VOLUNTARY ASSISTED DYING BILL 2019

Respectful Consideration — Statement by President

THE PRESIDENT (Hon Kate Doust) [10.06 am]: Members, just before we move to the Voluntary Assisted Dying Bill 2019, hopefully this will be our last sitting week for the year. I know that it is anticipated that we will be sitting some very long hours. When we commenced this debate, I asked that people pay due respect to the diversity of views in this chamber and I think that has occurred during the length of this debate. In these last few days, I remind members that there are different views about this issue in the chamber and I ask that each of you apply the appropriate level of respect to every other member in the chamber as you work your way through this very significant and complex legislation.

Committee

Resumed from 29 November. The Chair of Committees (Hon Simon O'Brien) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 60: Certification by administering practitioner following administration of prescribed substance —

Progress was reported after the clause had been partly considered.

Hon NICK GOIRAN: Given that clauses 25 and 36 of the bill provide the ability for the coordinating and consulting practitioners to each refer the patient for further assessment by a registered health practitioner who has appropriate skills and training to make a determination in relation to capacity, or another person who has the appropriate skills and training to assess the patient's voluntariness and the absence of coercion, why is a like provision not in place for the administering practitioner?

Hon STEPHEN DAWSON: I am advised that a referral is for the assessment of the eligibility criteria. The administering practitioner, if not satisfied under clause 60(2)(b), may take steps to address that.

Hon NICK GOIRAN: What are those steps and where is the provision in the bill that enables the administering practitioner to take those steps?

Hon STEPHEN DAWSON: I am advised that it is not necessary to spell out in the bill the steps that the administering practitioner may take in order to be satisfied; it is part of good medical practice. The steps would include looking at the patient's history, speaking with the assessing practitioner et cetera.

Hon NICK GOIRAN: If it is not necessary to do that under the bill, why is it being provided for in clauses 25 and 36?

Hon STEPHEN DAWSON: We have dealt with those clauses previously; but those clauses were about assessing eligibility.

Hon NICK GOIRAN: Yes, minister, and clause 60(2)(b) states that the administering practitioner has to certify that they are satisfied that the patient has decision-making capacity. They will also undertake an assessment at that particular point in time, precisely as they will be required to do an assessment under clauses 25 and 36, yet the bill is silent with regard to referral at this point in time. Is it the case that an administering practitioner, who could be a nurse practitioner, might not be confident or satisfied that the patient has decision-making capacity at the time and, according to the minister, would then have to refer the patient to another person? What powers exist in the bill for the nurse practitioner to refer in the circumstances that they are not satisfied that the patient has decision-making capacity, or will they not have that ability to refer?

Hon STEPHEN DAWSON: I am told that no power need be specified for referral or inquiry. Good medical practice will guide the practitioner as per the nurse practitioner standards for practice.

Hon NICK GOIRAN: This clause provides for certification by an administering practitioner whereby practitioner administration occurs. What certification is required under the bill when patient self-administration will occur?

Hon STEPHEN DAWSON: None.

The CHAIR: Members, the question is that clause 60 do stand as printed. There are several amendments proposed on the supplementary notice paper 139, issue 16, which is the latest edition. The earliest of those stands in the name of Hon Charles Smith.

Hon CHARLES SMITH: I seek to remove the amendment at 43/60.

The CHAIR: Hon Charles Smith has moved that at page 39, after line —

Point of Order

Hon STEPHEN DAWSON: I believe the honourable member said he was "removing" the amendment as opposed to "moving" the amendment. I think he does not intend to move the amendment. Perhaps we could clarify that.

Hon CHARLES SMITH: I withdraw that particular amendment.

The CHAIR: You are not going to proceed with it. Thank you for that clarification.

Committee Resumed

Hon ADELE FARINA: I move —

Page 40, lines 9 and 10 — To delete the lines and substitute —

(d) the date and time when the prescribed substance was administered;

(da) the date and time of the patient's death;

(db) the period of time that lapsed between the administration of the prescribed substance and the patient's death;

(dc) details of any complications relating to the administration of the prescribed substance, for example —

(i) the patient regained consciousness after the administration of the substance; or

(ii) the period of time that lapsed between the administration of the substance and the patient's death was longer than 2 hours; or

(iii) the patient had difficulty ingesting the substance or regurgitated the substance; or

(iv) the patient suffered any other kind of adverse reaction to the substance;

We have learnt through consideration of the bill that the schedule 4 and schedule 8 poisons may be approved as voluntary assisted dying substances by the CEO. We know that the schedule 4 and 8 poisons may not have been approved by the Therapeutic Goods Association for use by humans; therefore, the VAD substance does not need to be approved by the TGA for use by humans. When animals are euthanased, the substance is injected directly into the bloodstream, so it is quick and effective. Under this bill, people are required to ingest the substance; it is a much slower process, and it does not always go as planned. We know that the substance is very bitter and that even when taken with the syrupy substance, people experience difficulty ingesting the whole of the substance. We know that people can sometimes regurgitate the substance or drink it so slowly that they fall asleep before taking the entire dose. In 2012, the Netherlands recommended that the dosage be doubled from, I think, nine grams to 15 grams, due to 23 per cent of people taking longer to die than was considered desirable—that is, within two hours. Despite this, between 2014 and 2018, between seven per cent and 13 per cent of patients were not dead within the desired two hours and were euthanased. The 2018 data collection summary from Oregon indicates that 17.5 per cent of people took more than 30 minutes to die, and in 3.6 per cent of cases it took more than six hours, with the longest time being 104 hours. There has also been a least one case of a patient regaining consciousness.

A study published in the journal *Anaesthesia* in 2019 warned that there is a significant likelihood that in some cases there will be a persistence of awareness, called "accidental awareness" under general anaesthetic in a surgical context. Despite the patient having an apparent loss of consciousness, they are actually aware of what is happening. These prolonged deaths can be very distressing for the family and possibly painful for the patient; they are definitely shocking if the patient comes out of the coma. These are not peaceful and painless deaths as is being promised by the legislation.

I do not have an in-principle objection to voluntary assisted dying, but I do have some real concerns about the process we are seeking to adopt through this bill by which it is not able to be guaranteed that every death is going to be peaceful and pain-free. For that reason, when we were considering Hon Rick Mazza's amendment, I was keen that a medical practitioner be present during the process so that if something went wrong, there would be someone who could assess what was going wrong and intervene. However, judging from the views expressed around the chamber, not all members shared that view, and that debate was had and lost. We move on from that. This amendment seeks to ensure that if something goes wrong or if there are complications when the VAD substance is being administered by a medical practitioner, the medical practitioner will record those details and the information will be collected. Through the collection of that information, we can then review the scheme and make whatever amendments are needed to ensure that those complications are either eliminated or at least reduced in the future. If it were not for the Netherlands requiring a medical practitioner to be present at the time of self-administration, we would not be across the sorts of complications that have been experienced. We would not understand the situation. If that information had not been brought back and assessed in the Netherlands, they would not have been able to evaluate that the dosage, effectively, needed to be doubled.

All this amendment seeks to do is to use the best science, consider the ethical best standards and at least ensure that when something goes wrong, it is reported to the board for assessment and evaluation. The first part of my amendment 481/60 outlines the details that should be recorded by the medical practitioner. My next amendment, which is subsequent to this one, will require the medical practitioner to provide information in the required form to the board so it has the information. It is a very simple amendment.

We always talk about making decisions based on good science. One of my strong issues with this bill is that we appear to be using humans as guinea pigs. If we are to go down this path, let us at least make sure that we collect the data so that if there are complications, we can take appropriate steps to reduce or eliminate the likelihood of those complications in the future. I think this is a best practice model. It does not harm the bill in any way; it can only serve to improve it and improve our knowledge about whether what we are doing is effective in delivering a peaceful and pain-free death for all the people who opt to go through this.

Some people might be of the view that because only a small percentage of people experience complications whether we can really justify this extra measure My response is: if they were in that small percentage of people who experienced complications, their view would be, yes; it is completely appropriate to have this additional measure to ensure it does not happen to other people in the future. I ask for members' support for this amendment.

Hon STEPHEN DAWSON: I want to touch on one of the issues that Hon Adele Farina raised early in her comments and make the point that the substance is not yet determined in Western Australia. What the substance will be will depend on recommendations of the clinical expert panel on implementation. However, regarding the amendment as written, would Hon Adele Farina be amenable to this: the government could support her amendment from proposed paragraphs (d) to (dc), but it wants to enable the administering practitioner to more broadly capture complications, rather than focus on the four examples that Hon Adele Farina has given, which my advisers tell me would inevitably occur. Also, the terms used in proposed paragraphs (dc)(i) to (iv) may not be relevant in practice, for example, "2 hours", or "adverse reaction". If Hon Adele Farina would be open to this, I would be happy to move an amendment on the amendment. I acknowledge that the government would support it as it reads, but I would insert a full stop after "substance" and delete the examples (i) to (iv).

The CHAIR: Minister, are you moving that amendment at this stage?

Hon STEPHEN DAWSON: I will do so, but I first want to hear the view of Hon Adele Farina.

Hon NICK GOIRAN: I indicate that I support the amendment that stands in the name of Hon Adele Farina. I have some sympathy with the remarks that have just been made by the minister, and I leave it to the mover of the amendment to indicate her view on that. I just want to add one further thing for the consideration of Hon Adele Farina, the minister and members; that is, at proposed paragraph (d), where it is proposed to indicate the date and time when the prescribed substance was administered, I think it would be good practice to indicate the location at which the prescribed substance was administered. Proposed paragraph (d) could, in my view, read —

> the date, time and location, when and where the prescribed substance was administered;

This is for the same reasons of good data collection, and the possibility of any investigation that might need to take place at a later stage. Apart from that, the substance of what is proposed by amendment 481/60 has my support.

Hon MICHAEL MISCHIN: I indicate that I have an enormous amount of support for the proposal of Hon Adele Farina. This sort of information is essential for monitoring the operation of the legislation, and to see that it is being applied properly and not improperly. I also think that the suggestion made by Hon Nick Goiran has merit. One does not wish to become too bureaucratic about this, but these are the sorts of pieces of information that, in most cases, would not be required, but under a regime of this nature, it is important that more information, rather than less, is of advantage to not only the Voluntary Assisting Dying Board but also the State Coroner and others. I understand what the minister has said, but I do not see a problem with the way Hon Adele Farina has formulated this. These are examples, by way of guidance, of the sort of information that is required. Simply leaving at large details of any "complications relating to the administration of the prescribed substance" leaves it open to the interpretation of the practitioner or others who are providing the information. Specifying these examples—in some places they may not be applicable, but in other cases they will be—indicates the sort of information embraced by the idea of complications relating to the administration. It is important that those examples be specified to ensure that there is full collection of relevant information, rather than simply a practitioner, for example, taking the view that, although the patient regained consciousness, that was not really a complication; it is just one of those things that happens from time to time, so they will not report it. These examples focus on the sorts of difficulties and problems that Hon Adele Farina is concerned about, and I think that they should be included by way of examples.

Hon JACQUI BOYDELL: I rise to indicate my support for the arguments raised by Hon Adele Farina. Also, if the minister were to move an amendment on the amendment, I would be supportive of that, because it does not limit any of the issues that may arise. I think that, under proposed paragraph (dc)(iii), particularly where there is difficulty in ingesting the substance, for future use of whatever substance is determined in the first instance for patients, if it is not working, that needs to be reviewed. In particular, it needs to be a process that the patient, having gone through the whole procedure, can ingest the substance that is prescribed. I will be supporting the amendment, and if the minister wants to move an amendment on the amendment, I would also support that.

Hon COLIN TINCKNELL: Very briefly, once again, I also support this amendment. It is good to see that the minister is looking at supporting most of the idea behind the amendment—to get that detail. We must learn from the rest of the world, where assisted dying, for want of a better term, has been practised, and the science has told us a few things. It is important that we learn from that, and I applaud the member for putting this amendment up. The idea of location being included as well as date and time is a very important addition. It would be interesting to hear from the honourable member about the government's proposed changes.

Hon ADELE FARINA: I have no issue with the proposed amendment on the amendment by Hon Nick Goiran to include location. I more than happy with that amendment. I am willing to accept the minister's suggested amendment on the amendment if the minister can give me some assurance that those examples will be included in any practitioner guidelines that will be prepared, so that we can ensure that these are the sorts of things that are actually being picked up as complications. I am prepared to make it simpler for the legislation, but we need to ensure that medical practitioners understand the sort of information we are asking them to obtain, and what constitutes a complication.

Hon STEPHEN DAWSON: I am happy to indicate to Hon Adele Farina that those examples will be captured by the guidelines—those and more, so that we are not limited to those guidelines—so that we are collecting data that is helpful. I will move an amendment on the amendment moved by Hon Adele Farina , and I will take into consideration the proposed amendment of Hon Nick Goiran. I move —

proposed paragraph (d) — to delete "and time when" and substitute —

, time and location where

proposed paragraph (dc) — to delete all words after "substance" and substitute —

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The CHAIR: Members, I want to move quickly on this, while we are all in furious agreement, so we do not miss the moment. In the first instance, I am going to frame the question, and then if members want to make a contribution to that, they can do so. I am going to do this in two parts. Firstly, we are going to contemplate the proposed amendment on the amendment, to delete after "date", the word "and" and insert after "time", the words, "and location". So the question is that the words proposed to be deleted be deleted.

