EOLC Sub 284
Rec'd 16/10/2017

Brightwater

16 October 2107

Dr Jeannine Purdy
The Principal Research Officer
Select Committee on End of Life Choices
Legislative Assembly
Parliament House
Perth WA 6000

Dear Dr Purdy,

Brightwater submission to the Joint Select Committee Inquiry into End of Life Choices

In response to a letter of invitation from Mrs A. Sanderson, MLA (15 September, 2017) for Brightwater to provide a submission addressing the terms of reference to the abovementioned inquiry, Brightwater is pleased to provide the following response.

Brightwater has been a sector leader in the delivery of aged care and disability services to the WA community for over 116 years. Brightwater's goal is to *enable more people to enjoy life's possibilities by actively engaging with individuals and communities to deliver innovative, connected and responsive services*. Throughout its history, Brightwater has maintained a strong association with WA Health as a key provider of a range of sub-acute, residential, home based, transition and specialist disability services.

Brightwater supports people with Acquired Brain Injury, neurodegenerative disorder and ageing populations requiring rehabilitation, community transition, residential placement and palliative care services. Brightwater is also experienced at understanding and working with the complexities that end of life planning presents when the individual does not have the physical or cognitive capacity to articulate, develop or enact their end of life plan.

In 2009, Brightwater initiated a landmark case at its own cost in the Supreme Court of Western Australia (Mr Christian Rossiter) to clarify, support and govern a client's end of life process. This was also particularly important to provide direction and choice to staff involved in the day to day care of Mr Rossiter. The findings from this case can be found at Appendix A.

To this end, Brightwater demonstrates highly relevant and practical experience in understanding the individual, family, legal and systemic complexities associated with supporting ethical approaches to end of life choices for individuals with full, limited or no ability to articulate or plan their end of life choices.

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Addressing the terms of reference

Brightwater believes the following terms of reference would benefit from the addition of the following:

1. *Assess the practices currently being utilised within the medical community **and service sector** to assist a person to exercise their preferences for the way they want to manage their end of life when experiencing **complex,** chronic and/or terminal illness, including the role of palliative care.*

Key points to support the above additions:

- Increasingly, Non-Government Organisations (NGO) providing Rehabilitative, Residential and Palliative services for aged care and disability cohorts, are receiving individuals with higher complexity and comorbidities, and with reduced capacity to inform and plan their end of life process. This trend is due to the consumer demand for increased community based services that support the individual to remain in the home environment for longer, yet conversely become significantly more prone to unplanned health events that require urgent and unplanned transition to a residential environment. In addition, the hospital requirement to manage demand with high rates of patient turnover has meant that the NGO sector is the provider of choice for a range of transition, residential and palliative services. This demand will continue to grow in accord with the ageing demographic - increasing the complexity and demand for end of life planning and training for the NGO service sector.
- Many individuals requiring an unplanned entry into residential palliative and rehabilitation services have not made guardianship arrangements in the form of an Advanced Health Directive or the appointment of an Enduring Guardian. Impaired ability to now make end of life decisions due to cognitive impairment through dementia, brain injury or other neurological impact often results in families and NGOs lacking certainty around the individual choices.

2. *Examine the role of Advanced Health Directives, Enduring Power of Attorney and Enduring Power of Guardianship laws and the implications for individuals **(with or without decision making capacity) and service systems covered** by these instruments in any proposed legislation.*

Key points to support the above additions:

- The issue of 'capacity' needs to be considered both in terms of capacity to plan and capacity to enact or administer an end of life process. It is important to note also the context in which the matter of 'capacity' is considered. The entry into palliative stage is often a highly unplanned and complex process within a broad family, medical, and service system context. Whilst there exist static instruments to facilitate the process of dying, such as Advanced Health Directives and Enduring Power of Guardianship laws, invariably the process of dying is experienced by each participant in diverse and dynamic ways – and requires flexible and supportive decision making forums to navigate this reality.

- The dignity of risk is a principle that supports a person centred approach to dying. It is accompanied by service practices that ensure the least restrictive approach to supporting an individual's end of life plan. Yet, service providers remain concerned about their duty of care and legal obligations under existing legislation and regulation. Additionally, service providers are often required to reconcile the requirements set out in the Advanced Health Directive, and Enduring Power of Guardianship functions – within the changing, dynamic nature of the individuals' dying process.

