VOLUNTARY ASSISTED DYING BILL 2019

Council's Amendments — Consideration in Detail

Resumed from an earlier stage of the sitting.

Debate was interrupted after amendment 8 made by the Council had been partly considered.

Mr R.H. COOK: I rise in response to the comments of the member for Darling Range just prior to question time. She characterised this amendment as the government rejecting the amendment proposed by Hon Nick Goiran. We did not; we simply tidied up the wording, and I think that is accepted now. I made similar comments in response to those of the member for Hillarys. Further, I would like people to understand that this amendment simply codifies how medical practitioners have an ethical duty to make sure that they do not have issues of conflict of interest and, in that sense, these amendments simply enshrine good medical practice. This is not a question of something that we would expect medical practitioners to suddenly be aware of by virtue of this amendment; this is something that they do on a day-to-day basis. We accept that Hon Nick Goiran had some concerns about this and, as I said, to provide him with some confidence, we have made explicit what we already believe is implicit, and that is an appropriate way to go. In the context of the member for Darling Range's comments, I want to distance the government from the conflation that she made between elder abuse and the conduct of medical practitioners. I cast my mind back to the Legislative Assembly debate in which we discussed the issues of elder abuse and independence, or, the appropriate nature of the independence of medical practitioners. I do not believe we ever suggested that medical practitioners would actually undertake elder abuse or, in that context, behave unethically. I am not sure what the member's motives were, but I absolutely reject the notion that that would be something that medical practitioners would ordinarily engage in on a regular basis in their work. It is important that we put that on the record. I think our medical practitioners do an amazing job, and this amendment simply explicitly states what they would be duty bound through ethics to observe at any rate.

Mrs A.K. HAYDEN: Minister, thank you for that. I, too, would like to clarify that I was not alluding to that either, so I concur and agree with the minister. None of us would say that a medical practitioner would generally go out and do that type of thing. They are all professionals and are well respected in the community. I was referring to it not being a family member of the patient. That is the area we are always trying to avoid. Obviously, there are always rogue wolves in any industry, and making sure that it is not a family member who may have an additional reason for approving and being part of this process is what this amendment is clearing up. For the record, I agree with the minister.

Mr Z.R.F. KIRKUP: Paragraph (c) of this amendment reads —

> the medical practitioner does not know or believe that the practitioner —
>
> (i) is a beneficiary under a will of the patient; or
>
> (ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

I recall that under the Australian Medical Association's code of ethics, it specifically relates to a direct family member. The term zooms out to a larger, more extended family for a practitioner practising in a normal routine, to the best of my knowledge. If they are found to be a beneficiary of the will, for example, can the minister run me through a circumstance in which that might occur? In that case, what would the penalty be for that practitioner? Also, is there any obligation to advise the board of something like that, once that happened? I have a scenario in mind, whereby a practitioner did not reasonably believe that they were a beneficiary of a will, for whatever reason. They then find themselves going through the process after the death and find that they are. Is there any capacity for the board to deal with this? What process would that involve and what would the penalty be if they were a beneficiary and they were the ones who found out about it?

Mr R.H. COOK: The actual offence would occur if at the time of the death of the patient it could be reasonably believed that the medical practitioner would have knowledge. If they had no knowledge at the time, obviously they would not have contravened the bill. Contraventions of the bill by a registered health practitioner are covered under clause 10. Essentially, a contravention of the bill would occur if they knew and benefited, but if they did not know or could reasonably be believed not to have known, there would be no penalty.

Mr Z.R.F. KIRKUP: Thank you, minister. I appreciate that response. Subclause 2(c)(ii), which is proposed to be inserted, states in part —

> … other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Why does that not also cover the administering practitioner?

Mr R.H. COOK: It essentially goes to the issue of the drafters. This is with regard to the coordinating and consulting practitioner.

Mr Z.R.F. Kirkup: Requesting access?

Mr R.H. COOK: Yes. I refer the member to the proposed amendments to clause 53, which reflect a similar approach in relation to the administering practitioner. That is covered under amendment 30, which, as I said, was part of this suite of amendments that has been moved.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 9 made by the Council be agreed to.

This is the next amendment under this particular suite of amendments from Hon Nick Goiran and agreed to in the other place.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 10 made by the Council be agreed to.

This is a government amendment. It comes directly from consultation with the Australian Medical Association about what it wanted included in the bill. In a lighter moment, we have described this as the glass of wine or the dinner party conversation. That is, we do not think a medical practitioner should be captured under the first request for voluntary assisted dying if that request was made simply in the context of a conversation, or, as was put to us, we were having a glass of wine after dinner, farewelling a colleague or a friend, and they said, "By the way, I wouldn't mind." That would not considered to be the first request. This amendment simply explicitly states that the first request must be made during a medical consultation.

Dr D.J. HONEY: This is a critical amendment, and I am glad to see it go into the bill. In fact, it was not simply a glass of wine. I appreciate that was a metaphor. If we read the proposed law as it was written, someone would have been able to request access to this procedure using a mobile phone with FaceTime and simply ringing a medical practitioner and requesting that they participate. This is a very important change. I know that many medical practitioners who have actually read the bill were extremely concerned that they could be engaged in this process in any setting, and not in the normal setting of a patient requesting a consultation. I congratulate the originators of this amendment, and I also congratulate the government for supporting it.

Mr P.A. KATSAMBANIS: As the minister pointed out, amendment 10 came out in the discussions between the government and the Australian Medical Association. It is a very important amendment. It may seem pedantic, but we can all see in practice that it is an appropriate matter to be dealt with. It was an issue that was raised in the debate here in this chamber by various members, but we were at that stage that we spoke about earlier of not accepting any amendments. The legislation is now clear and unambiguous on when the request can be made; it must be made during a medical consultation, however that happens. The minister suggested that it cannot happen over a glass of wine, but as a number of people, including myself, have alluded to, some of the fears on how this sort of regime may be rolled out in practice are around the more entrepreneurial members of the medical fraternity—I do not use that pejoratively—perhaps during a seminar where a group of people are given information about the process of voluntary assisted dying. The question mark would have been whether a patient could have made a request in person that is clear and unambiguous as foreseen by the original clause 17 during that sort of seminar process. This amendment makes it very, very clear that it is a one-on-one consultation; it is a medical consultation. I think it is a good amendment and ought to be supported because it improves the workings of the bill.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: Amendment 11 is similar to amendment 20. It goes to the issue of coordinating and consulting practitioners having regard to reports or opinions that provide them with the necessary information they need to make an assessment of diagnosis and prognosis. It makes it clear that the assessing practitioner, when making the first and consulting assessments, can consider and rely on relevant information about the patient from a registered health practitioner. Again, this issue came out in consultation with health stakeholders. The health stakeholders were anxious to ensure that coordinating and consulting practitioners either have or could furnish themselves with

the necessary information to be able to make a call on a decision or assessment. From that perspective, I think this is an appropriate addition to the bill.

The ACTING SPEAKER (Ms L.L Baker): Just move it, please.

Mr R.H. COOK: I move —

That amendment 11 made by the Council be agreed to.

Mr P.A. KATSAMBANIS: This amendment has an interesting genesis as well. I note that in clause 23, as originally proposed in the bill, there are two conditions that must be followed at the first assessment by the coordinating practitioner. Both conditions must be followed: the coordinating practitioner must assess whether the patient is eligible for access to voluntary assisted dying and must make a decision on each of the eligibility criteria. The third limb that is being added to clause 33 by this amendment is not a must. The coordinating practitioner does not have to do it. They may have regard, but it is not couched in those words. It is not a "must" or a "may"; it simply says —

> Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

It is not an absolute obligation; it is an option that the coordinating practitioner can choose to follow or not follow. I think, simply from good drafting, it would have been better to have obligations on all three parts of the sections. That was rejected by the government in the other place. I know that the minister will say that there are all sorts of clinical and professional rules and obligations that doctors must follow, and a doctor who has a report before them who does not take it into account would be eligible to be brought up before the professional body that represents them and may be liable to punishment. That is true and I accept that. I am just pointing out that mandatory obligations are being placed on the medical practitioner in clauses 23, 24 and 25 and the like throughout the division. However, in relation to considering relevant information—I think that is the important point—about the patient that has been prepared at the instigation of another registered practitioner, there is no such mandatory obligation; it is just a best endeavour clause. It is still better protection than what existed before. I just point out that I think it could have been better but, clearly, the government contemplated it and chose not to go down that path.

Question put and passed; the Council's amendment agreed to.

The DEPUTY SPEAKER: Minister, do you want to say something, I have just put the amendment?

Mr R.H. COOK: No; I am getting up to the next one.

Dr D.J. Honey: We had questions for the minister to answer and you moved straight on to the question.

The DEPUTY SPEAKER: I am sorry; the minister did not indicate that he was going to answer, so I put the amendment. Of course, I will make sure I look your way.

Mr R.H. COOK: I move —

That amendment 12 made by the Council be agreed to.

As I foreshadowed earlier, this is part of a suite of amendments moved by Hon Nick Goiran in the other place and goes to the issue of which we spoke at length before about the practitioners not being a family member or financial beneficiary. It goes to provide further encapsulation or further voice in relation to those amendments.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 13 made by the Council be agreed to.

This is an amendment on which the government was beaten to the punch by Hon Nick Goiran, as indicated to the member for Scarborough.

Ms M.M. Quirk: Minister, you said they were slow in getting it passed.

Mr R.H. COOK: No, we were a bit slow.

Ms M.M. Quirk interjected.

Mr R.H. COOK: He beat us to the punch on this one. This is an issue that the Leader of the Opposition raised during debate in the Legislative Assembly. Upon further reflection, it was obviously absolutely appropriate to include the word "and" instead of "or" in clause 26, so we are happy to commend this hefty amendment to the house!

Mrs A.K. HAYDEN: On reflection, I note that on the night that it was raised by the Leader of the Liberal Party, it was not deemed necessary. It was put forward with a whole pile of other amendments that were not deemed necessary. When we look back at the way it was handled and what was said in the media, in the public arena, about how we were filibustering and wasting time on silly amendments such as small grammatical amendments, we are

now seeing that it was fixed in the upper house. As the minister said, the government was beaten to the punch by Hon Nick Goiran because the government was also going to put forward the amendment. On reflection, the government realised that what the Leader of the Opposition put forward was reasonable and was required and we are now seeing the amendment accepted. I just cannot let this amendment pass without putting on the record the misleading information that has been put into the public arena that people on this side were simply filibustering and wasting Parliament's time.

Ms J.J. Shaw: You did.

Mrs A.K. HAYDEN: With behaviour like that, that is why you are a disgrace as a government, an absolute disgrace as a government.

Several members interjected.

Mrs A.K. HAYDEN: This is the whole reason —

The DEPUTY SPEAKER: Back to the amendment please.

Mrs A.K. HAYDEN: This is the whole reason I am standing —

Mr T.J. Healy interjected.

Withdrawal of Remark

Mrs A.K. HAYDEN: Excuse me, member, would you like to withdraw that?

The DEPUTY SPEAKER: Excuse me, would you like to continue with your comments, member.

Mr T.J. Healy: Sorry.

The DEPUTY SPEAKER: Enough byplay, can we have the amendment, please.

Debate Resumed

Mrs A.K. HAYDEN: It is nice to see that regardless of what was put out in the public arena and media that we were simply wasting time on grammar and small amendments —

Ms J.J. Shaw interjected.

The DEPUTY SPEAKER: Go ahead, member.

Mrs A.K. HAYDEN: —we have the minister admitting that adding this in is required and needed. If only the government took this place seriously and listened to the real concerns of the people who raised them at the time, we would not be sitting here today, having to accept these amendments, because they would have been done when debating the bill in the first place. I thank the minister for accepting the amendment moved by Hon Nick Goiran, and I thank the minister for admitting that he got it wrong in this place the first time. He went away, reflected and agreed to those amendments.