Hon STEPHEN DAWSON: I have just been given further advice, Mr Chair, that rather than say "and location", we should say "and where".

I have moved an amendment that says "the date, time". The amendment circulated says "and location" but I have been advised that it is better to read "and where". I think that clears it up, Mr Chair.

Hon MICHAEL MISCHIN: I do not think it reads right. We are looking at "the date, time, and where when". It does not make sense.

Hon STEPHEN DAWSON: Let me clarify. It should read, "the date, time and location where the prescribed substance was administered."

The CHAIR: Order! Members with some further input from the clerks—I note Hon Robin Chapple is seeking the call; I will come to you in just a moment—the first question we need to consider is in proposed paragraph (d) where the proposal is to amend the amendment of Hon Adele Farina by deleting "and time when" and substituting after "date" the words ", time and location where". Therefore, it will read —

(d) the date, time and location where the prescribed substance was administered;

I think, minister, that is the position.

Hon Stephen Dawson: Thank you.

Hon ROBIN CHAPPLE: I have two questions arising from this. Firstly, what level of public availability will the certificate or practitioner administration form have? Will it be confidential or in the public domain? Secondly, arising from that, when we refer to the location, is it the address of the individual place where the patient resides? I am concerned that if that information got into the public arena, it might not be in the best interests of the family.

Hon STEPHEN DAWSON: It will be confidential information. It will go to the board, and the board will not disclose the location.

Hon ADELE FARINA: In those jurisdictions where they collect location information, it is usually home, hospice or hospital; that is the sort of data collected. It is just the type of location in which the death occurred.

Hon MICHAEL MISCHIN: I still think the amendment is ungrammatical. We are saying, "the date, time and location where the prescribed substance was administered;" it should read "the date and time, and location where, the prescribed substance was administered". Date and time are not "where".

Hon ADELE FARINA: Alternatively, we could just stick to "the date, time and location the prescribed substance was administered". I do not know that "where" adds anything to it, but that is just my humble view.

Hon Michael Mischin: Date, time and place.

The CHAIR: Members we are all free to put in any amendments to amendments that you wish. I can only deal with what I have before me and what I have before me is what is proposed and that is —

Proposed paragraph (d) — To delete "and time when" and substitute —

, time and location where

Amendment on the amendment put and passed.

The CHAIR: We now move to the second part of the minister's amendment on the amendment, which is —

Proposed paragraph (dc) — To delete all words after "substance".

That is, ", for example", and then proposed subparagraphs (i), (ii), (iii) (iv). The semicolon would remain, but that is a clerk's amendment. I think we can all approach that without getting too bound up on it.

Amendment on the amendment put and passed.

The CHAIR: The question now is that the amendment as amended be agreed to. We are returning to the amendment proposed by Hon Adele Farina that has been amended in several ways. For clarification, the amendment now is —

Page 40, lines 9 and 10 — To delete the lines and substitute —

(d) the date, time and location where the prescribed substance was administered;

(da) the date and time of the patient's death;

(db) the period of time that lapsed between the administration of the prescribed substance and the patient's death;

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

Amendment, as amended, put and passed.

The CHAIR: I think proposed amendment 44/60 will fall away as it has been accommodated in effect.

Hon ADELE FARINA: I move the amendment standing in my name at 482/60 —

Page 40, lines 17 and 18 — To delete "administering the prescribed substance," and substitute —

the patient dies,

I point out that on this occasion I went to parliamentary counsel to get these amendments drafted. Parliamentary counsel advised an amendment was needed to this clause as well to delete "administering the prescribed substance" and substitute "when the patient dies" as the point at which time the medical practitioner is required to provide the information. Reading it now, in circumstances in which the patient might not die, that might be a bit of a problem, so perhaps the advice I received from parliamentary counsel was not good on this occasion. The whole point of the amendment was to deal with complications, and one of those complications could be that the person comes out of a coma. On the strength of that, I am going to withdraw that proposed amendment.

Amendment, by leave, withdrawn.

Clause, as amended, put and passed.

Clause 61: Witness to administration of prescribed substance —

Hon NICK GOIRAN: Clause 61 provides for a witness to the process of physician administration. Why has this inconsistent approach been taken whereas no witness is required for self-administration?

Hon STEPHEN DAWSON: The administration of the voluntary assisted dying substance by the coordinating practitioner to the patient must be made in the presence of a witness. The requirement of a witness during practitioner

administration is yet another safeguard in the voluntary assisted dying process. It reflects that the voluntary nature of voluntary assisted dying is fundamental to the Western Australian model and that the decision to access death must be enduring.

The second part of Hon Nick Goiran's question is why a witness is not required for self-administration. Self-administration is at the time and place of the patient's choosing, so we determined that it was not appropriate to include it there.

Hon NICK GOIRAN: Why are the eligibility requirements of witnesses to the patient's written declaration more onerous than the eligibility requirements seen fit to be included at clause 61 for witnesses to the administration of a prescribed substance that will cause the death of the patient?

Hon STEPHEN DAWSON: I am advised that the eligibility requirements are not onerous, but are for another person administering to the patient. One is about practitioner assessment and the other is about self-administration.

The DEPUTY CHAIR (Hon Adele Farina): Members, there are a number of amendments on issue 16 of the supplementary notice paper and I notice that there are two in the name of Hon Rick Mazza. Do you intend on moving that amendment?

Hon RICK MAZZA: No.

Hon NICK GOIRAN: Noting that Hon Rick Mazza does not intend to move the two proposed amendments standing in his name, I move the amendment standing in my name at 487/61. I move —

Page 41, line 5 — To insert after "appeared to be" —

free, voluntary and

By way of explanation to members, I note that the Victorian equivalent of clause 61, which is section 65 of the Victorian Voluntary Assisted Dying Act, requires a person to bear witness to not only the administration of the prescribed substance, but also the making of the patient's administration request. This is analogous to the patient's administration decision made under clause 55. The bill before us does not require a person to bear witness to a patient making an administration decision under clause 55. In this respect, my respectful submission is that it falls short of the safeguards that the Parliament of Victoria saw fit to include in its act. Clause 61 requires a person who is eligible to act as a witness under the witness eligibility requirements of clause 61(2) to witness the administration of the voluntary assisted dying substance to the patient by the administering practitioner in circumstances in which a practitioner administration decision has been made. I note that the witness's certification requirements as required by clause 61(3) are different from or substantially less than those found in "Certification of witness to signing of written declaration" prescribed under clause 43(3) of the bill. I draw clause 43(3)(a)(i) to the minister and members' attention. We, as a chamber, have agreed with the government's mandate that a witness to the signing of a written declaration by the patient or by another person on behalf of the patient must certify in writing that, in the presence of the witness, the patient appeared to freely and voluntarily sign the declaration, which members can find at clause 43(2)(a). Alternatively, the witness must certify in writing that the patient appeared to freely or voluntarily direct the other person to sign the declaration on their behalf, which members can find at clause 43(3)(a)(i). It is unusual that a witness to the administration of the prescribed substance, which is ultimately the very last act to take place and directly causes the death of the patient, is not required to certify that the patient was acting freely and voluntarily, although a witness to the signing of a written declaration earlier in the process is required to do so. My amendment to clause 61 seeks to address this anomaly by inserting the same witness certification that is found in clause 43(3)—that the witness certify that the patient's request for access to voluntary assisted dying appears to be free and voluntary as well as enduring.

Hon STEPHEN DAWSON: I indicate that the government will support this amendment.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 62: Transfer of administering practitioner's role —

Hon NICK GOIRAN: Clause 62 provides for the transfer of the administering practitioner's role from the original administrator to another administering practitioner called the new practitioner. In what circumstances might this transfer be made, and why was this clause deemed necessary for inclusion?

Hon STEPHEN DAWSON: The ability to transfer the role of the administering practitioner will ensure that a patient is not disadvantaged when the original administering practitioner is no longer able to perform the role due to unforeseen circumstances, such as illness, injury or for other reasons.

Hon NICK GOIRAN: Clause 62(1)(c) provides that this transfer can be made if the original practitioner "is unable for any reason to administer the prescribed substance to the patient". Could this transfer be made if the original

administrator changes their mind and no longer wishes to proceed with the process of administering the poison that will cause the patient's death?

Hon STEPHEN DAWSON: No. This is about them being unable to perform the role—for example, if they have family obligations or there is a death in the family, or they could be out of the country. If they were unwilling to do something, that would be captured by the conscientious objection clauses.

Hon NICK GOIRAN: That being the case, in that scenario, would they be able to transfer under clause 62?

Perhaps to facilitate progress, maybe I could ask the minister, while he is considering this matter, whether in clause 62, at page 41, line 17, after the word "unable", he would be agreeable to me moving an amendment to add the words "or unwilling"?

Hon STEPHEN DAWSON: Honourable member, we would be happy to accept that amendment. My advisers tell me that if somebody said that they were "unable" to do it because they now have an objection to it, that would cover it. But I think it would be clearer to insert the words "or unwilling", and so we would accept that.

Hon NICK GOIRAN: I move —

Page 41, line 17 — To insert after "unable" —

or unwilling

Amendment put and passed.

Clause, as amended, put and passed.

Clause 63: Application of Division —

Hon NICK GOIRAN: Minister, why does division 3 apply only when the patient has made a self-administration decision?

Hon STEPHEN DAWSON: The short answer is: the patient is required to engage a contact person only for self-administration.

Clause put and passed.

Clause 64: Patient to appoint contact person —

Hon NICK GOIRAN: The explanatory memorandum states that the intent of appointing a contact person is to ensure that, once supplied, a voluntary assisted dying substance can be monitored and safely disposed of if unused. Clause 64 provides that the patient is to appoint their own contact person. What training or information will be required to be provided to the contact person to assist them in fulfilling their role of monitoring the voluntary assisted dying substance and its use or disposal?

Hon STEPHEN DAWSON: I am advised that clause 148 outlines that the Voluntary Assisted Dying Board must send the contact person information about the contact person's role when it receives the appointment form. In the implementation phase we would anticipate that a range of support materials will be developed for provision to the contact person to carry out their role. It is expected, and in line with good clinical practice, that the contact person will be part of discussions between the patient and the coordinating practitioner about their role as a contact person. When a person accepts the role of contact person, they will be required to make a statement that they understand their role under the act. They will be made aware that the board will be providing information to them and will be able to discuss aspects of their role with the coordinating practitioner and the board if they so require. The contact person will also be able to liaise with the coordinating practitioner for information.

Hon NICK GOIRAN: Clause 64(2) requires only that the contact person be a person who has reached 18 years of age. Is the government satisfied that this important role of contact person can be fulfilled by anyone so long as they have reached 18 years of age?

Hon STEPHEN DAWSON: As Hon Nick Goiran pointed out, the bill sets out that the contact person must be at least 18 years of age. It may be the patient's coordinating or consulting practitioner, or another registered health practitioner. Thus, the patient will be able to choose a family member or other person to be their contact person as long as they are at least 18 years old. In practice, the contact person will need to be a person who maintains close involvement with the patient to enable them to effectively undertake the role. It is likely that the contact person will be a close and trusted carer, family member or friend of the patient and will be involved in the discussions with the coordinating practitioner and the pharmacist, including receiving instructions about storing the voluntary assisted dying substance in a safe manner. The coordinating practitioner will have an important role to play in guiding the patient through the process. From that perspective, it is reasonable to expect that they will want to make sure that the contact person will be able to function under the act. The coordinating practitioner will discuss the

requirements of the contact person with the patient so that an appropriate person can be chosen. Should they have concerns, it will also be possible for the coordinating practitioner to take on the role of the contact person.

Hon NICK GOIRAN: Clause 64(5) provides that the patient may revoke the appointment of the contact person. If the patient does not comply with clause 64(6)(c), can self-administration still proceed?

Hon STEPHEN DAWSON: In practice, it could proceed, but the patient will most likely tell the coordinating practitioner. If the coordinating practitioner was aware, they could take steps to make sure that the act will be followed.

Hon NICK GOIRAN: Could the contact person who has been revoked not be the coordinating practitioner?

Hon STEPHEN DAWSON: Yes, it could be the same person. If they were told that their position had been revoked, they would make sure that another contact person was appointed.

Hon NICK GOIRAN: Clause 64(6)(c) states —

> the patient must make another appointment under subsection (1).

If there were a falling out between the patient and the coordinating practitioner, and the patient were to say, "I revoke your authority to be the contact person; I've already got the prescribed substance at home", and the coordinating practitioner said, "Well, you're within your rights to do that under clause 64, but I just remind you, even though you're not listening to me anymore, that you have to make an appointment of another contact person", the patient may say, to use an expression, "Well, up your jumper! I'm not going to do that anymore." The problem I have is that the prescribed substance would be, presumably, in the home of the patient, and if they had a falling out with the coordinating practitioner, nobody would be there to monitor the disposal of the substance. I am concerned about that. Maybe one solution, albeit not perfect, would be to insert a time frame in clause 64(6)(c) in which the patient must make another appointment under subclause (1). It seems open-ended at the moment. It is all very well for us to say that they must do it, but when must they do it? Self-evidently, it must be prior to death, but would the government be agreeable to inserting a time frame? For what it is worth, in my view it should happen immediately—that is, the patient must immediately, after informing the person of the revocation, make another appointment under subclause (1).

