deemed that the family was making decisions on behalf of the patient that were of their interest and not necessarily the patient's interest. It is a bit of a long ask.

[3.00 pm]

Ms BAGDONAVICIUS: In considering the submission that I made to this committee, I looked at the Victorian scheme. I have to say that was at the time I was making the submission; I have not gone back to it in any depth since. But I am aware that the clause in the bill that I referred to in making my submission—I think it was clause 138—is now section 140 under the assisted dying act in Victoria. That clearly excludes consideration of advance health directives. My understanding of the Victorian scheme is that it clearly excludes people who do not have the capacity to make the decision for themselves. At the end of the day, if a doctor was being approached about assisting someone and did not believe the person had the capacity to make those decisions, it would be up to the doctor to identify that this person does not have capacity. I am not sure what scheme may be put in place, if there were a scheme, and how many opinions would be sought in terms of doctors, psychiatrists and the like. That would be up to them to make that judgement call. If in the course of their conversation with the person they were concerned that family members might be acting inappropriately and not acting in the person's best interests, they could make an application to the State Administrative Tribunal or ask their treating team to make the application to the State Administrative Tribunal if they thought the appointment of a guardian or administrator was necessary.

Hon COLIN HOLT: My question is kind of an extension of that. Do you know of instances when, in the hierarchy of decision-making, someone needs someone else to make a decision so it has gone to the next of kin—maybe their spouse—and there has been an application that says, "Actually, we don't think the spouse has the capacity to make a decision on behalf of someone else"? Has that ever come to pass?

Ms BAGDONAVICIUS: If the treating team is not satisfied that someone has the capacity to make the decision they can move to the next person on the hierarchy of that treatment decision-maker, because they are not seen as suitable. If there is a doubt and there is a conflict then for the treating team in terms of providing treatment, what they would routinely do—it is not unusual; it does happen—is make an application to the State Administrative Tribunal to have a guardian appointed

instead as the treatment decision-maker. That guardian, and the tribunal in the first instance, would have to consider who in the family could make this decision, who has a close and personal relationship, and if there is no-one there suitable or if there is going to be too much conflict for that person to be able to operate effectively, that is when the Public Advocate may be appointed as guardian of last resort.

Hon COLIN HOLT: That must be pretty tricky. Imagine in an emergency situation. They would say, “What are we going to do? They are unconscious; they can’t make a decision. We’d better get the wife in”, or husband in, and then they say, “Hang on a minute: I don’t think you’re capable of making the decision either.” It must be pretty tricky.

Ms BAGDONAVICIUS: It is.

Hon ROBIN CHAPPLE: It puts it very much on the treating physician.

Hon COLIN HOLT: Yes, they must be stumbling around saying, “Hang on a minute: who do I go to next?”

Ms BAGDONAVICIUS: If somebody is in long-term care, they may well recognise that ahead of that situation developing and make applications.

Hon COLIN HOLT: Yes, in long-term care. But I am just thinking of an emergency situation, someone comes in unconscious, they cannot make decisions about their care, so the hierarchy of decision-making is gone to and the first couple they deem incapable given the situation. It could be pretty tricky; a fair bit of conflict.

Ms BAGDONAVICIUS: One incident comes to mind for me when I was appointed after hours in a very short space of time as someone’s treatment guardian. That was because the person had suffered from a domestic violence assault and the only other party who could give consent for her non-urgent treatment was the partner, about whom the allegations of concern had led into her current situation. In that case the treating team at the hospital made an urgent application, the SAT heard it at bedside and the Public Advocate was appointed.

Hon COLIN HOLT: Great example.

Hon NICK GOIRAN: But the treatment was non-urgent.

Ms BAGDONAVICIUS: Yes. The distinction becomes if the treating team can get on and do the urgent treatment in that sort of situation because of the provisions within the act, but then it is about the non-urgent treatment afterwards.

Hon COLIN HOLT: It still could create conflict though, couldn’t it?

Ms BAGDONAVICIUS: Absolutely, yes. That is sometimes the difficult situation that we are working with with families that are in conflict.

