1. MB: It is my submission that the inclusion of consent in section 259 would provide some clarification in relation to the lawfulness of medical treatment more generally. As noted in our previous submissions consent is only relevant to simple assault and assault occasioning bodily harm (depending upon the scope of consent) under the Criminal Code. Where wounding or grievous bodily harm is involved consent is irrelevant. As forms of surgical intervention involve, on the face of it, invasive and serious bodily interventions, the inclusion of consent in section 259 (which is directed to medical and surgical treatment) would resolve questions relating to this situation. Presently section 259 is constructed around a model of necessity, which is normatively associated with the person who is unable to consent to treatment. In relation to persons who lack decisional capacity it should be noted that the Guardianship and Administration Act 1990 (WA) provides a framework in which other persons can authorise 'treatment decisions', and this is essentially done on the basis of the provision of their consent, so the inclusion of consent in section 259 is one way of aligning the GAA with the Criminal Code, as well as providing a clear justification for the treatment of those persons who do have decisional capacity.

   MB and CS: It is our submission that this would be a more transparent way to address the situations of surgical treatment which involve significant bodily invasions and also the withdrawal of life-saving or life-sustaining treatment from both those persons who have the decisional capacity to request the withdrawal (the *Rossiter* type of case), as well as persons who lack decisional capacity and where the decisions are made on the person's behalf (as expressly provided for in the GAA). The common law and the Code (as evidenced by the *Rossiter* decision) have clearly accepted that it is the right of a person to refuse life-saving and sustaining treatment, and this is consistent with the law on assault. The law has also clearly accepted that such treatment can be refused or withdrawn in relation to a person who lacks decisional capacity where that is found to be in that person's best interests. In WA, the GAA clearly provides for this, and also provides for a person to make this decision while they have decisional capacity to apply at a time when they no longer have capacity. A clear provision on consent to medical treatment would provide some textual consistency and clearly align the Criminal Code both with the GAA and with accepted legal principle in the western legal jurisdictions.

   However, we would submit that the step of legislating for voluntary assisted dying is attended by clear concerns that go to not only the capacity of the person to make this decision, but also concerns about the voluntariness of the individual's decision. The act/omission distinction which exists deontological discourse has been strongly influential in shaping legal approaches to assisted dying, as has the conception of the doctor's duties as interpreted in professional conduct norms, dating as far back as the Hippocratic Oath. In light of these concerns we would submit that it is preferential to separately legislate for voluntary assisted dying in a way which allows there to be specific and tailored provisions which clearly set out the requirements for a valid consent, and can accommodate expressly and transparently the safeguards in place, including around the three accepted ingredients of a valid consent. This is not to suggest that the Victorian model should necessarily be replicated – in our previous submissions we pointed out the narrow nature of the scheme in that Act, particularly with respect to persons who would like to include assisted dying as part of their advance care planning. However, it is suggested that voluntary assisted dying is best approached as a specific social issue requiring a tailored approach. A separate piece of legislation could expressly acknowledge the principle behind the legislation in a way which gives consistency and clarity to the scope of any voluntary assisted dying scheme.