As demonstrated by the 2009 Rossiter decision, organisations such as Brightwater may require access to third party adjudication to assist with reconciling the competing interests of the individual, the regulatory framework and the organisation's duty of care to its clients and staff. A third party statutory authority would be a welcome addition to provide guidance and direction on navigating the system and reflecting an individual's wishes. This would serve to lessen the impact on staff who are dealing with the immediate and real issues of palliative support, as well as providing leadership to organisations who may be fearful of reputational and brand risk when trying to support a client's end of life plan.

Yours sincerely,

Jennifer Lawrence
Chief Executive Officer
Brightwater Care Group

Enc. Appendix A

AustLII
Supreme Court of Western Australia

BRIGHTWATER CARE GROUP (INC) -v- ROSSITER [2009] WASC 229 (20 August 2009)

BRIGHTWATER CARE GROUP (INC) -v- ROSSITER [2009] WASC 229 (20 August 2009)

Last Updated: 20 August 2009

JURISDICTION : SUPREME COURT OF WESTERN AUSTRALIA

IN CHAMBERS

CITATION : BRIGHTWATER CARE GROUP (INC) -v- ROSSITER [2009] WASC 229

CORAM : MARTIN CJ

HEARD : 14 AUGUST 2009

DELIVERED : 14 AUGUST 2009

PUBLISHED : 20 AUGUST 2009

FILE NO/S : CIV 2406 of 2009

BETWEEN : BRIGHTWATER CARE GROUP (INC)

Plaintiff

AND

CHRISTIAN ROSSITER

Defendant

ATTORNEY GENERAL OF WESTERN AUSTRALIA

Intervener

FILE NO/S : CIV 2436 of 2009

BETWEEN : CHRISTIAN ROSSITER

Plaintiff

AND

BRIGHTWATER CARE GROUP (INC)

Defendant

ATTORNEY GENERAL OF WESTERN AUSTRALIA

Intervener

Catchwords:

Legal obligations of a medical service provider which has assumed responsibility for the care of a patient - Patient is a quadriplegic - Patient is mentally competent - Patient has directed medical service provider to discontinue provision of nutrition and general hydration - Consequence of discontinuing provision of nutrition and general hydration will be that patient dies from starvation - Patient also requests prescription of analgesics for the purposes of sedation and pain relief as he approaches death

Provision of declaratory relief in respect of criminality

Common law - Mental capacity - Principle of autonomy or self-determination - Consent to medical treatment - Informed consent - Right of patient to determine whether or not they will continue to receive medical treatment

Criminal Code (WA) - Duty to provide necessaries of life pursuant to s 262 - Interpretation of 'having charge' of another - Surgical and medical treatment within the meaning of s 259 - Amendments pursuant to the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) - General principles relating to palliative care

Legislation:

Acts Amendment (Consent to Medical Treatment) Act 2008 (WA)

Criminal Code (WA)

Guardianship and Administration Act 1990 (WA)

Interpretation Act 1984 (WA)

Result:

Declarations given

Category: A

Representation:

CIV 2406 of 2009

Counsel:

Plaintiff : Mr J D Allanson SC & Ms J A Thornton

Defendant : Ms L B Black

Intervener : Mr R M Mitchell SC

Solicitors:

Plaintiff : Allens Arthur Robinson

Defendant : Hammond Legal

Intervener : State Solicitor for Western Australia

CIV 2436 of 2009

Counsel:

Plaintiff : Ms L B Black

Defendant : Mr J D Allanson SC & Ms J A Thornton

Intervener : Mr R M Mitchell SC

Solicitors:

Plaintiff : Hammond Legal

Defendant : Allens Arthur Robinson

Intervener : State Solicitor for Western Australia

Amicus Curiae: Mr P O'Meara (Right to Life Association)

Case(s) referred to in judgment(s):

Adult Guardian v Langham [2005] QSC 127; (2006) 1 Qd R 1

Airedale National Health Service Trust v Bland [1992] UKHL 5; [1993] AC 789

Auckland Area Health Board v Attorney General [1993] 1 NZLR 235

Bouvia v Superior Court of Los Angeles County 179 Cal App 3d 1127 (1986)

Commissioner for Corporate Affairs v Sansom [1981] WAR 32

Commonwealth v Sterling Nicholas Duty Free Pty Ltd [1972] HCA 19; (1972) 126 CLR 297

