VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Adele Farina) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 6: Decision-making capacity —

Committee was interrupted after the amendment moved by Hon Nick Goiran had been partly considered.

Hon STEPHEN DAWSON: Before we broke for question time, Hon Aaron Stonehouse had asked a question about memory loss. With regard to memory loss, it is important to recognise that an element of memory loss does not carte blanche mean that a person does not have decision-making capacity. Retention of information to the extent necessary to make the decision is inherent in the elements of decision-making capacity in clause 6. This has been confirmed with the Chief Psychiatrist. In order to be able to understand the information, the matters involved and the effect of the decision, and weigh up these factors, make a decision and then communicate that decision, clearly the person has to be able to retain information to the extent necessary to make the decision. I do not believe the amendment is necessary. It is not included in the Mental Health Act, and I believe it is not required in this bill.

Hon DONNA FARAGHER: Can I just clarify that? The minister is saying that it is not necessary. But would it cause any harm for it to be included and to make it more explicit?

Hon STEPHEN DAWSON: I responded to that part of the question earlier.

Hon Donna Faragher: I do not think you have.

Hon STEPHEN DAWSON: I responded to it before we broke for afternoon tea and question time.

Hon AARON STONEHOUSE: This is getting into something that I was pondering myself—whether the ability to retain information has an impact on capacity. The minister is telling us that that is not necessarily so, or at least that the standard employed currently under the Mental Health Act or according to the Chief Psychiatrist is that the ability to retain information does not necessarily impact capacity. That makes some sense to me, I suppose. A person's ability to understand what is going on and their capacity to consent in that moment is probably more important than their ability to retain information from some previous session. I suppose, though, that I am not completely convinced one way or the other yet, because I am not sure to what extent retention of information might have an impact on capacity. I think of the film *Memento*, which is about a person who loses his memory every minute or something. It was written by Christopher Nolan. It is a brilliant film. In a scenario like that, if a person is basically a blank slate every few minutes, surely they would not be able to retain the necessary information, or at least hold all that information in their mind at one time, and be able to assess that information properly internally to come to some kind of decision, whereas if a person is able to retain information perhaps over a longer period of time, that may have less of an impact on their capacity. Can the minister give us some idea of the extent to which the ability to retain information has an impact on capacity? I understand that in some cases, it may not have an impact, but to what extent, and in what instances, and can the minister give us any examples to help clear this up a bit more?

Hon NICK GOIRAN: While the minister is contemplating that question from the honourable member, can I just point out what we have learnt as a result of the responses to this amendment so far. We know from the minister that, according to the Chief Psychiatrist, it is already inherently the case that the words in my amendment would be taken into account in clause 6. In other words, if a person was trying to determine whether a patient has decision-making capacity, the patient would have to retain the information or advice to the extent necessary to make the decision. That is what the Chief Psychiatrist has told the government. Therefore, it is inherently already in clause 6; and, therefore, the government says that the amendment is not necessary, even though it will cause no harm. Can I put to members that we have two choices here. We can either rely on what the government has said by virtue of the Chief Psychiatrist or insert those words ourselves right now to put it beyond doubt, noting that is exactly what has been done in the Victorian legislation. I do not think this is a complicated decision. I am actually disappointed that the government has chosen to take a path of resistance to not simply facilitating this so that we can move on to the next part of the bill. That is really the decision that we have to make. We can leave it, if you like, in a nebulous state, whereby we rely on the fact that, potentially, on this occasion the information that has been provided to us by the minister is correct. Let us remember that, in the context of this debate, so far there have been multiple occasions on which I have asked questions, and the responses have only had to be corrected later. We can either rely on the verbal evidence provided by the minister now or simply enshrine the words in the legislation, as per the amendment in the exact same terms as the Victorian legislation.

Hon STEPHEN DAWSON: A person who suffers some memory loss may still understand all the relevant information and make an informed decision, even though he or she may later forget some of the information that was given previously. The impact of memory loss on decision-making capacity is contextual to the individual patient, and it is dependent on multiple factors.

Hon MARTIN PRITCHARD: I am not going to support this amendment, because what the minister just said rings true to me. If a person continues to make the same decision, given the same facts, I think of the matter as enduring. I have been thinking very hard about this one, because at first I thought it was a good idea to include it, but I think it would possibly knock some people out who have issues with short-term memory loss, but the fact that they would continue to make the same decision, given the same facts, convinces me not to support the amendment.

Hon MARTIN ALDRIDGE: I am a bit like Hon Aaron Stonehouse; I am trying to find my way through on this amendment. I understand from the briefings that I have had that a person who applies to qualify for voluntary assisted dying has to have decision-making capacity and has to maintain decision-making capacity. Despite that, the only two occasions on which, as a minimum, that person is going to be assessed for decision-making capacity is by the consulting and the coordinating practitioners. Keeping in mind that the other requirement is that the person is likely to die within six or 12 months from the disease with which they have been diagnosed, we would then need to consider whether the patient has the capacity to retain the information necessary for the six to 12 months post-qualification. I hope members are following me, and I hope that the minister will be able to correct me if my assumptions are wrong. If somebody has some inability to retain information throughout the course of the six or 12 months, knowing that this bill has no ability to require the patient, once they qualify, to be reassessed for capacity, could it not be the case that that person, through some limitation, or an inability to retain information, could indeed be consuming the voluntary assisted dying substance without having retained the information that was available to that person at the time they qualified for the process?

Hon MARTIN PRITCHARD: I was just going to make a comment on that. That would be the case if they get through the process. They could still then lose capacity at some further time, but they are not assessed. It is just a matter of timing in my view.

Hon NICK GOIRAN: It will be quicker if I explain it. The clause before us defines "voluntary assisted dying decision" to mean a request for access to voluntary assisted dying or a decision to access voluntary assisted dying. The purpose of this decision-making capacity clause is to say, "What does a doctor have to determine for that patient to have met the criteria for decision-making capacity?" It is these things that are set out here, but it is just in respect of the request for or a decision to access voluntary assisted dying. In other words, if the patient has decision-making capacity at the moment they make the request, for the purpose of what we are discussing with clause 6, it does not matter what their state is down the track. I think that goes to the heart of the member's question. I think it is a fair point that is probably worthy of consideration, particularly when we are thinking about self-administration. Should a person be able to self-administer at that point if they do not have decision-making capacity? However, that is a different issue for a different clause. What we are dealing with at this point is that moment of a request or a decision.

Hon COLIN HOLT: This is obviously about a capacity assessment to be undertaken by a medical practitioner at the time of a request to access voluntary assisted dying. I think the minister was earlier talking about the consistency of what doctors consider as they make an assessment of capacity. They do this all the time in a range of situations with patients, including decisions on life and death—for example, "do not resuscitate". At that point, a patient may have a request saying, "Please do not resuscitate" or "I have an advance health directive saying do not resuscitate." It is a life-and-death situation. A doctor, in witnessing an advance healthcare directive, would assess the patient's capacity based on how they have done it and on common law—as I think Hon Nick Goiran mentioned earlier—and in relation to the Mental Health Act. That would all be taken into account, but without the extra step about the retention of the information. Even when doctors and specialists discuss care options with patients—including cancer treatment, potential brain tumour operations, the whole thing—at that time, they have to make a decision on the capacity of the patient to understand the treatment, the options and the potential outcomes, and ask, "Do you understand what I'm putting to you about the risks and my evaluation of the treatment options?" The doctor would have to make a decision then about the patient's capacity. I find this clause to be completely consistent with that. Our doctors are well trained to make those decisions—does the patient have capacity at the time of making this request? It seems to me that if we include this amendment, we would be asking doctors to consider something beyond what they would normally do. If the clause is amended, the question could then arise for the doctor, "If I have to comply with this legislation, what extra things do I now have to consider to ensure that I assess capacity, even though it will be different from every other time I assess capacity?" That is my simple observation of this amendment.

Hon STEPHEN DAWSON: I thank Hon Colin Holt for his contribution, which I concur with.

Hon Nick Goiran: He just said something different from you, so how can you concur with it?

Hon STEPHEN DAWSON: No. The person is required to have decision-making capacity about the voluntary assisted dying decision. The voluntary assisted dying decision means a request for access to voluntary assisted dying or a decision to access voluntary assisted dying. Decision-making capacity is not about the patient being able to retain all the information presented to them. This is not some sort of school test, for example, that the patient must undergo.

Hon AARON STONEHOUSE: I think we are perhaps getting a little off track. There seem to be two views around the chamber about this amendment. One view seems to be that this is already part of an assessment, in which case the argument may be that there is no harm to include it in the bill. The other view is about whether this amendment is too onerous. It is not part of an assessment currently and to make it a requirement would make it too onerous and cumbersome, and there is no need for someone to have the ability to retain information as one of the decision-making capacity assessment criteria. The problem with that argument is that the amendment moved by Hon Nick Goiran does not refer to retaining all information or a large sum of information. It states —

> retain the information or advice to the extent necessary to make the decision;

We are talking only about retaining the information to the extent necessary to make the decision. It seems to me that that would absolutely have to be part of a capacity assessment, whether or not it is in the statute, because if a person cannot retain information to the extent necessary to make the decision, surely they do not have capacity. Therefore, I think we need some further clarification, which I suspect is what Hon Nick Goiran was going to ask for. Is the amendment proposed by Hon Nick Goiran currently part of a capacity assessment according to the Mental Health Act and the Chief Psychiatrist? If it is not, that is a concern to me. If it is, perhaps it is something worth including or perhaps it is not, but then we can at least narrow down what we are actually debating.

Hon NICK GOIRAN: The answer to the question asked by Hon Aaron Stonehouse is yes. Everything that Hon Colin Holt said earlier was correct except for one thing: we are not adding anything new here. The evidence provided earlier by the minister was that the information in my amendment is inherently in clause 6 already. I do not have a problem. If members wanted to vote against this amendment on the basis of saying, "Look, it's unnecessary because it's already in clause 6; it's inherently in there", they could absolutely hold that view. A view that would be wrong is to say that by putting this in here, we are adding something extra that does not need to be included. That is wrong as a matter of law and that is wrong pursuant to the evidence provided—not by me, but by the minister earlier. Therefore, I think the minister would help members, and we could make some progress, if he could reconfirm for us that the information provided to the government by the Chief Psychiatrist is that amendment 59/6, standing in my name, is inherently already in clause 6.

Hon STEPHEN DAWSON: Thank you. I can confirm that the retention of information to the extent necessary to make the decision is inherent in the elements of decision-making capacity in clause 6. Further, as I have said previously, this amendment would create an inconsistency with other Western Australian legislation, and we do not want to add an additional limb.

Division

Amendment put and a division taken, the Deputy Chair (Hon Adele Farina) casting her vote with the ayes, with the following result —

Ayes (16)

Hon Martin Aldridge	Hon Adele Farina	Hon Robin Scott	Hon Dr Steve Thomas
Hon Jim Chown	Hon Nick Goiran	Hon Tjorn Sibma	Hon Colin Tincknell
Hon Peter Collier	Hon Rick Mazza	Hon Charles Smith	Hon Alison Xamon
Hon Donna Faragher	Hon Simon O'Brien	Hon Aaron Stonehouse	Hon Ken Baston *(Teller)*

Noes (18)

Hon Jacqui Boydell	Hon Colin de Grussa	Hon Alannah MacTiernan	Hon Dr Sally Talbot
Hon Robin Chapple	Hon Sue Ellery	Hon Kyle McGinn	Hon Darren West
Hon Tim Clifford	Hon Diane Evers	Hon Martin Pritchard	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Samantha Rowe	
Hon Stephen Dawson	Hon Colin Holt	Hon Matthew Swinbourn	

Amendment thus negatived.

Hon NICK GOIRAN: The minister in the other place said the following on 4 September about this clause —

> … clause 6(2) sets out a range of matters about which the person must have a level of awareness and understanding. That would be ascertained through not only an exhaustive conversation with the patient, but also a thorough examination of that patient's records, and, indeed, a conversation with that patient's other specialists.

Where in the bill does it mandate that the practitioners involved in assessing a patient's decision-making capacity must consider the patient's medical records?

Hon STEPHEN DAWSON: It is not in the bill, but I am advised that it is good medical practice.

Hon NICK GOIRAN: That is not what the minister in the other place said. Is this another example of the minister misinforming the other place?