Mr R.H. COOK: This is a small amendment. I appreciate that members want to make a political point and they are perfectly entitled to do so, but I think that, in this case, the Premier himself was at the table and told the Leader of the Opposition that we would reflect on it and, if necessary, move an amendment in the other place. That is exactly what occurred. The Leader of the Opposition moved three specific amendments, of which one inserted the word "and" instead of "or" and one was in relation to finishing reports about assessments undertaken by the coordinating and consulting practitioner of the patient. It was either those two amendments or the last amendment for which the Premier specifically said, "Let us just have a think about that and we can make the change in the other place if necessary."

Mr P.A. Katsambanis: I think you were in the chair.

Mr R.H. COOK: No. We just checked the *Hansard* and it clearly shows that the Premier was in the chair. If we can all turn the temperature down a bit, we are at the final stages of this debate and we can just get through these amendments —

Mrs A.K. Hayden interjected.

Mr R.H. COOK: Member, with respect, this point has been made. I understand that the member wants to make it, but if we could just move through the amendments, we can make sure that we all, as members of Parliament, fully understand them, and that if we are to support them, we do so with that knowledge in mind.

Mr P.A. KATSAMBANIS: I rise because I want to ensure that there is no ambiguity in what is being done here. This is a small change. It is a change of just one word. But it does not mean that it is insubstantial, it does not mean that it is trivial and it does not necessarily mean that it is a grammatical mistake; in fact, it is not. It is actually quite a substantive change. Importantly, it fixes a mistake in the legislation that could have created significant problems in the future. It fixes an inconsistency between the bill as originally drafted and the explanatory memorandum that

accompanied the bill. I will not trawl through the specifics because they were outlined, firstly, by the Leader of the Opposition in this place and, secondly, by Hon Nick Goiran in the other place. It is on the record, so I will not trawl through it again. What strikes me—I share the minister's view that we should tone things down—is that a one-word change, which is substantive and meaningful and actually gives effect to the government's policy as articulated in its own explanatory memorandum, could evoke such vitriol from the government back bench. When the Leader of the Opposition proposed the original amendment, she was bullied and shouted down by members on the government back bench. Today when the member for Darling Range stood up and pointed out the horrific treatment meted out to the Leader of the Opposition, she was equally abused by similar people. It is unbelievable. It is just extraordinarily unbelievable. We have proven that what the Leader of the Opposition said was meaningful and substantive. Yes, perhaps the government needed a bit of time to reflect—I can give it credit—but do not come back and repeat the abuse on the same issue on the same clause!

I support respect. I think we have all dealt with this respectfully, in the main. Everyone who stood up to speak on the bill, including on the amendments, has been respectful to each other, but it has to work both ways. I am glad that we have got to the stage at which this amendment has not been dismissed out of hand. It has been a difficult process again, but it has corrected an obvious error that created doubts about the policy intention of the bill. There was a direct conflict between what was in the bill and what was in the explanatory memorandum—not conflict between the thoughts of the government, the opposition, and the proponents and opponents of the legislation, but inherent conflict between the bill and the explanatory memorandum, that that is now corrected. I thank the minister for considering it and supporting it. As the minister said, let us tone down the vitriol and in particular let us stop the abuse of members of Parliament who are trying to make things better.

Mrs L.M. HARVEY: I would like to place on the record my appreciation for the inclusion of this amendment. At the time that I picked it up, I could see by the look on the adviser's face, Hon Malcolm McCusker —

Mr R.H. Cook: I was going to say you should have seen the look on McCusker's face!

Mrs L.M. HARVEY: He was sitting opposite me and I could see that what I was saying made a lot of sense to him, hence my disappointment in not having that amendment accepted at the time. However, the beauty of the Western Australian parliamentary system is that we have a Legislative Council. These matters can be considered and given due consideration by the government of the day to allow amendments to be put forthwith in the Legislative Council and therefore accepted to improve the bill.

What the member for Hillarys said was absolutely abundantly clear: the difference between "or" and "and" in the sentence at clause 26(2) is incredibly important. By deleting "or" and substituting "and", this clause will make sense. With the word "or", the sentence made no sense whatsoever. It has often been said to me that I would be a very good subeditor because I read every word, particularly in legislation that is very important legislation such as the legislation we have before the house today. I am very pleased the minister has accepted what I considered to be a mistake in the legislation, which I picked up. It is now before the house to improve the bill, and this particular clause will now make sense.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 14 made by the Council be agreed to.

This is one of a number of what we will call "Harvey amendments". Again, Hon Nick Goiran beat us to the punch on this. It goes to the issue of patients being given copies of the first assessment form and the consulting assessment form. It will not surprise members to hear that amendment 22 is exactly the same as that relating to the consulting practitioner. In both cases, it makes sure that a copy of the assessment form is provided to the patient.

Mrs L.M. HARVEY: Once again, I thank the minister for the inclusion of this amendment. At the time of the debate in this house, it did not make any sense at all to me that the legislation was quite strict about who the application form for access to voluntary assisted dying should be provided to within a certain time frame. Even though, logically, one would assume that the patient requesting voluntary assisted dying might take a photocopy or a photograph, whatever it might be, of the form, it made sense to me that the legislation should require that the patient have a copy of the form. For example, their loved ones might be unaware of the process or the patient may wish to provide the information to them but may not necessarily wish to have a conversation about it. This will ensure that the patient is provided with a copy of their form for their own purposes and records and, should they pass away, for the executors of their will and their estate. It is really important to have that documentation so that family members can understand the process that the terminally ill person has gone through in order to access voluntary assisted dying if they take the poison and end their life. It is very important and I am very pleased that the minister has picked this up and included it in subsequent amendments, so that the legislation is crystal clear that any patient accessing

voluntary assisted dying must be provided with a copy of their form. They can read through the form a couple of times and determine whether they really want to continue with the process. It is really important that a person has a written form. They can go over it several times and make sure that they are comfortable with the decision before they proceed to the next stage. Some people need to read things through several times before it clicks in their head that this is what will happen as a result of the VAD process. I think this is very important. As I said previously, this and other amendments have given me comfort that protections are in place to ensure that only those people right at the end of their journey when things are terrible and they have perhaps unmanageable symptoms and pain can access voluntary assisted dying, as is the case in Victoria at present.

Mr P.A. KATSAMBANIS: I want to put on the record that when we debated the Leader of the Opposition's amendment on 5 September, the Premier was quite unambiguous in making clear that he wanted to use the process between the houses, if you like, for want of a better term, to consider whether it was an appropriate amendment. I quote the Premier's response from the *Hansard* —

> 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.

That is fair and good. I want to place that on the record to show that right from the outset the government picked up that this may well be an issue, and good on it. But it reminds us of the ridiculous process we were going through. It should also be placed on the record that the person who endured the most through a very, very difficult process was the Minister for Health sitting at the table. He got a bit of a chop out; the Attorney General and the Premier helped him out for a while. I use the term "help" in the case of both of those officers of the Crown rather loosely, but they certainly sat in the chair for a while. It reminds us of what we went through, I would suggest unnecessarily given the paucity of legislation we considered in the few weeks previous to this sitting. We unnecessarily went through the physical toll that it took on all members, particularly the minister and the advisers, who have had an unbelievable workload. The statement I just quoted was right; we should not be considering amendments to the bill at quarter to one in the morning. Hopefully in the future we will reflect on this process and come up with a better process than the one that we went through, but clearly the process between the houses worked. The minister gave his word and he was true to it, so thank you. Again, this amendment improves the original bill without changing the integrity of the bill in any way.

Question put and passed, Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 15 made by the Council be agreed to.

This amendment is the first of a suite of amendments moved by Hon Adele Farina and assisted by Hon Nick Goiran. It essentially goes to the issue of requiring information about a patient's language requirements, including interpreter details, to be included in the forms given to the Voluntary Assisted Dying Board. The amendment goes to the issue of details being captured at the first assessment and consulting assessment stage; the written declaration phase, which, to refresh members' memory, involves a first request, a second verbal request and a written request; the final request and final review; revocation of the request, if that has happened; and the administration decision. This particular suite of amendments includes amendments 15, 17, 24, 26, 28, 29, 32, 33 and 38. Essentially, the government supported this amendment because it will provide for further transparency in the work of the Voluntary Assisted Dying Board and will assist the board to gather information and identify any gaps in health service provision. It is the intent that the Department of Health will capture this information via the database that will be accessible by the board. It is usual good practice for clinical documentation to appropriately record the fact of an interpreter assisting during a clinical consultation. I think members will agree that this is an appropriate amendment that goes to the issue of those for whom English is not a first or, indeed, a second language. It will allow the Voluntary Assisted Dying Board to have a good line of sight over these issues.

Ms M.M. QUIRK: The minister will be grateful to know that, as this is a suite of various amendments that deal with the same topic, as he has said, I intend to comment only on this occasion. This amendment certainly has improved the legislation. Clear, concise communication is vital in this area and I think this will improve the situation. However—I mentioned this during the second reading debate and the consideration in detail stage—all these clauses refer to engaging an interpreter in accordance with clause 160(2). Clause 160(2) states that an interpreter must be accredited by a body approved by the CEO, which begs the question: as there is only one accrediting body, why would the CEO be qualified to have sufficient information or background to work out the appropriate bodies? As I said, there is only one body, so it is really just an academic gripe on my part. I think it should be the professional accreditation body, but that is something that the minister might want to consider during the implementation stage. Frankly, I think the CEO will have too much to do under this legislation. I thought this provision could have been

more elegantly worded. I do not need a comment from the minister; I am just disappointed that that point was not picked up during the consideration in detail stage.

Mr P.A. KATSAMBANIS: I also want to speak on this amendment because it goes to an issue that I am very passionate about. I spoke about this in the context of what I think will, in history, become known as the Buti amendment—the amendment that the member for Armadale moved to add new clause 9A, which was ultimately doomed. However, a different clause was introduced in its place. This is about people whose first language is not English and all the cultural sensitivities that go with that. I commend Hon Adele Farina in the other place for bringing this and the consequential amendments to the public debate and making sure that they were included in the bill. I do not want to labour the point at this stage, but it highlights a genuine lack of consultation with culturally and linguistically diverse communities throughout the process of developing this bill. That is not a criticism of the people who engaged in the consultation; perhaps there was an attempt at engagement without any meaningful response. I do not know; I was not involved in it. But after reading through the bill, it seemed clear to me and to others that there were these sorts of issues around language barriers, interpreters and the more general language issues related to ageing that we are becoming aware of. People who might have functional use of the English language may revert to their first language as they get older. I am living with my parents at the moment, and my father, who I would say has always had a good grasp and comprehension of written English and a functional grasp of spoken English, has practically lost the functional ability to speak the language, although he has retained a good ability to understand what he reads and hears. People are living that experience every day across Western Australia and Australia generally, and we are getting to know more about it as our multicultural communities age in place in Australia rather than in their original countries.

That was clearly missed in the legislation. I do not think it was an error; I just think it is something that happened there. Perhaps, as I said, the people engaging in the consultation tried in good faith, but just did not get much back. Maybe there was not much consciousness about it until it was raised in public after the bill had been introduced into this place and debate had taken place. Clearly, it is something that was missing from the original bill, and it may have led to unintended negative consequences for another vulnerable group in the community. It is a group that we should never forget, especially, as I said, because of that interaction between ageing and reversion to first language. It just slipped through the cracks.

So, with those words, I commend Hon Adele Farina—someone who obviously also grew up in a non-English speaking household, as I did. I wish this amendment good passage and thank the minister and other supporters of this legislation for seeing that this was necessary and agreeing to that suite of amendments.

Mr R.H. COOK: I want to place on the record that the use of interpreters is extensively engaged throughout the health system. In that context, I do not want people to gain the impression that because these issues were not explicitly canvassed in the legislation, the idea of providing health services to people from culturally and linguistically diverse backgrounds is somehow new to the health system; it is something we do every day, and we have an extensive process for that. To settle the member's concerns about this, the Ministerial Expert Panel on Voluntary Assisted Dying included Maria Osman, who is from a culturally and linguistically diverse background and has extensive experience of consulting CALD communities. I also acknowledge the presence in the Speaker's gallery of panel member Kate George, who is also from the culturally and linguistically diverse background known as the Indigenous communities of Western Australia. She was also on the Ministerial Expert Panel on Voluntary Assisted Dying, and, Kate, can I express my thanks to you for the great work you did.