F v R (1983) 33 SASR 189

Hunter and New England Area Health Service v A [2009] NSWSC 761

Imperial Tobacco v Attorney-General [1981] AC 718

Malette v Shulman (1990) 67 DLR (4th) 321

Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam); (2002) 2 FCR (UK) 1

Nancy B v Hotel-Dieu Quebec (1992) 86 DLR (4th) 385

Re BWV; Ex parte Gardner [2003] VSC 173; (2003) 7 VR 487

Re MB (Medical Treatment) [1997] EWCA Civ 1361; (1997) 2 FCR (UK) 541

Re T (Adult: Refusal of Treatment) [1992] EWCA Civ 18; (1993) Fam 95

Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479

Schloendorff v Society of New York Hospital 211 NY 125 (1914)

Secretary of Department of Health and Community Services v B [1992] HCA 15; (1992) 175 CLR 218

1 MARTIN CJ: (This judgment was delivered extemporaneously on 14 August 2009 and has been edited from the transcript.)

2 It is important to emphasise at the outset what this case is not about. It is not about euthanasia. Nor is it about physicians providing lethal treatments to patients who wish to die. Nor is it about the right to life or even the right to death. Nor is the court asked to determine which course of action is in the best interests of a medical patient.

3 The only issue which arises for determination in this case concerns the legal obligations under Western Australian law of a medical service provider which has assumed responsibility for the care of a mentally competent patient when that patient clearly and unequivocally stipulates that he does not wish to continue to receive medical services which, if discontinued, will inevitably lead to his death.

4 I will set out the particular circumstances in which that question arises in this case, by identifying the findings of fact which I make on the basis of the largely uncontested evidence which has been produced.

5 Brightwater Care Group (Inc) (Brightwater) operates a facility in Marangaroo, a suburb of Perth, which provides residential care for people with disabilities. Mr Christian Rossiter was admitted to Brightwater's facility on 4 November 2008. Since then, Brightwater has assumed the responsibility of providing all necessary services to Mr Rossiter, in conjunction with Mr Rossiter's treating medical practitioner, Dr Richard Benstead.

6 Mr Rossiter is quadriplegic. Over about 20 years he has suffered three serious injuries which have combined to cause that condition. In about 1988 he fell approximately 30 metres from an apartment in Sydney as a result of which he suffered head and other injuries. He made a substantial recovery from those injuries with the assistance of rehabilitation programmes. However, in 2004 he sustained a cervical spine injury following a collision with a motor vehicle whilst he was riding a bicycle. During 2008, he suffered two further falls - one whilst visiting his mother at her nursing home, and the second in the kitchen of his mother's house in Joondalup on or about 3 March 2008. This last fall caused his spastic quadriplegia. Following that last fall he was admitted to the Joondalup Health Campus. He was then transferred to Sir Charles Gairdner Hospital on 8 March 2008. He was transferred from that hospital to the Brightwater facility on 4 November 2008, as I have mentioned. He has remained at that facility since then.

7 As a consequence of his injuries, Mr Rossiter is generally unable to move. The extent of his capacity to move is limited foot movement and the ability to wriggle one finger. He is only able to talk through a tracheotomy. He is totally dependent upon others, generally those employed by Brightwater, for the provision of the necessaries of life. The services which he requires include regular turning, cleaning, assistance with bowel movements, physiotherapy, occupational therapy and speech pathology.

8 Mr Rossiter is unable to take nutrition or hydration orally. The nutrition and hydration which he requires in order to survive is provided by way of a percutaneous endoscopic gastrostomy tube (PEG). That is a tube which has been inserted directly into his stomach by way of surgical intervention. Appropriate

nutrition and hydration, determined in accordance with medical protocols, is provided to Mr Rossiter by Brightwater staff through the PEG.

9 Mr Rossiter is not terminally ill, nor is he dying. If the services to which I have referred are maintained, he could continue to live for many years. However, he has been advised that there is no prospect that his condition will improve, and in some respects, for example his eyesight, his condition is deteriorating.

10 This clinical description of Mr Rossiter's condition fails to adequately convey the tragedy of his present circumstances. Nor does it recognise the sympathy which any reasonable person would properly have for Mr Rossiter and the predicament in which he finds himself. These matters are, of course, profoundly significant at a human level, but for reasons which I will explain, they are irrelevant to the legal issues which I am required to determine. My lack of reference to these matters in the balance of my reasons should not be construed as any lack of appreciation of the significance of these matters to Mr Rossiter. But my task is to apply the law as dispassionately as I can.