Hon STEPHEN DAWSON: I cannot comment on what the minister said in the other place, but I can comment on the bill before me, and I can certainly answer the questions that the member asks about the bill before me.

Hon NICK GOIRAN: Where in the bill does it mandate that the practitioners involved in assessing the patient's decision-making capacity must consult with the patient's other specialists in reaching their own decision?

Hon STEPHEN DAWSON: It does not, but, again, I am advised that it is consistent with good medical practice.

Hon NICK GOIRAN: That is another example of the minister in the other place misinforming members there. Given that these things are not found in the bill, will the government ensure that these instructions are contained in the mandatory training for voluntary assisted dying–eligible practitioners?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: Will the Victorian mandatory training modules be used as a basis for that?

Hon STEPHEN DAWSON: The detail of that has not been worked out yet.

Hon NICK GOIRAN: On 4 September, the minister's colleague in the other place, the Minister for Health, also said about this matter —

> The assessment of decision-making capacity goes on all the time in medicine, and the member has just described a very good example. These sorts of cases, in which a GP or a medical practitioner of some form has made a call about a patient's capacity to make a decision, come before the State Administrative Tribunal regularly. It happens all the time. I am sorry if the member feels that there is too great a variation in the skills and qualities of the medical workforce. We have one of the best medical workforces in the world, but I accept that sometimes good decisions are made and sometimes bad decisions, or decisions that would otherwise be reflected on, are made. In health, they are made all the time.

Given the outcome of such a bad decision—in this case, a failure to identify impaired decision-making capacity—why does the government not mandate the best care for patients in Western Australia by requiring assessment by an expert in decision-making capacity such as a psychiatrist or a geriatrician?

Hon STEPHEN DAWSON: I am told that to suggest that only a psychiatrist can assess decision-making capacity mischaracterises the role of a psychiatrist. A psychiatrist treats mental illness. They are not general experts on decision-making. During consultation with the registered health practitioners, including the Office of the Chief Psychiatrist, it was made clear that it would not be appropriate or necessary for every patient who requested voluntary assisted dying to undergo psychiatric assessment. I turn to who assesses. Under the legislation, decision-making capacity must be independently assessed by two experienced medical practitioners. If they are unable to make a determination, they are obliged to refer the patient to a health practitioner with appropriate competency to make the assessment. The appropriate health practitioner will depend on the issue. For example, if the concern is mental illness, a psychiatrist may be appropriate; if the concern is decline due to ageing, a geriatrician may be preferable.

Hon NICK GOIRAN: The minister indicated that there had been some consultation with the Office of the Chief Psychiatrist and that as a result of that conversation, it was clear that it would not be necessary for every patient who requested voluntary assisted dying to undergo a psychiatric assessment. I think that is what I heard the minister say. Of course, that is not what I asked. I asked why an expert in decision-making capacity such as a psychiatrist or a geriatrician might not be the best person to make this assessment. It is not necessarily about having a psychiatric assessment. I draw the minister's attention to an exchange that took place between the Chief Psychiatrist and me during the yearlong inquiry of the Joint Select Committee on End of Life Choices. On 14 December 2017, the Chief Psychiatrist of Western Australia, Dr Gibson, said in evidence to the Joint Select Committee on End of Life Choices —

> … if you look at the Mental Health Act, it requires a psychiatrist to determine capacity to make someone involuntary under the Mental Health Act. My feeling would be why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

That was evidence given by the Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017. What was the date of the consultation that the government had with the Chief Psychiatrist that would suggest otherwise?

Hon STEPHEN DAWSON: The last correspondence that the government received from the Chief Psychiatrist, Nathan Gibson, on this matter was dated 14 November 2019.

Hon NICK GOIRAN: Can the minister table that correspondence?

Hon STEPHEN DAWSON: I have quotes from the email, but I do not have the full piece of correspondence, so I cannot table it.

Hon NICK GOIRAN: I will take a bit longer to go through this then. This is a very significant issue.

Hon Sue Ellery interjected.

Hon NICK GOIRAN: The Leader of the House is not paying attention so she should not get too disturbed.

Hon Sue Ellery: How do you know what I'm doing?

Hon NICK GOIRAN: It is pretty obvious. It is self-evident.

Through you, Madam Deputy Chair, evidence has been provided by the Chief Psychiatrist to a joint select committee of the Parliament. It is pretty rare to establish a joint select committee of the Parliament. It took evidence from the Chief Psychiatrist. The Chief Psychiatrist said in that evidence on 14 December —

> … why would you not then ask a psychiatrist to determine capacity in a perhaps more significant issue of somebody determining whether they wish to take their own life or not.

That is what the Chief Psychiatrist said in evidence to a parliamentary inquiry. I was present on that day, as I was for every meeting and hearing during that yearlong inquiry. To offset that evidence that was provided—a transcript of that evidence is available—we have an indication from the minister of some correspondence on 14 November 2019 that he says suggests something else, but we are not privy to that piece of correspondence. Can I suggest to members that greater weight needs to be given at this point to the transcript of evidence provided to the joint select committee. Members can read that for themselves to determine whether what I am saying is true. Am I misquoting the Chief Psychiatrist or can we rely on an unseen, untabled letter that the minister says he has in his possession?

Withdrawal of Remark

Hon STEPHEN DAWSON: I take a point of order. I have not said that I have a document in my possession. I ask the honourable member to retract that. He just said that the minister has said that he has a document in his possession. I have not said that. Please withdraw that comment.

Hon NICK GOIRAN: I will not withdraw it.

Hon Stephen Dawson: I said that I was aware of the correspondence. Do not put words in my mouth.

Hon NICK GOIRAN: The minister has a piece of correspondence dated 14 November.

The DEPUTY CHAIR (Hon Adele Farina): Order, members! This not a debatable issue. The minister raised a point of order. Based on my understanding of the conversation, I believe that the minister stated in his answer that he had extracts from the email or the letter, but he does not have a copy of the letter/email in his possession, so he is not able to table it. It is unclear to me whether Hon Nick Goiran was referring to this minister or the Minister for Health. I am not going to make a ruling, but I want to make it very clear that that is what I heard the minister say.

Committee Resumed

Hon NICK GOIRAN: I concur entirely. For any clarification necessary, it was absolutely the Minister for Health. That is who I understand has possession of a piece of correspondence from the Chief Psychiatrist dated 14 November 2019. Unless anyone wishes to correct the record and suggest that somebody else has it in their possession, I will proceed on that basis.

On 14 December, in evidence given to the Joint Select Committee on End of Life Choices, Dr Gibson said —

> … obviously we have said, again in the Mental Health Act, that anyone who is made involuntary has to be seen by a psychiatrist. It is so serious that a psychiatrist must see them to determine capacity, mental illness et cetera. What I would not like to see is a watered down version that would not apply the same rigour to individuals seeking to end their life, notwithstanding that palliative physicians are good at screening for mental illness. Palliative physicians would not call themselves psychiatrists. They would not say that they can, hand on heart, make diagnoses of mental illness in every case. They would screen for it. Except if you are Lisa Miller, you can do both, but most palliative physicians would say that they screen for it but they would ask for specialist advice if it was a complex situation, hence, I am trying to not have a lesser standard for individuals who are seeking to end their life, even in the case of terminal illness, than we apply already within the Mental Health Act.

That was from 14 December 2017. On that same day, Dr Gibson said to the committee —

> The issue is around when someone actually wishes to accelerate and end their life actively. Then, I think, there is an ethical and professional requirement to really make sure that we exclude mental illness in that situation.

He further went on to say in evidence to the committee on that same day —

> In some jurisdictions, GPs are, obviously, making these decisions with regard to assisted suicide. I am aware of that. It is about the stakes. The question is: are GPs good at doing capacity? That is one question. The answer is that it is extremely variable.

I pause there to remind members that I am quoting from the evidence given by the Chief Psychiatrist in Western Australia, who said to the Joint Select Committee on End of Life Choices —

> … are GPs good at doing capacity? That is one question. The answer is that it is extremely variable. The nature of GP practice is that they often do not have the appropriate time to do this, and they will acknowledge that.

The DEPUTY CHAIR: Order, members! The level of noise in the chamber is making it very difficult for me to hear the honourable member on his feet, which would make it very difficult if another point of order were called.

Hon NICK GOIRAN: I continue —

> They are the people seeing people in nursing homes. They are seeing lots of individuals who are incapacitous or may have capacity or not. So, they are seeing lots of it but they are not always thinking in that paradigm; they are thinking in more broad, holistic paradigms. In the situation where a GP is treating mental illness, assisting with the palliative care and making potential capacity assessments that are not leading to the potential death of the person, that may be reasonable. But the stakes go up when you are saying that someone is going to die. I do not think it is reasonable to have a GP make that capacity assessment at that point.

That was the evidence given by the Chief Psychiatrist to the Joint Select Committee on End of Life Choices on 14 December 2017. In contrast to that, the minister said that there is this infamous correspondence of 14 November 2019 in the possession of somebody that we cannot see. The suggestion—the implication—from the minister is that it is going to tell us something different or something new that the Chief Psychiatrist is going to inform us of that is very important. The minister has said that clause 6 is fundamental to the bill; he has said that decision-making capacity is crucial. If the Chief Psychiatrist has changed his view from the evidence he gave in that hearing that I attended on 14 December when he said that GPs are not the ones who should be doing that, I would like to know that, and I suspect that other members in this place would like to know that. Without having seen this correspondence from 14 November, I would not be surprised if the correspondence to the government says that the Chief Psychiatrist says that it is not necessary for every person who wants to access voluntary assisted dying to have a psychiatric assessment. He probably has said that, but is that the same as the Chief Psychiatrist saying that an expert in decision-making capacity, such as a psychiatrist, palliative care specialist or a geriatrician, should be involved? They are two different and distinct things. That is why I am pursuing this letter that the minister has said states something different. He may table it in due course later today. It may well demonstrate that the Chief Psychiatrist's view on this has evolved, which is the current language we are using when people change their mind—it has evolved. It may say that, but I would like to test it. I would like to be satisfied on that piece of correspondence to give that greater weight than the evidence that was given to the Joint Select Committee on End of Life Choices. During that hearing on 14 December 2017 this interaction between me and the Chief Psychiatrist occurred —

> **Hon NICK GOIRAN**: I notice that you distinguish between GPs and psychiatrists on the basis that the stakes are higher. Would you agree that the stakes are higher than a decision about whether to involuntarily detain a patient?
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> **Dr GIBSON**: Yes.
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> **Hon NICK GOIRAN**: In the process for determining capacity with regard to involuntary detention at the moment, is it the assessment of one psychiatrist?
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> **Dr GIBSON**: It is the assessment of one psychiatrist, that is right, but there is a check and balance in the sense that you have the Mental Health Tribunal, which has a psychiatrist on it, as well as a lawyer, as well as a community member, who automatically must—so, it is mandatory—review that decision. You automatically have a mandatory check.

I hope that when we, in due course, adjourn proceedings, that there will be an opportunity during that one-hour adjournment for this piece of correspondence of 14 November 2019 to be located and that when we return, the minister will be able to table that correspondence. From the recent debate that we have had it is clear that a lot of members are interested in decision-making capacity. I think there is, at least, agreement between the government and the majority of members that this is a crucial issue that needs to be determined. I am not satisfied to rely on the oral evidence that has been provided in the absence of a document that is available and in the possession of the government. In contrast to that, we have evidence given—sworn testimony—to a Parliamentary inquiry. I am going to continue to give greater weight to that evidence by the Chief Psychiatrist from 2017 than what has been related to us in what is, frankly, a hearsay fashion today. I will insist on the letter being tabled.

Hon STEPHEN DAWSON: The honourable member can, of course, place whatever weight he likes on whatever document he wants. I have made the point that correspondence was received from the Chief Psychiatrist that suggests that his opinion has evolved. I can quote from it and I will certainly give an undertaking that I will seek to access a copy of the email correspondence during the tea break. If I can provide it, I certainly will. I have a quote from it that states —

> - Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

I also draw to members' attention that the Royal Australian and New Zealand College of Psychiatrists made clear that although the practitioner's assessing capacity needs relevant expertise, they do not need to be a specialist, and that capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinician to do capacity assessments.