The MEP consulted specifically with the Office of Multicultural Interests, the Ethnic Communities Council of WA and the Equal Opportunity Commission of Western Australia. This was always intended to be captured in practice. As I said, it was not one of the things that we explicitly stated in the legislation, simply because this is what the Department of Health does every day. I take on board the member's comments, and I thank him for his support.

Ms M.M. QUIRK: I cannot really let that go without comment. Throughout the debate, when the minister was asked why this bill had to depart from the Victorian legislation, one answer was that Western Australia was much more culturally and linguistically diverse, and, for that reason, we could not use the Victorian legislation. I want to remind the minister that that was the whole rationale behind going in a different direction; rather than saying it was not forgotten, it was certainly sidelined.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 16 made by the Council be agreed to.

Amendment 16 is about referral reports. This is one of a couple of amendments that were moved by Hon Nick Goiran to require that not only the first assessment report and the consulting assessment report form include the outcome

of the referral made under clauses 25 or 36 to another practitioner or person, but also a copy of the report of their assessment of the patient's eligibility be provided by the practitioner or other person. This amplifies the amount of information that will be made available to the Voluntary Assisted Dying Board so that it can be satisfied that the coordinating practitioner or consulting practitioner has furnished themselves with the appropriate reports.

Mrs A.K. HAYDEN: Minister, again it is good to see that another amendment has gone through the other place that will improve this legislation. During the entire debate in here we often referred to the importance of the Voluntary Assisted Dying Board. Obviously, any amendment that provides the board with a bit more support so that it can function correctly and properly, and produce the best outcomes for the patients and people involved, is what we, as legislators, should be always striving to achieve. On that note, I again thank Hon Nick Goiran for this amendment and I thank the government for accepting the amendment. I put on the record that this is another good amendment. It is not one, as we keep hearing in the papers, that was not called for. I know that in this place we are in opposition on this legislation, and it is our role to highlight the amendments that we have fought for and that have been won. This amendment will improve the bill. It will not slow down or stop the bill; it will improve the bill. This is our opportunity to put that on the record. On that note, I thank the Legislative Council and the minister and advisers for accepting this amendment that will support the Voluntary Assisted Dying Board.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 17 made by the Council be agreed to.

Mr P.A. KATSAMBANIS: I am very pleased to support this amendment. I highlighted this issue in the debate during the consideration in detail stage. The amendment provides that a field must be included in the first assessment report form to detail whether a patient has been assisted by an interpreter, and to include the interpreter's details and accreditation. Again, I raised this matter late at night when the Premier was at the table. We had a bit of an exchange and the Premier indicated that clause 28 was not exhaustive, which I had also pointed out, and said that it was just about a series of minimum requirements and that other things could be included. I toned down my rhetoric and rather than asking that a specific clause be included, I suggested that when the minister or the Premier considered the form, they should add the translator field. The Premier indicated, almost by interjection rather than by standing up, that he would consider that.

Clearly, between the houses and at the instigation of Hon Nick Goiran, this has been firmed up into a requirement so that the first assessment report form, in addition to including a series of things, must now also include details about whether an interpreter was used and, if so, the details of that interpreter. Again, that is logical and sensible and it takes into the account the fact that English is not the first language of many people, be they Indigenous people or migrants to this country. It is another built-in protection to make sure that everything is considered and that people act of their own volition and understand everything they agree to. I thank the minister for considering this issue between the houses and agreeing to the amendment.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 18 made by the Council be agreed to.

This is another government amendment that requires that when the coordinating and consulting practitioners provide the first assessment report form and the consulting assessment report form to the board, they must include information about the palliative care options available to the patient and the likely outcomes.

Dr M.D. NAHAN: This is a very important amendment about which many of us argued, but during our debate it was said that this bill is about VAD, not palliative care. The government wanted to separate the two. Our argument—this amendment picks up that argument—was that as part of the assessment process, it is necessary to consider the palliative care options in the lead-up or perhaps as an alternative to VAD. We spent many hours debating this issue. It was a key issue for me and other members. Therefore I am very glad that the government—this is a government amendment, I believe—has in its wisdom moved this amendment, even though, I might add, it made it clear to us that it was an unnecessary amendment prior to our debate. Again, I emphasise that this is a government amendment. It is one of the issues that we extensively debated in the house, and the government accused us of grandstanding and unnecessarily postponing the passage of the bill. Here we are, back in December, after a record number of hours debating the bill and staying up all night on one occasion. This is one of the issues that we raised, but the government said that it was not necessary. When the bill went to the other house, the government decided to move an amendment. I hope that when the Premier talks about this, he will admit that he played politics with this most important bill for his own gain and did not consider the safe, secure and adequate passage of the VAD bill. Again, it is only appropriate that the consulting medical practitioner assess the palliative care program for the patient and

provide them records of that. It was denied as necessary when we debated it in this house, and that is why some of us did not vote for the bill.

Mr R.H. COOK: I will provide further information about amendments 18 and 25. This will assist the board to gather data and identify any gaps in the provision of health services and will include information such as whether the patient is currently receiving palliative care; and, if not, whether a palliative care service is available to which they can be referred to assist them; whether the patient has been offered a referral to that service; and whether the patient has or has not been referred to that service.

Mr P.A. KATSAMBANIS: I hate to be pedantic. I seek the indulgence of the minister and perhaps his advisers on this. Amendment 17, which we passed a moment ago, inserted in clause 28 on page 20, after line 27, new paragraph (ia). According to the Council's message, amendment 18 also inserts at clause 28, page 20, after line 27, a new paragraph (ia). To me that looks like there are two paragraphs (ia). I note that the marked up copy of the bill, the blue, if you like, which I was given this morning by the great staff here in Parliament, includes clause 28(3)(i), (j) and (k). I seek some clarity about whether the drafting of the clause, with these paragraphs, is going to be meaningful, because we are inserting two separate paragraphs with identical lettering.

The SPEAKER: Members, they will be amendments 17 and 18 on the Council's message. Even though they have the same paragraph lettering, they will be different in the bill. They will be amendments 17 and 18.

Mr P.A. KATSAMBANIS: Thank you, Mr Speaker. That answers my query.

Mr S.K. L'ESTRANGE: I refer to new paragraph (k) in the blue bill, which refers to the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment. Because the paragraph did not exist before, can the minister inform us, so we can get it on the record, what happens if the care and treatment options are not available? What does the patient or doctor do in that situation?

Mr R.H. COOK: They would do what a doctor and a patient do already. The question is about whether those options are available to the person before they access voluntary assisted dying. Ultimately, they may want to access voluntary assisted dying anyway, regardless of the availability of palliative care, but this was considered to be a policy point about which people wanted more information in the context of the work of the Voluntary Assisted Dying Board. It is about the data collection and basically building an understanding of the extent to which palliative care options are available to people who also wish to access voluntary assisted dying.

Mr S.K. L'ESTRANGE: I go to new subclause (2A), which states —

> As soon as practicable after completing the first assessment report form, the coordinating practitioner must give a copy of it to the patient.

Part of what must be given to the patient is listed in paragraph (k). Notwithstanding the motivations of the patient, if that must be given and, for example, the patient is in remote regional Western Australia and the coordinating practitioner establishes that there are not any palliative care and treatment options available and the likely outcomes of that care and treatment are therefore non-existent, would the minister expect that to be written in the report?

Mr R.H. COOK: What will be written in the report is what the chief executive, through the implementation phase, decides is the appropriate style and form in which information should be provided. Here we are legislating to make sure that that information is captured so that future policymakers at least have a line of sight about how the availability of palliative care may or may not impact on the way in which people access voluntary assisted dying. As the member would be aware, this point was occupying people's minds in both chambers. We thought these amendments would provide that line of sight to simply make sure that this information is available to everyone.

Mr S.K. L'ESTRANGE: The reason I raise it is that we did not get to debate this, obviously, when the bill was last in the chamber and it is a key aspect of end-of-life choices that people want to understand. I think the minister said in his answer that it is not implied, but if it were thought that the options must be provided to the patient as part of the process of giving them end-of-life choices so that they can choose the palliative care option or the voluntary assisted dying option, and if they are in an environment in which there are very few palliative care options and that is what is given to them in the report, that could steer them to one course of action, whereas, if more options were available to them, they may give palliative care more serious consideration. Is the Minister for Health's view that a consequence of this amendment could be that if there is no palliative care for someone in a particular region, that could influence the outcome of their decision on end-of-life choices?

Mr R.H. COOK: No, member.

Mr S.K. L'ESTRANGE: If the minister does not think that is a concern, but the patient thinks it is a concern, how will the government respond to it?

Mr R.H. COOK: I assume that if the government of the day could see through the reports from the Voluntary Assisted Dying Board that patients who do not have ready access to palliative care are accessing voluntary assisted dying, that may invite further inquiry about why that is the case. Is there an emerging pattern around this? Do we need to look at these issues more closely? The only way that the government of the day will be able to make that decision is if it has the information in front of it, so this is about the provision of that information.

Mr S.K. L'ESTRANGE: Are you as the Minister for Health satisfied that the palliative care options exist in remote and regional Western Australia to satisfy the writing of this report?

Mr R.H. COOK: Yes, member, I am. It will be not only through the current provision of palliative care services, but also through the funding to which we have committed in both the budget and in recent times. There is a need to make sure that we enhance those services, but palliative care services are available in all rural regions and outreach. We will soon be moving to engaging in palliative care telehealth, so that not only patients but also their carers are in a better position to get further support. This has been one of the aspects of the debate; it has allowed to us have this community conversation about end-of-life choices and for this significant investment of funds to continue to improve palliative care.

Mr S.K. L'ESTRANGE: On that final answer, does the minister envisage that the implementation strategies he just spoke about will be in place prior to the actual voluntary assisted dying process being in place?

Mr R.H. COOK: Significantly so, member. As the member would be aware, the implementation phase for the Voluntary Assisted Dying Bill will take some 18 months. We are on the ground developing these other services and making sure that people in rural and regional communities have good palliative care.

Dr M.D. NAHAN: The intent of this amendment is manifold but includes data collection for the board to review decisions around the provision of voluntary assisted dying. Will it be recorded that a patient simply does not want it; they have palliative care available, which will have a certain outcome, but they choose not to avail themselves of those options? Will that be recorded in this report?

Mr R.H. COOK: The member could envisage that that is the sort of information that will be made available. Just to repeat, we initially anticipate that the sort of information would include whether the patient is receiving palliative care; if not, whether a palliative care service is available to which they could be referred to assist them; whether the patient has been offered a referral to the service; and whether the patient has been referred to the service. It is about encapsulating that whole availability of services, whether they have been made available to a patient and, basically, to provide that insight.

Dr M.D. NAHAN: To follow up, it is what services are available, whether patients avail themselves, to what extent, or whether they choose not to do it. I understand that is often an issue.

Mr R.H. Cook: Yes.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 19 made by the Council be agreed to.

This is a government amendment to make clear that the consulting practitioner, when assessing a patient's eligibility to access voluntary assisted dying, must not adopt the coordinating practitioner's decision without question, but must independently form their own opinion on the matters to be decided. This is one of the amendments we agreed to following extensive discussions with the Australian Medical Association.

Ms M.M. QUIRK: This is one of the more glaring drafting errors. In a number of places the explanatory memorandum asserted that the doctors were to act independently. Despite questioning that in relation to a number of clauses, that was not expressed in the legislation itself. I think it is a bit cute to say that it was following representations from the AMA. This glaring error was pointed out very early on in the process.

The SPEAKER: Are you happy to answer, minister?

Mr R.H. COOK: I did not think the member was asking a question, but I will put on the record once again that for something not to be in the bill does not make it something that should be excluded from clinical activity.