11 Mr Rossiter has clearly and unequivocally indicated to representatives of Brightwater and to Dr Benstead that he wishes to die on many occasions. However, because of the limitations upon his movements to which I have referred, he lacks the physical capacity to bring about his own death. He has therefore directed the staff of Brightwater to discontinue the provision of nutrition and general hydration through the PEG. He has repeated that direction on a number of occasions and maintains, through his evidence and through his counsel, that he requires that service to be discontinued. However, he wishes the PEG to be maintained and for such hydration as is necessary to dissolve his painkilling medication to be provided. Where in these reasons I refer to the withdrawal of hydration, I mean general hydration, not including the limited hydration which Mr Rossiter wishes to continue to receive.

12 Mr Rossiter is aware that he will die from starvation if nutrition and hydration is no longer administered through the PEG. The evidence of Dr Benstead is that he has described to Mr Rossiter, as best as he can, the physiological consequences which will ensue during the process of starvation. However, in a statement given to his legal advisors, Mr Rossiter asserted that apart from what he had read, he had received no specific advice on the effects of starving to death. He augmented that statement in evidence before me to refer to advice he had received from Dr Colin Eagle who is a friend of his but it is not clear from that evidence that the advice covered all aspects of the physiological consequences of discontinuing the provision of nutrition and hydration. This is a matter to which I will return.

13 Mr Rossiter is assumed to have the mental capacity to give a direction to discontinue the provision of nutrition and hydration unless and until there is evidence which would suggest that he lacks that capacity. There is no such evidence in this case. On the contrary, Dr Benstead deposes that based upon his observations of Mr Rossiter, he has the capacity to comprehend and retain information given to him in relation to his treatment, and has the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.

14 Also in evidence is a report from Ms Rachel Zombor, who is a clinical neuropsychologist. That report is dated 19 February 2009. In that report, Ms Zombor sets out the various observations which she made during her neuropsychological assessment of Mr Rossiter, and the tests which she administered. As a result of those observations, and the results of the tests, she concluded that Mr Rossiter was capable of making reasoned decisions concerning his own health and safety, and in particular was capable of making decisions in respect of his future medical treatment after weighing up alternative options, and was capable of expressing reasons for the decisions which he made in that respect. She also reported that, in

her view, Mr Rossiter unequivocally demonstrated that he understood the consequences of withholding the provision of nutrition and hydration through the PEG, and displayed insight into the consequences of that decision.

15 Although Mr Rossiter was previously the subject of a guardianship order made under the *Guardianship and Administration Act 1990* (WA), on 10 March 2009, the State Administrative Tribunal revoked that order.

16 This case therefore lacks many of the factors which have complicated other cases in this area. Mr Rossiter is not a child, nor is he terminally ill, or dying. He is not in a vegetative state, nor does he lack the capacity to communicate his wishes. There is therefore no question of other persons making decisions on his behalf. Rather, this is a case in which a person with full mental capacity and the ability to communicate his wishes has directed those who have assumed responsibility for his care to discontinue the provision of treatment which maintains his existence. The question I am asked to decide is whether, in those circumstances, Brightwater is legally obliged to comply with Mr Rossiter's direction or, alternatively, legally obliged to continue the provision of the services which will maintain his life.

17 Each of Brightwater (in CIV 2406 of 2009) and Mr Rossiter (in CIV 2436 of 2009) ask the court to make declarations with respect to their respective rights and obligations. In the case of Brightwater, their concern includes the prospect that compliance with Mr Rossiter's directions might result in criminal prosecution. Declaratory relief is sought to avert that prospect.

18 The court will only grant declaratory relief in respect of the criminality of a proposed course of conduct in exceptional circumstances: *Imperial Tobacco v Attorney-General* [1981] AC 718, 742. That approach is taken for a number of sound reasons, including the fact that whether or not conduct is criminal may depend critically upon a range of precise facts and circumstances which cannot always be accurately estimated in advance. Another reason for this approach is that in our system, the determination of whether particular conduct is criminal or not is, in serious cases, generally left to a jury, not a Judge.

19 But the cases recognise that in exceptional circumstances, declarations may be made in respect of conduct that could be the subject of criminal charges: *Commissioner for Corporate Affairs v Sansom* [1981] WAR 32, 36. Those cases also establish that in this respect there is a vital distinction between making a declaration with respect to the lawfulness of conduct which is proposed but has not occurred, and making a declaration as to whether or not conduct which has occurred constitutes a criminal offence. Declarations in respect of proposed future conduct add to the practical utility of this jurisdiction, but a declaration in respect of conduct which has occurred has little practical utility and would usurp the jurisdiction and role of the criminal courts, and for those reasons, will not be made: *Commonwealth v Sterling Nicholas Duty Free Pty Ltd* [1972] HCA 19; (1972) 126 CLR 297, 305.