Hon NICK GOIRAN: I move —

> Page 9, line 5 — To delete "unless the patient is shown not to have that capacity." and substitute —
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> unless —
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> (a) the patient is shown not to have that capacity; or
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> (b) the patient has, within the last 7 days, received medical advice relating to their disease, illness or medical condition that contains —
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> (i) a terminal or life-limiting diagnosis; or
>
> (ii) a poor prognosis.

The genesis of this amendment before us arises from a concern raised by Dr Mike Nahan, the member for Riverton, in the debate in the other place. On 4 September this year, at page 6431 of *Hansard*, he said —

> We are talking about capacity to understand and make this very important decision. We have heard stories in this place and we have talked to people who have had to give the bad news to a person that they have a terminal illness. We have also read some of the reports about that. I admit that I am a layman in this area. As I have mentioned, it is often traumatic for people to be given a death sentence, and they go into existential shock. My brother experienced this when he was diagnosed with Parkinson's disease. His initial diagnosis was that he would live for about two years—I forget what it actually was. He lived for 15 years, by the way, and he passed away not from Parkinson's but from something else. There is deep psychological impact on people when they get the bad news. The question is: would those people have the mental capacity to make a rational decision of this nature?

The response provided by the Minister for Health is very instructive at this point and has led me to move this amendment. Minister Cook said in response to Dr Nahan —

> The member is right. A number of members have made that observation about people who receive bad news. People receive that kind of bad news all the time. Medical practitioners will be very familiar with the scenario in which they say, "Chum, I'm sorry; it's bad news." Indeed, a medical practitioner in that career would frequently be faced with a patient sitting in front of them who is receiving bad news and, quite frankly, that person would not be rational and we cannot expect them to be. In that context, they would not have decision-making capacity, as is defined in this legislation. That is a common scenario, and that is why medical practitioners are well practised and trained in assisting patients to deal with what is essentially a death sentence; that is, they are told, "I'm sorry, but the news is not good." That is not a time that a patient would be demonstrating decision-making capacity. That is a time when that patient would be informed about their treatment options—is it option A or option B? Even though that patient would be in a world of pain at that time, unfortunately, the medical practitioner would then have to assist them to make that decision as well. Obviously, how they manage that patient's state of mind is a very important part of their trade as a medical practitioner, but in that context, having just received the information, the patient would be very distressed.

At page 6459, the minister went on to say —

> A person who would have been given a diagnosis that would in any way make them eligible under this bill would have an advanced and terminal disease. We are not talking about someone who suddenly discovered that they have something wrong with them.

Anecdotal evidence from Victoria tells us that some individuals have indeed made their first request for access to voluntary assisted dying on the same day on which they received their diagnosis, including one case in which a person made their first request on the day on which they received their diagnosis of motor neurone disease. There is nothing in this bill, nor in my proposed amendment, that can prevent someone from making their first request on the day on which they receive the prognosis. That is the reality of what the passage of voluntary assisted dying legislation will mean—that individuals will turn to voluntary assisted dying before they have had an opportunity to process their diagnosis and prognosis. This amendment seeks to make it clear to those practitioners who receive a first request under those circumstances that the individual cannot be assessed as having decision-making capacity at that point in time.

The Minister for Health suggested in the other place that the scenario that I suggest should be avoided under this bill simply could not possibly take place. On 4 September 2019, at page 6459 of *Hansard*, he said —

> A person who would have been given a diagnosis that would in any way make them eligible under this bill would have an advanced and terminal disease. We are not talking about someone who suddenly discovered that they have something wrong with them. This is a process that is significantly advanced. The decision that that person would have to make has to be enduring, as set out in clause 15, and in addition to that, the request will have to be overseen by two medical practitioners. I understand the member's anxiety, but he can be assured through the processes that will be in place that the scenario he described quite simply would not be possible.

He continued at page 6460 —

> I appreciate the member's anxieties, but it is simply not a realistic scenario. The checks and balances in place would simply not allow for that. Under this clause, the person has to demonstrate that they have decision-making capacity and they would have to be knowledgeable about what is happening. In subsequent clauses we will learn that if they are to be eligible in the first place, the condition has to be advanced and the prognosis has to be on the balance of probabilities that that person will pass away within six months. Their decision has to be enduring, not simply made on the spur of the moment or an act of inspiration, and they have to be suffering. I can assure the member that the scenario he painted could not take place. A medical practitioner would have to consider all the conditions and issues that confront that patient. Simply suffering from the shock of the news would not provide them with the opportunity to be considered eligible for voluntary assisted dying.

Sitting suspended from 6.00 to 7.00 pm

Hon NICK GOIRAN: Prior to the interval, I was explaining to members the basis behind the amendment we are considering at the moment, which is 75/6 on the supplementary notice paper. I indicate to members that the genesis of the amendment was a dialogue that took place in the other place between Dr Mike Nahan, the member for

Riverton, and the Minister for Health, Hon Roger Cook. To paraphrase that debate, the indication from the minister was that at the moment a person receives a diagnosis of a terminal illness, according to the Minister for Health, they do not have decision-making capacity, and it would not be appropriate for them to make that decision at that time. I have a lot of sympathy for what the Minister for Health was saying in the other place, as found in *Hansard* on 4 September this year. That is the basis for my amendment. I remind members that the suffering requirement under this legislation is an entirely subjective one, and the honourable Minister for Health, Mr Cook, made it very clear in the other place that suffering does not need to be physical. On 4 September this year, at page 6401 in *Hansard*, he said —

> Suffering is not defined because it is entirely subjective. I think the member for Kalgoorlie spoke quite a lot about one person's suffering being another person's niggle. From that perspective, it is to resolve issues of suffering as felt by the person involved. The Joint Select Committee on End of Life Choices and the ministerial expert panel formed the view that a patient's suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential.

In the debate in the other place during the course of the progress of the bill, different ministers had momentary carriage of the bill. At one point, the Premier of Western Australia, the member for Rockingham, Mark McGowan, had carriage of the bill. He made this point the following day on 5 September this year, as found in *Hansard* at page 6580, when he said —

> Whether a disease, illness or medical condition causes suffering to a patient that cannot be relieved in a manner that the patient considers tolerable, is a subjective element to be determined by the patient. This is consistent with the person-centred approach of the bill to voluntary assisted dying. Both the joint select committee and the ministerial expert panel formed the view that a patient's suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential, or, probably a mix of all, to be frank. It is up to the individual to determine the level or standard of suffering and how much they can withstand. It really is up to the individual to make that decision. I suspect in most, if not all, cases, the person in question will have gone through considerable suffering over an extensive time prior to making the decision to access voluntary assisted dying. Even then, it would be a decision they would make after some further consideration. By necessity, a person's pain and suffering is subjective and the decision is on their advice. I do not know whether it is physically possible to determine it objectively.

The Premier said a little late that day, at page 6584 —

> As I said earlier about suffering, it is a subjective test of what the individual involved can tolerate. That is contained within the clause. It will be up to the individual to determine what amount of suffering they can withstand. I think individual circumstances will be different depending upon the individual involved, but that is just one of the many eligibility criteria.

It is clear that the requirement that a person be suffering would be clearly satisfied on the day on which that person receives that diagnosis. In other words, when they receive the diagnosis or the bad news, they would be suffering. It would be wrong to assume that a patient cannot receive a diagnosis when the disease, condition or illness is already advanced as required by clause 15(1)(c)(i) of the bill. A lot of people receive a diagnosis when their disease, condition or illness is already advanced. For example, Associate Professor Kelvin Kong is concerned that Indigenous people with cancer tend to present late, when their symptoms are well advanced. This quote is found in the article entitled "Indigenous surgeon 'terrified' by WA euthanasia provision" published in *The Australian* —

> While Australia's overall cancer survival rates were among the best in the world, there was a big disparity between the incidence and survival rates of Australians who were non-indigenous and Australians who were Aboriginal and Torres Strait Islander.
>
> "We are jumping to an end-stage conversation when we haven't got all the pathways in cancer management leading up to palliative care," he said.

Contrary to the assurances given by the Minister for Health in the other place, some individuals will qualify as eligible, under clause 15, for voluntary assisted dying on the day their diagnosis takes place, but their decision-making capacity being impacted by the news of their diagnosis and poor prognosis will be in play. This amendment seeks to make very clear to practitioners that, as the minister has said in the other place, a person in those circumstances would not have decision-making capacity for the purposes of accessing voluntary assisted dying. In summary, this amendment will give effect to what Minister Cook said in the other place, that at that time a patient would not be demonstrating decision-making capacity. I agree with him and this amendment would ensure that for a period of seven days, a practitioner would not determine that that person has capacity.

Hon STEPHEN DAWSON: The government does not support Hon Nick Goiran's amendment. As I said previously, the definition of "decision-making capacity" in the bill is consistent with the WA Mental Health Act 2014. The presumption of decision-making capacity, unless shown otherwise, is a fundamental principle. Decision-making capacity cannot be removed on the basis of a person having received a certain diagnosis within a certain time frame. This is not part of the accepted criteria for determining decision-making capacity. Furthermore, it is unlikely that a patient, within seven days of receiving medical advice relating to their disease, illness or medical condition that contains a terminal or life-limiting diagnosis, will seek to access voluntary assisted dying. It is more likely that the patient will take time to process and understand the diagnosis that has been given, and may seek further medical opinion as part of this process. It is in human nature to do something like that. The government also has a concern about the member's use of the words "poor prognosis". A poor prognosis could be absolutely anything that a patient is not happy about. I am told that "poor prognosis" is an ill-defined term and unsuitable for use in this context. A fundamental flaw in the amendment is that the aspects contained in proposed paragraph (b) cannot be a basis for removing someone's decision-making capacity.

While I have the floor, Mr Chairman, I had undertaken before we broke for dinner to seek access to some correspondence in relation to comments made by Dr Nathan Gibson, the Chief Psychiatrist, on 14 November 2019. I will table that document.

[See paper 3415.]

Hon RICK MAZZA: I am trying to consider whether I will support this amendment. From what I can see, I think the mover of the amendment is concerned that someone might be given bad news and that they would be able to make a rash decision to access voluntary assisted dying in a short period. If someone makes a decision to access voluntary assisted dying, how quickly could that occur for them to be able to end their life?

Hon STEPHEN DAWSON: Typically, the period is nine days, but there is provision under clause 47 for that time frame to be shortened.

Hon NICK GOIRAN: Would it be possible for a patient in Western Australia, under the voluntary assisted dying scheme, to make a request on the same day that they receive a terminal or life-limiting diagnosis or, to use the phrase used by Hon Rick Mazza, on the same day that they receive bad news?

Hon STEPHEN DAWSON: Yes, they could make the request on the same day.

Hon RICK MAZZA: Someone could be diagnosed with a terminal disease, have a very poor prognosis and be emotionally affected by that, and then make a very quick and rash decision to access voluntary assisted dying. To ensure that someone does not access this too quickly, if they have just been given a diagnosis and they drop their bundle somewhat, for want of a better word, and decide that they do not want to go on, what other safeguards are there around somebody having a more rational decision, maybe to slow things down a bit, so they can come to terms with the position that they are in before they access voluntary assisted dying? My concern about the amendment before us is that I would not like to see someone be given a prognosis and make a rash decision and within a week be able to access voluntary assisted dying. I have heard a number of stories of people being given a short time to live. Their initial reaction was to access some sort of voluntary suicide, but once things had slowed down a bit and time had passed, they went on to live for a time and made more rational decisions and maybe enjoyed a bit of time with their family. What are the safeguards around someone making a very quick decision in accessing voluntary assisted dying?

Hon STEPHEN DAWSON: The person would have to go through the assessment process. Obviously, they would have to be assessed by a coordinating practitioner and a consulting practitioner, both of whom would make an assessment of the person's decision-making capacity. If there is any question, they can refer the person to a specialist. Could this event happen? It is possible. Humans tend to cling to life. More commonly, if we were given that information, we would seek a further opinion and advice from someone else rather than make a rash decision and rush into something. Certainly, the safeguards are the consulting practitioner and coordinating practitioner. Both have to make an assessment and that is the safeguard.