Hon STEPHEN DAWSON: We would not support inserting a time frame. I am further advised that if no time frame is specified, the meaning is "as soon as practicable". Section 63 of the Interpretation Act states that it should be "done with all convenient speed."

Clause put and passed.

Clause 65: Contact person appointment form —

Hon NICK GOIRAN: Clause 65(1)(e) provides that the contact person must provide a statement that they understand their role, including the requirements under clause 104, to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer. Who is required to explain to the appointed contact person the responsibilities and obligations of the contact person role?

Hon STEPHEN DAWSON: The requirement is on the coordinating practitioner or the patient. But certainly after someone has been appointed as the contact person, the coordinating practitioner is required to provide the contact person appointment form to the Voluntary Assisted Dying Board. It should be noted that the Voluntary Assisted Dying Board must, within two business days after receiving a copy of the contact person appointment form, send information to the contact person that explains the contact person's requirements under the bill and outlines the support services available to them.

Hon NICK GOIRAN: I am concerned that there are some pretty onerous requirements on the contact person, and although it could be a coordinating practitioner who should have some expertise and proper training, it could also be a layperson. Clause 65(e) states that the appointment must include —

> a statement that the contact person understands their role under this Act (including the requirements under section 104 to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer;

The minister will see that in the bracketed part of clause 65(1)(e) is a non-exhaustive list of information that needs to be provided to the contact person. I support that, but I think we need to go one step further to ensure that the contact person is aware of the penalties for the offences under proposed section 104. When we look at proposed section 104, which is referred to in this clause, we can see that some of the penalties include imprisonment for up to 12 months. For those reasons, and on the understanding that Hon Rick Mazza is not moving the amendment in his name, I move —

> Page 44, line 3 — To delete — "disposer);" and substitute —

disposer and the penalties for offences under that section);

Hon STEPHEN DAWSON: It was certainly the intention of government to provide information to the contact person about the penalties associated with this area of the legislation, but certainly we have no issue with accepting the amendment moved by Hon Nick Goiran.

Amendment put and passed.

Hon NICK GOIRAN: I move —

Page 44, after line 3 — To insert —

(ea) if the patient was assisted by an interpreter when making the appointment, the name, contact details and accreditation details of the interpreter;

Hon STEPHEN DAWSON: I indicate that the government is supportive of this amendment as per similar amendments moved earlier.

Amendment put and passed.

Hon NICK GOIRAN: I move —

Page 44, line 11 — To delete "patient." and substitute —

patient if —

(a) the patient directs the person to complete the contact person appointment form; and

(b) the person has reached 18 years of age.

By way of explanation, this amendment is a simple mechanistic amendment to clause 65 to address a flaw found in subclause (2). Although clause 65(2) seeks to provide for the event in which a patient cannot complete their own contact person appointment form, it does nothing more than state that another person can complete the form on the patient's behalf. I ask the minister and members to compare clause 65(2) with another clause that we agreed to earlier, specifically clause 41. Clause 41(4) provides for the event in which a patient is unable to sign their own written declaration and allows another person to sign the written declaration on behalf of the patient if the patient directs the person to sign the declaration—members can see that at clause 41(4)(b)—and the person has reached 18 years of age, as found at clause 41(4)(c)(i). My amendment seeks to insert at clause 65(2) the same prescriptions as appear in clause 41(4)(b) and 41(4)(c)(i). Without this amendment, clause 65(2) does not require direction on the part of the patient or that the other person who completes the contact person administration form is to be an adult.

Hon STEPHEN DAWSON: This is consistent with some actions that we took earlier on. The government will support this amendment.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 66: Role of contact person —

Hon NICK GOIRAN: Clause 66(1) provides that the contact person can receive the prescribed substance, possess the prescribed substance and supply the prescribed substance to the patient. Can the contact person also assist the patient in preparing the substance for self-administration?

Hon STEPHEN DAWSON: No, they are not authorised to do that. I am further advised that if the patient is not able to prepare the substance, they should be advised that self-administration is not for them.

Hon NICK GOIRAN: I agree; that is my reading as well. Why is this not explicitly stated in clause 66(1) so that there is no doubt on the part of the contact person that they are not able to assist in preparing the substance? In fact, I would even go further to say that they are not able to assist the patient in self-administering the substance.

Hon STEPHEN DAWSON: The clause sets out what the contact person can do. I am advised that it is not appropriate to include a list of what they cannot do, but that information will be sent to the contact person in the information that is provided to them.

Hon NICK GOIRAN: Earlier, clause 57(7) provided that an agent of the patient can receive, possess and supply the prescribed substance. Is there any requirement in this clause or another part of the bill for the contact person to be made aware that the substance has been received by and is in the possession of an agent?

Hon STEPHEN DAWSON: When the agent picks up the medication, the authorised supplier needs to verify and enter the information onto the database. The coordinating practitioner and the Voluntary Assisted Dying Board will be made aware of this and can advise the patient and contact person.

Hon ADELE FARINA: I move —

Page 45, after line 3 — To insert —

(1A) The contact person for the patient must —

(a) be present when the patient self-administers the prescribed substance; and

(b) witness the self-administration.

Division 3 details the role and obligations of the contact person, which includes the disposal of any unused or remaining voluntary assisted dying substance. The minister told us in answer to earlier questions that the expectation is that the contact person will be a close family member or carer and will more than likely be present when the patient self-administers. However, there is no requirement in the bill for that to be the case. This is a deficiency in the bill because the bill places a significant penalty on the contact person for failing to comply with his or her obligations to return any unused or remaining voluntary assisted dying substance to the authorised disposer. I do not understand how the contact person can be certain in his or her knowledge as to whether there is unused substance unless the contact is person is present when it is self-administered. I have been told on a very reliable basis that the quantity of the substance that is being dispensed in Victoria is similar to that in the Netherlands and Oregon, and is sufficient in some cases to kill two people. We also know that all of the substance is not always ingested by the patient. It is critically important that the contact person is present at the self-administration so that they are able to secure any of the unused substance and comply with their requirements under the act. The very fact that the contact person will be present will provide us with an opportunity for the contact person to collect the same data that we agreed the medical practitioner should collect in cases that involve complications. Is it ideal for the contact person to do that rather than a medical practitioner? In my view, no. It would be preferable for a medical practitioner to do that, but this chamber has determined that it does not want to include in the bill that a medical practitioner be present when a person self-administers. The sorts of things that we are asking the contact person to record include the date and time when the substance was administered, the location—accepting the amendments made to the previous clause—and whether there were any complications. A person will not need to have a medical degree to record and report those observations. In fact, if members are a little bit concerned, I draw their attention to clause 149 of the bill, which provides —

(1) The Board may request any person (including the contact person for a patient) to give information to the Board to assist it in performing any of its functions.

In my view, the amendment I have proposed will cause no harm. It is in two parts. The part I have moved relates to the contact person being present. If that is agreed to, a subsequent amendment will deal with information that needs to be collected and provided to the board. In my view, the amendment does no harm to the bill. Again, it will help us to make good science-based decision-making in the future and will ensure that if complications are experienced, those issues can be addressed and eliminated, or at least we can avoid a recurrence of those complications. I think it is a reasonable proposition. I ask members to support it; not supporting it would be negligent. We cannot just pass this bill and then put our heads in the sand about any possible complications that may occur during the process. We need to have a process by which that information comes back to us and we are able to assess it and make the necessary decisions that need to be made as a consequence of the assessment.

Hon STEPHEN DAWSON: I indicate that we do not support this amendment. I recall there was a debate on this issue last week, during which I spoke about self-administration and the fact that it is the patient's choice. We do not believe it is appropriate to require the patient to have a particular witness or contact person with them in a private place at the time of self-administration of the prescribed substance unless the patient wishes to do so. To require this would create a fundamental shift in the patient autonomy attached to self-administration. I am further advised that the problem with this amendment is that the patient may decide to self-administer alone, and that to require the contact person to be present would mean that he or she could be committing an offence if not present.

Hon RICK MAZZA: I absolutely agree with the sentiments that have been put forward by Hon Adele Farina, but I am a little concerned about how this amendment would actually operate. As the minister pointed out, there is no mechanism that will require a contact person to be present. If the contact person is simply going to get possession of the substance and provide it to the patient, the patient can take it without the contact person even knowing about it. The other issue, too, of course, is the agent. The agent can collect the substance and can also provide it to the patient. The only thing the agent cannot do is to dispose of any of the substance that remains. My only concern with this amendment is that there is no mechanism for the contact person to know when the patient will want to self-administer. What will happen if the contact person is not present and the patient just decides to self-administer without anybody being there at all? I am just a bit concerned about how this would operate.

Hon NICK GOIRAN: I rise to support the amendment that has been moved by the honourable member. I draw to the attention of members and the minister the penalties for a contact person found in part 6 of the bill, "Offences". I recall that at clause 104 there is an offence that deals with the contact person. I think it is useful in particular to look at subclause (2), which says —

> If a patient who has made a self-administration decision dies —

Remember, the clause the honourable member is trying to amend deals with self-administration —

> and the patient's death occurs after an authorised supplier has supplied a prescribed substance for the patient, the contact person for the patient must, as soon as practicable and in any event within 14 days after the day on which the patient dies, give any unused or remaining substance to an authorised disposer.
>
> Penalty … imprisonment for 12 months.

Perhaps the minister or somebody else, if they intend to oppose the amendment moved by Hon Adele Farina, can explain to me how it is appropriate for a Western Australian to be made a contact person and then to say to them that they will be put in jail for up to 12 months if they do not return the substance within 14 days of the date of the patient's death. As Hon Rick Mazza has just pointed out, there is not necessarily a mechanism provided for making sure that the contact person knows about the death, let alone for them to be present. Hon Adele Farina is trying to ensure that this person, who could be put in jail for up to 12 months, is at least aware of the death. Indeed, the member is going one step further and saying that the person should be present to witness the process. I think there are good reasons for that in order to deal with complications. We had that discussion earlier and there was a view by some members that if there are complications, so be it; the patient has been advised of those risks, and if they want to choke, asphyxiate or any of those things as a result of those complications, they have been warned. I remain entirely uncomfortable about that, but, as has already been discussed, we have had that debate. The reason to support this amendment is that if we do not do this, the contact person faces a potential penalty of up to 12 months in jail despite the fact they know nothing about the death. The honourable member is at least endeavouring to improve a current deficiency in the bill.

Hon AARON STONEHOUSE: I am concerned that this amendment will further complicate an already pretty complicated obligation on a contact person. It is true that a contact person will be responsible for returning the prescribed substance or any unused or remaining prescribed substance. That will be a rather onerous requirement, because they may not know when the patient has taken the substance, where they left it or where they put it. We are putting an obligation on the contact person that may be very hard to comply with. The amendment goes further and puts on the contact person a new obligation that will be very hard to comply with in the sense that they will have to withhold the prescribed substance from the patient until the patient is ready to take it in order to be absolutely certain that the patient does not take it when the contact person is not present. I fear that the contact person may be put in the position of having to make that choice; that is, they can either give the substance to the patient now, and the patient can call them when they are ready so they can be with the patient and witness the patient take the substance; or the contact person must hold the substance until they know when the patient is ready to take it. Ideally, there would be an understanding between the patient and the contact person, but the contact person will have no power to facilitate the compliance with that obligation. I think the contact person could be put in a very, very difficult situation. Perhaps if clause 66 were amended to allow the contact person to hold and retain the substance until the patient was ready to take the substance, much like a medical practitioner would in the case of practitioner administration, it might at least ensure that the contact person was able to comply with their new obligation. Merely putting an obligation in place for the contact person and not having a way for the contact person to ensure that the patient facilitates it, puts them in a very difficult situation. I think that this amendment would further complicate things. I understand why it has been put forward, but I think it might make it more difficult rather than easier for a contact person in this instance.

Hon STEPHEN DAWSON: There is a difference between requiring the contact person to be a witness to self-administration and requiring them to return the medications. The purpose of the contact person is to safeguard the return of the medications. The contact person will be aware of the death, will be a person close to the patient, and will be advised that the patient has died if they are not there at the time of self-administration. The contact person is aware of their responsibilities when they agree; therefore, they should maintain close contact with the person so that they know what is happening. Furthermore, under clause 104(3), the contact person has to know about the substance, and I also make the point that the CEO would have discretion about whether to commence prosecution or not.

Hon ADELE FARINA: It was not my intention to require the contact person to hold onto the substance. I think members need to take a step back and think about what we are doing here. We are actually placing an obligation on the contact person to return any unused substance, and if they do not, and if another person, in their grief, ingests the remaining substance, the contact person is liable to 12 months' imprisonment. We know that the quantity that has been given for people to ingest is more than is understood to be needed to kill someone, and may be sufficient to kill two adults. We also know that people have difficulty ingesting the substance. There will be circumstances in which an unused portion of the substance needs to be returned, and that is clearly understood; otherwise, we would

not have all these provisions in the bill., . When I asked how they would know that there was an unused substance, I was concerned that the minister could not, on the one hand, say that it is expected that the contact person would be a family member or a carer who would be present, and then say that it was too onerous an obligation for that family member or carer to be present when the person self-administered. The likelihood is that they will be present. I do not believe that this provision places any additional burden on the contact person, because I agree with the minister: the contact person is more than likely to be a family member or carer who is there caring for the patient and will be there in any event. It is critically important for us to understand that there is every likelihood that a portion of the substance is not used. It is a lethal substance, and it needs to be secured and returned to the authorised disposer, and securing it needs to be done as quickly as possible. In my view, this is all best achieved if there is a requirement that the contact person is actually present when it is being self-administered. If it is a family member, they are more than likely to be present anyway. The minister has told us that that is the expectation. I understand the argument that people have about personal autonomy, but it is not infinite. There must be limits for the protection of other people in the household, and this amendment simply seeks to do that. I do not think it is an unreasonable imposition. Let us not forget that if the contact person does not return the substance, they will go to jail for 12 months. That is a very onerous imposition. I urge members to support the amendment.