20 The exceptional nature of the jurisdiction I am exercising imports two significant constraints. They are:

. I should only answer questions directly and explicitly raised by the facts of this particular case, and refrain from making any observations with respect to any other hypothetical scenarios; and
. I should only grant declaratory relief if I am satisfied that I have received all the evidence which is relevant to the issues to be determined, and all the facts necessary to determine the issues which arise have been established to an appropriate level of satisfaction.

21 If I conclude that Brightwater is legally obliged to comply with Mr Rossiter's direction, there is a subsidiary question which I am also asked to determine. That is because Mr Rossiter wishes Dr Benstead

to prescribe analgesics for the purposes of sedation and pain relief as he approaches death by starvation. Dr Benstead is concerned that he might face criminal prosecution in the event that he prescribes medication for those purposes and, to that end, Brightwater also seeks declaratory relief on that issue. For reasons which I will give, that subsidiary issue seems to me to raise more complex questions than the primary question I am asked to decide.

The position at common law

22 Leaving to one side the statutory provisions relevant to these issues in Western Australia, the answer to the primary question posed in this case at common law is clear and unambiguous. That answer comes about as a consequence of a number of well-established principles.

23 The first is that a person of full age is assumed to be capable of having the mental capacity to consent to, or refuse, medical treatment: *Re MB (Medical Treatment)* [1997] EWCA Civ 1361; (1997) 2 FCR (UK) 541 (per Lady Justice Butler-Sloss); *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); (2002) 2 FCR (UK) 1 [10] (per Dame Butler-Sloss); and *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [23] (per McDougall J). That presumption applies in this case, but in any event, there is direct medical evidence which establishes to my satisfaction that Mr Rossiter has the mental capacity necessary to make an informed decision in respect of the future provision of treatment, and if provided with the necessary information, could do so with a full appreciation of the consequences of that decision.

24 Another principle well established at common law is the principle which has been described in the cases as the right of autonomy or self-determination. Lord Hoffmann has described this right as being related to respect for the individual human being and in particular for his or her right to choose how he or she should live his or her life: *Airedale National Health Service Trust v Bland* [1992] UKHL 5; [1993] AC 789, 826. Included within the right of autonomy or self-determination is the right, described as long ago as 1914 in the United States by Justice Cardozo, as the right of 'every human being of adult years and sound mind ... to determine what shall be done with his own body: *Schloendorff v Society of New York Hospital* 211 NY 125 (1914) , 129.

25 That right has been recognised in Australia and referred to with approval by the High Court: *F v R* (1983) 33 SASR 189, 192 - 193 (per King CJ); *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479, 487. That right also underpins the established legal requirement that the informed consent of the patient is required before any medical treatment can be undertaken lawfully. That principle has been affirmed by the High Court on a number of occasions: *Secretary of Department of Health and Community Services v B* [1992] HCA 15; (1992) 175 CLR 218 (*Marion's case*), 233 and *Rogers v Whitaker*, 489. Also see the English case of *Airedale NHS v Bland*, 857.

26 The corollary of that requirement is that an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life. That principle has been established by decisions in each of the major common law jurisdictions, including the United States (*Bouvia v Superior Court of Los Angeles County* 179 Cal App 3d 1127 (1986), 1137 and 1139 - 1141); Canada (*Nancy B v Hotel-Dieu Quebec* (1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 321, 328); the United Kingdom (*Airedale NHS Trust v Bland*, 857 (Lord Keith) and 864 (Lord Goff); *Ms B v An NHS Hospital Trust* [16] - [21]); New Zealand (*Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 245) and Australia (*Hunter and New England Area Health Service v A*, [9] - [15]).

27 The principle is applied without regard to the reasons for the patient's choice, and irrespective of whether the reasons are rational, irrational, unknown or even non-existent: *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18; (1993) Fam 95, 113 (cited with approval in *Ms B v An NHS Hospital Trust* [18] and *Hunter and New England Health Service v A* [15]).

28 However, the conflict in the evidence on the extent to which Mr Rossiter has been informed of the precise aspects and effects of the physiological deterioration which will occur during the process of starvation raises a question on the extent to which the decision to refuse to consent to treatment must be an informed decision. In *Hunter and New England Area Health Service v A*, McDougall J (at [28] - [30]) rejected the notion that a refusal to consent had to be informed to be effective in the context of an advance directive given by a person who, at the time of the court hearing, lacked the capacity to receive further information or make any further decision.