Hon AARON STONEHOUSE: I am considering this amendment carefully. However, in this instance, I am not sure that it is entirely necessary. I can see the desire to put in some kind of, for want of a better term, cooling-off period to ensure that people do not take rash decisions. However, it seems to me that the capacity assessment should provide for that anyway. If we think the capacity assessment does not provide for preventing people from making rash decisions before they are fully informed, we need to go back to the capacity assessment in its earlier stages and address that there, as opposed to having, without meaning to sound insulting to the drafter of the amendment, what seems like a rather arbitrary cooling-off period of seven days. Why not two weeks? Instead of a seven-day cooling-off period, why not have some mandated counselling or something else in place? It seems that a passage of merely seven days may or may not provide for a patient to clear their head and properly assess the situation.

For those people that it does not, we rely on the standard capacity assessment. For those people that it does, what is it about seven days that is so special? I am a little unconvinced about the need for this, and I would think that the regular capacity assessment would be sufficient; and, if it is not, we have a serious problem. To begin with, we would probably need to go back and look at the capacity assessment. Therefore, at this point, I am not sure that this is necessary and at this stage, I am unconvinced.

Hon KYLE McGINN: I think it was pretty well covered there. Hon Rick Mazza was saying that people would not get access to carry out voluntary assisted dying on that day; they would still have to run through the process and it would then go back to the Voluntary Assisted Dying Board. The minister covered it pretty well in that there would be a test of their mental state. I was a little confused about whether we were talking about getting access to voluntary assisted dying straightaway or just being able to put in the first referral, but it seems that it was just the first referral.

Hon NICK GOIRAN: In response to Hon Aaron Stonehouse: honourable member, I agree with you entirely. Allow me to explain it this way. My preference is indicated a little later on the supplementary notice paper where I say that there needs to be a mandatory referral to a psychiatrist, and that psychiatrist is obviously then going to be involved to ensure that there is proper decision-making capacity. I say that because of the testimony given by the Chief Psychiatrist in evidence to the Joint Select Committee on End of Life Choices in 2017. Members might remember that before the adjournment, I sought the provision of a document of which we have now been provided. Hopefully, members now have it available to them, and if they do not, I strongly encourage them to get a copy of this document, dated 14 November 2019. Members will be interested to know that this document, which is six days old, originates from an individual titled Malcolm McCusker. I am not too sure what role he has in doing consultation on behalf of government, but this gentleman, Malcolm McCusker, on 14 November 2019, wrote to Dr Gibson. For members who do not know, Dr Gibson is the Chief Psychiatrist in Western Australia. This individual, Mr Malcolm McCusker, writes —

> Dear Dr. Gibson,
>
> If you have any time available, I would be grateful if you would call me , to clarify your opinion on whether the assessment of a patient's capacity to understand and make an informed decision on applying to qualify for VAD may be made by a medical practitioner , who may not have specialist psychiatry qualifications, but who , if uncertain of a patient's capacity in a particular case , would be obliged to refer the patient to someone with relevant expertise .
>
> Or is it your view that assessment of capacity must always be made by a psychiatrist ?
>
> Regards,
>
> Malcolm McCusker

I can only assume that this individual, Malcolm McCusker, must have some expertise in what is called "leading questions" because, as members who are familiar with this bill would know—I invite the minister to correct me if what I am about to say in any way misleads members—there is no obligation to refer the patient to someone with relevant expertise in this bill. There is no obligation to do that. In fact, that goes to the very heart of one of my concerns, and I know a number of members have that concern because there are a number of amendments that address that. This individual who has written to Dr Gibson, the Chief Psychiatrist, has sought to steer him into a situation of answering a question that asks, "Well, look, would it be possible for someone, effectively, other than a psychiatrist, to make a decision on decision-making capacity on the basis that if they are not sure, they would be obliged to refer it to another person?" Of course, there is no obligation in this bill. Nevertheless, members can read the interesting response in the penultimate paragraph from the Chief Psychiatrist, which goes to the heart of my answer to Hon Aaron Stonehouse. He writes —

> - Psychiatrists and Geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate- with the option to refer to a relevant psychiatrist in complex or challenging cases.

There is a lot of material in that for members who want to intellectually engage on this particular issue, not only on this clause, but also into the future. I strongly recommend that members look at the document that was tabled by the minister this evening. I thank Mr Malcolm McCusker for taking the opportunity, presumably in a voluntary capacity on behalf of Western Australians and as a gesture of goodwill, to write to Dr Gibson to get this information.

I note for Hon Aaron Stonehouse that I have an amendment on the supplementary notice paper to amend a later part of the bill to include mandatory referral to a psychiatrist for exactly that reason. That member will appreciate that, at this point in time, I have no confidence that any amendment standing in my name will receive support from this government. I have received no indication whatsoever that that will be the case in terms of the history of this

debate so far or from any member of the government that they will support any of my amendments. If I use that as a basis for forecasting into the future, I assume that my amendment to provide for mandatory psychiatric referral will be defeated. Mandatory psychiatric referral would be my preference, but since that is probably not going to happen, the next best thing I can do in terms of a safeguard is to say that we should enshrine into statutory law that a person cannot make this request within the first seven days.

The second point that Hon Aaron Stonehouse raised, which was a very legitimate question, was why I chose a period of seven days. All I can tell Hon Aaron Stonehouse is that I had this dialogue with parliamentary counsel—they also raised it with me—and I had to pick a period of time. I emphasise to the honourable member that this is not my preferred approach. My preferred approach is mandatory psychiatric assessment for the purposes of decision-making capacity, but I have no confidence that that amendment will be supported by this government or the chamber. To use the member's words, this seven-day cooling-off period seems to me to be appropriate in those circumstances.

Hon STEPHEN DAWSON: First of all, that was a very defeatist attitude, Hon Nick Goiran. I make the point that we will consider each of the amendments on the supplementary notice paper on their merit, whether they are in his name or the name of any other honourable member in this place.

Hon Donna Faragher: Really?

Hon STEPHEN DAWSON: Absolutely. In relation to the correspondence, I should have pointed out that any contact details have been removed—their email address has been removed. I just wanted to be clear on that.

In relation to the status of Mr Malcolm McCusker, he is a special adviser to the Minister for Health for the purposes of this bill. His appointment has been through the cabinet process. That is his standing and status.

I want to make the point that I do not think the Chief Psychiatrist is someone who would be steered by anyone. I take issue with anyone suggesting that he was asked leading questions or steered to give this answer. Having served as shadow Minister for Mental Health in a previous Parliament and having had many interactions with the Chief Psychiatrist, whether in briefings or things like estimates, I know that he is not one to be steered by anyone. He tells us what he thinks. He has certainly told people what he thinks in this regard. Furthermore, I believe it is entirely appropriate for the government to ask the Chief Psychiatrist to clarify the position he gave to the Joint Select Committee on End of Life Choices, given that he provided that some time ago. That is what has happened.

Hon ADELE FARINA: I want to make a few comments. I agreed with Hon Aaron Stonehouse's concern about the reason for having a period of seven days, and I think Hon Nick Goiran has explained that quite clearly. I note the minister's concerns about the words in paragraph (b)(ii) of the amendment—"a poor prognosis"—being too general. I am just wondering whether the government's position would change if that were to be amended to read "a prognosis that the illness, disease or medical condition will, on the balance of probabilities, cause death within a period of six months". That adopts the words used in clause 15 and provides consistency in the wording used. I wonder whether the minister and the government would feel more comfortable if that amendment were to take place. It seems to me that there is merit in a cooling-off period, given what the Minister for Health has said about people often being very distressed when they first get a diagnosis, that they probably do not have decision-making capacity at that time and that it would be highly dangerous to make an assessment about decision-making capacity then. This seems to provide a bit of protection. That change in words should address the concerns raised by the minister.

Members might recall in my second reading contribution that I talked about the situation of my dad having a medical procedure performed on him that he did not consent to. I find it really interesting that in his response to Malcolm McCusker, the Chief Psychiatrist said that psychiatrists and geriatricians were by far the best placed to assess capacity. The person who performed that procedure on my father was a geriatrician. That was the person who spoke to my dad and apparently got informed consent, which my dad never gave. This whole area is really fraught with difficulty, particularly in circumstances in which the person has had very little schooling or for whom English is not their first language. Making these sorts of assessments is extremely difficult. I think we should provide some protections to ensure that this is done properly, with the clear intent that we in this place all want. The intention of the bill is for it to be done properly as well, but I do not think it hurts to have protections in place to help ensure that that is the case. I ask the minister whether that amendment would be more palatable with the change to proposed section 6(3)(b)(ii).

Hon STEPHEN DAWSON: I appreciate the spirit in which Hon Adele Farina seeks to be helpful about the amendment. We would not be any more supportive of the amendment if it was worded in that way. I have said before, but I will say again, that decision-making capacity cannot be removed on the basis of a person having received a certain diagnosis within a certain time frame. This is not part of the accepted criteria for determining decision-making capacity. I also point out, as I have before, that the college of psychiatrists took a different view from the Chief Psychiatrist. It has made clear that although the practitioner assessing capacity needs relevant experience, they do not need to be a specialist in that capacity assessment is not solely in the domain of psychiatrists.

Psychiatrists are rarely the most appropriate clinicians to do capacity assessments. Under the training program of the Royal Australian and New Zealand College of Psychiatrists, psychiatrists are well placed to support upskilling colleagues. The WA branch suggests that training be provided to non–psychiatrically trained professionals by psychiatrists with relevant expertise, and that resources be developed to cover screening tools for mental disorders and neuropsychiatric conditions. Another risk factor to look out for is the inclusion of vulnerable populations such as older isolated women, who may seek access to voluntary assisted dying more often. There needs to be guidance on the appropriate use of telehealth, noting its potential to not only increase access but also compromise the integrity of assessments; how to interact with families or carers; and what to do when a patient does not wish to involve their family. The best person to assess decision-making capacity is a person who has been appropriately trained to do so and receives contemporaneous upskilling in this area.

The CHAIR: Members, we seem to be straying somewhat into related but distinct areas that are not covered by clause 6 itself. I remind members that we are dealing with clause 6. The question is that the words proposed to be deleted be deleted.

Hon NICK GOIRAN: I seek the support of members for the amendment standing in my name. It is all very well for the minister to say that the Royal Australian and New Zealand College of Psychiatrists has recommended that GPs and the like be trained by psychiatrists in decision-making capacity. That statement alone should cause members to pause for a moment and ask why they would need to be trained by psychiatrists. Because they need to be upskilled. Minister—this is a rhetorical question—where in this bill is there a requirement that such people have to be trained by a psychiatrist as recommended by the college? It does not exist; hence why it is rhetorical. The minister will tell me that there are some training requirements but there is nothing in this bill that says that before someone can sign off on decision-making capacity, they must have received training by a psychiatrist as recommended by the college. This safeguard would at least press the pause button for seven days. For every Western Australian who wants to access this, if they receive that news, a pause button will be pressed for seven days. That is all that this will achieve. I think that is a helpful safeguard in the overall scheme of things, and I encourage support for it.

Division

Amendment put and a division taken, the Chair casting his vote with the ayes, with the following result —

Ayes (12)

Hon Jim Chown	Hon Adele Farina	Hon Michael Mischin	Hon Charles Smith
Hon Peter Collier	Hon Nick Goiran	Hon Simon O'Brien	Hon Colin Tincknell
Hon Donna Faragher	Hon Rick Mazza	Hon Robin Scott	Hon Ken Baston *(Teller)*

Noes (21)

Hon Martin Aldridge	Hon Colin de Grussa	Hon Kyle McGinn	Hon Darren West
Hon Jacqui Boydell	Hon Sue Ellery	Hon Martin Pritchard	Hon Alison Xamon
Hon Robin Chapple	Hon Diane Evers	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Tim Clifford	Hon Laurie Graham	Hon Aaron Stonehouse	
Hon Alanna Clohesy	Hon Colin Holt	Hon Matthew Swinbourn	
Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Dr Sally Talbot	

Amendment thus negatived.

The CHAIR: Members, that deals with that amendment. We return to the question that clause 6 do stand as printed.

Hon NICK GOIRAN: At page 6461 of the *Hansard* of 4 September 2019, the Minister for Health in the other place is reported as saying —

> The assessment of capacity in a clinical setting cannot be tick a box, but will involve a robust, international assessment as well as consideration of the specific criteria.

What is this robust, international assessment to which the minister referred?

Hon STEPHEN DAWSON: It would be a best practice clinical assessment, but we are not aware of the international assessment that the minister in the other place referred to.

