JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

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

TRANSCRIPT OF EVIDENCE
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SESSION THREE

Members

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

Hearing commenced at 4.09 pm

Ms CAIT CALCUTT
Personal and Project Officer, Palliative Care WA, examined:

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

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

Ms CALCUTT: My name is Cait Calcutt. I am here in a personal and a professional capacity, if that is acceptable—personally, having cared for my partner, who died in 2014, and our experience of the health system; and then palliative care as part of that at the end, which obviously led me to becoming involved with Palliative Care WA, and I suppose my experience as a consumer carer. It reflects many of the calls, inquiries and comments that we receive on a daily basis from the Western Australian community in relation to access and experience of palliative care.

The CHAIR: Do you have any questions about your appearance here today?

Ms CALCUTT: No, I do not think so. Should I?

The CHAIR: Not necessarily. You have been well briefed. Before we ask any questions, do you want to address the committee or make an opening statement?

Ms CALCUTT: I am going to, if that is all right. I apologise; I might read something, otherwise I might waffle on.

The CHAIR: Reading is good.

Ms CALCUTT: It is something I wrote. I was asked to present to the models of care workshop that was run by the WA Cancer and Palliative Care Network in 2015. I was asked to provide a consumer and carer perspective around palliative care. That models of care workshop has provided the basis of what is about to be released, which is the new end-of-life and specialist palliative care strategy. It is anticipated that it is going into its final review stages. I am going to read what I said there. I hope that is all right.

The CHAIR: That is fine.

Ms CALCUTT: Up until 2014, I had very little understanding of what palliative care meant. Most of my very limited knowledge was derived from media debates around voluntary euthanasia, in which a palliative medicine specialist would be wheeled out to offer an option to assisted dying and the discussion was narrowly focused on the alleviation of acute pain and suffering in the last week or so of life. At age 41, such limited exposure and understanding of palliative care might be expected.

However, my life experience was different from that of my friends and many of my peers. Since 2005, I have been caring for my chronically ill partner, who was diagnosed with three chronic life-limiting diseases in his early 40s: diabetes type 1, ulcerative colitis and primary sclerosing cholangitis, which is a liver disease. He had survived two cancer diagnoses in eight years and he was living with the disabling consequences of surgeries, treatments, opioids, medications and dealing with chronic pain. As well, he was living with an ostomy, so he had bowel cancer and his bowel removed in 2006.

It was an increasing challenge for my partner to find a way to live a fulfilling and meaningful life, with diminishing physical and mental health, and for me to care and support him and our very young daughter. Nigel's excellent GP had a lot of experience in caring for patients with chronic disease and implemented a number of care plans but really had an almost impossible task in trying to treat the complexity of his many illnesses and coordinate fragmented and privately provided physical and mental care, which included surgeons, endocrinologists, gastroenterologists, neurologists, pain specialists, psychiatrists, psychologists and pharmacists. Managing all of these felt overwhelming and extremely stressful to Nigel and me.

At the beginning of 2014, we returned home to Perth after 15 years of living and working on the eastern seaboard. Our small family was battered and bruised and broken after so many years of living in isolation from family with chronic and acute illnesses. Within six weeks of this move home, my partner's health deteriorated rapidly and he was back in emergency and ICU et cetera again. He was told during that hospital visit that tests showed that the glandular carcinoma had returned, was not curable and he had 12, but probably six, months to live. At that point he was not referred to the hospital palliative care team or to a palliative care service. It was only after being discharged that another health crisis came soon after, which resulted in another emergency hospital admission. That was when the palliative care team was asked to be involved. This was not at the request of the doctor but at the urging advocacy of a family member, who was a health professional and knew the hospital and its systems. The introduction of the palliative care team to my partner's care was immediately transformative for him and I. It felt like a great weight had been lifted. From the hospital, he was transferred to in-hospital hospice care, where the treatment was focused on the whole person for the first time and there was clear, honest and caring communication with my partner and our family. The hospice helped arrange services to enable him to live independently at home, with the support of Silver Chain and HACC services.

From an expectation that Nigel would never leave hospital alive again, he was able to live for another six months with the care and support of these services. So this is the reason why I am passionate about the access to quality palliative care services early in the trajectory of a person's illness. Palliative care not only supports our loved ones and us to have a good death relatively free of pain and unnecessary suffering; palliative care is also life giving and affirming. It is powerful and it has a transformative impact on people's lives and their experience of death.