Hon AARON STONEHOUSE: Just to try to provide a little more clarity, I am concerned about exposing the contact person to further liability. The contact person has no control over where or when the patient may take the substance. They may take the substance, and the container may get lost or whatever. We do not know where that will end up, and we do not know who might be present at the time of self-administration. The contact person will have no control over that. It will put a further imposition on the contact person to be a witness to the person taking the substance; again, the contact person will have no control. In some sense, in trying to address a concern that the contact person will be exposed, we are now introducing a new element by which they may be additionally exposed by not being present when the patient takes a substance. I am worried about that. We are putting the contact person in a situation in which they have no control over when the patient takes the substance, which is why I said that we may end up creating a situation in which a contact person is reluctant to hand over the substance, and may say, "Okay, if I give this to you, you'd better make sure you call me when you take it, because if I'm not there, I'm going to be liable for breach of the act for not being present when it's taken." I understand that the contact person is already exposed to risk due to the obligations they have under clause 66(1)(d), but we will be inserting a new element here by which contact persons will be further exposed. That is my concern.

Hon JACQUI BOYDELL: I understand the premise of the amendment, but I find myself probably not being able to support it. If I flick the situation, the contact person, in this regard, as Hon Aaron Stonehouse has said, almost becomes the person in charge of when the patient can determine to self-administer, because they have to be present. If the patient makes a decision that their children might be visiting them on Saturday, and wants to self-administer at that point, and if the contact person says they cannot be there on that day, so how about doing it on Thursday instead, is that coercion or a concern for the patient that they lose control at that point? We have set out such a process to allow the self-administration decision to remain with the patient, and I think that is fundamental to the process of closing the loop—that this has been voluntary assisted dying and not a process that has been determined by someone else being able to be there. For those reasons, I cannot support the amendment.

Hon MARTIN ALDRIDGE: I understand the problem that Hon Adele Farina is trying to address, and I share her concern, particularly in light of the debate and division that occurred last week about agents. But even if this amendment passes, I do not think it will address the concern fully. I think this is a concern that is not easily mitigated. If a patient makes a self-administration decision, the drug can be supplied to the patient. The patient is not required to use a contact person or an agent. My preference was that we do not have agents, but we do, and although the contact person is authorised under this clause to receive, possess, supply and return the substance, a patient could still receive the substance themselves and not involve the contact person in either the awareness that the patient has the drug or that the patient is about to ingest the substance. It does not address fully the issue of the contact person being able to perform their legal obligations to return the substance. I thank the minister for pointing out that clause 104(3) limits clause 66(2) with respect to a contact person having some knowledge that the substance is unused or remaining after the patient's death. I guess that is something that we will consider further in due course, but I am concerned that having a contact person present when the patient self-administers as well as witnessing the self-administration could be contrary to the requests or the views of the patient. In balancing that, I am not sure that this amendment would fully resolve the issue. Noting that we have already had a debate about agents that has made things much more messy, I think the risk remains about dealing with a substance after the fact. I think some other members have asked what the appropriate mechanism is.

Given that no-one has been able to articulate what that is, in some ways, it is probably symptomatic of the difficulty of respecting a patient's right to ingest the substance at a time of their choosing and dealing with the substance

after that time, knowing that nobody may know that the patient has ingested the substance. To fully mitigate that issue, we will probably have to go much further than this amendment in not allowing the patient to receive the substance in the first place. We could probably go as far as saying that only the contact person can receive, possess and supply the substance. That would be the only way to fully mitigate the risks because the patient could not then receive the substance until they were ready to ingest it, so there would be no way the contact person would be unaware of the patient's intent or the patient's death and, therefore, would be fully able to comply with their lawful responsibilities under the legislation for the return of the substance.

Hon ADELE FARINA: I think members seem to be missing the point. The contact person will be a carer or family member who is caring for the patient in that last period of their life. They will be with the patient. The patient is not likely to put out an ad seeking someone to apply for the job of contact person because I doubt they would receive many applicants if they did. I think people are being a little overly concerned about the extent of the obligation that this is placing on the person. In response to a question asked earlier, the minister indicated that it is the expectation that a family member will be caring for the person or a carer who will be a contact person will be caring for the person. They will be present; they will have gone gently in all their advocacy for this legislation and talked about being surrounded by family and friends at the point of deciding to self-administer. Now members are telling me that no family and friends will be present; the person will administer on their own. I am having a problem with the picture we are trying to paint here.

It is a matter of balancing things. I think in balancing, ensuring that the unused substance is secured and returned as quickly as possible is very important. The other aspect to this, which will be moved in a subsequent amendment, is that it is with self-administration that we see the majority of the complications. Therefore, it is reporting those complications with self-administration that is absolutely critical to collecting that data so we can make science-based and ethical decisions into the future. Because this chamber chose not to have a medical practitioner present for self-administration, the only other option open was to assign that task to the contact person. As I have pointed out, under clause 149 the board can ask for that information from the contact person in any event. All I am seeking to do is to put in place some greater protection so that we can deliver on what we promised Western Australians—that is, through this scheme, they will have a peaceful and pain-free death. The only way we can be sure of that is by getting back data, evaluating it and making improvements along the way. The reality is that everyone is making their best assumptions here, but that is what they are, assumptions. No clinical testing of lethal doses has been undertaken. The mere fact that people are taking a very bitter substance and are unable to ingest it is when complications can arise. I am seeking to ensure that we can make science-based decisions into the future if not straightaway. I do not think this is an onerous obligation. There is every likelihood the person would be present in any event.

Hon MARTIN PRITCHARD: I think we are all trying to work out what best protections the bill requires. However, I will take it from the very start. We are talking about a person who is in intolerable pain or suffering and cannot access voluntary assisted dying at that moment. We are trying to introduce different views about what protections are required. I am supportive of this amendment, but I go back to a situation in which a patient is in intolerable pain or suffering and we require them to go through all the precursors to get to that point. I think I mentioned in a previous debate—I know a lot of people disagreed—that I think it is quite onerous to require a person in that situation to have to go through the coordinating practitioner and the consulting medical practitioner. I am in favour of this protection because I agree with Hon Adele Farina that a contact person will not be unknown to the patient. The person who will take on that role is likely to be a family member, a close friend or someone involved in the process. I think there is nothing worse than encouraging patients to take the substance by themselves. I do not think a loving family will always be around the patient, but there would be nothing sadder than encouraging a patient to take the substance on their own.

Having a guarantee that someone is there is worthwhile. I think the contact person will have such onerous responsibilities that it will be appropriate to have them there so they can fulfil all their functions. However, I do not think we should get away from the fact that the patient will have to do some things in order to access voluntary assisted dying. Whether, like me, members think it means having to go through two doctors and exactly the same process twice or having someone present when they take the substance, there will be some responsibilities on the patient to access this, and this is one I support.

Division

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

Ayes (8)

Hon Adele Farina	Hon Martin Pritchard	Hon Dr Steve Thomas	Hon Alison Xamon
Hon Rick Mazza	Hon Charles Smith	Hon Colin Tincknell	Hon Nick Goiran *(Teller)*

Noes (27)

Hon Martin Aldridge	Hon Peter Collier	Hon Colin Holt	Hon Tjorn Sibma
Hon Ken Baston	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Aaron Stonehouse
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Matthew Swinbourn
Hon Robin Chapple	Hon Sue Ellery	Hon Michael Mischin	Hon Dr Sally Talbot
Hon Jim Chown	Hon Diane Evers	Hon Simon O'Brien	Hon Darren West
Hon Tim Clifford	Hon Donna Faragher	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Robin Scott	

Amendment thus negatived.

Clause put and passed.

The DEPUTY CHAIR: I am sorry, Hon Adele Farina, I should have checked that you were not going to move the proposed amendment in your name at 484/66 on issue 16 of the supplementary notice paper, and that it fell out with the first one. Can I confirm that?

Hon ADELE FARINA: Yes.

Clause 67: Contact person may refuse to continue in role —

Hon NICK GOIRAN: In what circumstances might a contact person wish to refuse to continue in the role of contact person?

Hon STEPHEN DAWSON: I am advised that there are a number of different circumstances. They may be out of the state or they may be ill, for example.

Hon CHARLES SMITH: Does the voluntary assisted dying process stop if a patient's contact person refuses to assist?

Hon STEPHEN DAWSON: No, because another appointment of a contact person must be made.

Hon NICK GOIRAN: Could one of the circumstances in which a contact person may refuse to continue to perform their role be because they are observing coercion and duress being exercised by family members upon the patient?

Hon STEPHEN DAWSON: There are a variety of reasons that the contact person may refuse to assist, and this is one of those reasons.

Hon NICK GOIRAN: In those circumstances, could the patient still have access to the lethal substance while not having appointed another contact person?

Hon STEPHEN DAWSON: In such a hypothetical situation, the contact person would be expected to tell the coordinating practitioner and the coordinating practitioner would tell the board.

Hon NICK GOIRAN: The minister indicated earlier that the contact person could be the coordinating practitioner.

Hon STEPHEN DAWSON: In which case, the coordinating practitioner would advise the board directly.

Hon RICK MAZZA: I have a question on the provision that the person must inform the patient of the refusal. What method of conveyance can that be? Could it simply be verbal? Can the contact person simply say to the patient, "I don't want to be your contact person any more", and that is the end of it?

Hon STEPHEN DAWSON: I am advised it could be as simple as that.

Hon RICK MAZZA: If the contact person simply says to the patient, "I'm not going to be your contact person anymore today", what time frame does the patient have to reappoint a new contact person?

Hon STEPHEN DAWSON: I thank the honourable member. I have answered this already. It should be done as soon as practicable. I answered this earlier.

Hon ADELE FARINA: It is possible that a contact person could refuse to continue to act as contact person of a patient who already has the voluntary assisted dying substance and the patient elects to take that substance before appointing another contact person? Is that correct?

Hon STEPHEN DAWSON: The answer is yes.

Clause put and passed.

New clause 67A —

Hon ADELE FARINA: I intend to move new clause 67A, which will fit into division 4, "Prescribing, supplying and disposing of voluntary assisted dying substance", just before clause 68. I apologise for the late notification. I have been furiously debating with myself all morning about the best location to put this provision and I have decided to go with putting in a new clause at this point. The chamber attendants have copies and I am sure they will distribute them. I move —

Page 45, after line 19 — To insert the following new clause —

67A. Coordinating practitioner for a patient must not prescribe a voluntary assisted dying substance that is not therapeutic good registered

(1) The coordinating practitioner for a patient must not prescribe a voluntary assisted dying substance for the patient unless the substance is a therapeutic good registered in the Australian Register of Therapeutic Goods under the *Therapeutic Goods Act 1989* of the Commonwealth.

(2) An authorised supplier who is given a prescription for a voluntary assisted substance must not supply the substance in accordance with the prescription unless the substance is a therapeutic good registered in the Australian Register of Therapeutic Goods under the *Therapeutic Goods Act 1989* of the Commonwealth.

Hon STEPHEN DAWSON: Mr Deputy Chair, this is a significant amendment at a very late stage, so I ask that you leave the chamber until the ringing of the bells.

The DEPUTY CHAIR (Hon Robin Chapple): I will leave the chair until the ringing of the bells.

Sitting suspended from 12.21 to 12.46 pm

Hon STEPHEN DAWSON: I indicate to the chamber that the government does not support this amendment. I am advised that it is not appropriate to limit the schedule 4 or schedule 8 substances that may be prescribed to the patient because it may result in a substance that is less clinically efficacious than required. It would be up to the clinical panel to determine the relevant medical protocols during the implementation stage. We do not wish to be unduly restrictive and limit the protocols at this stage. I make the point that just because a product is not on the Australian register of therapeutic goods that does not mean that there is not appropriate evidence of efficacy and safety for the proposed use. It means that the manufacturer has not applied to the Therapeutic Goods Administration to have it assessed. It is a costly and lengthy process and, ultimately, is a commercially driven decision. I am also advised that there are medicines that are made from scratch from raw ingredients that do not need approval from the TGA.

Hon ADELE FARINA: I will speak to my amendment. Normally, drugs for use in humans need to be approved by the Therapeutic Goods Administration. It is a national scheme that we have signed up to be part of so that we know that when we ingest a drug or it is given to us by injection, it has been clinically tested and is safe for human use. In this case, we will not know what the drug is or what side effects the drug is likely to have.

We know that the voluntary assisted dying substance will be a schedule 4 or schedule 8 poison or a combination of them. We have been told by the minister that the schedule 4 and schedule 8 poisons that will be used to make up the voluntary assisted dying substance do not need to be approved by the TGA. In my view, we have established the Therapeutic Goods Administration for a very important reason—that is, to provide us advice and to make sure that we do not use human beings as guinea pigs, but run all the proper clinical trials to ensure that drugs are fit for human use. I think it is vitally important in this situation that we also require the voluntary assisted dying substance to be assessed by the Therapeutic Goods Administration and put onto the register. Clearly, the list of schedule 4 and schedule 8 drugs is very long, so there will be plenty of options on those two lists. There is no reason that the voluntary assisted dying substance cannot be made up of those that have already been approved for human use.