Hon NICK GOIRAN: I can respect that, but if this minister is not aware and he is representing the Minister for Health, I certainly am not aware and the other 35 members who are trying to cast their conscience vote cannot possibly be aware either. At page 6461 of the *Hansard* of 4 September, Hon Roger Cook, Minister for Health, a minister of the Crown of the state of Western Australia in the other place, is reported as saying —

> The assessment of capacity in a clinical setting cannot be tick a box, but will involve a robust, international assessment as well as consideration of the specific criteria.

A reasonable observation is that the reason the Minister for Health provided that response in the other place was to ensure that some comfort was given to members, but when we ask what the international assessment is, we are told that this minister, who represents the other minister, does not know. That is how we are supposed to cast our conscience vote on clause 6, and the minister has said previously that if it is defeated, the bill would still be operative anyway.

Clause 6(2)(e) requires that a patient communicate a voluntary assisted dying decision in some way. Can the minister indicate what is intended to constitute an acceptable form of communication under this clause? I am particularly interested to know about any non-verbal communication, such as hand gestures and the like.

Hon STEPHEN DAWSON: Examples include sign language, use of a communication board or an iPad communication aid. Such strategies are often established with the person by a speech pathologist.

Hon NICK GOIRAN: My final question about clause 6 is: what safeguard is in the bill to ensure that decision-making capacity remains at the time of self-administration?

Hon STEPHEN DAWSON: With the greatest of respect, I think that is a question for clause 57 of the bill, which deals with self-administration. It would be best asked at that point.

Clause put and passed.

Clause 7: Voluntary assisted dying substance —

Hon NICK GOIRAN: What regard would the CEO have for whether the substance is a therapeutic good on the Australian register of therapeutic goods?

Hon STEPHEN DAWSON: The commonwealth Therapeutic Goods Act 1989—the TGA—provides for the establishment and maintenance of a national regulatory system of controls relating to therapeutic goods that are used in, and exported from, Australia. The TGA also provides a framework for the states and territories to adopt a uniform approach to poisons in Australia. The Standard for the Uniform Scheduling of Medicines and Poisons—the SUSMP—is made under the TGA and classifies medicines and poisons into schedules for inclusion in relevant state and territory legislation. The classification of medicines and poisons into schedules depends on the level of regulatory control required over the substance for the protection of public health and safety—the higher the schedule number, the greater level of regulatory control required. The SUSMP is registered on the Federal Register of Legislation as the Poisons Standard. Hopefully, that answers the member's question.

Hon NICK GOIRAN: My question was what regard would the CEO have to have for whether the substance is a therapeutic good registered on the Australian Register of Therapeutic Goods?

Hon STEPHEN DAWSON: He would not have to have regard to that. He would have to have regard to whether it is a schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: Would the CEO be able to approve a poison under clause 7 if it is not registered as a therapeutic good?

Hon STEPHEN DAWSON: Yes, he would. The CEO would just have to have regard to whether it is a schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: For clarification, if a poison is a schedule 4 or schedule 8 poison, is it automatically a registered therapeutic good?

Hon STEPHEN DAWSON: The answer is no.

Hon NICK GOIRAN: A poison can be a schedule 4 or schedule 8 poison but not necessarily a registered therapeutic good. Does that mean that we do not have to give any consideration at this point to the commonwealth's Therapeutic Goods Act 1989 and its intersection with clause 7?

Hon STEPHEN DAWSON: I already explained the intersection when I read to the member earlier that the Therapeutic Goods Act provides for the establishment et cetera and the standard.

Hon NICK GOIRAN: Yes, I do know that, minister. That is not my question. My question is: is it the case that because a schedule 4 or schedule 8 poison—on the advice that the minister is giving me now—does not necessarily have to be a registered therapeutic good, it means that we do not have to have regard for or consideration of the intersection between the commonwealth's Therapeutic Goods Act 1989 and clause 7? The context of this question is that the Joint Select Committee on End of Life Choices was asked by this chamber and the other place to look into the intersection with federal law, and from a previous debate, we know that that committee did nothing whatsoever on federal law. Not one paragraph, chapter, or sentence in its report dealt with that particular issue. It systemically failed in addressing that term of reference given to it by the Parliament. The competency of that

committee fulfilling its job on the terms of reference and the secret minutes that are associated with it is a debate for us to have another day. Because that committee has done nothing whatsoever on that issue, I just want to know now: does the Therapeutic Goods Act 1989, which is a commonwealth law, have any intersection with clause 7 that might have any bearing on it? If it has absolutely no relevance whatsoever, then we can move on.

Hon STEPHEN DAWSON: The intersection is about the establishment of schedule 4 and schedule 8 poisons. Our schedule 4 and 8 poisons are defined by reference to the Poisons Standard made under the TGA. Members can see in particular regulation 6 of the Medicines and Poisons Regulations 2016.

Hon NICK GOIRAN: A schedule 4 or schedule 8 poison may be approved by the CEO for use under this legislation. If the CEO approves that poison, it is already a schedule 4 or schedule 8 poison; it has to be one of the two. Actually, before I ask that question, could it be a combination of the two?

Hon STEPHEN DAWSON: Yes, it could.

Hon NICK GOIRAN: There are three scenarios here. The CEO might approve a schedule 4 poison, a schedule 8 poison or a combination of the two to be used under this act, and that approval will elevate that particular substance to the status of a voluntary assisted dying substance. Will it have to be registered in any way with the commonwealth under the register of therapeutic goods?

Hon STEPHEN DAWSON: No, it will not have to be.

Hon NICK GOIRAN: Clause 7 provides that the CEO may approve a schedule 4 or schedule 8 poison for use under this act for the purpose of causing a patient's death. Does the CEO of the Department of Health currently have the power to approve any schedule 4 or schedule 8 poisons under any other act?

Hon STEPHEN DAWSON: Sorry; will the member ask that again?

Hon NICK GOIRAN: The minister will see at clause 7(1) that we are going to give the power to the CEO to approve a schedule 4 or schedule 8 poison for use under this act. Does the CEO currently have a power to approve schedule 4 or 8 poisons under any other act for any other purpose?

Hon STEPHEN DAWSON: We do not believe so, honourable member. I am not sure whether he is trying to make a point. Perhaps the member might make it for us and then we can give him an answer to that.

Hon NICK GOIRAN: Basically, I am really trying to ascertain whether this is the first time in WA history that we are giving the CEO the power to approve a schedule 4 or schedule 8 poison for use under a statute. Clearly, that is what we are doing here. We are giving him or her the discretionary power to do that. I am interested to know whether the CEO already has that power for other purposes or whether this is the first time that we are doing that.

Hon STEPHEN DAWSON: Not to our knowledge.

Hon NICK GOIRAN: I thought that might be the case, so I guess that leads to my next question. I do not know how the minister wants to describe it, but it is certainly the first time a power has been given, as I understand it from the minister's advice to the chamber, to a public servant—albeit a very senior public servant, the CEO of the Department of Health—to approve a poison, or a combination of poisons. In this particular instance the use is elevated, because it says here in clause 7 that it is for the purpose of causing a patient's death. We can all agree, no matter where we sit on this debate, that we are giving this particular individual a fairly significant power. If it is the first time in Western Australia's history that we are giving the CEO that power, I am curious to know why the decision was made to give it to the CEO and not the Minister for Health.

Hon STEPHEN DAWSON: I am told that this has been done as an important safeguard to restrict what a medical practitioner can prescribe.

Hon NICK GOIRAN: I agree that the poisons need to be approved; we are in furious agreement about that. The question really is: who should have that power to approve? The choices seem to me to be either the CEO of the Department of Health, which is the choice at the moment in the bill or, as I am suggesting, the Minister for Health because, according to the advice given to us, never in Western Australia's history before have we given the CEO of the Department of Health power to approve a substance for the purpose of causing a patient's death. If I can perhaps just take a moment to explain some of my concern here, the minister has indicated in previous answers that the CEO has the power to delegate. I am not entirely comfortable with the CEO having the power to approve a poison for the death of Western Australians, let alone for it to be delegated, whereas I feel that there would be far greater accountability if a publicly elected person, in the form of the Minister for Health, whoever that might be, and whatever party is in government at the time, had the responsibility of signing off on this. That is the context in which I am asking the question.

Hon STEPHEN DAWSON: It is intended that, as part of the implementation of the bill, a clinical panel will be convened to determine the schedule 4 and schedule 8 medication protocols suitable for voluntary assisted dying. The clinical panel will also inform the operational requirements for supply, dispensing and ensuring the safe management of these medications. It is expected that this clinical panel will include appropriate representation from pharmacy, medical and nursing experts, from a Department Health and clinical perspective. The CEO has the appropriate expertise at his—in this case—disposal to make recommendations about which schedule 4 and schedule 8 poisons should be approved. For example, he has access to the Chief Pharmacist.

Hon NICK GOIRAN: I accept that minister, but so will the Minister for Health. I draw to the minister's attention fundamental legislative scrutiny principle 3, which the Standing Committee on Legislation routinely uses to guide scrutiny of legislation. It states —

> Does the Bill allow the delegation of administrative power only in appropriate cases and to appropriate persons?

This is a point for discussion. Is the CEO the appropriate person, and is it appropriate to be giving the CEO this power to approve schedule 4 and schedule 8 poisons for use under this act for the purpose of causing a patient's death? I take the minister's point that the CEO will obviously have access to other administrators and experts, but so will the Minister for Health. It strikes me that a greater accountability mechanism would be if the Minister for Health rather than the CEO were the authoriser. In the spirit of wanting to make progress, would this be an example of something the minister might take away to talk to the Minister for Health about? All that would be required, potentially, is for clause 7(1) to read "the minister" rather than "the CEO". It would require one word to change and then we could move on. I guess I am asking: is the minister willing to defer clause 7 in the spirit of asking this question of the minister?

Hon STEPHEN DAWSON: Under section 4 of the Medicines and Poisons Act 2014, the minister will have already recommended which poisons are to be schedule 4 and schedule 8 poisons. The next step is for the CEO to approve a particular schedule 4 or schedule 8 poison.

Hon NICK GOIRAN: Do all schedule 4 and schedule 8 poisons have the capacity to cause a patient's death or is it only certain schedule 4 and schedule 8 poisons?

Hon STEPHEN DAWSON: The answer to that is possibly. Any medicine or poison is potentially fatal to a person, depending on the dosage they take.

Hon NICK GOIRAN: I guess it goes to the heart of why schedule 4 and schedule 8 poisons were specifically chosen for insertion in clause 7, in contrast with any other poison.

Hon STEPHEN DAWSON: It came out of discussions with the Chief Pharmacist, who indicated that these two schedules were the most appropriate.

Hon NICK GOIRAN: The minister mentioned that a clinical panel would be involved. From what he has just said, I assume that the Chief Pharmacist will most likely be a participant in that clinical panel. Maybe the minister will indicate whether that will be the case. I have a real concern for the complications that arise as a result of taking these poisons. We know from the international experience that there is a complication rate for that. Will those international experiences, particularly around complications, be taken into account by the clinical panel and will the Chief Pharmacist be a member of the clinical panel?

Hon STEPHEN DAWSON: To answer the first question, yes, the Chief Pharmacist would be on the panel and the panel would take into consideration international learnings.

Hon NICK GOIRAN: Minister, what if the CEO does not want to approve the poison, whether it is a schedule 4 or a schedule 8 poison or a combination of both, because the bill states "may", not "must"? The CEO "may" approve one of these poisons, and this refers to an earlier discussion the minister and I had under clause 5 regarding the term "CEO". What if the CEO has a conscientious objection and uses that as the reason for not wanting to approve a schedule 4 or schedule 8 poison? How will that situation be dealt with?

Hon STEPHEN DAWSON: I am just being reminded of our earlier conversation. The CEO has specific obligations under the Voluntary Assisted Dying Bill. The CEO in his role as CEO is not a registered health practitioner. Clause 9 does not provide scope for the CEO to object to his functions as CEO under the bill. The CEO would not be in a position in which his functions overlap with the matters referred to in clause 9. Obviously, clause 9 relates to a registered health practitioner being able to refuse to participate in voluntary assisted dying.