My family's positive experience of palliative care and its positive impact on the experience of end-of-life care is reflected in often the much positive experience we receive at Palliative Care WA from carers whose loved ones received palliative care services for the last stage of life. But there are definitely gaps in access to palliative care services. One of the things that we experienced, and still do, is that there is a lack of bereavement care beyond the six weeks after someone's death. We have many people who call Palliative Care WA who are still experiencing tremendous grief even one year, two years after death, and there is a lack of referral options for specialist bereavement, grief and loss support services in WA. Many were unsure about approaching their GP for assistance in referral. Is there a service that provides 24-hour care at home? That is the question that we often get asked. Indeed, I was just speaking with a woman whose mother had been diagnosed with

advanced cancer and had been able to live at home, but suddenly deteriorated and is no longer able to and now requires assistance to go to the bathroom and get dressed. She wanted to know if there was 24-hour care that she could access. Unfortunately, I had to say no, that her only option for her mother was to be rushed into an aged-care facility if she could or to die in hospital because there are only private nursing services available. Plus, their family did not have private health insurance. So most people want to be cared for at home and possibly die at home but do not have adequate care and support from family and friends to enable this to happen. Many people who are accessing palliative care services also require assistance and home help around the clock. Silver Chain and regional services provide wonderful support and provide access to 24/7 medication management services, but provide only limited services in the home.

The aged-care and disability services are also limited in the hours they provide. Some younger people who may have partners are in a dual caring and breadwinning role, with mortgages, children et cetera, and are unable to care for their loved one 24/7 and need more than the occasional respite.

Is there a palliative care hospice near my suburb? Again, this lady today said she lived in Mt Lawley and her mother was in St John of God Midland as a public patient. Her father was in High Wycombe and they were referring her mother to Kalamunda palliative care unit. This woman has three young children and is the primary carer for her mother and for her father and she said she just did not know if she could be able to travel between her home and Kalamunda. I recommended St John of God or Bethesda, but she was really looking for something that was much closer to home or somewhere that she could have her mother in her home and care for her in her last month of life.

[4.20 pm]

Finally, do we need a statewide consumer-focused palliative care advice service in WA? People call Palliative Care WA seeking practical information about palliative care support services, like the example I gave today, but also emotional support. Many are upset and crying when they call us. It is a challenging and stressful time in their family when someone has received a life-limiting diagnosis. However, Palliative Care WA is not currently funded or able to respond necessarily to the complexity of consumers' needs, and also referral pathways to palliative care information and support can be fragmented in WA, but is improving. And that is all I have to say.

The CHAIR: I just have a couple of questions and members may also. You have obviously got a lived experience of the palliative care system. I note that in the first trip to hospital with your partner, there was no referral made despite a diagnosis.

Ms CALCUTT: No, and can I say there was no communication with myself as the carer either. My partner had obviously been very unwell and we had to rush him to hospital on Australia Day, which is never a good time to be in an emergency department, and he had a number of interventions that I knew he was going to have. Like many people probably experience, the gastroenterologist/oncologist came to visit him 24 hours after and told him the bad news and said that he would refer him on to the oncology service at the hospital but not the palliative care service and also various other services as well, but palliative care was not mentioned and the prognosis was not clear.

The CHAIR: Can I ask why you think that was the case?

Ms CALCUTT: I do not know. I think there is still a perception—I hope it is improving—that palliative care is only for the last few weeks of life, and because there was a possibility that Nigel could live for longer than six months, that was not necessary. I think there is a lack of awareness amongst doctors and also about the importance of what palliative care can provide to someone at the end of life as well. I think that is a big misnomer. It is another thing that is reflected in the calls that we

get to Palliative Care WA. Family members are calling up about their father or their mother who has been living with an advanced cancer who has a life-limiting diagnosis but the situation has suddenly deteriorated and now they cannot care for themselves or the carers can no longer care for them, yet the GP has not made a referral to a palliative care service such as Silver Chain or to any other services to get support. By the time they call us, the person has only got a month or so to live. It takes a while to put in place access to services—even Silver Chain hospice and particularly in relation to help in the home. I consider us really lucky actually in terms of being able to get those HACC services that we did. We got them within a month of referral. I was told by a carer's representative in Geraldton last year that with the release of the NDIS, people who are under 65 and requiring access to HACC services go on the National Disability Insurance Scheme waiting list and can still be waiting by the time they pass away for services in the home.

The CHAIR: You said that when palliative care was introduced to your partner, it was transformative.