29 The circumstances of this case are quite different. Mr Rossiter has the capacity to receive and consider information he is given, and to make informed decisions after weighing that information. Also relevant is the fact that Brightwater have assumed responsibility for providing nutrition and hydration through the PEG for quite some time now, so the question is whether there should be a change in that regime.

30 As I have mentioned, it is clearly established that medical service providers have a legal duty to inform patients of all aspects and risks associated with any medical procedure before seeking their consent to that procedure. With respect to McDougall J, in the circumstances of this case, where it is perfectly feasible to ensure that OMr Rossiter is given full information as to the consequences of any decision to discontinue treatment before he makes that decision, I can see no reason why his medical service providers should not be under a similar obligation. This view is consistent with the views expressed in the English and Canadian cases to which I have referred, where emphasis is placed on the need for an informed decision to discontinue life support: *Airedale NHS Trust v Bland*, 864, and *Nancy B v Hotel-Dieu de Quebec*. There will obviously be cases in which it is not possible to obtain such a decision, but this is not one of them, and I will refrain from proffering any view as to what should be required in such cases. At the moment, on the evidence before me there is some doubt as to whether Mr Rossiter has been given the information that he would need to be fully informed on these issues.

31 Another corollary of the principles to which I have referred is that a medical practitioner or service provider who provides treatment contrary to the wishes of a mentally competent patient breaks the law by committing a trespass against the person of that patient: *Marion's case*, 264 and 309 - 310.

32 It follows that, at common law, the answers to the questions posed by this case are clear and straightforward. They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment contrary to Mr Rossiter's wishes. In the particular circumstances of this case, in my view, Brightwater has a duty to ensure that Mr Rossiter is offered full information on the precise consequences of any decision to discontinue the provision of nutrition and hydration prior to him making that decision.

The Western Australian statutory provisions

33 The question then becomes whether this clear position at common law is altered by any relevant statutory provisions in force in Western Australia. The provisions to which the parties have pointed are those to be found within the *Criminal Code* (WA). Prominent amongst them is s 262, which provides:

Duty to provide necessaries of life

It is the duty of every person having charge of another who is unable by reason of age, sickness, mental impairment, detention, or any other cause, to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and he is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

34 However, that section must be read in conjunction with s 259 of the *Criminal Code* which makes specific provision in relation to surgical and medical treatment:

Surgical and medical treatment

(1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) -

(a) to another person for that other person's benefit; or

(b) to an unborn child for the preservation of the mother's life,

if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

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

35 There is no doubt that the nutrition and hydration provided to Mr Rossiter through the PEG is 'surgical or medical treatment' within the meaning of s 259. The PEG was inserted by surgical means, and the precise mix of nutrition and hydration is supplied in accordance with medical principles and protocols. This conclusion is consistent with views expressed in other jurisdictions: *Re BWV; Ex parte Gardner* [2003] VSC 173; (2003) 7 VR 487 [74] - [79]; *Adult Guardian v Langham* [2005] QSC 127; (2006) 1 Qd R 1 [32].

36 It is of considerable significance to the resolution of the issues in this case that s 259 was amended by the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA). Indeed, subsection (2) of s 259 only came into operation on 27 June 2009. I will explain the significance of that amendment a little later.

37 There are other provisions of the *Criminal Code* which could come into operation if s 260 is construed as imposing upon Brightwater a legal duty to continue to provide Mr Rossiter with the necessaries of life even though he has directed them not to. For example, if s 262 has the effect of imposing such a duty on Brightwater, it may be arguable that breach of that duty would lead to the conclusion that Brightwater had caused the death of Mr Rossiter within the meaning of s 270 or s 273 of the *Criminal Code*, with the consequence that the homicide provisions of the *Criminal Code* (including s 268 and s 277) might apply. Further, s 304 might also apply. That section provides that if a person omits to do any act that it is the person's duty to do, as a result of which the life, health or safety of any person is likely to be endangered, that person is guilty of a crime.

38 I digress to observe that if s 262 of the *Criminal Code* is to be construed as imposing a legal duty to provide medical treatment against the wishes of a mentally competent patient, it would represent a drastic alteration of the common law position. That is because it would require a medical service provider who is under a common law duty to not provide services against the wishes of a patient, to provide services against the patient's wishes or face criminal prosecution for not doing so. Given the strength of the principle of self-determination to which I have referred, it seems inherently unlikely that the Parliament intended such a drastic change when enacting s 262 in its current form, and I would only conclude that it was Parliament's intention to make such a drastic change if compelled to that conclusion by the clear and unequivocal language of the section. It seems to me that there is no such clear and unequivocal language in that section and that therefore the first answer to the proposition that s 262 might apply to the circumstances of this case is that the section should not be read as extending to the imposition of duties which would be unlawful at common law.