Hon NICK GOIRAN: I agree with that, minister. However, under clause 7(1), at the moment, it appears that the CEO may approve it, but, equally, he may not. It seems to me that he may not approve it for any reason, including

the fact that he—privately and personally—holds a conscientious objection and says, "Look, I'm just not going to approve this." He does not need the benefit of clause 9; he can simply say that he conscientiously objects. I just want to confirm that that is in fact the case.

Hon STEPHEN DAWSON: The member is correct in saying that under clause 7, the CEO has discretion to approve or not.

Hon Nick Goiran: For any reason?

Hon STEPHEN DAWSON: No. But, as I have outlined, clause 9 identifies that he cannot conscientiously object. Clause 9 does not provide scope for the CEO to object to his functions as CEO under the bill, so the CEO would not be in a position in which his functions overlap with the matters referred to in clause 9. The CEO could not object for reasons of conscientious objection. For other reasons, though, he may decide not to approve a schedule 4 or schedule 8 poison. We need to bear in mind, of course, that we have indicated that he will obviously be reliant on the clinical panel when he makes a decision on those schedule 4 or schedule 8 poisons. I have also been advised that clause 7 is an enabling clause, which is why "may" is used.

Hon ADELE FARINA: I would like to get some clarification. My understanding in this area is not as good as Hon Nick Goiran's. Doctors currently prescribe schedule 4 and schedule 8 drugs, or poisons, and they do not need to get the CEO's approval to do so. Why do we have a requirement in the bill that the CEO needs to approve the dispensing of a schedule 4 or schedule 8 poison for the purposes of the legislation?

Hon STEPHEN DAWSON: Let me be clear: it is not about approval for dispensing. What this clause says is that the CEO may approve a schedule 4 or schedule 8 poison. It is not about dispensing a poison; it is about what poisons on the list can be used.

Hon ADELE FARINA: Does that mean that not all schedule 4 and 8 drugs can be used for the purposes of voluntary assisted dying?

Hon STEPHEN DAWSON: The list of schedule 4 and schedule 8 drugs is long. The CEO will narrow down that list and decide which schedule 4 and schedule 8 drugs can be used as a poison in reference to this bill.

Hon ADELE FARINA: The usual practice in these sorts of circumstances is that there would be a schedule to the bill listing those drugs—that decision would have already been made and the Parliament, in passing the bill, would know exactly what drugs would be used for the voluntary assisted dying substance. Alternatively, that would be provided in the regulations. As I understand it, while there is a regulation-making head of power in the bill, a view has been expressed that there is no need to make regulations pursuant to this legislation because everything is contained within it. We are now hearing that the CEO will, at some later date, identify those schedule 4 and 8 drugs that will be used for the purposes of the voluntary assisted dying substance. We have no idea what they will be, we have no idea of the basis on which that decision will be made, and no-one will be able to easily access that information because it will not be in the act or the regulations. My question is: why were those decisions not already made and those substances that will be used for the voluntary assisted dying substance not identified in a schedule to the legislation, which would have made it very clear for everyone? We would then have known exactly what we were passing and approving to be used, rather than leaving it to some other person to make a decision at some later point in time. It is not even clear to me whether the CEO, once he has made a decision about which drugs will be used for the voluntary assisted dying substance, will be able to vary that from time to time, and the basis upon which he would vary that from time to time. I would have thought a schedule to the bill or using the regulation-making power to provide that list in the regulations would have been a far better way to go.

Hon STEPHEN DAWSON: I am advised that they are already listed in the Poisons Standard, which is available in the federal register of instruments on ComLaw, which is the commonwealth legislation database. What is prescribed would depend on each patient themselves, taking into consideration their particular condition, weight and capacity to consume the voluntary assisted dying substance. The coordinating practitioner must prescribe a sufficient amount to cause death for that particular patient in their circumstance. This is particularly important, as some diseases or previous medications may restrict the absorption or counter the effectiveness of other medications. The coordinating practitioner is authorised to prescribe a voluntary assisted dying substance for the patient that is of a sufficient dose to cause death. Schedule 4 and 8 poisons are currently supplied to persons for therapeutic purposes, pursuant to the WA Medicines and Poisons Act 2014. It would not be prudent to allow the public to know which of these poisons, as this may encourage persons to stockpile their supply for the purpose of suicide, assisted suicide or voluntary assisted dying outside the protections of the Voluntary Assisted Dying Act. Furthermore, evidence from overseas has shown that once a substance becomes known as a voluntary assisted dying substance, manufacturers of that substance significantly mark up the price. In summary, there are two main reasons. The first

is that the clinical panel is to determine the appropriate poisons and recommend them to the CEO, and the second is obviously that we do not believe it is in the public interest.

Hon ADELE FARINA: Clause 7 of the bill identifies schedule 4 and 8 drugs as those that are going to be used as voluntary assisted dying substances. To the best of my recollection, in answer to an earlier question the minister indicated that any of the drugs on those lists, if taken in sufficient quantity, could result in death.

Hon Stephen Dawson: I said any medicine taken in enough quantity could result in death, not necessarily schedule 4 and 8.

Hon ADELE FARINA: Therefore, the reason the minister provided for not attaching a schedule of the voluntary assisted dying drugs to the bill does not make sense, because they are already listed in schedule 4 and 8 of the Medicines and Poisons Act, so the information is already publicly available. I am just not clear. Is it intended that each time a doctor prescribes a voluntary assisted dying substance that that prescription goes to the CEO and the CEO checks that that quantity is sufficient to kill the person, given the person's weight and drug history? I am just not clear at what point the CEO is making their decision here and the basis of the decision they are making.

Hon STEPHEN DAWSON: The clinical panel would establish the protocols. Just because an individual medication is a schedule 4 or 8 poison does not mean that it is clinically appropriate for use in voluntary assisted dying. This is a complicated area. Can Hon Adele Farina please excuse me for interjecting while she was on her feet, but I had made the point to Hon Nick Goiran that any poison or any medicine taken in sufficient quantity could lead to a person's death. In this case we have identified that schedule 4 or 8 poisons, either individually or together, are those that will be used under this legislation. The CEO will not have a role in determining the cocktail, if I can call it that—the mixture of two substances. That will be up to the clinical panel to work out. It will then provide that advice to the CEO.

Hon ADELE FARINA: Just so I am clear, will a table be produced by this panel that indicates that a person at this weight needs this much of substances A and B mixed together, and that a person of much lesser weight only needs a smaller dose? Is that what is going to be produced by this expert panel?

Hon STEPHEN DAWSON: I have a few things to say in response to the member's question.

Hon Adele Farina: Minister, you do not need to keep turning around. Talk into the microphone.

Hon STEPHEN DAWSON: Okay; thank you. I wanted to have a break from looking at those opposite! I mean no disrespect to any honourable members here; I am just being lighthearted this late in the evening.

Hon Adele Farina asked about a few different things, so I want to cover off a few different points. I restate that the names of all schedule 4 and schedule 8 poisons can be found in the Poisons Standard. The CEO will approve one or more of those schedule 4 and schedule 8 poisons, subject to panel recommendations. The clinical panel will establish the protocol. It will look at the schedule 4 or schedule 8 poisons and choose which are appropriate. The CEO will then agree, or not. The panel will then decide on the prescription protocol. Obviously, doctors will be trained in that during the training process. The coordinating practitioner will decide on the dose that is provided to the patient. That is based on those things that I mentioned earlier. As I said, what is prescribed would depend on each patient's condition, weight and capacity to consume the voluntary assisted dying substance.

Hon NICK GOIRAN: The minister mentioned that the panel will establish these protocols. Will the protocols then be approved by somebody else, like the CEO, or will the clinical panel have the power to do this?

Hon STEPHEN DAWSON: The bill is silent on the protocols, but in practice they would be agreed by the CEO of Health. It is a clinical operational mechanism. The other point I want to make is that the Chief Pharmacist administers the Medicines and Poisons Act and he provides advice to the CEO.

Hon NICK GOIRAN: We can see at clause 7 that we are giving the power to the CEO. Incidentally, I do not know whether we finished that conversation about whether it should be the minister. I flagged whether we could possibly consider deferring clause 7 for the moment to consider whether the minister would be the person with the power, but I may have missed that. As an aside, assuming that clause 7 proceeds unamended, the CEO will have the power to approve. Once the CEO approves a poison under this particular provision, will the CEO also have the power to remove that approval?

Hon STEPHEN DAWSON: The short answer is yes, but the CEO approves the list of the schedule 4 and 8 poisons, rather than the individual one.

Hon NICK GOIRAN: That is not what it says in clause 7. Clause 7(2) states —

> A poison approved under subsection (1) is a ***voluntary assisted dying substance***.

The CEO approves either a schedule 4 poison or a schedule 8 poison, or a combination of the two. He approves it and at that time, pursuant to clause 7(2), it becomes a voluntary assisted dying substance. As a matter of statute, it becomes a voluntary assisted dying substance that is approved. It is not clear to me where the CEO has the power to disapprove that. That is my concern. To give some explanation about why I am concerned about this, other jurisdictions have experimented with some of these poisons and have found them to be unacceptable. I will give an example. In Washington and Oregon, a large proportion of the deaths that took place under those regimes in 2016—this is recent data—were caused by the self-administration of a combination of phenobarbital, chloral hydrate and morphine sulfate. In December 2016, it was identified that there were problems with that experiment of those three particular poisons, because, as I understand it, the combination turned out to be too harsh. The chloral hydrate mixture was too caustic for some folks. An individual by the name of Dr Robert Wood from that jurisdiction was reported on Kaiser Health News as saying that it proved to be "too caustic for some folks and our volunteers didn't like using it". An alternative to the phenobarbital–chloral hydrate method, which involved a three-drug mixture of diazepam, digoxin and morphine, was then used. However, I understand that in March 2017 it was reported in *The Seattle Times* that 20 per cent of cases were taking three or more hours for death to occur, with the longest time of death being 31 hours. When the death takes far longer than expected, family members would obviously become worried and even distressed. That three-drug cocktail has now been abandoned in favour of a four-drug cocktail of diazepam, digoxin, morphine and propranolol. That is the context of my concern. Those other jurisdictions—in this instance, Washington and Oregon—have had these problems as recently as 2016 and 2017. As I said earlier, it should be the minister who approves the substance, but regardless, I do not want our CEO in Western Australia to find that the substance has been approved and, as a matter of law at clause 7(2), he cannot remove that approval because we have not given him the power to do so. We will give him only the power to give approval, but not to take it away. I want clarification that the government has received advice on that and can provide some comfort that the CEO will have the power to disapprove these things.

Hon STEPHEN DAWSON: Under section 50(2)(c) of the Interpretation Act 1984, the power to approve includes the power to withdraw approval thereof, so that is covered.

Hon Nick Goiran: Did you check whether that is for the minister or the CEO?

Hon STEPHEN DAWSON: I sought further advice. We are happy with the bill as it reads, and we think it is most appropriate that the CEO has that power.

Hon NICK GOIRAN: I respect that. The minister has sought advice and I thank him for taking the opportunity to do that. What oversight will exist over this? The minister may not agree with my language, but I think it is a very significant power that we will be giving the CEO. What oversight will be in place over the significant power that we will be delegating to the CEO?

Hon STEPHEN DAWSON: Can the honourable member clarify whether he is referring to potential misconduct? Is that the point that he was getting to or not necessarily? Can the member clarify that for me, please?

Hon NICK GOIRAN: I had moved on in preparation for the next question.

Hon Stephen Dawson: Perhaps I can give you an answer.

Hon NICK GOIRAN: Yes.

Hon STEPHEN DAWSON: The member has said the CEO will have a significant power. I would say that the whole bill is fairly significant. It is a new way of doing things in Western Australia. In that regard, we think it is appropriate for the CEO to be responsible and have the power. I refer to oversight, if that is what the member was getting at. The CEO is captured by the Public Sector Management Act and the Corruption and Crime Commission, so if he did something untoward, that would apply. If there were an issue to do with the act, clause 162 allows for a review of the act. If the issue were to do with the act, it could be captured that way. But if the member is talking about misconduct or something along those lines, the Public Sector Management Act applies to the CEO and the misconduct could be reported to the CCC.

Hon NICK GOIRAN: My final question on clause 7 is: has the government considered any issues that may arise with importation licences or does the government anticipate that all voluntary assisted dying substances will be compounded locally?

Hon STEPHEN DAWSON: That is a matter for the implementation phase of the bill.