Ms CALCUTT: It was.

The CHAIR: Can you give us some examples of how it was transformative?

Ms CALCUTT: Because of the complexity of my partner's illnesses—it was not just the one—it was very fragmented, so he was seeing a range of different specialists and the GP. No-one had raised the importance of advance care planning, which I did not talk about there—talking about what it is that you do want and do not want in terms of treatments at the end of life. Given that he had had this first cholangiocarcinoma, the likelihood of it coming back—now I know—was very high and the only way to ensure that it did not come back was a liver transplant, but he was not eligible for that because he was a type 1 diabetic. For me, I would have thought that he should have been referred to palliative care services at that point, but he was not. By the time we got to the palliative care hospice, which was Bethesda by the way, we were exhausted by the illness and I was exhausted by caring for him and the complexity of it. He was just ill and very much unable to focus on the fact that it might be life limiting, and he struggled anyway. It was the first time that medical practitioners did not say, "But despite all this, you're doing well. You look good" and the first time that people were realistic about what his prognosis was, which enabled us to confront it and also realistic because we were still in the dark. As I said, I had not been told by the oncologist; all we had notice of was that the cholangiocarcinoma had come back and he had six months to live. That was the only information that we had, and I am going, "Right. I'd like to hear it and have the opportunity to talk about it." The hospice doctors and nurses took a lot of time with us to discuss the diagnosis, and they immediately set about trying to find ways in which they could help us find services to help him at home, the referral to Silver Chain and getting that kickstarted, trying to get his medication sorted and managed because he was on ridiculous amounts and it was not being managed well, particularly given that he was a diabetic type 1, and also looking into what supports they could offer me and directing me in terms of the supports that I could access in a meaningful and practical way and also providing us with the information around advance care planning and talking about what it might be that Nigel would want and where he might want to die. All of those conversations we had never had before. They were like the elephant in the room. We were always wondering. Living with a diabetic type 1, sometimes in the morning you cannot wake them up and you wonder: "Is this it? Are they in a coma? Do I call the ambulance?" I had called the ambulance many times. So you always live, as a carer of someone with so many chronic illnesses and cancer, that one bad turn could be the last; it could be the last trip to hospital. It was quite transformative in that way. Does that answer your question in a very longwinded way?

The CHAIR: It does.

Mr R.R. WHITBY: Caitlin, thank you very much for coming along and sharing your story with us. We really appreciate it. It has given us some real insight. Your husband passed away at home, did he?

Ms CALCUTT: He did not and that was the discussion. I suppose the discussions we had also reflect the discussions and the issues that others in the community who are caring for dying loved ones have as well. Dying at home means you require a lot of support. You need a lot of family around and friends around who can be there 24/7 to assist the person to be able to wash, eat—not eat, but you know—and all those sorts of things that happen, particularly with Nigel's health issues and the fact that he had an ileostomy, so he had a colostomy bag. It was just me—I was the primary carer—and we had a five-year-old. His family just were not in Perth and our friends were great, but they all had children as well, so they were not able to be there. The issue was in the middle of the night, things seem to happen at 10 o'clock at night.

[4.30 pm]

It was really tricky. He, obviously, by that stage hated hospitals because he had been in them for so long. He said he would have probably preferred to die at home, but he also wanted to make sure that his pain was managed as well, because he had quite high chronic pain. He chose to die at Bethesda. Unfortunately, he was not able to because at the time there was not a bed available, so he was in St John of God, Subiaco.

Mr R.R. WHITBY: But he was able to stay at home for longer than you might have thought, was he, with the help of Silver Chain?

Ms CALCUTT: With the help of Silver Chain and with the help of the HACC services as they were then. But they were only—we had 14 hours a week. He was assessed as high care. We got 14 hours a week. Because he required one nursing visit, that was double time, so he had one nursing visit a week. That basically meant he was able to have half an hour in the morning and half an hour in the evening, when someone would just come and double-check and make sure that he had had his medication.

Mr R.R. WHITBY: How was pain controlled at home?

Ms CALCUTT: For him?

Mr R.R. WHITBY: Did you have a pump at home?

Ms CALCUTT: No, he did not have a pump. His pain was controlled by methadone and fentanyl patches.

Mr R.R. WHITBY: But at some point that got too great to handle at home, did it, or was it the only way to use it?

Ms CALCUTT: What happened is that he just became too ill one day. What would usually indicate that he was becoming very ill was that his blood sugar was extremely high, and despite insulin, you could not bring it down. He was quite delirious and his liver shut down and that is how it happened; it happened all quite fairly quickly, which it often does.