39 I have not been able to find any previous cases dealing with the scope and application of s 262, or any similar statutory provision, in circumstances such as these. On a superficial reading of s 262, it might be thought to apply to this case and to impose a duty on Brightwater to provide Mr Rossiter with the necessaries of life, irrespective of Mr Rossiter's wishes. That is because the section appears to apply in circumstances where a person has charge of another who is by reason of sickness unable to withdraw himself from such charge and who is unable to provide himself with the necessaries of life. However, upon a more considered reading, it is clear that the section is aimed at a wide variety of circumstances in which, by reason of age, sickness, mental impairment, detention or any other cause, a person lacks the capacity to control or direct their own destiny and to provide themselves with the necessaries of life. Put another way, it seems to me that in s 262 the reference to a person 'having charge of another' is a reference to a person who, by reason of one or more of the various disabilities identified in the section, lacks the capacity to direct or control their own destiny and is therefore dependent upon the person 'having charge' of them.

40 Mr Rossiter lacks the physical capacity to control his own destiny, but enjoys the mental capacity to make informed and insightful decisions in respect of his future treatment. In that latter respect he is not relevantly within 'the charge' of Brightwater. Rather, Brightwater is, in that respect, consistent with the well-established common law position to which I have referred, subject to Mr Rossiter's direction.

41 There is another reason why, in my view, s 262 might have no application to the circumstances of this case. Mr Rossiter has the capacity to give directions as to his future care, and it seems may have the financial capacity to implement those directions. There would be nothing preventing him from finding another service provider, and discharging himself from Brightwater and into the care of that other provider. If that were the case, he would not therefore be a person who is 'unable to withdraw himself'

from the charge of Brightwater, but I lack the evidence to arrive at any final conclusion on this aspect of the possible application of s 262.

42 I therefore conclude that s 262 of the *Criminal Code* does not impose upon Brightwater a duty to provide the necessaries of life to Mr Rossiter against his wishes.

43 Even if I am wrong in that view, in my opinion, s 259 of the *Criminal Code* provides Brightwater with a good defence to any claim that it would contravene the *Criminal Code* by discontinuing treatment in accordance with Mr Rossiter's informed decision to that effect.

44 Subsection (2) of that section specifically provides that a person is not criminally responsible for not administering medical treatment (including palliative care) if that course is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. Plainly, the phrase 'all the circumstances of the case' is quite broad enough to include the informed decision of a mentally competent patient. Having regard to the common law principle of self-determination to which I have referred, it is clearly 'reasonable' to act in accordance with the informed decision of a mentally competent patient who refuses to consent to medical treatment.

45 That proposition is strongly reinforced by the other provisions of the *Acts Amendment (Consent to Medical Treatment) Act* which caused subsection (2) to be introduced into the *Criminal Code*, which were all aimed at providing measures sometimes described as 'living wills' whereby persons are given the legal capacity to give directions as to the course of medical treatment which is to be followed after they lose mental or physical capacity. Many of those provisions have not yet been proclaimed, but they provide clear guidance to the intention of the legislature when enacting subsection (2) of s 259. It would be utterly inconsistent with the philosophy of that legislation to construe subsection (2) of s 259 in any way other than as reflecting the right of a patient to give directions in respect of their medical treatment, and the legal obligation of medical service providers to not provide services contrary to those directions.

46 If and to the extent that it is said there is any ambiguity in the terminology used in subsection (2) of s 259, it is appropriate and legitimate to have regard to the Parliamentary Debates at the time of its enactment (see the *Interpretation Act 1984* (WA), s 19).

47 In the Second Reading Speech given in support of the Bill, the Hon Mr Jim McGinty MLA said:

> The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition, including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance health directive and or alternatively treatment decisions can be made by an enduring guardian chosen by them. ... The bill, however, will not change the position at common law whereby a health professional is under no obligation to provide treatment that is not clinically indicated. In other words, although a patient, or someone on the patient's behalf, will be entitled to refuse lawful treatment, there will still be no legal entitlement by a patient to demand treatment.

48 It is therefore clear that the entire thrust of the legislation which resulted in the introduction of subsection (2) of s 259 was aimed at giving force and effect to the common law principle of autonomy and self-determination to which I have referred. It would be utterly inconsistent with that legislative objective

to construe s 259 as detracting from that common law position. Plainly, it was intended to give effect to it. This reinforces my view that s 259(2) of the *Criminal Code* provides Brightwater with a complete defence if they discontinue providing nutrition and hydration services at Mr Rossiter's request.