We have made the decision in this place not to have a medical practitioner present during self-administration, or even to require the contact person to be present, because the majority view is that the autonomy of the individual—the patient—is paramount. However, we also know that there is substantial research out there that these drugs are not effective in 100 per cent of cases. There are complications, and those complications can be painful, distressing and can prolong death. Surely, we do not want to make the situation worse. The whole point of this bill is to try to alleviate suffering and bring about a more peaceful outcome. I do not think that can be achieved by using poisons that have not been approved by the Therapeutic Goods Administration. If people are not going to be present to assist patients who run into complications when they self-administer, it is absolutely critical that, at the very least, we choose the scientifically based option of deciding which poisons to use as a voluntary assisted dying substance

and do what is ethically right—that is, not ask people to ingest a substance that might bring about unintended side effects and outcomes.

Through this amendment, I am suggesting that the drug would need to be registered as a therapeutic drug in order to be prescribed. The Therapeutic Goods Administration ensures that drugs have their intended effect. Without a review by the Therapeutic Goods Administration, we can expect there to be a range of problems with the drug—whatever it might be—and the likelihood is that it will increase suffering rather than decrease suffering. The minister is right that there are drugs that operate without the approval of the Therapeutic Goods Administration, however, those drugs are for only very specific purposes and are tailored to the individual. If, for example, a person has a rare topical skin infection and it is not economical for a major pharmaceutical company to produce a very specific agent, a pharmacist can mix it up after the doctor prescribes it off-label. In those very specific individual circumstances, there is capacity for exemptions to apply with no formal requirement for a TGA review of the final product. However, that is an exception, and it is not intended to be used to produce a drug for a group of patients as is proposed with the voluntary assisted dying substance. Government policy is that drugs have to be TGA reviewed, and there is no reason why this drug should not be TGA reviewed like every other drug. The TGA review helps to ensure that the drug works as intended and does not increase suffering. It is a safeguard. I am really struggling with aspects of this bill, and this is one of them; that is, we are proposing to prescribe a substance for someone to ingest knowing that the substance can cause problems and complications. No-one has to be present when a patient self-administers to assist them through that process if there are complications. At the very least, we should make sure that the substance is TGA approved so that any side effects are not greater than they need to be or so that there are no side effects at all. It is not an onerous obligation. We should be making scientific-based and ethical decisions. We should not use people as human guinea pigs.

Hon NICK GOIRAN: I rise to support the amendment. I entirely agree that one of the safety mechanisms in Australia is that the TGA authorises what can and cannot be used on humans. I was thinking what would be the best evidence to present to members in support of this amendment moved by Hon Adele Farina, and so I will go to some of the complications that arose in Washington state, which I touched on in my minority report. Washington state is one of a few jurisdictions around the world that has an assisted suicide regime, which is not to be confused with voluntary euthanasia in which the practitioner fulfils the act. I refer to an article on page 138 of the minority report, which states —

> *The first Seconal alternative turned out to be too harsh, burning patients' mouths and throats, … causing some to scream in pain. The second drug mix, used 67 times, has led to deaths that stretched out hours in some patients—and up to 31 hours in one case. [Twenty per cent] of the cases were 3 hours or more before death, which we think is too long," said Robert Wood, a retired HIV/AIDS researcher who volunteers with the advocacy group End of Life Washington, in an email. The longest was 31 hours, the next longest 29 hours, the third longest 16 hours and some 8 hours in length. "Patients and families are told to expect sleep within 10 minutes and death within four hours.*
>
> *When it takes far longer, family members get worried, even distressed, …*

I stop there. This is why the amendment moved by Hon Adele Farina is important. Let us remember that this is a rare practice around the globe and if we spend a moment to study the few jurisdictions that have done this, we know that they have had to experiment with the drugs that are used because they are not really sure whether they will work on a particular person. Over the journey, many people have said to me, "Oh, look, euthanasia already happens in the western world because, nudge-nudge, wink-wink, the doctor just ups the morphine." That myth is perpetuated time and again, but the best speaker against it is none other than Dr Philip Nitschke. Dr Nitschke said in a hearing of the committee that I was on—I was on it for a year and was the only member who attended every meeting and every hearing—that it is, and I am paraphrasing here, actually very hard to kill someone with morphine. Dr Philip Nitschke said that the worldwide myth—nudge-nudge, wink-wink, that doctors up the morphine rate and take care of business that way—is much more complicated than that. We know it is much more complicated because if it is that easy, why not use morphine? We will not need to have a clinical panel and all those kinds of things; let us just use morphine and move on. We know that that is not the case. The government is going to implement a clinical panel. We know that because in other jurisdictions they have had to experiment with different drugs. At least with this amendment, we will have the confidence to know that the TGA has approved the substance for use, which is its remit and job. For those reasons, I support the amendment.

Hon ADELE FARINA: I omitted to mention when I rose earlier that I have made an error in subclause (2), lines 2 and 3. It reads "voluntary assisted substance" and it should read "voluntary assisted dying substance". I do not know whether that requires a formal amendment to my amendment or whether the chamber is happy to accept that that is what was intended.

The DEPUTY CHAIR (Hon Robin Chapple): Hon Adele Farina seeks leave to alter her new clause 67A.

New clause, by leave, altered.

Sitting suspended from 1.00 to 2.00 pm

Hon STEPHEN DAWSON: During the lunchbreak we had a conversation with the Chief Pharmacist and can confirm the following matters that are important to bring to the chamber's attention. The main role of the Therapeutic Goods Administration is to make sure that medications are being manufactured well. Not all medications currently prescribed are available on the Australian register of therapeutic goods. On many occasions, a medical practitioner will request that a specific medication be compounded by a pharmacist. Normally, this would be done for medications that are not available in Australia such as when there is sufficient evidence for a medication to be used but it has not been made commercially available in Australia. An example of this is some hormone replacement therapies. Pharmacists have the specific skill set and expertise to do the compounding, which is governed by Pharmacy Board of Australia guidelines. If the clinical panel recommends such a substance, only approved pharmacies would do this for the voluntary assisted dying substance.

Division

New clause, as altered, put and a division taken, the Deputy Chair (Hon Martin Aldridge) casting his vote with the noes, with the following result —

Ayes (7)

Hon Adele Farina	Hon Rick Mazza	Hon Aaron Stonehouse	Hon Ken Baston *(Teller)*
Hon Nick Goiran	Hon Charles Smith	Hon Colin Tincknell	

Noes (26)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Kyle McGinn	Hon Matthew Swinbourn
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Michael Mischin	Hon Dr Sally Talbot
Hon Robin Chapple	Hon Sue Ellery	Hon Simon O'Brien	Hon Darren West
Hon Jim Chown	Hon Diane Evers	Hon Martin Pritchard	Hon Alison Xamon
Hon Tim Clifford	Hon Donna Faragher	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Robin Scott	
Hon Peter Collier	Hon Colin Holt	Hon Tjorn Sibma	

New clause, as altered, thus negatived.

Clause 68: Information to be given before prescribing substance —

Hon NICK GOIRAN: Clause 68 requires certain information to be provided by the coordinating practitioner to the patient before the substance can be prescribed. How will the substance be required to be stored under clause 68(1)(c)?

Hon STEPHEN DAWSON: The advice is that the substance must be stored in accordance with the information provided by the authorised supplier of the substance.

Hon NICK GOIRAN: Why is the requirement for secure storage in a locked box not included in the bill as it is in section 61 of the Victorian scheme?

Hon STEPHEN DAWSON: The bill does not specify the use of a locked box as this may not always be the most appropriate method for securely storing substances. It is not a default position to have it in the bill as the use of the locked box is not best practice and may confirm a misplaced sense of security or contravene national and Western Australian guidance about the safe storage of medication in the home. Specific medication protocols will be developed and implemented to ensure the safe storage, preparation, administration and disposal of unused prescribed substances.

Hon NICK GOIRAN: Could a locked box be one of the methods set out in clause 68(1)(c)?

Hon STEPHEN DAWSON: I am advised it is impossible to say. I cannot forecast that.

Hon NICK GOIRAN: Is that because nobody has turned their mind to this issue as yet or because the government has not received any advice from the Chief Pharmacist, the ministerial expert panel or the joint select committee? Is it because nobody has turned their mind to this and it will just be left to the implementation period?

Hon STEPHEN DAWSON: I am advised that we have turned our minds to it and considered it, but it is not the best default position.

Hon NICK GOIRAN: What is the best default position?

Hon STEPHEN DAWSON: The default position that we believe is best is as the bill reads. It enables individual and personalised storage solutions.

Hon NICK GOIRAN: How is the schedule 4 or 8 poison to be prepared and self-administered under clause 68(1)(d)?

Hon STEPHEN DAWSON: I am advised that it would depend on the make-up of the substance.

Hon NICK GOIRAN: I take it that we do not know at this stage what that is.

Hon STEPHEN DAWSON: The honourable member is correct.

I am going to move the amendment standing in my name. It is on a supplementary piece of paper that was circulated to honourable members before we broke for lunch. I give my apologies, because this was an issue I took on board last week; however, I did not receive the properly drafted amendment until just before lunch today. I apologise to the chamber for the late presentation of it. I provided it before lunch during the last debate to at least give honourable members the opportunity to read it. It came about because at an earlier stage of the debate, Hon Adele Farina had intended to move amendments to this effect at clauses 57 and 58. I gave an undertaking that the government would move an amendment on this issue, and I am doing that now, so I so move.

The DEPUTY CHAIR: Minister, I might get some clarification from you, because there are not any amendments standing in your name. You circulated some draft amendments. I think the safest approach would be for you to move your amendment and then I will put the question.

Hon STEPHEN DAWSON: I move —

Page 45, after line 20 — To insert —

(1A) In this section —

Schedule 4 poison and ***Schedule 8 poison*** have the meanings given in the *Medicines and Poisons Act 2014* section 3.

Hon MARTIN PRITCHARD: Would proposed subclause (1A) come before subclause (1) in this circumstance? I thought we had determined that subclause (1A) would come after subclause (1). I just ask for clarification.

Hon STEPHEN DAWSON: I am advised that because it is proposed subclause (1A) with a capital A, it comes before.

The DEPUTY CHAIR: To your point of clarification, Hon Martin Pritchard, that will be addressed as a clerk's amendment.

Amendment put and passed.

Hon NICK GOIRAN: The next amendment on the supplementary notice paper is at page 45, line 24, so I will need to move my amendment at this stage. I move —

Page 45, line 24 — To insert after "patient," —

including

My amendment at clause 68(1) would also be complemented by a subsequent amendment by me at clause 68(2) in the event that the chamber was agreeable to this first one. It supports the principle of informed consent that is central to the operation of the bill. My amendments would ensure that the information is not only documented in writing, but also, much more importantly I suggest to the minister and members, communicated to the patient in a way understood by the patient. As clause 68 is currently drafted, the very important information to be provided to the patient need only be provided in written form. This does not account for the fact that the patient may be unable to read the documentation, amongst many other issues. This issue was taken up by the member for Cottesloe in the debate in the other place on 17 September 2019, and there was a detailed exchange between him and the Attorney General, who was filling in for the Minister for Health. Members interested in that exchange can find it in *Hansard* at pages 6824 and 6825. My concern here is that clause 68(1) indicates that the coordinating practitioner must provide this information set out in paragraphs (a) to (f) in writing. I have no difficulty whatsoever with this information being provided to the patient in writing. My concern is that it is a bit like when we subscribe to terms and conditions. After having maybe downloaded the latest app, we are simply asked whether we have read all the terms and conditions. We all simply press "yes", and none of us bother to read those things. I do not want this in a voluntary assisted dying context. I do not want a practitioner to be given the information from the CEO or the government as maybe a large set of documents the size of this bill and for them to then give it to the patient and say that they have complied with clause 68 because clause 68 says that it has to be provided in writing. In earlier parts of this legislation, the government has quite rightly enshrined a desire to ensure that information is communicated to the patient in a format and a way that is understood by the patient. That is quite right. By inserting

these words, all we would be doing is saying that the information needs to be communicated to the patient, including in writing, rather than the implication here that it be only in writing. I accept, and it may be a retort from the government, that nothing in this clause as currently drafted prohibits the practitioner from communicating to a patient in a form other than in writing. That is true, but I do not want a practitioner slavishly following clause 68(1), and simply providing this information in writing, and indicating that they have satisfied clause 68. Let us make sure that the patient is properly informed and understands the information. If they receive a document in writing, that is all well and good, but, as I said, I suspect, and I would not be at all surprised, that a person in the end-of-life situation is not going to spend an inordinate amount of time reading every single thing that the practitioner has given them. They are far more likely to absorb the information and retain it if it is communicated to them verbally, and if time is taken by the practitioner to step the patient through the process and make sure that they clearly understand everything that is being communicated to the patient at this time. This would be in the best interest of the patient and consistent with the principle of informed consent.

Hon STEPHEN DAWSON: We are not supportive of the amendment as it stands. The bill clearly and properly provides for the provision of information. The amendment to the clause is slightly confusing. Clear guidelines will be provided. It is an operational issue that will be dealt with during the implementation phase of the bill.