Mr R.R. WHITBY: Just for the record, when was your husband given the diagnosis and told that he had between six and 12 months?

Ms CALCUTT: In January 2014, and he died in August 2014.

Mr R.R. WHITBY: At that stage, as you said before, there was no advice about contact with palliative care assistance?

Ms CALCUTT: No. When he came back up, when he came for that second admission in February, which was again an emergency admission, he had been staying with some family members down in

Margaret River just to recuperate and also give me a break, and deteriorated rapidly down there. He was flown up to Perth. This is another story in itself. He was in great pain when he arrived at the hospital emergency department. They applied the standard pain medication, morphine drip, that they would give someone and it still was not able to manage his pain. So the doctor thought that the end was nigh and put him on a pain pump and asked him if he was ready to go, and that he could put him on a pain pump—a NIKI pump—to relieve the pain, and then within a few weeks, as the pain grew, the morphine would be increased so much that he would pass away because of the dose of morphine. The doctor had a 10-minute consultation with us and that is what he told his sister and myself, that he thought that Nigel was in the last stage of life, in the last couple of weeks of life, and that this was the way of managing it, and that Nigel had said to him that he did not want to have the pain anymore. There was no referral—this was on a Friday afternoon. I don't know what it is? It always happens on Fridays in hospitals! There was no involvement of the pain management team and there was no involvement of the palliative care team in that decision.

What transpired in terms of them being able to manage the pain, which I found later, is that he had fentanyl patches and when he had come in, obviously, it had come off and no-one had checked to see on his notes from the previous visit that he had been discharged with fentanyl patches and, therefore, not having them on—he was on a quite high dose because he was dependent on opioids for the pain. Anyway, it was a very long and traumatic story, but because Nigel's sister had worked in ICU and knew that there was a palliative care team, we spent the next four days requesting the palliative care team to become involved in his care, against the wishes of the doctor. When they finally did come and see him, which was three days later, they were able to very clearly talk with him and explain the situation with us in the room as well—not just the appointment with the patient, because so much happens in hospitals where the carer or the loved ones are not there when the doctor turns up to give you the bad news or to talk about the treatment. So they ensured that we were there; they made a time that we were going to be there with him, talk to him about what the process was that was happening, and that if he followed this course, he would die within the next week or two and did he want that. He said, "No, I don't." So that course of treatment was slowly reverted and, again at our request, through the palliative care team, we were transferred to Bethesda. That is when they finally kind of—we got to find out from then as well, with the doctors, about what the actual diagnosis was and what that meant, what the prognosis was, what the treatment options might be, and what we could expect. That was not until we got into a specialist palliative care unit, which was via the wonderful palliative care team, who are often extremely underfunded. The palliative care nurse who looked after Nigel was a half-day position and she did not even have a desk in the hospital; she just shared people's desks. She was an absolute angel.

Mr R.R. WHITBY: Before that involvement with the palliative care team and without any other advice, is it possible that you could have believed that what the doctor was saying was the only alternative and that is the course that would have occurred?

Ms CALCUTT: Yes; probably, but because I also have a background in health advocacy and had been a carer and an advocate and had annoyed surgeons and specialists for many years with questions about prognoses and treatments and options and all those sorts of things, I was not afraid to push.

Mr R.R. WHITBY: How much longer did he live after that?

Ms CALCUTT: Six months, and he was able to live at home. He was able to go with us to my daughter's soccer. She still remembers him being at joeys soccer games when she was in preprimary. She always says that daddy would cheer louder for her than I did—just because you do not have enough parent guilt!

The CHAIR: Absolutely.

Ms CALCUTT: So, it was not only that extra six months; it was the support that we felt. When the Silver Chain came in again, it was very inclusive of the family in terms of how they worked, so sitting down with both of us and talking about things, as well as giving Nigel the option to talk to them as well alone. I think it is important that patients do have the opportunity to speak to health professionals, their treating professionals, without necessarily family being there; I respect that right. But as the primary carer, it was fantastic that I knew exactly what was going on, and what care plans were in place and was part of planning for that. It was very empowering. I was then able to access also psychology and social work support and to access financial services as well.

[4.40 pm]

Hon Dr SALLY TALBOT: Thanks, Ms Calcutt, for coming back and sharing your story with us. It is a very powerful story and very useful for us. In your account that you read to us, you used two examples of people who had contacted you, I think with your palliative care hat on.