Ms M.M. Quirk: It was in the explanatory memorandum.

Mr R.H. COOK: Indeed, member. These issues are implicit. We accept that members were seeking more confidence about that. We had the opportunity to reflect on the comments in this place and to observe the comments made in the other place, which provided us with the opportunity to put this amendment.

Mrs A.K. HAYDEN: Just to clarify, this amendment is to make sure that the consulting practitioner is independent and that the coordinating practitioner is not able to sway them or give them opinions. They have to do that themselves. Was any consideration given to extending that? What is "independent"? Can the minister describe what the government means by stating that the consulting practitioner must make the decision independently of the coordinating practitioner? What is it independent of? Is it just the view of the coordinating practitioner or is something else behind that? Can the minister clarify that for me?

Mr R.H. COOK: To provide further context, this highlights that the coordinating and consulting practitioner must make decisions in a clear and distinct manner separate to each other's assessment. Although both practitioners may look at the same material, such as the patient's medical history and reports from specialists, they must each make their own determination on each of the eligibility criteria.

Mrs A.K. HAYDEN: Can they be of the same organisation or have business ties? Does being independent go as far as meaning that they do not work together or have a business together, or does it just mean that they do not collude on a result?

Mr R.H. COOK: It means that they make a clinical assessment independent of each other. The issue of the independence of medical practitioners was canvassed extensively both inside and outside the chamber. Western Australia is a big place, but it is a small community. In such a small community, we could get ourselves in all kinds of problems by trying to define what independence would look like. The key element we are looking for is that they make an assessment that is independent. That is why we have explicitly stated that in this fashion.

Dr M.D. NAHAN: I understand the independence of the assessments. They can look at the same data in evidence and reports, which is understandable, and there is no need to duplicate it. Does the consulting practitioner have to go and see the patient, or go through a parallel process of assessing the patient?

Mr R.H. COOK: Yes.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

> That amendment 20 made by the Council agreed to.

This amendment refers back to amendment 11, with regard to the coordinating and consulting practitioner relying upon other information from a registered health practitioner.

Dr D.J. HONEY: I wished to talk on this at amendment 11, but I will use this opportunity to raise the points I wanted to raise then. One of the matters that I debated at length during the second reading debate and in consideration in detail was the issue of undue influence. Undue influence has two parts to it in this case. The first one that is of concern is the greed of people who wish to get an inheritance early and put pressure on someone to go down this course of action. The other is observer stress. I think that is actually the more potent one. I have seen this firsthand recently. I will not say who the person is, but it is someone close to me who was in hospital, and it was the distress of the medical staff suggesting a course of action of perhaps someone terminating their life. That discussion was to the considerable distress of that person, who did not think that at all. The person involved had no intention of ending their life until it ended naturally, but the caring medical personnel in that establishment were concerned and distressed, and they were expressing that in ways that, as I said, were quite distressing to the patient.

One of the issues we have here is determining whether there is undue influence on a patient. In this clause, although other information can be obtained, there is no compulsion to do so. One of the concerns raised during the debate was that there is no requirement whatsoever for the person's normal medical practitioner to have any involvement in this process, or to have any input or any report in this process. Although the coordinating and the consulting practitioner can get reports from the medical practitioner, there is no requirement for them to get that from the person they know, or other people who know the person. How do we determine that undue influence is occurring if these people do not know the patient? Equally, there is no requirement whatsoever for the consulting practitioner or the coordinating practitioner to be an expert in the illness that they are diagnosing. This amendment, which I think is a positive move, allows them to get reports from people who are experts and take that into account, but there is no requirement to do that.

I accept that this amendment confers an explicit ability, if you like—it may have been said that it existed before—to get that opinion. There is no requirement for the practitioners involved to have any knowledge of the patient; hence, it would be very difficult, I would contend, for them to understand whether there are family situations or otherwise that are unduly influencing this decision. Also, there is a risk of practitioners who are not experts in the condition making an expert assessment on the time of death. Pivotal to this legislation is the estimate of the time of death—six months in the case of a physical illness and 12 months in the case of a degenerative mental illness.

Again, there is no requirement. The reason for raising this is to highlight that this is a positive step in that the practitioner can get that information, but I believe it is a shortcoming of this bill that there is no requirement for the practitioners to know the patient and, hence, at least understand whether there is undue influence. The other issue is that there is no requirement to have expertise in the area, and that could lead to a misdiagnosis.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 21 made by the Council be agreed to.

This goes back to some of the earlier amendments moved by Hon Nick Goiran that we discussed. It is the fourth in a suite of amendments regarding the independence of a practitioner, by not being a family member or financially benefiting, materially or otherwise.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 22 made by the Council be agreed to.

This is the second of a couple of amendments that the Leader of the Opposition, with the assistance of Hon Nick Goiran, moved regarding the patient being given forms. This is specifically about the consulting assessment form.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 23 made by the Council be agreed to.

This is the second in a suite of amendments moved by Hon Nick Goiran, so that subsequent referrals made under clause 25 or 36 to another practitioner or other person, or a copy of those reports, will also be made available to the board.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 24 made by the Council be agreed to.

This the third in a suite of amendments from Hon Adele Farina and Hon Nick Goiran regarding the use of interpreters.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 25 made by the Council be agreed to.

This the second of a couple of government amendments regarding palliative care information being provided to the Voluntary Assisted Dying Board.

Mrs A.K. HAYDEN: I just want some clarification. This amendment was moved by the government. Can the minister explain why it had to be put in?

Mr R.H. COOK: This was provided and we discussed this in some detail a short while ago. It goes to the information that is provided to the Voluntary Assisted Dying Board. The first time was under the coordinating practitioner's assessment. This is under the consulting practitioner's assessment. They both have to provide that information.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 26 made by the Council be agreed to.

This the fourth in a suite of amendments regarding interpreters.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 27 made by the Council be agreed to.

This amendment, moved by Hon Nick Goiran, is to prohibit the coordinating or consulting practitioner being the person who may sign the written declaration on behalf of the patient. This is an extra safeguard for a patient who has someone sign the written declaration on their behalf. They cannot be a coordinating or consulting practitioner; it must be a subsequent party.

Mrs A.K. HAYDEN: I just want to clarify. Does this relate back to another amendment?

Mr R.H. COOK: No, member. This is about the clause under which the patient makes a first and second request, and a written declaration. There may be circumstances in which the patient cannot sign their own name. In that case, under this legislation, they can have an assistant sign on their behalf. This is just an extra element that Hon Nick Goiran wanted in the bill—that that person cannot be the coordinating or consulting practitioner but must be a third party, or a fourth party in that particular instance.

Mrs A.K. HAYDEN: Is that part of the same changes—that the person is not a beneficiary of the will and so forth?

Mr R.H. COOK: No, not as such, but it will put that extra arm's length into that process. Obviously, the written declaration is another point at which this person, at a single point in time, says they want to continue with the voluntary assisted dying process. It is just to make sure that that is a fresh declaration. I think the view was—although I was not listening to the debate at that particular point in time—that it would muddy the waters a bit if it was the coordinating or consulting practitioner. It just provides that extra clarity.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I want to do something now that is a bit audacious and exciting. I would like to seek leave to move amendments 28 and 29 en bloc.

The SPEAKER: Is leave granted?

Mr Z.R.F. KIRKUP: Perhaps the minister could just explain amendments 28 and 29, to satisfy the house?

Mr R.H. COOK: With the house's indulgence, this is another couple of amendments with regard to the amendments around the use of interpreters.

Mr R.H. COOK — by leave: I move —

> That amendments 28 and 29 made by the Council be agreed to.

Mrs A.K. HAYDEN: If I could get the house's indulgence, I am quickly trying to turn my pages to catch up in time, because we are moving so fast. Proposed clause 50(3)(da) states —

> if the patient was assisted by an interpreter, the name, contact details and accreditation details of the interpreter;

I want to confirm that that will all be provided and made clear, so that everyone is well aware of who the interpreter is. I am trying to turn to the page to find exactly where we are at in relation to amendments 28 and 29, because we are dealing with them together, and the words "if the patient was assisted". I am trying to understand the difference between the two amendments, if the minister does not mind.

Mr R.H. COOK: This is to enshrine the inclusion of interpreters in relation to the coordinating practitioner's notification to the board of the final request, and also the review by the coordinating practitioner of the final request, on pages 35 and 36. This is to enshrine the role of the interpreter in that process.

Mrs A.K. HAYDEN: Thank you very much. Was this a government amendment?

Mr R.H. COOK: This amendment was originally moved by Hon Adele Farina, and I think Hon Nick Goiran did some quick writing to sharpen it up a bit in terms of drafting.

Question put and passed; the Council's amendments agreed to.

Mr R.H. COOK: I move —

> That amendment 30 made by the Council be agreed to.

This is the final amendment in relation to Hon Nick Goiran's amendment about the practitioner not being a family member or financial beneficiary. For members' benefit, this goes to the eligibility of those who can be an administering practitioner and is a further enunciation of that principle.

Mrs A.K. HAYDEN: Am I right in saying that the primary amendment in relation to this is amendment 8?

Mr R.H. Cook: Correct.

Mrs A.K. HAYDEN: Excellent. I want to take this moment to highlight that —

Mr Z.R.F. Kirkup: I thought it was 12.

Mr R.H. Cook: The first was amendment 8, but I think amendment 12 was the larger part. I think the member is on the right number.

Mrs A.K. HAYDEN: It is amendment 8; thank you very much.

I want to highlight, I suppose, for *Hansard* and for people who will be listening to or reading this down the track and comparing it with the material that was in the public arena about how many amendments were put by the upper house, and that three amendments were needed to make this one amendment work. It highlights that three amendments are needed to make one change to the bill. I want to use this time right now to clear that up. Those who do not live and breathe our world in this place—lucky for them that they do not, and good luck to them—do not always understand the way we work through things. When people read in the media that hundreds of amendments were put by one side—by one member or by a couple of people—they think they were delaying the debate. I want to highlight that right now we are about to pass amendment 30, which relates to two other amendments. This will happen throughout this entire process today. Although a couple of hundred amendments were listed, of the 55 that got through, there were a number of government amendments. When we boil it all down, probably a handful of real amendments will go through this place, not the hundreds of amendments. For example, amendment 15 reflected proposed amendments 15, 17, 24, 26, 28, 29, 32, 33 and 38 to make one change in this bill. For those who think it is a waste of time, putting all these amendments —

The SPEAKER: Member, are you talking about the clause?

Mrs A.K. HAYDEN: I am talking about amendment 30, which relates to two other amendments that are required. I thought I would take this time to make that note and thank the minister for putting through this amendment.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: At this stage, I would like to announce a swap of policy advisers, if I may.

THE SPEAKER: Certainly, minister.

Mr R.H. COOK: Amanda Bolleter will now be replaced by Lisa Furness.

The SPEAKER: You will still be staying, minister?

Mr R.H. COOK: My word. Thank you, Amanda, for all your assistance.

[Applause.]

Mr R.H. COOK: I move —

> That amendment 31 made by the Council be agreed to.

This is a technical amendment not picked up by the thousands of eyes that scanned this document over the course of drafting, proving and legislating, and was clearly missed in this place—that is, in clause 55 by adding the word "dying" to "voluntary assisted" instead of "voluntary assisted substance".

Mr P.A. KATSAMBANIS: Picking up on what the minister said, this is clearly simply a drafting error where a word disappeared—probably chewed up by the word processor! It highlights again what happens when we come into this place and say, "We're simply not accepting any amendments", which is what the government did when we debated the bill—even simple things. This adds the word "dying" after "voluntary assisted" so we get "voluntary assisted dying substance" in clause 55(2), rather than what is printed in the original bill, "voluntary assisted substance". The term "voluntary assisted dying substance" is defined in clause 7 of the bill. In fact, the division that this clause is in—division 2 of part 4—is titled "Administration of voluntary assisted dying substance". There is no definition of a "voluntary assisted substance", and nor should there be. If this slipped through and was never picked up and became part of the legislation, I am sure it would not be a material issue in any proceedings of any sort, but it should have been amended right at the outset, simply for logic and consistency. However, because the government took the attitude that there would be no amendments, we have had to go through this tortuous process. It was clearly a drafting error. I would imagine that at some stage, as I said, the word was probably deleted by accident. Everyone supports this. Let us get it through.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I seek leave to consider amendments 32 and 33 en bloc. In seeking leave, I signal to the chamber that these are the third and second-last amendments with regard to interpreters, and go to the issues of revocation of administration decision and coordinating practitioner notification to the board of an administration decision and prescription of substance.