Hon NICK GOIRAN: In respect of the alleged confusing nature of the amendment, it seeks to include one word—"including"—so that the clause would read —

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

It then sets out the parameters, as per the government's proposals at paragraphs (a) to (f). What is confusing about the insertion of the word "including"?

Hon STEPHEN DAWSON: My advisers tell me that it does not read well.

Hon NICK GOIRAN: I have no objection if the government has a preferred form of wording. The spirit of the amendment is to ensure that the patient understands the information, and it is communicated to them in a form that will be understood. I am not confident that simply providing a stack of brochures or prescribed information will ensure that the patient understands —

(a) that the patient is not under any obligation to obtain the substance;

(b) that the patient is not under any obligation to self-administer the substance;

(c) that the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;

(d) how to prepare and self-administer the substance;

(e) that, if the patient decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;

(f) that, if the patient dies, their contact person must give any unused or remaining substance to an authorised disposer for disposal.

Some patients, if they are given all that information in writing, may well understand all of it and may well then proceed by providing informed consent, but I very much suspect that, for some, providing the information in writing will be a useless exercise, and that some other form of information—for example, verbal—would be far more appropriate. I note that that is consistent with many other provisions in the bill. This strikes me as potentially the only provision in the bill in which we limit the information. We prescribe that it is to be provided in writing, whereas the phrase that is used in the rest of the bill is that the practitioner inform the patient. Here, at clause 68, we suddenly take a different turn and say that the practitioner must inform the patient in writing. I am not confident that that is in the best interests of the patient. If there is an alternative wording, I would be very happy to consider it.

Hon STEPHEN DAWSON: I do not have alternative wording, but my advisers tell me that it is not necessary to amend this clause. Department of Health practice and good clinical practice means that information given in writing by a doctor is also explained orally, or in some other way. This clause serves to emphasise that the information must be provided in writing, but not to limit it to this method only.

Hon NICK GOIRAN: Is there agreement from the government that my amendment would not limit it only to writing?

Hon STEPHEN DAWSON: Yes.

Division

Amendment put and a division taken, the Deputy Chair (Hon Martin Aldridge) casting his vote with the ayes, with the following result —

Ayes (13)

Hon Martin Aldridge	Hon Nick Goiran	Hon Charles Smith	Hon Ken Baston *(Teller)*
Hon Jacqui Boydell	Hon Rick Mazza	Hon Aaron Stonehouse	
Hon Donna Faragher	Hon Simon O'Brien	Hon Colin Tincknell	
Hon Adele Farina	Hon Martin Pritchard	Hon Alison Xamon	

Noes (20)

Hon Robin Chapple	Hon Stephen Dawson	Hon Colin Holt	Hon Robin Scott
Hon Jim Chown	Hon Colin de Grussa	Hon Alannah MacTiernan	Hon Matthew Swinbourn
Hon Tim Clifford	Hon Sue Ellery	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Alanna Clohesy	Hon Diane Evers	Hon Michael Mischin	Hon Darren West
Hon Peter Collier	Hon Laurie Graham	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*

Amendment thus negatived.

Hon STEPHEN DAWSON: I move —

Page 45, after line 24 —To insert —

(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

Amendment put and passed.

The DEPUTY CHAIR: Hon Rick Mazza, can I confirm that you will not move the amendment standing in your name on the supplementary notice paper?

Hon RICK MAZZA: Just by way of explanation, all the remaining amendments I have on the supplementary notice paper are consequential to my amendment at clause 57; therefore, I will not move any of those amendments.

The DEPUTY CHAIR: Thank you for that clarification.

Hon STEPHEN DAWSON: I move —

Page 46, after line 4 — To insert —

(da) the method by which the substance will be self-administered;

(db) the expected effects of self-administration of the substance;

(dc) the period within which the patient is likely to die after self-administration of the substance;

(dd) the potential risks of self-administration of the substance;

Hon NICK GOIRAN: To what extent does the list the minister is proposing to insert differ from that proposed by Hon Adele Farina in the amendment that was the genesis of these amendments?

Hon STEPHEN DAWSON: My advisers tell me it is the same issue as Hon Adele Farina raised.

Hon NICK GOIRAN: Just to clarify, I had understood that the government's objection to the honourable member's amendment was that there could be some different wording and the like. If it is the same, why did the minister not agree to the earlier amendment?

Hon STEPHEN DAWSON: It is the same substance, but it has been drafted slightly differently.

Hon Nick Goiran: Okay.

Amendment put and passed.

Hon STEPHEN DAWSON: I move —

Page 46, after line 14 — To insert —

(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

Amendment put and passed.

Hon STEPHEN DAWSON: I move —

Page 46, after line 16 — To insert —

(ab) the method by which the substance will be administered;

(ac) the expected effects of administration of the substance;

(ad) the period within which the patient is likely to die after administration of the substance;

(ae) the potential risks of administration of the substance;

Amendment put and passed.

Clause, as amended, put and passed.

Clause 69: Prescription for substance —

Hon NICK GOIRAN: At clause 69(5), it states —

> The prescription cannot provide for the prescribed substance to be supplied on more than 1 occasion.

I note that the guidelines in the Netherlands for the practice of euthanasia and physician-assisted suicide mandate that practitioners should carry with them an emergency set of euthanatic agents whenever administering euthanasia to a patient. The Dutch guidelines state —

> Even for the most experienced doctors, things can sometimes go wrong. For this reason, the doctor must bring an extra set of intravenous euthanatic agents and materials for the preparation and administration of the agents.

Will the operation of clause 69(5) impact on the ability of the CEO to mandate that a similar emergency set be carried by Western Australian administering practitioners in line with the Dutch guidelines?

Hon STEPHEN DAWSON: The purpose of this clause is to ensure that there are no repeat scripts.

Hon NICK GOIRAN: Will the CEO be able to mandate?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: They are not able to? In other words, if the administering practitioner runs into trouble when administering the substance to the patient, so be it. They will have to just cope with it. Whether they asphyxiate, choke or whatever happens as a result of that, the practitioner can do nothing about it.

Hon STEPHEN DAWSON: They can provide care to the patient but they will not be able to provide drugs.

Hon NICK GOIRAN: Why does clause 69(4) prohibit the prescription from being in the form of a medication chart?

Hon STEPHEN DAWSON: The prescription for the voluntary assisted dying substance cannot be in the form of a medication chart. The medication chart is the chart that records the medications used for a patient in a hospital or care facility. It serves as a communication tool between doctors, nurses, pharmacists, other health professionals and hospitals regarding the patient's medicines. It is used to direct how and when drugs are to be administered and as a record of their administration. It would not be prudent to allow a voluntary assisted dying substance to be prescribed in this manner. All prescriptions of voluntary assisted dying substances by the coordinating practitioner will go directly from the medical practitioner to the authorised supplier. This provision overrides any ability for the use of a medicine chart under the WA Medicines and Poisons Act 2014.

Hon NICK GOIRAN: Why must the prescription include a statement certifying that the request and assessment process has been completed in respect of the patient in accordance with this legislation? Is there a duty upon the authorised supplier to verify that the matter is certified, including that the request and assessment process has been completed?

Hon STEPHEN DAWSON: There is a duty. As well as the obligations under clause 70, it is a mechanism to ensure that the proper process for voluntary assisted dying is being followed.

Hon NICK GOIRAN: As we discussed earlier, clause 69(5) provides that the prescription cannot be supplied on more than one occasion. A dialogue took place in the other place on 17 September between the member for Darling Range and the Attorney General on this issue. If the patient has not self-administered the substance by the use-by date, will the patient be required to go through the entire request and assessment process again in order to acquire a new prescription?

Hon STEPHEN DAWSON: Given the six-month eligibility criteria, it is unlikely that a patient will delay the decision to the point at which the medication goes out of date. However, should this occur, this could be proactively managed and picked up by the authorised supplier. This will be looked at operationally during the implementation phase.

Hon NICK GOIRAN: The minister can say that it might be unlikely, but that is not the experience in Oregon. In Oregon, there have been many occasions on which a patient has taken the substance well after the six-month original prognosis. That being the case, it does not provide me with any confidence that the government says that it will deal

with this under the implementation phase. Nevertheless, I note that under clause 69(6), there is a requirement that the coordinating practitioner must give the prescription directly to an authorised supplier. Are there any other substances for which a practitioner is required to provide the prescription directly to the supplier rather than to the patient?

Hon STEPHEN DAWSON: Is the honourable member asking outside of this bill before us?

Hon NICK GOIRAN: I am just looking at clause 69(6), which says —

> The coordinating practitioner must give the prescription directly to an authorised supplier.

Clause 69(6) will mandate by law that that is the only person to whom the coordinating practitioner can give a prescription. That seems irregular to me, because I think that it is ordinarily and routinely the case that a practitioner gives a prescription directly to a patient. Here, we are doing something different. Clause 69(6) says no, they must give it directly to the authorised supplier. I am clarifying whether that happens with any other substance that is used in Western Australia, or will this be the first time we are mandating this type of supply chain?

Hon STEPHEN DAWSON: I am not aware of any other instance, but this is an additional safeguard in the bill.

Hon MARTIN PRITCHARD: I read the same clause and was a little bewildered by it, particularly how it might actually work in the country, where we are looking at the hub-and-spoke method. Are we saying that the doctor will have to actually travel to the supplier, or would that be by electronic means, possibly?

Hon STEPHEN DAWSON: It is through a database, honourable member.

Hon CHARLES SMITH: I have just a quick question. In relation to clause 69(6), has the government actually decided yet who shall be an authorised supplier?

Hon STEPHEN DAWSON: No, not yet.

Clause put and passed.

Clause 70: Authorised supplier to authenticate prescription —

Hon NICK GOIRAN: Minister, how will an authorised supplier confirm the authenticity of the prescription under clause 70(a)?

Hon STEPHEN DAWSON: I am advised that the contact details are on the prescription, so the details of the coordinating practitioner and the telephone number of the patient will enable the authorised supplier to make the necessary checks to confirm the matters above.

Hon NICK GOIRAN: How will an authorised supplier confirm the identity of the person who issued the prescription in accordance with clause 70(b)?

Hon STEPHEN DAWSON: I am advised that they can speak to the prescriber.

Hon NICK GOIRAN: An authorised supplier can speak to a person who issued the prescription, and that is somehow intended to be sufficient to identify the person. If someone rang the minister later today and said to him on the telephone, "This is Hon Nick Goiran speaking", because the minister has been hearing my voice for quite some time during the course of this debate, he would be able to identify —

Hon Stephen Dawson: I would hope so!

Hon NICK GOIRAN: — through that experience whether that voice sounded anything like me. But in this context, an authorised supplier might never ever have heard the voice of the practitioner who writes the prescription, yet the minister indicates that speaking would be sufficient to confirm the identity of the person. I suspect that that is not going to be sufficient to satisfy the provisions of clause 70(b), and I wonder whether the minister has any supplementary advice to give us on this point.

Hon STEPHEN DAWSON: I am advised that the prescription will come through the database and only particular people can access that database.

Hon RICK MAZZA: Under clause 70(c), the authorised supplier is to identify the person to whom the substance is to be supplied. How is it envisaged that that will take place? We have heard through this debate that that could be the contact person or an agent such as Silver Chain going into town to pick up the substance. If the contact person says, "I can't get in to pick this up from the authorised supplier", does the authorised supplier need something in writing to say that the agent will collect the substance? How is it envisaged that this will operate?

Hon STEPHEN DAWSON: I am reminded that this issue has been asked about and answered previously. However, the patient can call ahead or provide a letter. They can contact the patient to ascertain the identity.

Hon RICK MAZZA: Just to confirm that, someone can just call ahead—a phone call is sufficient—to the authorised supplier to say that Joe Blow will come and pick it up at four o'clock this afternoon, so a telephone call on its own will be sufficient.

Hon STEPHEN DAWSON: There is a requirement that the authorised supplier will have to confirm the identity, so they might ask for identification.

Hon ADELE FARINA: What happens if an agent who is under the age of 18 goes to collect the medication? What proof of identification would that person have?

Hon STEPHEN DAWSON: They may have to provide a passport or a student identification card.

Clause put and passed.

Clause 71: Information to be given when supplying prescribed substance —

Hon NICK GOIRAN: Clause 71(2) requires certain information to be provided when a prescribed substance is supplied by an authorised supplier. This information does not include information on adverse reactions or complications arising from self-administration and what the patient should do in the event that an adverse reaction or complication does arise. Why is this information deemed unnecessary for provision to the patient and is left out of clause 71(2)?

Hon STEPHEN DAWSON: I am advised that that discussion will have already been raised by the coordinating practitioner with the patient.

Hon NICK GOIRAN: Clause 71(3) requires that if the poison and the information provided under clause 71(2) is received by a recipient who is not a patient, the information must be passed on by that recipient to the patient. There is no requirement in the bill for the authorised supplier or coordinating practitioner to provide this information directly to the patient or for either the authorised supplier or the coordinating practitioner to follow up with the patient to confirm that they have received the necessary information with their prescribed substance. How can the authorised supplier be sure that the patient has received the relevant information at the time that they received the prescribed poison, particularly given that the self-administration of the substance is intended to and will most likely cause the death of the patient?

Hon STEPHEN DAWSON: The onus of passing on the information then falls to the agent. This agency is a relationship between the patient and the person they have elected as their agent.

Clause put and passed.