Ms CALCUTT: Yes.

Hon Dr SALLY TALBOT: I do not know whether they were real examples or not, but they served to illustrate the point that people cannot find the resources that they need. Can you tell us a bit more about each of those Specifically, what was it that each of those people needed that they could not get?

Ms CALCUTT: I suppose there are so many and I think actually before I go in to talk about that, we had discussed—we actually log all our phone calls sort of as case studies and we feel at Palliative Care WA that it might actually be instructive for us to provide you with that log and you can see the types of questions and how we respond to those in terms of the unmet needs. That might be useful for the committee. There are so many calls, but just the one that came to mind today was a woman whose mother has been relatively well, but deteriorated very suddenly two weeks ago and found herself in St John of God Midland hospital. There were a lot of tests done and it was found that she had cancer and, finally, the oncologist today spoke with the family and said that she probably only has a few weeks left to live and that she will need to be referred to a palliative care service and that the closest one was Kalamunda palliative care unit.

Hon Dr SALLY TALBOT: She is too unwell to go home

Ms CALCUTT: She is too unwell to go home. She could go home but she would need 24-hour care. So, she requires help with showering, dressing, eating—everything. So, she is basically bedridden.

Hon Dr SALLY TALBOT: When you say 24-hour care, you do not mean the kind of service that Silver Chain offers where the nurse is on-call 24 hours a day?

Ms CALCUTT: No. What Silver Chain do is manage pain and symptoms. What the Silver Chain palliative care hospice in the home service provides is the on-call nurse to manage a patient's pain symptoms and other symptoms as a result. They do not provide any personal or other treatment assistance. It is purely about being kept comfortable.

Hon Dr SALLY TALBOT: It is nursing care.

The CHAIR: It is clinical support.

Ms CALCUTT: It is clinical care. Yes, that is right. So, it is the personal care, and also there is a wait. It depends on where you are and proximity and staffing. So, some people do want do want to, if they can, employ a registered nurse to be in the home to manage the symptoms constantly to make sure the person does not become distressed by the pain and symptoms.

Hon Dr SALLY TALBOT: So what this person who contacted you today needed was 24-hour care—not 24-hour nursing care necessarily.

Ms CALCUTT: Twenty-four-hour care, yes, because her father was too elderly to be able to provide that. The prognosis is too short for her to be able to access services into the home because that requires an ACAT assessment and usually takes a couple of weeks or so to put in place.

Hon Dr SALLY TALBOT: She was being offered a hospice bed?

Ms CALCUTT: She was being offered a hospice bed in Kalamunda and she lives in Mount Lawley, and she said she just cannot travel that distance because she has the care of three young children.

Hon Dr SALLY TALBOT: That is the daughter.

Ms CALCUTT: That is the daughter, yes.

Hon Dr SALLY TALBOT: So, why was she offered Kalamunda?

Ms CALCUTT: Because it is close to St John of God Midland, so St John of God Midland will refer their patients to. Then I spoke with her about the possibility of St John of God Murdoch, which might be closer to her, in Mount Lawley. She was looking for something in the northern suburbs, but the services in the northern suburbs that would be closer to her would probably be Hollywood Private or Glengarry Private, which offer hospice services, and her mother does not have private health insurance. So her options in terms of in-patient are Kalamunda, St John of God Murdoch hospice and Bethesda.

Hon Dr SALLY TALBOT: Was she in Midland because that was closest to her home?

Ms CALCUTT: Where the ambulance took her, yes.

Hon ROBIN CHAPPLE: There seems to be an indication that GPs or medical practitioners either do not understand palliative care or just do not think of it as an option. You are nodding your head, so I am getting an idea that that is your observation as well. Do you want to expand on that a bit?

Ms CALCUTT: Yes. I am sure you have found this as well in the hearings that you have undertaken. There is still that old-fashioned idea about palliative care, so if you go into aged-care homes or into hospitals, you will hear often nurses saying, "Oh, they're palliative", which means that they have only got two or three days, maybe a week, to live. They are palliative and they are at the end of life, rather than understanding that palliative care is the treatment and services and support that can be offered to people from the point of the diagnosis of a life-limiting illness—so, the point of being diagnosed with dementia essentially, or Alzheimer's.

The CHAIR: Ms Calcutt, can you just focus on the question, which is why do doctors not understand that?