Mr R.H. COOK — by leave: I move —

> That amendments 32 and 33 made by the Council be agreed to.

Dr M.D. NAHAN: I want to point out, further to the member for Darling Range's point, that we have been dealing with 55 amendments. People were repeatedly told that those who were scrutinising the bill had unnecessarily put forward frivolous amendments. However, this amendment, relating to interpretation, actually led to eight amendments.

Mrs A.K. Hayden: Nine.

Dr M.D. NAHAN: There are nine amendments. A very large proportion of the 55 amendments actually deal with something that is absolutely vital; that is, when somebody has difficulty with English, it should be recorded whether that person has had access to an interpreter, which, as the minister pointed out, is standard practice in our health system. However, it was necessary to include it in the bill. It just shows that the number of amendments can be inflated, in that one change can lead to multiple changes in bills such as this. Again, these nine amendments were not frivolous.

Question put and passed; the Council's amendments agreed to.

Mr R.H. COOK: I move —

That amendment 34 made by the Council be agreed to.

This amendment was put forward by Hon Adele Farina and then amended by the government for the purposes of drafting and scope. It essentially provides that the date, time and location of where the substance was administered, the date and time of patient's death, the period of time between administration and death, and the details of any complications will be included.

Mr Z.R.F. KIRKUP: Minister, I will be very quick. We raised a number of times in this place the question of what information would be captured upon a patient's death. I welcome the amendment moved by Hon Adele Farina in the other place to reflect the concerns that we had here; it is a prudent amendment. A lot of the information that should be collated would not necessarily have been reported. This amendment is eminently sensible. I think the minister said that these requirements could have been optionally captured in any case, but I think it is important that they are enshrined in the bill to make sure that these important issues, such as when and where a patient died and the like, are formally captured. I appreciate the government moving the amendment and agreeing to it in this place.

Mrs A.K. HAYDEN: I believe this amendment will also assist in addressing a few of the issues raised by many members in this place, including complications. We all do not want complications to occur, but unfortunately we do not know what the chemical will be, and obviously different people's weight and reactions can be different. Council's amendment 34 states, in part —

(dc) details of any complications relating to the administration of the prescribed substance;

Will an actual process be in place if there are complications? Obviously if they have done it on their own, there will not be a witness, but if a family member or someone else is alongside the patient, is there a process for them to be able to report that complication? Can the minister explain that and how this amendment allows that?

Mr R.H. COOK: Member, obviously we anticipate that this sort of information will be captured. As the member for Dawesville said, we made a commitment that it will be captured. It is the sort of stuff that will be considered during the implementation phase. In the context of the debate in the other place, we thought if that will provide members with further confidence, we are happy to move in that direction. The member is quite right that any complications will be recorded. It is important in providing quality and safety.

Mrs A.K. HAYDEN: Can the minister outline how that will happen? I do not understand. If I have witnessed it, is there a form that I will fill in or will I go back to the coordinating practitioner? How is that information fed back?

Mr R.H. COOK: This is in the context of an administering practitioner. If it is self-administered, obviously there is no opportunity to capture the medical information. There may be opportunities for discussions if there are people witnessing it or a part of it. This relates specifically to the administering practitioner's responsibilities.

Mrs A.K. HAYDEN: This is for administration only, if someone has taken it home. Quite a few people have told me that their wish is to pass away in their home, surrounded by loved ones. The minister said that he may be able to look into this down the track. Is the minister prepared to make a commitment today that he will look at avenues? If more people go home to die and there are complications, that will be quite a confronting thing for the family who are there. There needs to be a mechanism in place so that if a complication were to occur, there is support for the family who has witnessed it, and we need to ensure that we get it right because we certainly would not want this to happen again. If there is a complication due to self-administration, that could easily be fixed if the minister and the board were aware of it. As much as I think it is important that we are protecting those who are being administered the substance in hospital or within a medical environment, I really think we need to ensure that the people who are self-administering at home are safeguarded and protected, and being followed up on. The least we could do is make sure that there is support for family members who witness any complications. Will the minister make a commitment that that is something he will look into? We are not moving amendments, but could the minister look into making a commitment that that will happen?

Mr R.H. COOK: Absolutely. I do not want to give the member the impression that these things would happen in isolation, without discussions and consultations, both with the family doctor and other people involved in the care of

someone who is obviously at the end of a period of palliation. Those conversations would go on. I will absolutely make sure that part of the implementation phase is that we capture that sort of information, albeit that it would not be medical information. It may not be relied on in terms of time of death and so forth because they are laypeople—that is, not professionals in that field. That is the sort of information I would expect. I am certainly happy to make that commitment.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 35 made by the Council be agreed to.

This amendment was moved by Hon Nick Goiran. It relates to the clause titled "Witness to administration of prescribed substance". The witness to the administration of the prescribed substance to a patient must certify in the practitioner administration form for the patient that the patient's request for access to voluntary assisted dying appeared to be—we originally had "enduring". Hon Nick Goiran sought to include the reference "free, voluntary and enduring", and we were happy to agree with that. It is consistent with the original clause; it just takes it that little extra step further. It enjoys the government's support.

Mr P.A. KATSAMBANIS: This is an important amendment. Again, it is small, but it makes the roles of witnesses at various stages of this process equal. Clause 43(3) states that the witness needs to certify—to declare—that the patient appeared to freely and voluntarily sign the declaration. Similarly, the witness to the administration of the prescribed substance previously had to certify only that the person's request appeared to be enduring. However, adding that it has to be free and voluntary makes the witnesses' roles equal and analogous in the entire process outlined in the bill. It is also extraordinarily important because, at the end of the day, the policy intention of the legislation is that the patient freely and voluntarily enters into this decision, so there is absolutely no harm in a witness certifying that that was the case.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 36 made by the Council be agreed to.

This is in the context of transferring the administering practitioner's role if the original practitioner is unwilling to administer. The original text of the bill was that the original practitioner is "unable for any reason". Hon Nick Goiran moved that we insert the words "or unwilling" after "unable". Although we believed that "unable" captured the issue of a practitioner's willingness, we thought that it provided extra clarity, so the government supported this amendment. This will capture circumstances in which the practitioner is no longer willing to participate in the voluntary assisted dying process. This may be because the practitioner may themselves have had a change in circumstances, such us that they no longer want to participate. This amendment is not intended to enable the medical practitioner to simply elect to take on a request for an administering role on the premise that they may then transfer the administering role to another medical or nurse practitioner. Practitioners who are unwilling to undertake the administering role when a first request is made to them should decline participation in the voluntary assisted dying process. In the context that they do not feel they could or are unable to go through the whole process, they should excuse themselves at that point. This amendment will provide an opportunity for them to do that at the final stage.

Dr D.J. HONEY: I think it is a very important addition to this bill. It is critical that at every stage there is no sense in anyone's mind that there is a compunction on the patient to go ahead with the process, and that has been made clear, but it is, of course, also on the part of the practitioners. Anything that could be seen to be an implied barrier to that would be undesirable, so I very much support the adoption of this amendment. One could say it is a small point of interpretation, but I think it makes it very, very clear that this will be a voluntary process throughout.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 37 made by the Council be agreed to.

This amendment was put forward by Hon Nick Goiran and goes to the responsibilities of a contact person. The point that was being made was that explicit information should be provided to the contact person about the penalties involved if they do not return any unused or remaining prescribed substance to an authorised disposer. It just makes explicit the penalties associated with their role.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 38 made by the Council be agreed to.

This is the final amendment in relation to the role of interpreters. It goes to the issue in clause 65, "Contact person appointment form", and includes the same form of words that has been used in the previous amendments.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 39 made by the Council be agreed to.

This amendment provides for the requirement that the person completing the contact person appointment form on behalf of the patient is doing so at the request of the patient and is over 18 years old. This amendment, proposed by Hon Nick Goiran, includes the requirement that a person completing the contact person form must explicitly state that they are doing so on behalf of the patient and also that they are over the age of 18 years.

Mr P.A. KATSAMBANIS: I make the point that this is clearly a regime that is intended for adults only, and this amendment clarifies it. Again, sometimes with these things, we can sit back and think that it is self-evident, but history tells us that what might be self-evident to me, the minister or even the man on the Clapham omnibus, if I go back to my old law school days, may not necessarily be considered to be self-evident by all sections of the community or even by the law itself. Clarifying it is important. It points out again that this is a regime for adults by adults, and that the only people involved in this process will be over the age of 18 years.

Mrs A.K. HAYDEN: Again, unfortunately, I cannot let this one go. This is why we have a bicameral system. This is why we have an upper house. The democratic process needs to take place when we find errors such as this in legislation. It would have been embarrassing for the government if someone under the age of 18 years had been able to sign off on this form. It would have been embarrassing for this state if this bill had passed without this amendment. I am sorry, but I had to stand up; and, if the minister were on this side, he would have done exactly the same thing. When we have proper scrutiny and proper amendments and we allow debate to take place, we end up with far better legislation. This amendment to ensure that no-one under the age of 18 is able to sign off is vitally important. I congratulate Hon Nick Goiran for identifying it, the other place for accepting it and the minister for taking it on board.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK — by leave: I am going to test the chamber now. Here we go! Amendments 40 to 44 all apply to clause 68, so we can have a big discussion about clause 68. I move —

That amendments 40 to 44 made by the Council be agreed to.

This is a suite of amendments to enshrine in the legislation that particular information pertaining to the voluntary assisted dying substance and the likely effects of the administration of that substance is provided in writing to the patient by the coordinating practitioner prior to the substance being prescribed. These amendments put forward by Hon Adele Farina essentially allow for information regarding the substance to be provided to the patient—for example, the method by which the substance will be self-administered, the expected side effects, the period within which the patient is likely to die from the substance, and the potential risks with the substance, as well as the responsibilities of the coordinating practitioner in prescribing the substance. It goes without saying that it is good clinical practice to provide all this information as part of the prescription process. When people go to a doctor, the doctor says, "I'm going to prescribe you with this; this is what it will do to you, this is how often you should take it, this is how long you should take it for, and these are the likely side effects", and that is part of the prescribing process. Hon Adele Farina wanted these elements to be made explicit in the legislation, and given that this is what we would expect as part of good clinical practice anyway, the government is very relaxed about accepting these amendments. Members will see that they run throughout clause 68. There is a bit of repetition, because there will be patients who self-administer and other patients for whom the practitioner will administer the substance. Clause 68(2) is about self-administration and clause 68(3) is about practitioner administration.

Dr D.J. HONEY: Could the minister explain the reason for the wording that is repeated with regard to schedule 4 and schedule 8 poisons, and the meanings given under the Medicines and Poisons Act? What was the argument or debate behind having to include that specific definition?

Mr R.H. COOK: The member will remember that when we debated the bill in this place, we talked at length about the role of the Medicines and Poisons Act in the legislation. This is, I guess, another element of explicitly stating what poisons would be used. As we said during that debate, it will be schedule 4 and schedule 8 drugs, or combinations thereof. It was considered appropriate to reference them in the context of the Medicines and Poisons Act to provide clarity around the definitions.

Dr D.J. HONEY: Just to clarify, is the minister saying that it is to make sure that we keep the types of substances that are used within quite a tight range, if you like, and that this cannot be expanded into a broad, experimental range of substances?

Mr R.H. COOK: Spot on, member, yes.