Hon Dr SALLY TALBOT: I really think you have done a brilliant job in helping us, who are not experts in this area, get our heads around what you actually do. I think we all have a sort of abstract sense of it, but the fact that you have used integral examples is immensely helpful. Just to follow up on the point made by Hon Colin Holt, the other side of the coin is that if you have somebody who you cannot find a suitable person to take on that role, do you have a process for drafting reluctant conscripts? Do you have an education program or do you have a part of the procedure when you sit down with someone and say, “You really do need to step up here because it has to be you because there’s nobody else.” Do you help that person make a decision? I am not talking about the person who needs the guardian. I am talking about the person who might fill those shoes.

Ms BAGDONAVICIUS: If we are in a phase when the Public Advocate has not yet been appointed and one of the staff from my advocacy and investigation team is working with family members and thinks there is potential. Sometimes through talking through what is required in terms of making decisions and how they can get help around making those decisions, people may then be prepared to take on the role.

Hon Dr SALLY TALBOT: So that is part of the work that your officers do?

Ms BAGDONAVICIUS: Yes. Certainly we do that in the pre-appointment phase because we are looking for the Public Advocate not to be appointed. It is obviously better in terms of working with the principles of the act.

Hon Dr SALLY TALBOT: So you actively encourage —

Ms BAGDONAVICIUS: We will actively seek out whether there is someone suitable before us.

Hon Dr SALLY TALBOT: Because the obvious person in the case described by my colleague would be a son or daughter whose other parent is incapable of doing it.

Ms BAGDONAVICIUS: Yes. In that case there were not any other family members immediately available.

Hon Dr SALLY TALBOT: So the first onus on you is to find someone else?

Ms BAGDONAVICIUS: Yes. If I am appointed and over time we do get in contact with someone else, again it becomes another circumstance where we go back and seek a revocation of our appointment.

Mr J.E. McGRATH: I have one further question. You talked about the Victorian legislation. I am not sure what you were saying to us. Where does the Victorian legislation start and finish when it comes to people who do not have the competency to make that decision? Does that mean they are excluded from the right to die?

Ms BAGDONAVICIUS: My reading of it and my understanding from talking to the Victorian Public Advocate is yes, they are excluded. I think section 140 is the critical section of the Voluntary Assisted Dying Act.

Mr J.E. McGRATH: What is your view on that decision in that legislation?

Ms BAGDONAVICIUS: That is the position that I have recommended; that if there is any similar legislation to be enacted here in Western Australia, we similarly exclude people without the capacity to make their own decision. It is a decision to end life prematurely, rather than for treatment purposes or making critical decisions about what is life-sustaining treatment. It is a different kettle of fish.

Hon NICK GOIRAN: When you are appointed you are making what I am going to describe as everyday decisions, even though that is probably not a good way of describing it, on behalf of the person. When it comes to financial decisions, is that done by the Public Trustee?

Ms BAGDONAVICIUS: Yes. It is very rare for the Public Advocate to be appointed as administrator of last resort. I am appointed for about three people currently, but they are complex matters where there is a conflict of interest for the Public Trustee in representing that person in relation to that part of their estate.

Hon NICK GOIRAN: Are there circumstances or is it routinely the case that an order is made that both the Office of the Public Advocate and the Public Trustee act concurrently?

Ms BAGDONAVICIUS: Yes. There are a number of orders made where both of us are appointed because there is no-one else. The tribunal must satisfy itself around mental capacity as defined

under the act for the making of administration orders, but again the same principles apply. Again, the Public Trustee is appointed as administrator of last resort if there is no-one else suitable and willing to do that role.

[3.10 pm]

Hon NICK GOIRAN: When it comes to a treatment decision which needs to be funded, is there therefore then a two-stage process: first of all you have to consent to the treatment being provided, and then the trustee has to agree to the distribution of funds?

Ms BAGDONAVICIUS: Yes. Treatment is not usually the question around where we have need to collaborate in that way because treatment is very much the Public Advocate working with the treating team, rather than the administrator. Where the issue around funds is important is if, say in the example I have given you, the Public Trustee needs to ascertain the person's funding situation prior to somebody moving into a residential care facility because of all the costs et cetera involved. They need to be very clear about the person's financial situations before we make the decision to shift them in terms of the accommodation. That is where that comes into play.

The CHAIR: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. Thank you very much for your evidence today. It was very useful.

Hearing concluded at 3.11 pm