Hon NICK GOIRAN: The problem is that if we are looking at importation licences, I assume that this legislation will then intersect with federal law. Has any specific advice been obtained on that issue?

Hon STEPHEN DAWSON: We are not looking to breach federal law. We believe that the substances—the poisons—are already available here on the schedule 4 and schedule 8 list, so they are available now without needing to import or to breach federal law.

Hon NICK GOIRAN: Are the poisons used under the Victorian regime also schedule 4 or schedule 8 poisons for the purposes of clause 7?

Hon STEPHEN DAWSON: I am looking for the answer for the honourable member now, but we are starting to stray outside of clause 7. We are looking to see what the Victorian act says. Clause 7 before us does not mention the Victorian act, so I think the question is outside the scope. In saying that, my advisers have the Victorian act in front of them, so if I can provide the information now, I will.

Hon NICK GOIRAN: Minister, I am not asking about the Victorian act. I am simply saying that Victoria has a scheme in place; I did not mention the act. Poisons are being used under that scheme. This goes to the heart of my question on whether there would be problems with importation licences or whether it would be compounded locally. In Western Australia, we would be giving power to the CEO to approve certain schedule 4 or schedule 8 poisons. I would like to know whether Western Australians would have access to the same poisons that Victoria has access to—that is my question. It falls very much under the scope of clause 7.

Hon STEPHEN DAWSON: The Victorian Voluntary Assisted Dying Act states —

> ***voluntary assisted dying substance*** means a poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person's death;

The CEO in Victoria approves the permit. In effect, he is doing the same thing as our CEO would be doing here.

Hon NICK GOIRAN: Perhaps I have not explained the question correctly. They must be using some poisons in Victoria to give effect to this scheme. I do not know what those poisons are.

Hon Stephen Dawson: Neither do I, but ask the question anyway.

Hon NICK GOIRAN: That is what I want to know. Let us call the poisons they are using in Victoria poisons X and Y. Are poisons X and Y schedule 4 and schedule 8 poisons as defined under section 3 of the Medicines and Poisons Act 2014? In effect, I am asking whether WA will have access to the same poisons as Victoria.

Hon STEPHEN DAWSON: I am told that Victoria has not released what medications it uses, so I cannot give the member a definitive answer.

Hon NICK GOIRAN: I will just round this out; the minister probably knows where I am headed. Victoria has not released the information, but is there any capacity for the WA government to extract that information from Victoria to say, "Look, you guys have already started this process. You've decided what poisons are working or not working." Remember that the context of my question is that as recently as 2016 and 2017, Washington and Oregon experienced significant problems with the cocktail of poisons they have been using. The minister will recall the information I provided earlier that when the combination of two was not seen to be successful they then tried a combination of three poisons. Now they have a combination of four. I would like to have some comfort that whatever experiment is going on in Victoria, we might have the lessons of that.

Hon Stephen Dawson: If that is your point, I can answer that.

Hon NICK GOIRAN: Yes. If it is not possible for us to know, because there is some shroud of secrecy in Victoria that we cannot penetrate, then I guess that is bad luck for us, but I would be keen to know the answer to that.

Hon STEPHEN DAWSON: We can certainly learn from Victoria. Members of the clinical panel could contact their colleagues in Victoria and discuss on a confidential basis the poisons used. We are not aware of what Victoria uses now, but certainly during our implementation phase we can seek to learn from Victoria so that we are not reinventing the wheel, if I may use that phrase.

Clause put and passed.

Clause 8: When request and assessment process completed —

Hon CHARLES SMITH: Mr Deputy Chair.

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Charles Smith, if I could just advise you that if you were intending to move the new clause 8A standing on the supplementary notice paper, that would occur after consideration of clause 8 and before consideration of clause 9.

Hon NICK GOIRAN: Clause 8 provides that the request and assessment process will be completed once the coordinating practitioner has completed the final review form and certified in that form that the request and

assessment process has been completed. Further assessment of capacity, the voluntariness of the request and the enduring nature of the request is made by the administering practitioner, when the practitioner administration is decided upon. This will occur, I think the minister will agree, after the request and assessment process is deemed completed. Can the minister clarify for us how the request and assessment process will be considered to be completed under clause 8 when the final assessment immediately before the practitioner administration required under clause 58(5) has yet to occur?

Hon STEPHEN DAWSON: It is the end of the request and assessment process. The additional step to which Hon Nick Goiran refers is about the administration decision. The concept of the request and assessment process being completed is important, as it is only after completion that the patient is able to progress to the next stage to access voluntary assisted dying.

Hon NICK GOIRAN: What confidence can we have that the safety and wellbeing of the patient can be safeguarded when clause 8 requires only that the coordinating practitioner be satisfied that they have completed the request and assessment process in accordance with this legislation?

Hon STEPHEN DAWSON: The final review will provide the coordinating practitioner with the opportunity to ensure that all the necessary steps in the request and assessment process have been completed. The coordinating practitioner is not required to repeat these steps. They are required to ensure that every step has been properly adhered to. I draw the member's attention to clause 50, which lays out the steps in the final review by the coordinating practitioner on receiving a final request. It states —

> (1) On receiving a final request made by a patient, the coordinating practitioner for the patient must —
>
> (a) review the following in respect of the patient —
>
> (i) the first assessment report form;
>
> (ii) all consulting assessment report forms;
>
> (iii) the written declaration;
>
> and
>
> (b) complete the approved form … in respect of the patient.

Hon NICK GOIRAN: Why is the Voluntary Assisted Dying Board's consideration of the coordinating practitioner's completion of the request and assessment process not required before part 4, division 2, "Administration of voluntary assisted dying substance", can be applied?

Hon STEPHEN DAWSON: The board does not have a medical decision in the process. It has no clinical role, but it has a monitoring role.

Hon NICK GOIRAN: That is my point. I think the board does have a monitoring role, but it strikes me that clause 8(b) provides that the coordinating practitioner for the patient has certified in the final review form that the request for an assessment process has been completed in accordance with this legislation. At the moment, the safeguard, if you like, is one person—the coordinating practitioner. They sign off and say, "Yes, I certify that I have complied with the act." I am suggesting that it would be safer if the board were then to do that certification, to say, "We have received the final review form from this coordinating practitioner, and we certify that we have received it." At the moment, it stops one step earlier. I am wondering whether any consideration was given to that safeguard.

Hon STEPHEN DAWSON: Clause 50(4) of the bill provides that within two business days of completing the final review form, the coordinating practitioner must give a copy of it to the board.

Hon NICK GOIRAN: Clause 50(4) reads —

> Within 2 business days after completing the final review form, the coordinating practitioner must give a copy of it to the Board.

If we look back to clause 8, there is no reference to the fact that that has happened. The request and assessment process is completed, and then, apparently within two days, the board can be involved, and perhaps not even be involved, but it does not get to certify the role. What I am getting to here is that a greater safeguard would be if the board certified that the coordinating practitioner has completed things in accordance with this legislation, rather than the person themselves. It is a bit like them being required to grade themselves, and it would be better if they, as the minister said, performed the clinical functions, and then an independent body—in this instance, the Voluntary Assisted Dying Board—did the certification. I am questioning whether any consideration was given to that as a safeguard mechanism.

Hon STEPHEN DAWSON: I am advised that consideration was given, but that was not the one that was chosen.

Clause put and passed.

New clause 8A —

Hon CHARLES SMITH: I move —

Page 9, after line 22 — To insert —

8A. When request for access to voluntary assisted dying ceases to be enduring

(1) For the purposes of this Act, a patient's request for access to voluntary assisted dying ceases to be enduring if the patient, at any time, indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

(2) Subsection (1) does not limit the circumstances in which a patient's request for access to voluntary assisted dying ceases to be enduring.

(3) If a patient's request for access to voluntary assisted dying ceases to be enduring under subsection (1), then —

(a) if the request and assessment process in respect of the patient has not been completed — the request and assessment process ends; and

(b) if the request and assessment process in respect of the patient has been completed — the process for accessing voluntary assisted dying under Part 4 ends and no step under that Part (including the prescription, supply or administration of a voluntary assisted dying substance) is to be taken in relation to the patient.

(4) Nothing in subsection (3) prevents the patient from beginning a new request and assessment process by making a new first request.

New clause 8A is a simple clause. It seeks to better define the existing concept of when a patient's request for access to voluntary assisted dying is considered to be enduring. Members may like to know for their interest that this, and indeed other proposed amendments, are taken from a Northern Territory piece of legislation called the Rights of the Terminally Ill Act 1995. In this case, it is taken from section 7(o). Clause 15(1)(f) of the Voluntary Assisted Dying Bill 2019 in front of us requires —

the person's request for access to voluntary assisted dying is enduring.

Prior to practitioner administration, the administering practitioner must also be satisfied that "the patient's request for access to voluntary assisted dying is enduring". That is at clause 58(5)(c). They must also certify that they were satisfied of this in the practitioner administration form. That is clause 60(2)(b)(iii). As I said, the amendment simply seeks to define the existing concept when a patient's request for access to voluntary assisted dying is "enduring". This new clause will provide clarity for the coordinating and consulting practitioners assessing a patient's eligibility under clause 15(1)(f) and for an administering practitioner to satisfy themselves of the enduring nature of the request under clause 58(5)(c) about what it means for the patient's request to have been enduring. This amendment will ensure that the requirement that the patient's request be enduring will apply to all stages during the VAD process, including the first assessment, the consulting assessment, the final review and at the moment of the administration of the voluntary assisted dying substance itself. The new clause is very simple. It will provide further clarity and a further safeguard. I commend it to the chamber.

Hon STEPHEN DAWSON: I appreciate Hon Charles Smith moving this new clause, but we are not in a position to support it. "Enduring" is given a common, everyday meaning in the bill and we do not think it requires defining. Clause 18 of the bill already provides that the patient is under no obligation to continue after making a first request and clause 52 states that there is no obligation on the patient to continue after completion of the request and assessment process. We do not believe the amendment is needed so we will not support it.

Hon NICK GOIRAN: I am inclined to support this amendment by Hon Charles Smith. I am interested that the minister says it is not necessary. Would the amendment moved by the honourable member undermine any element of the bill or make it in any way inoperative? It is one thing for the minister to say that he does not think it is needed, but, again, I suppose it goes to the question that has been asked on some other clauses: what harm would be done if it provides greater clarity? I am mindful—the minister probably is as well—that the stakes are pretty high here if we get something wrong, so if this adds an extra level of comfort or safety and does not do any harm or undermine anything, it is not clear to me why it ought not be supported.

Hon STEPHEN DAWSON: This amendment relates to some other amendments that Hon Charles Smith put on the supplementary notice paper. He has parked the definition of "enduring", which is on page 1 of the supplementary notice paper, issue 9, but he has further amendments later on, which seek to formalise a situation in which a patient decides not to continue with a request and assessment process. It is our belief that the inclusion of the amendment adds to the complexity and bureaucratic burden of the bill. Therefore, we are treating the amendments that Hon Charles Smith is moving as a package, linking the three together and not dealing with them alone. We are not supportive of the package.

Hon NICK GOIRAN: It is fair enough that the minister wants to deal with it as a package. One of the amendments the minister referred to is amendment 25/5, standing in Hon Charles Smith's name, on the supplementary notice paper. It seeks to insert in clause 5, which deals with terms, the word "enduring". It states —

> ***enduring***, in relation to a request for access to voluntary assisted dying, has a meaning affected by section 8A;

We are dealing with that clause now. In terms of the package, I assume that that one is not objectionable?

Hon Stephen Dawson: It's the later one.

Hon NICK GOIRAN: It is the latter one. Can the minister indicate what the latter one is that he is referring to?

Hon STEPHEN DAWSON: It is new clause 52A.

Hon NICK GOIRAN: Therefore, minister, if I understand the objection correctly, it really relates to the package, as you say, and, specifically, new clause 52A. I am reading this on the run here because, as the minister can appreciate, I was not aware that the government's position was that new clause 52A was relevant to the amendment in front of us. However, amendment 38/NC52A states that the board be notified if the patient decides not to continue or if request for access to voluntary assisted dying ceases to be enduring. Without looking at the ins and outs of all of that now, the title at least seems to suggest that if the patient decides that he or she does not want to continue, the board should be notified. What is objectionable about that?