Mr Z.R.F. KIRKUP: I am curious about what will become clause 68(2)(aa), which provides for the schedule 4 poison or the schedule 8 poison, or a combination of those poisons, constituting the substance. The patient must be informed of that in writing. There is obviously a range of penalties in place for any person who publicly discloses what those schedule 4 or schedule 8 poisons might be. I assume they might also apply to the patient, up to the time at which they administer the substance. What is the intent of providing that information to them? I realise that it is out there, online, and that it is relatively accessible, but we asked this question a number of times during debate and there was quite a lot of pushback. The minister will appreciate that I support the bill, but there was quite a lot of pushback on making sure that that information would not be made public. I am curious about why there was a determination to include this. I realise there is a desire to inform the patient what they will be administering, taking orally, as there is with any other prescription, but of course this is something unique. Is it going to be provided with broad information, without the dosage amounts? What does that mean? Of course, there is a risk that revealing the combination of poisons could lead to people copying that in some way, shape or form. They might have X amount of the drug in their medicine cabinet at home and all they would need to do is take enough of it and they would go through the same thing. I am curious to understand this. We obviously have tried to contain this as much as possible—there is a very clear process of containment—yet it now seems as though this is going beyond that.

Mr R.H. COOK: Ultimately, the patient will have the right to know what the voluntary assisted dying substance is and how it is constituted in their particular case. In the scheme of things there is still an obligation on the patient to not disclose that to members of the public and there is an obligation on the contact person to safeguard the substances, as such. This is simply an expression of the right of the patient to know exactly what the substance they will be taking is. I accept the point the member has made. He is right: we did make a bit of noise about making sure that the information loop is kept fairly tight because we do not want this information to become widely known and, as the member equally observed, the internet can provide us with all manner of information nowadays, but this will formalise the right of the patient.

Mr Z.R.F. KIRKUP: I appreciate the minister's response. Does he anticipate that the patient will be provided with only the generic name of the poison rather than the dosage or something like that? Is that what we will see here? Will it specifically have the dosage? I appreciate that anything that we take can be lethal in a high enough dose, but will the information be very bland or will it say specifically, "You're a 68-kilogram male. This is what you will be taking; this is the dosage"? That is very specific information. Or will the patient be given, broadly, the poison's name and it will be left at that? Does the minister have any insight at this time how detailed that information will be?

While we are on that, the minister referred to clauses 68(2)(g) and 68(2)(h)—the expected side effects of self-administering the substance, the period within which the patient is likely to die, and also paragraph (i), the potential risks of self-administration. I assume all that will be provided in writing, as well as the expected "period within which the patient is likely to die". This is relatively untested ground in the Western Australian jurisdiction. How will the period within which someone might die be established? I realise there are international studies and anecdotal evidence, but part of this amendment is asking for a lot of certainty, and I am curious how that will be established in Western Australia.

Mr R.H. COOK: Ultimately, the information on the poisons and the way that the substances will be used will be determined by the clinical panel as part of the implementation period. Considering that we have not undertaken this process before, we will know by looking to the clinical evidence that informs the particular drug. Obviously, we will also be looking at the information that is provided by the manufacturer. That evidence will be there. We will not be able to point to a specific period of time, but we will be able to say that within a period of time the patient will feel this or that, and there is an expectation that this will happen. That stuff, ultimately, will be determined by the clinical panel during the implementation phase.

Going back to the member's point about the specificity of information, it essentially will be simple information so that the patient is informed about what they will be getting; it will not be the full recipe and so on.

Mr Z.R.F. KIRKUP: Mr Speaker.

The SPEAKER: Member for—I have had a blank!—Dawesville. How could I forget the best looking man in the house—so you have told us!

Mr Z.R.F. KIRKUP: Thank you very much, Mr Speaker.

Several members interjected.

The SPEAKER: You missed the last bit. I said as he has told us.

Mr Z.R.F. KIRKUP: I appreciate that it has been a long year, Mr Speaker.

Mr R.H. Cook: He has become very fond of you in that time!

Mr Z.R.F. KIRKUP: Indeed!

Minister, for what it is worth, I feel the least level of comfort about this amendment when it comes to revealing the identification of the schedule 4 and schedule 8 poison. The government has put in place very severe and heavy penalties if any information like that is revealed. A lot of safeguards have been put in place to effectively say, "We're not going to tell you this, but this is what you're taking." I appreciate that a patient has to be informed of what they will be self-administering—I totally understand that—but I very much worry that the patient will be provided with a detailed breakdown. I am not comfortable with that at all. The level of information provided should not go beyond, "You're going to be taking this particular poison." I appreciate the intent of the government's other amendments, but I place my concern on the record that I do not necessarily like the idea of the dosages being included.

Mrs A.K. HAYDEN: I disagree with my colleague. We debated this issue quite a bit; I think it was quite early in the morning. My main issue is that we did not know what the substance would be and how it would be self-administered. I am delighted to see this amendment. I congratulate Hon Adele Farina on getting this amendment through. Given that information will now be given in a document about the effects of self-administration, the potential risks of self-administration and the substance that will be used, is the minister any closer to knowing what the substance will be, and will that information be brought back to Parliament so that we, as legislators, can understand how it will be self-administered, what the poison will be and the potential risks and side effects? We asked about this issue quite a lot during the debate but we were told that it had not been decided and that it was not for us to know. It sounds as though the minister is a bit closer to knowing what that will be.

Mr R.H. COOK: The answer to that question is no, we will not provide information to Parliament about what the substances are, potential side effects and things of that nature. The substance will vary from patient to patient and will depend on the medical protocols in place for the particular patient at the time. This will be part of the implementation phase and will be oversighted by the clinical panel in a very careful manner. It is not for Parliament to delve into these matters. Obviously, some important information will be provided to the patient because it is the patient who will experience the substance. Important information will be provided to Parliament via the annual report of the Voluntary Assisted Dying Board, which will provide good insight into the way the system is working, how it is being administered and the other elements that go with that. But we will not be providing the information that the member just outlined.

Mrs A.K. HAYDEN: My second question was: is the minister any closer to knowing what substance will be used and how it will be administered?

Mr R.H. COOK: That will be part of the implementation phase. I will not be seeking that information. That will be the responsibility of the Department of Health. I am not a doctor so I would not be able to tell the member whether a substance was good anyway. We will leave it up to the experts. They have provided us with a world-class health system and I am sure they will continue to do so.

Mrs A.K. HAYDEN: Just one last question. I am not trying to be difficult, it is just that we debated this at length. The minister is saying that the other patient will be able to get that information. At what stage would they be provided that information—at the beginning or in a certain time frame? Once they seek advice and they want to go down that path, when are they provided with the information?

Mr R.H. COOK: Clause 68(2) says —

> The coordinating practitioner for a patient who has made a self-administration decision must, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following —

That is the point at which they would undertake that. It is the same then for the coordinating practitioner in the case of an administration decision.

Question put and passed; the Council's amendments agreed to.

Mr R.H. COOK: I move —

> That amendment 45 made by the Council be agreed to.

This amendment corrects a technical error in the bill and regards who is obliged to return any unused substance. It removes the words "patient to whom it is supplied or their contact person" and substitutes the words "contact person for the patient to whom it is supplied".

Mr P.A. KATSAMBANIS: I seek some clarification from the minister about why this amendment is necessary. I note it was moved by the government but I do not know its genesis. On first reading, the amendment seems sensible because this is about labelling requirements and what is done with any unused or remaining substance after it has been given to a person. The label must say that the substance must be given to an authorised disposer by the patient to whom it is supplied or their contact person. The words "patient to whom it is supplied" are being removed. Logically, a person who has been given the substance and has taken it will not be able to supply it. In that context, I understand why this amendment might have been moved, but when I first read the original clause prior to its amendment, I thought that the reason the words "the patient to whom it is supplied" was that it foreshadowed the possibility the patient may choose not to take the substance, which we have discussed before. Are we trying to correct a potential error that was not actually an error but something that was contemplated? The way I read the amended clause, if someone did change their mind, they could not return the substance to an authorised disposer; they would have to give it to their contact person to give to an authorised disposer.

Mr R.H. COOK: I thank the member. I think it is an appropriate question to ask. As currently drafted, the subclause requires that, amongst other things, the label or statement—that is, what is included on the label—attached to the container of the prescribed substance must state that any unused or remaining substance must be given to an authorised disposer by the patient or a contact person. However, only the contact person is obliged under the legislation to return the substance to an authorised disposer and faces a penalty for failing to do so. Although a patient may also return the substance, they are not obliged to do so under this legislation, nor do they face penalties for failure to return it. In most circumstances it is unlikely that the patient will be in any physical condition to return the substance if unused, but this explains why it would have been explicit in this context.

Mr P.A. KATSAMBANIS: That is a good explanation. It reinforces the important role that a contact person plays in this regime and, as the minister pointed out and as we will discuss in some subsequent amendments, the penalties that would apply to the contact person if they did not follow the legislation. I thank the minister for clarifying that.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: Amendment 46 relates to information relating to medical practitioners and, in some respects, it concerns four amendments.

Mr P.A. Katsambanis: Do you want to do 46 to 49?

Mr R.H. COOK — by leave: Let us try that. I move —

> That amendments 46 to 49 made by the Council be agreed to.

They all relate to the role of the administrative tribunal and the naming of practitioners.

This was a range of amendments moved by Hon Nick Goiran. Amendments 46 and 48 ensure that personal information on a former coordinating or consulting practitioner who is not a party to a State Administrative Tribunal hearing is not made public. Amendments 47 and 49 ensure that personal information on an administering practitioner who was transferred into the role is not made public. Obviously, it is a requirement under the bill for the State Administrative Tribunal to provide reasons for its decision. This is about explicitly stating that the reasons for its decision removes information that would expose or provide the identity of the former coordinating or consulting practitioner or a person to whom the role of administering practitioner is transferred under section 62(2). These are fairly technical amendments and it is not surprising that a member like Hon Nick Goiran, who has much experience in this, moved these amendments, and it is even less surprising that the member for Hillarys with his experience is nodding furiously to these amendments.

Mr P.A. KATSAMBANIS: I think they are logical and sensible amendments. I commend Hon Nick Goiran for moving them. It again highlights what good scrutiny brings to legislation. The provisions that are being amended concern what parts of decisions made by the State Administrative Tribunal can be published, and there is a presumption of anonymity of all the parties involved in the publication of those decisions. It is a bit like cases in the Family Court and Children's Court and some other protected matters that happen in our courts. We want the State Administrative Tribunal to publish the flavour of the debate or the argument for the sake of precedent and informing the public without naming the participants, because they are irrelevant to the public discourse. It gives them that protection. The original clause failed because it did not take into account the fact that all these roles, the coordinating practitioner and the administering practitioner and the like, can be transferred during the process either because of death, incapacity or unwillingness, as we have added. Those former practitioners who transferred out of the role could inadvertently have been named simply because they were not one of the parties listed as specifically protected by the cloak of anonymity. That has been fixed up here. I think it is worthwhile and it is another exercise in good scrutiny between the two houses.

Question put and passed; the Council's amendments agreed to.

The SPEAKER: Before we move on to the next amendment, I wish to advise members that I have approved the presence of media to take photographs and footage of the Legislative Assembly concluding with the Voluntary Assisted Dying Bill 2019.

Mr R.H. COOK: I move —

That amendment 50 made by the Council be agreed to.

This government amendment removes the penalty of $10 000 for a medical practitioner who fails to report a first request to the board. This amendment was inserted after extensive discussions with medical practitioners. Members would be aware that not all doctors are alike. There are interns, junior doctors and some very experienced doctors. It was considered unfortunate that a junior doctor, who might be fresh to the scene, may be confronted with an initial request and have to discharge their duties as a doctor—a fully-fledged doctor, but nevertheless a doctor with little experience—and inform the Voluntary Assisted Dying Board. In actuality, that junior doctor would probably liaise with more senior doctors or consider the patient as part of a team, and, ultimately, that initial request would be notified to the Voluntary Assisted Dying Board, but it would be more likely to be by a senior doctor. We considered this very carefully and wanted to be able to capture that scenario. It was very difficult to identify and chop up the doctors depending on different levels of skill and experience. We thought it more appropriate to make sure that there was simply an obligation under the act that the doctor notify the board of the first request, but there not be a penalty. Amendment 50 removes the penalty of $10 000 for a medical practitioner who fails to report a first request to the board.