Clause 72: Labelling requirements for prescribed substance —

Hon STEPHEN DAWSON: I move —

> Page 49, lines 6 and 7 — To delete "patient to whom it is supplied or their contact person." and substitute —
>
> contact person for the patient to whom it is supplied.

The amendment is to correct a technical error in the bill. As currently drafted, the subclause requires that, amongst other things, the label or statement attached to the container of the prescribed substance must state that any unused or remaining substance must be given to an authorised disposer by the patient or the contact person; however, under the bill, only the contact person is obliged to return the substance to the authorised disposer, and faces a penalty for failure to do so. Although a patient may also return the substance, they are not obliged to do so under the bill nor will they face penalties for failure to return it. In most circumstances, it is unlikely that the patient will be in any physical condition to return the substance if unused.

Hon NICK GOIRAN: Minister, why would we want to take the patient out of this clause? I understand that there will be many scenarios in which the patient is maybe not in a fit state to do it and therefore the contact person will do it. But, equally, minister, let us remember that what happens here is we have a person who qualifies for the scheme because they have been told by a doctor that they have only six months to live. We know of many circumstances in which doctors get that wrong. There have been many medical negligence cases as a result of that. What happens at a later stage if the doctor informs the patient that they no longer have a terminal illness and no longer qualify for this, and the patient says, "This is excellent news and I now wish to return the substance"? Why would we have any issue with them returning it? It seems unnecessary to delete the patient from this, so my question to the minister is: why is the proposed amendment 462/72 that the minister is moving necessary?

Hon STEPHEN DAWSON: The patient is not under an obligation, so a label that states that the patient "must" do something is incorrect.

Hon NICK GOIRAN: Minister, by saying that, are we saying that a patient has the liberty and licence to retain the substance, notwithstanding the fact that they have no intention of using it?

Hon STEPHEN DAWSON: No, they may return it. But, on further advice, the statutory obligation is with the contact person.

Amendment put and passed.

Hon NICK GOIRAN: What are the labelling requirements under the Medicines and Poisons Act 2014 that relate to clause 72?

Hon STEPHEN DAWSON: The labelling requirements are in addition to stringent labelling requirements under the Medicines and Poisons Act 2014, WA—noting that where the two are inconsistent, the Voluntary Assisted Dying Act will prevail. All labels for medicines and poisons have to comply with extremely detailed requirements under part 2 of the Standard for the Uniform Scheduling of Medicines and Poisons, known as the poisons standard, including minimum size requirements for labelling. The label of the VAD substance will clearly identify that it is a voluntary assisted dying substance to make it distinguishable from other medications.

Hon NICK GOIRAN: We know from a statement that was made by the Attorney General in the other place when he had interim carriage of the bill that the voluntary assisted dying substance will have a date by which it should be used, or else it is to be disposed of. The Attorney General said this on 17 September. Assuming that that is correct, why are the dates not included in the labelling requirements under clause 72?

Hon STEPHEN DAWSON: The Medicines and Poisons Act requires a use-by date and these are in addition to the requirements of the Medicines and Poisons Act.

Hon NICK GOIRAN: The Netherlands guidelines state —

> Following delivery of the euthanatic agents, the doctor must ensure that they are properly stored in order to prevent any accidents at the patient's home or elsewhere.

Earlier we discussed that section 61 of the Victorian legislation mandates a locked storage box to ensure secure storage of these poisons. Given that this bill does not mandate a locked storage box like the Victorian legislation, what proper storage requirements will the government be including in the approved form of clause 72(2)?

Hon STEPHEN DAWSON: That information will be decided during the implementation phase; we do not have an answer to it yet.

Clause, as amended, put and passed.

Clause 73: Authorised supplier to record and notify of supply —

Hon NICK GOIRAN: I note that under clause 73, the authorised supply form will not certify that the patient received the substance, only that the substance was supplied to a person, who, of course, may be a contact person or an agent of the patient. Where does the bill provide for the board to be notified that the substance has in fact been received by the patient—that is, that the contact person or agent has actually provided the substance to the patient?

Hon STEPHEN DAWSON: We do not ordinarily require a pharmacist to ensure that prescribed substances have been received by the patient. The board can contact the contact person at any stage. We do not want the board to be seen to be influencing the use of the substance. If a patient does not receive the substance, they would advise their coordinating practitioner.

Hon NICK GOIRAN: Could it be the case that the board knows who the patient is, who the coordinating practitioner is and who the contact person is, but it has no idea who the agent is who has the substance in their possession?

Hon STEPHEN DAWSON: Clause 73(2)(d) says that the name and contact details of the person to whom the prescribed substance is supplied needs to be on the authorised supply form, so it would know.

Hon NICK GOIRAN: The authorised supply form requires the authorised supplier to also certify that they provided the information required to be provided under clause 71 to the person who received the substance, who might be, as we have discussed, a contact person or indeed an agent of the patient. Where does the bill provide for the board to be notified that the information has in fact been received by the patient—that is, that the contact person or agent has actually provided the requisite information to the patient?

Hon STEPHEN DAWSON: There is no obligation on the pharmacist to check whether the information they have given the contact person or the agent has been passed on, but it is a statutory obligation that the information be passed on.

Hon NICK GOIRAN: Clause 73(3) requires that the authorised supply form be provided to the board within two business days after the prescribed poison has been supplied. What will the board be required to do with this

form, and what oversight function will the board notification serve if the patient self-administers the prescribed substance within the time frame of two business days and before the board even receives the form?

Hon STEPHEN DAWSON: The intent of this provision is to record the details that are relevant to the supply of the prescribed substance; ensure that the Voluntary Assisted Dying Board is notified progressively of the patient's participation in the voluntary assisted dying process, including the outcome of each assessment; monitor that the correct processes are being followed in each case of voluntary assisted dying; and maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia. These requirements will be in addition to any notification requirements under the Western Australian Medicines and Poisons Act 2014, noting that if the two acts are inconsistent, the Voluntary Assisted Dying Act will prevail.

Clause put and passed.

Clause 74: Disposal of prescribed substance by authorised disposer —

Hon NICK GOIRAN: What requirements of the Medicines and Poisons Act 2014 referred to in clause 74(4) will apply to the disposal of prescribed substances under this legislation?

Hon STEPHEN DAWSON: I am told that there are provisions in part 9 of the Medicines and Poisons Regulations 2016.

Hon NICK GOIRAN: Yes, but what requirements would apply under this legislation?

Hon STEPHEN DAWSON: We are looking for more information, but I will provide some. The Department of Health has issued a table of recommendations for the disposal of schedule 8 medicines, which is available on the Department of Health website. For the disposal of any small quantities of schedule 8 medications—for example, the disposal of any unused or remaining voluntary assisted dying substances—the administering practitioner can request disposal by community pharmacies in their return of unwanted medicine bins; dispose of the medications specifically in their medical facility or practice; or remove all packaging, crush and disperse contents, and dispose of it as clinical waste in a sharps or clinical waste container, for incineration. These methods can also be used to destroy other schedule 4 voluntary assisted dying medications.

Hon NICK GOIRAN: Why must the authorised disposer dispose of the prescribed substance "as soon as practicable after receiving it", not immediately after receiving it?

Hon STEPHEN DAWSON: The intent is that they would do it as soon as possible, but it would depend on what else they are doing at the time; whether they are consoling family members, or other things.

Hon NICK GOIRAN: The language used in clause 74(3) is "as soon as practicable". I understood from the minister earlier that there were particular provisions in the bill in which that phrase was not used and it was to be read in accordance with the Interpretation Act. Why have we chosen to use it in this particular provision and not in others?

Hon STEPHEN DAWSON: This is how it has been drafted by the parliamentary draftspeople. It is to make the intention clear at this stage.

Clause put and passed.

Clause 75: Authorised disposer to record and notify of disposal —

Hon NICK GOIRAN: Unlike the supply and disposal provisions in the Victorian act, the authorised disposer does not have to be the authorised supplier who supplies the prescribed substance. In that case, why is it that there is no requirement under clause 75 for the authorised disposer to advise the authorised supplier of the disposal of the substance, to adequately monitor and track the whereabouts and use of the substance prescribed and supplied?

Hon STEPHEN DAWSON: I am advised that they may be one and the same; both advise the board. The information is on the database and can be accessed by both. Ordinarily, a pharmacist who disposes of returned medication does not notify the person who prescribed the medication of the disposal.

Hon NICK GOIRAN: The voluntary assisted dying substance disposal form in schedule 1 of the Victorian legislation requires substance-specific or poison-specific information to be included in the form, including the type of substance and the quantity returned. Why is this information not required to be recorded in the authorised disposal form under clause 75?

Hon STEPHEN DAWSON: Determining the quantity returned is not consistent with current practice and it could be problematic. If the substance has already been prepared for ingestion—for example, mixed with another substance to make it more palatable—then the authorised disposer would not readily be able to determine the quantity of the scheduled substance in the preparation.

Hon NICK GOIRAN: If the authorised disposer is required to record and notify of disposal, is it the case that the minister is indicating that they will be recording and notifying a quantity of which they are unaware? The suggestion is that they are unaware of the quantity of the substance of which they are disposing, which is contrary to the whole idea of recording and notifying. If they are going to record and notify that they are getting rid of something, they should have to identify what it is and how much of it they are getting rid of. It seems counterintuitive to me that we would simply say, "Let the board know that you've gotten rid of this thing" when they do not know what it is, let alone how much there is of it. Presumably in order for clause 75 to trigger a requirement on the disposer, they must have some knowledge that part of the thing that they have in their possession includes a voluntary assisted dying substance. If they do not know that, clause 75 is not enlivened. How is the disposer to know that they are required to do anything under clause 75 if they do not know whether the substance is a voluntary assisted dying substance, to say nothing of the quantity?

Hon STEPHEN DAWSON: We are saying that any quantity returned will be disposed of. We are not testing what we are supplying and what is returned. It is our belief that that is overly prescriptive.

Hon NICK GOIRAN: If the board receives an authorised disposal form, it will be the case that the disposer has disposed of a substance that might be entirely a voluntary assisted dying substance or partly a voluntary assisted dying substance and something else. Is that right?

Hon STEPHEN DAWSON: That is correct. Adding to the earlier comment I made, we will be guided by the voluntary assisted dying substance packaging, but we cannot independently verify the elements that come back to us.

Hon ADELE FARINA: That being the case, where is the harm in recording the volume of whatever it is sent back, because we will know how much powder is provided as part of the voluntary assisted dying substance and the quantity of the syrup that is provided to be mixed with the powder? How big a problem is it to simply record how many millilitres are returned?

Hon NICK GOIRAN: While the minister is thinking about that, this dialogue has been useful for me as I contemplate the amendment standing in my name at 474/75. It is clear that if I move the amendment in its current form, it will not receive the support of the government, for the reasons the minister has indicated, which I respect. I wonder, therefore, whether the solution would be that I delete the word "prescribed", so that at least the form would indicate the type and quantity of the substance that has been given to the disposer and we will know what they are disposing of.

Hon STEPHEN DAWSON: In relation to Hon Adele Farina's question, volume is not an effective indicator. A substance may be returned in tablet or powder form, or after it has been mixed in water, et cetera, so it is a very difficult thing to measure. Therefore, I am not sure that it will give the honourable members who have concerns about this issue the comfort that they are seeking to get from it.

Hon NICK GOIRAN: I guess the issue is that clause 75 of the bill mandates that an authorised disposer must complete the form and send it to the board so that there is some regulating around the disposal of the substance. The government, at clause 75(2) of the bill, has determined that it is sufficiently important that the form must also include the name, date of birth and contact details of the patient; the name and contact details of the authorised disposer; the name and contact details of the person who gave the substance to the disposer; the date when the prescribed substance was given to the disposer; the date when the prescribed substance was disposed of by the authorised disposer; and the signature of the authorised disposer and the date when the form was signed. The authorised disposer must do all those things, but they do not have to tell the board what substance, and how much of it, they are getting rid of. I do not quite understand the rationale behind the importance of, for example, setting out the date of birth of the patient when we are disposing of the substance. In many respects, without meaning to in any way sound disrespectful, who cares who the patient is at this particular point in the journey? It is about disposing of a lethal substance in a manner that is safe for the community. I would have thought it would be appropriate that there be some identification of that.

I will explain the mischief that I am concerned about. A rogue disposer may be given a quantity of the substance, but they decide, for improper purposes, to dispose of only some of it. They continue to pretend that they are complying with the law, but they retain a portion of the substance—not the whole lot, but let us say, for the purpose of this example, that they retain half—and they say, "I'm going to dispose of only half of it, and I'm going to keep half and supply it to somebody improperly." The board would have no idea about that, of course, because the board has simply been told that they have disposed of the substance; it is not told how much.

I query what the objection would be if the board was simply told, "This is the type of substance that I, the disposer, was given, and this is the amount that I have disposed of." There would then at least be clear tracking of that, rather

than a situation in which a form is given to the board, without any particular purpose. The form is giving the board details that it already knows. The only thing the board does not know at this point is in subclause (2)(d) and (e)— the date when the substance was given to the disposer; and the date when the substance was disposed of. The rest of it is not particularly beneficial. A piece of information that would be beneficial is, "What exactly were you given, and how much were you given?" I wonder whether the minister is in a position to provide any further advice on that point.