49 I therefore conclude that the statutory provisions to which I have referred do not in any way alter the clear position established pursuant to the common law principles which I have enunciated. It follows that it seems to me to be absolutely clear that after he has been provided with full information with respect to the consequences of any decision he might make, Mr Rossiter has the right to determine and direct the extent of the continuing treatment in the sense that treatment cannot and should not be administered against his wishes. If, after the provision of full advice, he repeats his direction to Brightwater that they discontinue the provision of nutrition and hydration to him, Brightwater is under a legal obligation to comply with that direction.

50 In the course of submissions, reference has been made to the possible application of subsection (1) of s 259 of the *Criminal Code*, and in particular, to the proposition that this subsection might provide Brightwater with a defence to any claim or charge brought as a consequence of the provision of medical treatment to Mr Rossiter against his wishes in the past. It would be entirely inappropriate for me to express any view on that issue. As I have mentioned, while declarations are sometimes given in respect of the criminality of proposed future conduct, declarations are not generally made in respect of the criminality of conduct which has taken place. To do so would entirely usurp the criminal process and the possible role of a jury. In any event, the expression of a view on that subject would depend upon findings of fact with respect to the precise circumstances in which medical treatment has been provided in the past, and I do not have adequate evidence before me to enable me to make those findings.

51 This brings me to the more difficult question of the provision of palliative care to Mr Rossiter following his withdrawal of consent to the provision of nutrition and hydration. That issue squarely raises the prospective application of subsection (1) of s 259, and in particular, that portion of the subsection which refers to the provision of palliative care.

52 There are a number of general principles which can be confidently stated in relation to this issue. The first is that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter's withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. Put another way, Dr Benstead's rights and obligations with respect to the provision of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration are no different to the obligations which attend the treatment of any other patient who may be approaching death. Even more specifically, in my view there is no reason why s 259(1) would not apply to the provision of palliative care to Mr Rossiter, even though the occasion for the provision of that palliative care comes about as a consequence of Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

53 The second general principle that may be stated is that if and to the extent that palliative care is administered with the informed consent of the patient, and does not have the effect of causing or hastening the death of that patient, no question of breach of legal obligation arises.

54 The third general principle which can be stated is that it is unlawful for any person, including any health professional, to administer medication for the purpose of causing or hastening the death of another person.

55 It will be seen that these general principles cover the ends of a spectrum of possible facts and circumstances. Within that spectrum is the circumstance in which medication which might be administered for the purpose of relieving pain or easing discomfort might have the incidental effect of hastening death. Section 259(1) might well provide a defence to any criminal charge brought in such a circumstance. Whether or not it does will, of course, depend upon all the particular facts and circumstances of that case, including the condition of the patient and the palliative care provided. Within the range of possible facts and circumstances, the application of the provisions of subsection (1) of s 259 will depend critically upon the particular facts and circumstances of the individual case. I have insufficient evidence before me to make any findings with respect to the particular facts and circumstances that might apply to the administration of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration. Accordingly, I should not grant any declaratory relief in relation to those issues, other than to declare that any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

56 However, I would hope that the general principles I have enunciated would provide sufficient guidance to Dr Benstead and enable him to provide appropriate palliative care to Mr Rossiter if and when the occasion arises.

57 Finally, I would observe that although the evidence establishes that Mr Rossiter has on a number of occasions in the past directed Brightwater to cease the provision of nutrition and hydration, the question of whether or when he repeats such an instruction after this ruling and after the issue of the extent of the information given to him has been put beyond doubt, is entirely a matter for him. I would also observe that any such direction would not be irrevocable, and while he retains his capacities, could be revoked by him at any time. It follows that the precise terms of any declaratory relief granted in order to give effect to these reasons should take account of those contingencies.

58 I make declarations as follows:

(1) If after Mr Rossiter has been given advice by an appropriately qualified medical practitioner as to the consequences which would flow from the cessation of the administration of nutrition and hydration, other than hydration associated with the provision of medication, Mr Rossiter requests that Brightwater cease administering such nutrition and hydration, then Brightwater may not lawfully continue administering nutrition and hydration unless Mr Rossiter revokes that direction, and Brightwater would not be criminally responsible for any consequences to the life or health of Mr Rossiter caused by ceasing to administer such nutrition and hydration to him.

(2) Any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) of the *Criminal Code* would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.