Ms M.M. QUIRK: My question is about the table. It is an administrative thing because of various other insertions having to change the section numbers; is that correct?

Mr R.H. COOK: Yes. My understanding is that the amendment is —

Clause 107, page 70, after line 27, the Table the 1st row the 1st column — To delete —

s. 21(1)

Dr D.J. HONEY: Just to be clear, I appreciate that this will remove the fine of $10 000 if the form is not submitted within 48 hours. I thought that was an especially egregious part of the bill. Will the medical practitioner still potentially be subject to a charge of professional misconduct and unprofessional conduct if they do not submit the form?

Mr R.H. COOK: That is correct.

Dr D.J. Honey: In the time, I should say.

Mr R.H. COOK: The practitioner can still be held accountable by clause 10 of the bill. Contravention of the act is still capable of constituting professional misconduct or unprofessional conduct.

Mrs A.K. HAYDEN: I want to again congratulate the minister on making another amendment to this perfect piece of legislation. The last thing we want to do is get our medical providers caught up in unnecessary consequences that were not intended. It is good to see the removal of the $10 000 fine. I think the minister's consultation with the Australian Medical Association was one of the main drivers behind this, so it will be very happy with this amendment.

Mr R.H. COOK: I thank the member. That is the case. This clause was amended following concern from medical practitioners that doctors who are otherwise ineligible to participate, or inexperienced doctors such as junior doctors, would inadvertently fail to lodge a first request form. It simply clarifies that.

Mr P.A. KATSAMBANIS: For the same reasons outlined by the member for Darling Range, I fully support what this amendment does in substance. I think it is a good outcome. We had the debate a moment ago about Hon Nick Goiran, myself and others in this place who are legal practitioners. This is not a criticism of the minister, but when we draft legislation that we expect members of the public, who are not legal practitioners, to use and that will apply to the general public, I think the current form of legislative drafting, which is exemplified in clause 107, is a real failure. Originally, 18 provisions, including 21(1) and 32(1), were included as penalty clauses. It will now be 17 because 21(1) is being taken out. When we read those clauses on their own, they create obligations, but there is absolutely no indication that there is a penalty attached to those obligations. Some of these penalties apply to good Samaritans, just members of the public, in relation to being contact persons for returning unused substances and the like. This is not a criticism of the minister or the people who drafted this specific bill, but to expect a member of the public, who is not a legal practitioner and may never have read a piece of legislation before, to then check to see whether there is a table, or a section including a table, at the back of the legislation, is really poor. It would have been very simple, in each of these clauses, to add a subclause at the bottom stating that a person who contravenes this provision commits

an offence with a penalty of a fine of $10 000. It just would have been better. As I said, I am not going to labour the point. It happens in a lot of pieces of legislation, but this one is really important, and we do not want people to be caught out unnecessarily, not understanding the gravity of the penalty for contravening an obligation that is placed upon them by this bill.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 51 made by the Council be agreed to.

This is a government amendment to specifically address concerns that a doctor should not be protected from civil or criminal liability when they act negligently—that is, without reasonable care and skill. The existing clause implicitly provided that negligent conduct would not be protected, but this amendment makes it explicit in the bill.

Mr Z.R.F. KIRKUP: I am assuming that this amendment was suggested by the Australian Medical Association, in consultation with the government.

Mr R.H. COOK: Yes, it was explicitly raised by the AMA, and on its request we included these words.

Mr P.A. KATSAMBANIS: Just for completeness, I point out that although this amendment was sought by the AMA and the minister listened and has included it, the clause that has been amended applies to all persons under this bill, not just doctors. It goes without saying, but it is good to put on the record, that the standard to which each individual will be judged as having exercised reasonable care and skill would be commensurate with their profession and their professional obligations, so if it is an individual who is simply going to be the contact person—the example used in the previous clause—to return the remaining substance, they would not be held to the same standard of reasonable care and skill as a doctor would be. All professionals, including doctors but also extending to nurse practitioners and the like, would also be subject to professional misconduct rules et cetera. This is a good provision. It was requested by the AMA, but it will apply to a broader range of people than just doctors.

Mr R.H. COOK: That is correct. A number of provisions of the Criminal Code make something unlawful unless it is done in good faith and with reasonable care and skill, or exempt a person from criminal liability if they do something with reasonable care and skill. As such, the proposed amendment reflects the language used in other WA legislation.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 52 made by the Council be agreed to.

Members will recall from earlier in today's discussions that a range of amendments were proposed by Hon Martin Aldridge about the impact of voluntary assisted dying on regional patients and their ability to access voluntary assisted dying. Amendments 52 and 54 are two of the amendments he moved. They form a suite of amendments to address regional residents. It has always been the intent of the government that the Voluntary Assisted Dying Board collect comprehensive statistics on voluntary assisted dying, including statistics pertaining to access to voluntary assisted dying by residents from regional, remote and metropolitan areas. The amendment to clauses 151(1) and 154(2) enshrined this intent. This will assist the interpretation of the bill when specific reference will be made to regional residents such as regarding collection of data by the Voluntary Assisted Dying Board.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 53 made by the Council be agreed to.

All the amendments to clause 154 go to the issue of the content of the annual report of the Voluntary Assisted Dying Board. Obviously, we pulled up a list of issues that must be on there. We never saw it as an exhaustive list, but again, members of the other place sought extra information to be included in it as part of providing them with the confidence to support the legislation. Amendment 53 was moved by Hon Nick Goiran to require the board to include the number of referrals it makes under clause 117(c) in the annual report. For members' information, clause 117(c) goes to those issues that are referred by the Voluntary Assisted Dying Board to either the office of the Commissioner of Police, the Registrar of Births, Deaths and Marriages, the State Coroner, the CEO, the chief executive officer of the department of the public service principally assisting in the administration of the Prisons Act 1981, the Australian Health Practitioner Regulation Agency, or the director of Health and Disability Services Complaints Office. To underscore that point, this is about making sure the Voluntary Assisted Dying

Board reports on those instances it feels compelled to refer matters to another authority for further investigation or inquiry. Hon Nick Goiran wanted that explicitly stated; we were happy to comply.

Mr Z.R.F. KIRKUP: I assume that as part of the annual report process, there would be a breakdown of the referrals made. Would that be right? If not, would the minister make an attempt for that to be the case, with a breakdown of matters referred to police, HADSCO and the like?

Mr R.H. COOK: It is fair to say that we are not going to be talking about a large chunk of instances each year. Ultimately, it would be essentially qualitative advice that will not come in a table form: "20 this, 50 that". It would be information that would explicitly state the actions that the board took on those referrals.

Mr Z.R.F. KIRKUP: Just to clarify, I appreciate that the number would be relatively small, but we would hope it was not a number. I imagine it would still have to say specifically, "X number was referred to police, X number to the coroner and the like." Is that the minister's expectation about what would be represented in the annual report?

Mr R.H. COOK: That is correct.

Mrs A.K. HAYDEN: I am sure the minister is not surprised that I cannot let this one go to the keeper.

Several members interjected.

Mrs A.K. HAYDEN: We were doing so well until you all heard the cameras were in here, and then you came in. Where have you been all day?

Several members interjected.

The SPEAKER: Members! Can you talk to the clause please and cut the rest of the stuff out.

Ms S. Winton interjected.

The SPEAKER: Member, we got this far. A lot of you were not here for the whole lot, so let us just finish it off as quickly as possible.

Mrs A.K. HAYDEN: Thank you, Mr Speaker. As we said at the beginning, and at a few other amendments, this was debated at length for quite some time during our time debating it in this chamber when we were forced to sit until 5.30 in the morning.

Several members interjected.

The SPEAKER: Members!

Mr P. Papalia: You're embarrassing yourself.

Mrs A.K. HAYDEN: Are you saying I am embarrassing myself?

The SPEAKER: Member, if you do not talk to the clause, I will sit you down.

Mrs A.K. HAYDEN: Thank you, Mr Speaker. I will seek your protection, but I will be heard in silence, like everyone else has been during this debate.

The SPEAKER: Yes. Could you just get onto the clause, and I will protect you.

Mrs A.K. HAYDEN: As we have raised a few times, this was debated at length, yet the minister and the government sat there and said that they would not even entertain this amendment. I would like to know what debate turned the government in the other house to bring on this amendment. As we have been talking about, this is a life-and-death bill. We did ask that if any referrals to the board went off to another authority, they would be reported on. It would be greatly appreciated if the minister was able to say what caused him to change his mind. We are pleased that the amendment is here, because we need nothing but transparency in this legislation. This legislation is not a joke. It is to be taken seriously, and that is what we have tried to do through this whole process. I am delighted to see this amendment. But, again, like with so many other amendments, we had an opportunity to do that when we debated the bill in this chamber, but we did not, and we are now back here again today, having been called back after Parliament last sat and after the government removed a week of the parliamentary sitting because we had nothing to do.

Mr R.H. COOK: This issue was not raised in the Legislative Assembly. This issue was raised solely in the Legislative Council and goes to the —

Several members interjected.

Mr R.H. COOK: Members, please! It was about the number of referrals made by the board. We did have an extensive discussion in this place about the powers of the board to undertake an inquiry, during which we clarified that it basically had referral powers, but this particular amendment was not raised. It was raised by Hon Nick Goiran. We

are happy to support it. As I said repeatedly during the debate in this place, this is not a list that constrains the board. The board can report on whatever it feels necessary under this bill. In the context of wanting to see the bill receive the support of those in the other place, we were happy to endorse the amendment, because, as I said on a number of occasions, it explicitly states what we said we believe was implicit.

Mrs L.M. HARVEY: I would like to put on the record that I think this is a very good amendment. It goes to providing better accountability of the operation of the legislation. That will certainly put my mind and other members' minds at ease on the management of the legislation and the potential problems with the legislation, or problems with people potentially accessing voluntary assisted dying in an inappropriate way. I commend the minister for including this in the legislation. Better accountability is what we are all about. Indeed, that is the advantage of having a Legislative Council that is able to do its job appropriately, interrogate the legislation and make sure protections are in place for vulnerable people, which is what we were all about at the outset.

Mr P.A. KATSAMBANIS: I am really glad the minister supports this amendment, because it was moved in this place. It is interesting that when it was debated and voted on in the other place, it was passed by 18 votes to 17, and the government members voted against it. I am glad it was agreed to in the other place, and that with the message that has come here, the minister has seen fit to agree to this small, but important, amendment that will add to the quality of the statistics that will be provided on an annual basis to not just the minister but also the Parliament. Remember, the Parliament is the chief accountability mechanism of the public of Western Australia in holding the executive and the bureaucracy to account, especially in this sort of bill, which deals with the most vulnerable people at the most difficult time of their lives. The more transparency we have and the more statistics we have available, the better. I thank the minister for agreeing to that amendment. That will stop us, of course, from having to continue to bounce messages from this place to the other place. I am sure that will make the Premier happy as well, because we will meet his deadline 15 days early.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I will move —

That amendment 54 be agreed —

An opposition member: Go on, move both of them.

Mr R.H. COOK: No; I cannot; they are different. Well, we possibly could.

Several members interjected.

The SPEAKER: Members; we are doing amendment 54.

Mr R.H. COOK: — by leave: I move —

That amendments 54 and 55 made by the Council be agreed to.