Hon STEPHEN DAWSON: As I indicated, honourable member, the inclusion of the amendment adds to the complexity and the bureaucratic burden of the bill. If the patient makes a formal decision to withdraw from the voluntary assisted dying process, the coordinating practitioner would be able to make a note in the person's medical file and record it via the electronic portal.

Hon NICK GOIRAN: The other thing that strikes me, looking at new clause 52A, is would new clause 8A not be able to stand on its own without new clause 52A? Therefore, would it be open to the government to support new clause 8A and then not support new clause 52A because, as the minister says, it is too bureaucratic?

Hon STEPHEN DAWSON: New clause 8A could stand alone. We have considered the amendments as a package, but this new clause has also been considered by itself. I indicated in my earlier response that we do not support the package, but we also do not support any of the three amendments either. They have been considered and we are not supportive of any of them.

Hon NICK GOIRAN: On that basis, I am going to indicate my support —

Hon Stephen Dawson: Are you going to say that you support it because I said that I don't?

Hon NICK GOIRAN: No; it is because the explanation was unsatisfactory. The explanation was that there is a package of three amendments. We have already agreed that the first one is consequential and not objectionable. The second part of the package is before us at the moment. The third part is the one that the minister indicated the government is concerned about. We have just identified that that one can be dispensed with and that that would not have a consequential impact on the second amendment. It seems to me that it is quite open to members to support this amendment, because we can deal with new clause 52A in due course—it is not necessarily relevant to this amendment. I understand from the minister that it does no harm and does not undermine the provisions of the bill. The minister said that it is not necessary; I think it provides clarity.

I heard the honourable member make some reference to the Northern Territory legislation. I have a copy of that legislation—the Rights of the Terminally Ill Act 1995. If I heard the member correctly, he made reference to section 7(1)(o). Section 7 of that act is headed "Conditions under which medical practitioner may assist". Subsection (1)(o) states —

> at no time before assisting the patient to end his or her life had the patient given to the medical practitioner an indication that it was no longer the patient's wish to end his or her life;

I would like to think that we would all agree with that—that if a patient did express that desire, the practitioner could not proceed. If this amendment gives effect to a provision similar to section 7(1)(o), I think it is worthy of

support. What consultation has the government undertaken into the operation and effectiveness of that particular section of the ROTTI act?

Hon STEPHEN DAWSON: We have not looked into that particular section of the ROTTI act. We have not consulted on it.

Hon NICK GOIRAN: The government has not given us any advice that section 7(1)(o) of the ROTTI act is a problem. I was on the select committee for a year and attended all the meetings and the hearings, and I can certainly attest that section 7(1)(o) of the Northern Territory legislation was never raised as a problem, so I am inclined to support the amendment.

Hon STEPHEN DAWSON: I cannot say that section 7(1)(o) was never raised as a problem.

Hon Nick Goiran: Well, I can.

Hon STEPHEN DAWSON: Certainly, the whole act was a problem for the federal Parliament. I am not in a position to say that section 7(1)(o) was not a problem, but neither of my advisers were briefed on that act and we have not consulted on that act. As I have indicated previously, we are not supportive of the motion before us in Hon Charles Smith's name.

Hon NICK GOIRAN: Just to be clear, did the minister just indicate that the government did not review, consider or consult on the Northern Territory legislation prior to the drafting of this bill?

Hon STEPHEN DAWSON: To clarify, we have not specifically consulted on the section that the member has raised.

Hon MARTIN ALDRIDGE: I have a question about this amendment. Subclause (3) anticipates two circumstances. The first, under paragraph (a), is that the process is underway—for example, the patient has not yet qualified; they are mid-assessment—and the second, in paragraph (b), anticipates that the process has been completed. Given that we are contemplating a situation in which a patient is mid-process, why does subclause (1) refer only to a coordinating practitioner or an administering practitioner and does not recognise a consulting practitioner?

Hon NICK GOIRAN: I will move an amendment. I move —

> New clause 8A(1) — To insert after "coordinating practitioner" —
>
> or consulting practitioner

I think that will then alleviate the concern of the honourable member.

The DEPUTY CHAIR: We may have to have that in writing. I presume in the second line of new clause 8A(1) after "indicates to the" you could put "consulting practitioner," which would then be followed by "coordinating practitioner or administering practitioner". Is that the intent of your amendment?

Hon NICK GOIRAN: Yes, Mr Deputy Chair.

The DEPUTY CHAIR (Hon Dr Steve Thomas): We are dealing with new clause 8A, moved by Hon Charles Smith. It is on page 3 of supplementary notice paper 139, issue 9. We are now dealing with the amendment to new clause 8A moved by Hon Nick Goiran. I do not propose to read the entire motion moved by Hon Charles Smith again, but I draw members' attention to the amendment to new clause 8A. It consists of an insertion on the third line—to insert the words "or consulting practitioner" after "coordinating practitioner". The amended new clause 8A(1) would read —

> For the purposes of this Act, a patient's request for access to voluntary assisted dying ceases to be enduring if the patient, at any time, indicates to the coordinating practitioner or consulting practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

Therefore, the question on the amendment to the amendment is that the words to be inserted be inserted.

Hon MARTIN ALDRIDGE: I wanted to ask a few questions before the amendment was moved.

The DEPUTY CHAIR: Can you make sure that you direct your comments to the amendment to the amendment rather than the original amendment. You can come back to the original amendment after the amendment to the amendment.

Hon MARTIN ALDRIDGE: That could be an easy way of dealing with it.

Hon AARON STONEHOUSE: I seek clarification, for my satisfaction. As amended, new clause 8A would read —

> … the coordinating practitioner or consulting practitioner or administering practitioner …

I wonder whether there should be a comma so it would read —

> … the coordinating practitioner, consulting practitioner or administering practitioner …

Several members interjected.

Hon AARON STONEHOUSE: I am not being silly.

A member interjected.

Hon AARON STONEHOUSE: Shoosh, member. If you have a contribution, you can make it rather than making quite silly interjections because I actually have a serious point to make.

The DEPUTY CHAIR: Order! Hon Aaron Stonehouse, proceed with your question and I might respond.

Hon AARON STONEHOUSE: I have a serious point. I seek clarification. If it is determined that a comma rather than the word "or" is more appropriate, would that be easily fixed through a Clerk's amendment? That is all the clarification I seek. It is a very serious point. I do not think it needs silly interjections, but thank you for your protection, Mr Deputy Chair.

The DEPUTY CHAIR: We consulted the clerks on the proposal to the amendment to determine whether "or" or a comma was more appropriate and it was deemed that "or" was perfectly adequate for the purposes of the amendment. Therefore, I propose to proceed.

Hon COLIN HOLT: I wonder whether we can get an indication from the mover of the original amendment about whether he is happy to accept Hon Nick Goiran's amendment because there is an oversight or he had some other plan for his amendment originally excluding "or consulting practitioner".

Hon CHARLES SMITH: It is not an oversight. I support the amendment to the amendment moved by Hon Nick Goiran.

Hon STEPHEN DAWSON: We are not supportive of the amendment to the amendment. We are not supportive of the amendment either for the reasons that I outlined previously.

Division

Amendment on new clause put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the ayes, with the following result —

Ayes (18)

Hon Martin Aldridge	Hon Nick Goiran	Hon Martin Pritchard	Hon Dr Steve Thomas
Hon Jim Chown	Hon Colin Holt	Hon Robin Scott	Hon Colin Tincknell
Hon Peter Collier	Hon Rick Mazza	Hon Tjorn Sibma	Hon Ken Baston *(Teller)*
Hon Donna Faragher	Hon Michael Mischin	Hon Charles Smith	
Hon Adele Farina	Hon Simon O'Brien	Hon Aaron Stonehouse	

Noes (17)

Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Alison Xamon
Hon Robin Chapple	Hon Sue Ellery	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Tim Clifford	Hon Diane Evers	Hon Matthew Swinbourn	
Hon Alanna Clohesy	Hon Laurie Graham	Hon Dr Sally Talbot	
Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Darren West	

Amendment on new clause thus passed.

Hon MARTIN ALDRIDGE: I wanted to flesh out a few questions before we dealt with the amendment. I heard the minister reflect on the government's satisfaction with clause 52, which states —

> A patient in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

Clause 52 relates to a patient who has qualified through the process, whereas the amendment proposed by Hon Charles Smith anticipates the two scenarios that I mentioned—a patient who is mid-process and has not yet qualified, and a patient who has qualified. The reason I am erring on the side of not supporting this amendment is that if we look at new clause 8A in isolation, it simply requires a patient to indicate that they no longer want to continue; therefore their consent is no longer enduring. In my view, there is no difference between what would occur under new clause 8A and clause 52, as the minister has suggested.

The other thing that concerns me about the amendment as amended is the problem with being too specific in these matters. The amendment now includes the coordinating practitioner, the consulting practitioner and the administering practitioner. I might seek the advice of either the mover of the amendment or the minister in helping me understand this. Several clauses in the bill allow for referral for a range of reasons to assist either the consulting or coordinating practitioner in making a decision on qualification under the legislation. If a patient were to indicate to that medical practitioner—perhaps it is a psychiatrist or a palliative care specialist—that they were no longer willing to participate in the process, would that class of practitioner be captured under the amendment as it now stands, which specifically refers to the coordinating practitioner, the consulting practitioner and the administering practitioner?

Hon CHARLES SMITH: I understand the member's need for further explanation on enduring consent at each stage of the process. New clause 8A simply seeks to ensure that at each stage that a patient sees various practitioners, if their consent becomes no longer enduring, that is assured from that moment onwards. It is as simple as that. Again, new clause 8A is merely based on the Northern Territory's Rights of the Terminally Ill Act. I aimed to replicate that additional safeguard in this new clause 8A.

Hon NICK GOIRAN: I think Hon Martin Aldridge's question is a good one. He has identified that during this process other practitioners can get involved. The minister has indicated that the government does not support new clause 8A because it is unnecessary. If it is unnecessary, what part of the bill will take care of the concern that Hon Martin Aldridge has raised? For example, I will give the minister a hypothetical situation. If one of the doctors is not sure about a patient and refers them to a specialist to get their opinion, that specialist is neither the consulting practitioner nor the coordinating practitioner. If the patient speaks to that specialist and says, "Look, I've had enough of this, I don't want to go ahead with this voluntary assisted dying process", how is that communicated back to the Voluntary Assisted Dying Board, the consulting practitioner or anyone in authority to make it clear that this process has now come to an end?

Hon STEPHEN DAWSON: There are a few questions floating around at this stage. No; new clause 8A would not include the practitioner or persons the patient has been referred to. Clauses 52 and 18 of the bill contemplate all the roles. I am just waiting on a further bit of advice on that last question.

If I can answer further: the patient who does not want to proceed simply will not proceed. If they tell the referred person, then the referred person would tell the coordinating or consulting practitioner who made the referral.

New clause, as amended, put and negatived.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Hon NICK GOIRAN: As I understand it, clause 9 deals with the conscientious objection provision, which I know is of interest to several members. The minister indicated in earlier dialogue that the CEO would not be captured by this provision because the CEO is not necessarily a registered health practitioner. In any event, when the CEO is performing his functions, he is doing so in that capacity, not as a registered health practitioner. Is there a common law right to conscientious objection that we are enshrining in this statute, or does this conscientious objection only exist because of clause 9?

Hon STEPHEN DAWSON: A person does not have a broader ability to conscientiously object that is not set in this legislation. However, the wider ability does not abrogate a statutory duty. The narrower statutory exemption in the bill would limit the broader application of non-statutory conscientious objection provisions. The bill makes clear that we only seek to extend statutory exemption to a registered health practitioner to conscientiously object. A wider ability would not abrogate the statutory duty of the CEO. The CEO has specific obligations under the Voluntary Assisted Dying Bill. This is supported by section 20(1)(o) of the Health Services Act 2016, which also provides that the functions of the department CEO includes "other functions given to the Department CEO under this or another Act".

Honourable member, there is a bit of noise around. I would urge Mr Deputy Chair to remind people to keep their voices quiet, in anticipation of the next questions I am going to be asked. I was struggling to hear myself that time.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Certainly, minister. It is a good piece of advice for everybody to keep the noise in the chamber to a minimum if we will. Noting the time, I propose to interrupt business to report progress.

Progress reported and leave granted to sit again, pursuant to standing orders.