Ms CALCUTT: I do not know. I cannot say why the doctors do not understand that, but they do not seem to understand it. But I think there are two —

Hon ROBIN CHAPPLE: Is this an age issue with the doctors—the young ones?

Ms CALCUTT: I think the younger ones are probably getting a bit better. Again, I do not know what is taught in medical school. I think they are improving in terms of awareness of what palliative care is. The other thing I wanted to say is that Silver Chain are overloaded in terms of their home hospice in terms of the number of referrals. They may not accept someone who, say, is given a 12-month prognosis, and so then I think that offers a sort of—this is my own opinion. There is self-censoring by GPs, where they will not refer someone who may have six to 12 months to live because they think that Silver Chain will not accept them. So, they wait until they are much closer to the end of life. I also think that doctors do not quite understand as well that issue that Silver Chain just offer the nursing services, but not the 24-hour personal care that people do need to be able to stay and

die at home. Again, that goes back to the importance of advance care planning and doctors doing that with patients.

Hon ROBIN CHAPPLE: I have one further question. You mentioned early on that there was a lack of bereavement services.

Ms CALCUTT: Yes.

Hon ROBIN CHAPPLE: Again, can you expand on that, just touching on that? So a loved one has passed away—end of story; get on with it.

Ms CALCUTT: It is not quite as harsh as that. So, my experience—and it is relatively kind of standard—is that if you are the carer of someone who dies in the care of Silver Chain hospice service, you continue to receive six weeks of psychosocial support following the death, and then you are discharged. There is nowhere really to be discharged to, because you are then advised, if you need more services, to go to your GP and get a referral for psychology support. Some psychologists—I tried three—are good at dealing with grief and loss and have a lot of experience, but some do not, so there is a bit of a gap there. Again, as well, if your relative dies in hospital, usually the pastoral care department will offer you again that six weeks post support, but then you are again on your own.

[4.50 pm]

Hon ROBIN CHAPPLE: So what you are really saying is there is no —

Ms CALCUTT: Ongoing.

Hon ROBIN CHAPPLE: — ongoing but palliative support, in a way?

Ms CALCUTT: Ongoing, bereavement support, yes. I am sure that is due to probably just their needing to place restrictions around their own services, but we used to—we do not anymore; we do not receive the funding for it—run an annual commemoration service which was for family and friends of loved ones who had died in the past year. That was sent out to all the clients of palliative care services, so family and friends would come along. Often when they were RSVP-ing a lot of them were still very distressed a year or so after their relatives passing, and often would ask, "Is there a grief or bereavement service that you can refer me to? My friends don't really understand." We do have in our society a very sort of "get on with it", and we all try to get on with it and sort of get back to a normal after the passing of a loved one, but for some people they need extra support.

The CHAIR: Miss Calcutt, from a hospice point of view, who provides the psychosocial support after a death?

Ms CALCUTT: Silver Chain have a fantastic social worker and psychology service —

The CHAIR: They are actual psychologists?

Ms CALCUTT: Yes, yes, I think. I think one of them is a psychologist, but I know they have counsellors and they have social workers and you can access them prior to and after, yes. Very helpful. They will also speak with children as well, which is very useful, yes.

Hon NICK GOIRAN: I have a quick question. I know we have run over time, so I just want to say thanks for your patience with the committee. I know it is four months since you first appeared before you have now come back.

Ms CALCUTT: A lot has happened!

Hon NICK GOIRAN: Yes. It is appreciated. With your professional cap on, National Palliative Care Week is coming up next month.

Ms CALCUTT: It is; the 21st to 27th.

Hon NICK GOIRAN: There you go! If you want to take this on notice, that is absolutely fine. I would just be interested in whether there is anything happening that week that you think would be beneficial for the committee to go and participate in or view?

Ms CALCUTT: We hold our annual breakfast for the National Palliative Care Week every year on the Tuesday, so it is Tuesday, 22 May. The theme this year is What Matters Most, so we will be focusing on advanced care planning and talking about the work that Palliative Care WA is doing and will do in the future around raising awareness about planning for the last stage of life with the community. We are also hoping that the Palliative Care Network's new strategy—the end-of-life and specialist palliative care strategy—will be ready to be launched as well at the breakfast. We are hoping that the Chief Medical Officer will be free to talk to that. At the breakfast it is an opportunity for the sector to come together and to network and to catch up on news; opportunities are few and far between because they are incredibly dedicated, hardworking people who do not actually get much time off to come to social occasions.

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

Hearing concluded at 4.53 pm