The final amendments go to the work of Hon Martin Aldridge in wanting to make sure that regional residents have access to voluntary assisted dying. In particular, he moved two amendments, one of which was the extent to which regional residents who have access to voluntary assisted dying is included in the statistical information provided by the Voluntary Assisted Dying Board's annual report. That is to be pursuant to new clause 154A, also moved by Hon Martin Aldridge, which goes to denoting an access standard. Essentially, the chief executive officer will have a responsibility to set an access standard, setting out how the state intends to facilitate access to voluntary assisted dying for persons ordinarily resident in Western Australia, including how the state intends to facilitate those persons' access to the services of medical practitioners and other persons and prescribed substances and information about accessing voluntary assisted dying. The access standard must specifically set out how the state intends to facilitate access to voluntary assisted dying for regional residents. The chief executive officer may modify or replace the standard. The chief executive officer must publish the access standard on the department's website. Members will understand what Hon Martin Aldridge is trying to achieve with these two amendments. One requires that the chief executive officer state how he will make voluntary assisted dying available to all Western Australians, particularly regional Western Australians, and to make sure the Voluntary Assisted Dying Board provides information by way of its annual report about how that access standard has been brought to bear. From that perspective, I think these are well considered words and from that point of view, the government was very happy to support them.

Are there any other speakers on this?

Ms M.J. DAVIES: Yes. As the minister has indicated, this was part of the work Hon Martin Aldridge undertook. I will put on record my thanks to the minister and his staff for going through the process with the member. We started from a slightly different point, and I think this is a demonstration of us working through some of the concerns that

the member had, particularly from the Nationals WA's perspective around capturing information on regional access and making it very clear to those who are seeking to access voluntary assisted dying that there would be a clear published pathway and it would be measured by the board and part of the statistics that are collected.

From our perspective, the amendment does not restrict or prescribe the form that the standard has to take. There was not an appetite for a prescription for how that might be done within the legislation. However, it must be set out as part of the standard. Although there is no penalty for not meeting the standard, it seeks to establish what might be expected of the government as the provider of last resort when we are assuming that in regional areas there will be some challenges in accessing the service.

We thank the minister for taking the honourable member's concerns on board. I understand that during the debate in the other house and in writing to Hon Martin Aldridge, the Minister for Health confirmed it was his intention to direct the Department of Health to establish a charter of patients' rights to illustrate what all Western Australians can expect as part of this legislation and how to access it and the accessibility.

Mr R.H. COOK: Yes, member, that is right.

Mr D.T. REDMAN: This is the only amendment that I have spoken on today, but I think it is a reasonably important one. To start, I want to put on the record my general support for the bill, which I have supported right the way through. In my second reading contribution, I talked about the importance of palliative care, as many members here have done so, and as it applies to regional Western Australia's access to voluntary assisted dying. The point that I made at the time was that as we go out to the far reaches of regional Western Australia—I point to the east of Halls Creek, for example—services deplete. That is just the reality and the nature of our geography in Western Australia. The reality is that it is almost impossible to prescribe or define the services that we can get to those people, and put it down in writing. Hon Martin Aldridge put clauses in the bill that will allow a level of public scrutiny of the statistics about regional access to these services and that lay out a defined standard that is open and published. I think that has been a really good step, although it would not have been a show stopper for me. The bill would have had my support, but I pay tribute to Hon Martin Aldridge for what he has achieved in trying to have something that gives members of the public an opportunity to look at what is happening and, if necessary, through their elected politicians, to change it or have some influence on it.

I would also like to congratulate the Minister for Health for the carriage of this bill. This bill is the most significant bit of legislation that I have dealt with in 15 years as a member of Parliament. Today is a massively significant day. I think the way that everyone has dealt with it, in both this place and the other place, has been outstanding.

[Interruption from the gallery.]

The SPEAKER: People in the gallery—we love having you here, but you are not allowed to be part of the show.

Ms M.M. QUIRK: Minister, I know the natives are restless, so I will be very brief. It is consistent with what we have said all along—that in the framework of this bill the CEO has too much discretion. A lot of this stuff should have been prescribed, as it was in the Victorian legislation. This New clause 154A is yet another example of this. As much as members of the Nationals WA might like to congratulate themselves, they have delivered absolutely nothing additional for their constituents, because, as the minister conceded earlier today, the statement about everyone in Western Australia having access to voluntary assisted dying was a statement of principle and unenforceable. I make the point that the Law Society of Western Australia—unfortunately, very belatedly—issued a number of concerns about the bill. One concern was that the making of guidelines should be subject to being tabled in Parliament and in the case of regulations be subject to a disallowance motion. This access standard does not have that status. It is not a disallowable instrument. The idea of publishing something on the website and not tabling it in Parliament is also anathema to me.

Before I sit down, I commend the minister's very professional, diligent and hardworking staff who have had to bear the brunt of numerous requests on numerous issues from all of us. I thank them for their efforts and wish them a restful festive season.

Members: Hear, hear!

Mr R.H. COOK: Before we conclude the discussion around amendment 55, I would like to take the opportunity to make some further remarks, if I may. We are at the end of a very long process—a momentous moment for the Western Australian Parliament and, indeed, the Western Australian public. To paraphrase Otto von Bismarck, "If you like laws and sausages, you should never watch either being made"! I appreciate this has been a very long process and one that is essentially the culmination of extensive community engagement over the past two years. I just want to take the opportunity to commend my parliamentary colleagues for having the courage and determination

to support the Voluntary Assisted Dying Bill 2019. I would like to thank members in this place and the other place for their valuable contributions, and careful and thoughtful consideration of this legislation.

It has been a long debate—over 175 hours. I believe that the amendments made in the other place and agreed to today in this place do not in any way undermine the fundamental policy intent of the bill and, indeed, as I have said on a number of occasions, if everyone can see a little bit of themselves in this bill, all the better. We would not have reached this milestone without the overwhelming support of the Western Australian community. I want to thank everyone for their numerous letters and emails, attendance at community events and consultations, and the many conversations. The carriage of this bill through both houses of Parliament is a testament to their commitment to expanding WA's choices at end of life. In particular, I want to thank the Joint Select Committee on End of Life Choices that paved the way for this legislation. I would also like to thank the members of the ministerial expert panel whose work has ensured a safe and compassionate bill. I want to thank the member for Morley and Hon Colin Holt for their extraordinary leadership on this debate. I am privileged to stand on the shoulders of those who have gone before me, including Hon Robin Chapple and Norm Kelly before that. Hon Alannah MacTiernan has campaigned extensively for this, but if it were not for the leadership shown by the member for Morley and Hon Colin Holt in the last two years or so, we would surely not have been in this place. I am a very lucky minister to be able to acknowledge their work.

Laws are difficult things; they take us to difficult places. They put intolerable workloads and pressure on the public servants who support us in this place. I want to acknowledge all those people, including the clerks who have been responsible for drafting the legislation. Members, I know this is tough stuff. Things have been said to make sure that we get to this particular point. I accept that the Premier, in providing leadership to this community, as he said, sometimes had to crack a few eggs to make this particular omelette. I think we owe it to him to acknowledge the leadership he has provided to basically get us to this point.

I have had the privilege of being able to work with members from all sides of Parliament to get the bill to this point. I am thoroughly proud of this legislation, but I am overwhelmed by the support I have had from the Attorney General, the Premier, the Joint Select Committee on End of Life Choices and all those who have been involved to date. I want to thank my office and all those who have contributed to this debate in both this and the other place. This is an extraordinary piece of legislation.

Western Australia is not known for its progressive social reform. I would like to think that we have come a respectable second on this occasion in leading the nation in respect of this important legislation. It is not a moment for jubilation. Everyone understands what this legislation is about. It is a time for reflection—to reflect that we have chosen compassion and a right to choose. I thank members for their support of the legislation.

[Applause.]

The SPEAKER: No; we haven't passed the bill yet!

Mr M. McGOWAN: Mr Speaker, I would like to take a moment to reflect on the historic decision this Parliament will shortly make. Beyond the fact that Western Australia is the second place in Australia to legislate a regime for voluntary assisted dying, beyond the fact that all members, regardless of party, were offered a conscience vote and beyond the marathon length of this debate inside and outside this Parliament, we have done something amazing. We have passed laws that end the needless suffering of Western Australians at the end of their lives, should they choose to do so. We have acted to give Western Australians genuine choice about the end of their lives. We have given so many in the community hope as we go into Christmas.

I said in my second reading contribution that we do not like talking about death; we all find it hard. But this Parliament rose to the occasion. We have had the hard conversations with our electorates, with each other and with ourselves. Many members came to this debate genuinely not knowing how they would vote. I would like to acknowledge the hard work they undertook in grappling with not only the detail of the bill but also the emotional and moral questions that they had to answer for themselves. It is an incredibly difficult question to grapple with if you have not given it much thought before. I would also like to acknowledge those who were and are still opposed to this bill. I understand that their issues with these laws are deeply personal and sincerely held and shared by many others in the community; however, I reiterate that there are over 100 safeguards in this legislation and it is based on the fundamental premise that it is voluntary for those who are terminally ill and in pain.

I would like to acknowledge those who have worked tirelessly for this to become the law in Western Australia—your hard work has achieved something historic. I would like to acknowledge some people by name, as a reform like this has many, many parents. Firstly, the Minister for Health for his excellent handling of this bill. It is a credit to him and to his staff. We saw that just now. Also, to the Attorney General for his hard work both in the chair and behind the scenes. To Hon Stephen Dawson for the carriage of this bill through the upper house. That took an

incredible amount of patience and attention to detail. I believe he won universal praise for the role he played. I would also like to acknowledge Hon Sue Ellery and Hon Alannah MacTiernan for the role they played in managing the business of the upper house so we could get to a vote in a timely manner. I make special mention of the member for Morley for her essential role in shepherding these laws from the Joint Select Committee on End of Life Choices through to passing both houses. I would like to acknowledge the other members of the select committee for the essential work they did in both setting the policy basis for these reforms and their continued advocacy for them, especially across the party divide. I am thinking about Hon Colin Holt, Hon Robin Chapple, Hon Dr Sally Talbot and the member for South Perth, as well as other members across the Parliament, who were the most staunch advocates for the bill and other important end-of-life choices reforms, from advance directives to palliative care. I take a moment to acknowledge the role played by the Leader of the Opposition, Liza Harvey, and Hon Peter Collier in ensuring that this bill came to a vote in the Legislative Council this year. On behalf of the supporters of this bill, I pass on our thanks to you.

Outside the Parliament, I thank the Ministerial Advisory Panel on Voluntary Assisted Dying and its chair, Malcolm McCusker, for their hard work, the Parliamentary Counsel's Office for drafting these laws, and the advisers on the bill who were outstanding despite being sleep deprived. I acknowledge their encyclopaedic understanding of the legislation. I acknowledge the advocacy and campaigning from organisations like Go Gentle Australia and Dying with Dignity Western Australia. In particular, Andrew Denton, Rhonda Taylor, Belinda Teh, Lenda Oshalem and Joey Armenti. There are far too many campaigners for me to name you all. I thank the Western Australian media for its mature coverage of and deep interest in this issue, as well as its support for what we have done.

This is something that has been talked about and attempted for decades; success was never guaranteed or assured. In fact, I believed there was a good chance of failure. At various times over the last two and a half years, I thought that we may fail. We had to summon the courage to match that of the public, to meet them along the way. There is often cynicism that Australian politics cannot do difficult things anymore and our Parliaments are paralysed despite what people would like to see happen. Today we showed that at least in Western Australia we can do big things.

Mr D.R. MICHAEL: Mr Speaker, I would like to hear more from the Premier.

Mr M. McGOWAN: In this Parliament we have big, compassionate hearts and we are willing to take some political risks to do the right thing. We should all be very proud of that.

Finally and most importantly, to all the supporters of voluntary assisted dying, for those of you who watched your mum or dad die in pain, begging for relief from the agony and distress, to those of you who are worried about your own futures and do not want to die that way and to every Western Australian who has lost a loved one who wanted a choice, we thank you for your unwavering support, your contributions, your stories, your consultation and for entrusting us with this task. Thank you for your patience. We did it for you. Have a great Christmas, stay safe and we will see you next year.

Question put and passed; the Council's amendments agreed to.

The Council acquainted accordingly.

[Applause.]