Hon STEPHEN DAWSON: The substance has a chain of custody from the supplier, agent or contact person to patient, and then it is collected by the contact person. The proposed amendment offers no additional safeguards and my advisers tell me that it may well offer a false sense of security.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, I note that you have not moved this amendment yet. Do you intend to move it?

Hon NICK GOIRAN: I have just decided that I will not. I take the points that have been made by the minister, in particular that there may be some difficulty because the substance has been mixed and so on. However, it still troubles me that we are disposing of something that a person has not fully identified. I might pick this up at a later clause because if we are to concede that it is asking too much of the disposer to identify what it is and how much of it that they are disposing of, at some point in the reporting requirements there should be an obligation to make sure that the board knows how much was provided in the first instance. Let us imagine for a moment that we are talking about practitioner administration. I would want to make sure that the board was aware that the practitioner who was going to administer the substance had to declare or certify what the substance was and how much they received even if they could not identify it at the point of disposal. At this point I will not move the amendment standing in my name at 474/75.

Clause put and passed.

Clause 76: Disposal of prescribed substance by administering practitioner —

Hon NICK GOIRAN: Will the administering practitioners, including nurse practitioners, be trained and have the facility to dispose of prescribed substances as required by this clause?

Hon STEPHEN DAWSON: They will have the necessary training. In most cases the administering practitioner will be able to dispose of the substance within the facility at which they work. Alternatively, the administrating practitioner will be able to arrange for disposal with the local authorised disposer.

Hon NICK GOIRAN: Clauses 76(3) and 76(6) provide that the prescribed poison must be disposed of by the administering practitioner as soon as practicable after the practitioner administration decision is revoked or after the patient's death. Similarly to the last situation, what is the rationale behind that not being done immediately rather than as soon as practicable?

Hon STEPHEN DAWSON: It is for the same reason I gave before, honourable member.

Hon NICK GOIRAN: Is the administering practitioner required to notify the authorised supplier that they have disposed of the substance in accordance with clause 76?

Hon STEPHEN DAWSON: No, but it will be on the database so the information can be accessed.

Hon NICK GOIRAN: This is my final question under this clause: what requirements of the Medicines and Poisons Act 2014 must the administering practitioner comply with under clause 76(7)?

Hon STEPHEN DAWSON: It is the same answer as I gave last time on this issue, when we dealt with it on a recent clause. I have some further information, though; that is, that the Medicines and Poisons Regulations may be amended to impose additional requirements for disposal of a VAD substance upon the passage of this bill.

Hon NICK GOIRAN: Is the minister indicating that clause 76(7) is to be read in like fashion as clause 74(4)?

Hon STEPHEN DAWSON: The answer, honourable member, is yes.

Clause put and passed.

Clause 77: Administering practitioner to record and notify of disposal —

Hon NICK GOIRAN: Under clause 77(2), there is no requirement for the administering practitioner to record the type of prescribed substance and quantity disposed of. Earlier, the minister gave reasons why that is the case, but he may recall that I indicated I would like to take up this issue, at least with respect to the prescribed substance that was supplied, even if we are not going to deal with the prescribed substance disposed of. I ask the minister to take a look at clause 77(2)(c), which indicates that the practitioner has to report to the board on the date when the prescribed substance was supplied to the administering practitioner. At this point, it would be

appropriate for the practitioner to also advise the board the type and quantity of the substance that was supplied to the practitioner at that time; in other words, to give more details of the prescribed substance supplied, rather than merely the date. My question to the minister is: Is that already captured in some other provision? If it is, that would make it unnecessary; but, if it is not, would the government have any objection to the practitioner disclosing to the board more than just the mere date that they were supplied with the substance, but actually the type and quantity?

Hon STEPHEN DAWSON: I am told that the prescription would state the dosage, and the board can access prescription details on the database.

Hon NICK GOIRAN: Does the government object to the administering practitioner providing in the practitioner disposal form the type and quantity of the prescribed substance supplied to the administering practitioner on the date set out in clause 77(2)(c)?

Hon STEPHEN DAWSON: We do not support an amendment. The information is already available to them if they so require it.

Clause put and passed.

Clause 78: Authorised suppliers and authorised disposers —

Hon NICK GOIRAN: Can someone other than a pharmacist be authorised by the CEO to act as an authorised supplier under clause 78?

Hon STEPHEN DAWSON: The clause provides that the CEO can authorise a registered health practitioner, so the answer is yes.

Hon NICK GOIRAN: Is that the intention?

Hon STEPHEN DAWSON: The authorised supplier will be a registered health practitioner at a hospital, pharmacy or medical facility who has been approved by the CEO of Health to supply a voluntary assisted dying substance for the purposes of the legislation. The authorised supplier will be limited to registered health practitioners authorised under the WA Medicines and Poisons Act 2014 to supply schedule 4 and 8 poisons. It is likely that the authorised supplier will include a public health service hospital or pharmacy, with pharmacists and practitioners who are also authorised under the WA Medicines and Poisons Act 2014 to supply schedule 4 and 8 poisons. These registered health professionals, including pharmacists, are already bound by professional obligations that require them to act within the scope of practice and area of expertise. The intention at this stage is for pharmacists to take that role.

Clause put and passed.

Clause 79: Certain directions as to supply or administration prohibited —

Hon NICK GOIRAN: Clause 79(1) refers to an "authorised health professional" under section 3 of the Medicines and Poisons Act. Can a vet, who is included in the section 3 definition of health professional of the Medicines and Poisons Act 2014, be given approval by the CEO to act as an authorised supplier under clause 79?

Hon STEPHEN DAWSON: This provision reflects that only a person so authorised by the CEO may supply a poison for the purposes of voluntary assisted dying. This is an intentional safeguard that cannot be overridden by a coordinating practitioner or other health professional. This clause excludes the operation of regulations 15 to 17 of the Medicines and Poisons Regulations 2016. The answer to the honourable member's question is no.

Hon NICK GOIRAN: Nevertheless, this clause as drafted in the definition of "authorised health professional" in section 3 of the Medicines and Poisons Act is still very broad and captures a broad group of people who can be authorised by the CEO. In Victoria, these substances can only be prepared by a pharmacist and only one pharmacy has been approved to supply that substance, as I understand it. Why has the government chosen to draft this clause so broadly in contrast with the Victorian experience which limits it to one supplier, one pharmacy, and only pharmacists are able to prepare the substance?

Hon STEPHEN DAWSON: At section 78(1), the CEO may appoint an authorised supplier but they must be a registered health practitioner. For the purposes of the voluntary assisted dying legislation in WA, this bill makes it clear that, notwithstanding the authorisation under the Medicines and Poisons Act, a practitioner must be specifically authorised under the bill to prescribe and supply these medications.

Hon NICK GOIRAN: Where will authorised suppliers obtain these substances from? For example, will they require importation?

Hon STEPHEN DAWSON: I am told that detail will be determined during the implementation phase, honourable member.

Hon NICK GOIRAN: Given that you do not know—this is no criticism of you; when I say "you" I mean the government—or given that the government does not know, how confident can we be that there will even be a substance available to people? We are saying to people, "Quick, quick, quick, we need to make sure this bill passes before Christmas," and any members who want to ask any questions about this are merely described as wreckers and blockers. Christmas Day, 25 December, is a very important deadline, apparently, according to the Premier of Western Australia. But as I understand the minister's answer just now, the government, of which the Premier is the chief, does not know what substance is going to be provided. That will be dealt with under the implementation phase, which I understand from an earlier answer the minister gave—not necessarily today, but on a previous occasion—will be a period of at least 18 months. When I asked the minister whether this substance might require importation, he indicated that the government does not know whether it will require importation. The substance might not even be available. While we move at great speed to make sure that the Voluntary Assisted Dying Bill 2019 is passed before Christmas to meet this artificial deadline, we do not actually know whether the substance will be available. Why is that? It is because we do not even know what the substance is. I find that quite remarkable. I will not phrase it in the context of a question; it is more just a comment at this point. My final question on clause 79 is: why does clause 79(3) include a prohibition against a coordinating practitioner or administering practitioner directing an authorised health professional to administer a prescribed substance?

Hon STEPHEN DAWSON: The intent of this clause is to override provisions in the Medicines and Poisons Act that allow other people to administer various schedule 4 or 8 drugs. Regulation 15 of the Medicines and Poisons Regulations allows a prescriber to give such a direction to an authorised health professional, and clause 79(3) of this bill operates to override this.

Clause put and passed.

Clause 80: Structured administration and supply arrangement not to be issued for substance —

Hon NICK GOIRAN: In what circumstances might a structured administration and supply arrangement be documented, and how does the structured administration and supply arrangement operate in those circumstances?

Hon STEPHEN DAWSON: A structured administration and supply arrangement means a document that sets out the circumstances in which a health professional specified, or of a class specified in the document, may administer or supply a medicine specified in the document. The intent of this clause is to override any provision in the Medicines and Poisons Act 2014, particularly regulations 33 to 35 of the Medicines and Poisons Regulations, that allows for a structured administration and supply arrangement to be made. It would not be prudent to allow such an arrangement pertaining to the voluntary assisted dying process.

Hon NICK GOIRAN: Why would it not be prudent? Are there any other drugs, medicines and poisons for which a structured administration and supply arrangement is prohibited from being issued?

Hon STEPHEN DAWSON: I ask the member whether the question is pertinent to his support of this clause. My advisers at the table cannot give me an answer to that question. I am very happy to provide it at a later stage of the consideration of the bill if the member is able to wait and if it is not pertinent to his support of the clause before us.

Hon NICK GOIRAN: I am happy for that question to be answered at a later stage, if the minister could give an indication of the clause under which that information will be provided.

Hon STEPHEN DAWSON: We are seeking advice now. If I can provide it later today, I will. I will provide it as soon as I can.

Hon ADELE FARINA: I am a bit confused about the answer that has been given relating to this provision. The minister has consistently told us that detailed guidelines will be provided to medical practitioners involved in this process about how they are to administer the substance. Maybe I am reading this clause incorrectly, but does a structured administration and supply arrangement not do that?

Hon STEPHEN DAWSON: I am told no, because the only people who can administer the substances are listed in the bill before us.

Clause put and passed.

Clause 81: Notification of death —

Hon CHARLES SMITH: I seek leave to withdraw my amendment 45/81.

Amendment, by leave, withdrawn.

Hon NICK GOIRAN: Mr Chair, I have a number of questions relating to clause 81. Before I ask them, I seek your guidance on amendments 16/81 and 333/81 on the supplementary notice paper. There are a lot of similarities between those amendments, not the least of which is that they both seek to delete the same lines. I notice that Hon Colin Tincknell is away from the chamber on urgent parliamentary business. As I said, I have some general questions relating to clause 81 in any event. The point of clarification that I am seeking at this stage is that if I were minded to move my amendment at 333/81, which is simply to delete lines 6 to 8, I take it that nothing would stop Hon Colin Tincknell, in the event that my amendment was successful, from moving to insert words supplementary to that. I seek clarification on that before I take any precipitous action.

The CHAIR: The consideration of the clause in the first instance requires consideration of the clause in its entirety. From time to time, members may move amendments. At that time, the focus of debate in consideration is then on the amendment in question. In relation to the live situation that Hon Nick Goiran has just described, I will seek to give the call to Hon Colin Tincknell to move his amendment in due course, if he is of a mind to do so. Conversely, if he is not present to move it, and Hon Nick Goiran moved his, which is nearly identical, and then Hon Colin Tincknell were to come in, we could still consider his amendment anyway because they are not in conflict with each other; they seek to delete exactly the same lines in the bill, so we have not moved them on. That is purely hypothetical of course until we come to it. I do not know whether anyone knows where Hon Colin Tincknell is. For all we know, he may be returning to the chamber now. In the short term, the question is that clause 81 do stand as printed.

Hon NICK GOIRAN: Thank you for your helpful advice, Mr Chair.

Under clause 81(5), the medical practitioner who knows or reasonably believes that a person was a patient who self-administered or was administered a voluntary assisted dying substance is required to notify the board of the patient's death within two business days after becoming aware of that person's death. How might that medical practitioner become aware of the person's death?

Hon STEPHEN DAWSON: It is highly likely that the certifying medical practitioner will know that the person has gone ahead with the voluntary assisted dying process because at that stage, the person will have family members, a contact person or an administering practitioner who will already have been engaged in the process. The patient will not be making this decision in isolation, so when everyone is sitting around wondering what went wrong, it will be in the context of the ongoing care that the patient is under. For instance, the patient might be sitting in a wheatbelt town surrounded by family and supervised by the general practitioner, but the general practitioner may not be the administering or consulting practitioner; they may simply be a member of the medical community in that town. Even though there has been audiovisual contact between the patient and the coordinating and consulting practitioner, the general practitioner is obviously competent for the certification process.

Hon NICK GOIRAN: I agree that the GP in the scenario the minister painted would be competent to do the task. My question is that clause 81 is triggered only if voluntary assisted dying is in play. How will the general practitioner necessarily know that that is the person before them; in other words, that that person has died as a result of a voluntary assisted dying substance and clause 81 has been triggered? They may be completely unaware of that situation. How will that be addressed?

Hon STEPHEN DAWSON: It is likely that the general practitioner will know if it is voluntary assisted dying, but if not, the contact person certainly will know. We will encourage the patient to tell their GP whether they are self-administering and if it is self-administration, the container will be there.

Hon NICK GOIRAN: We identified earlier in the debate that there may be no contact person at this point because the contact person has been revoked. When the government provides an explanation that, effectively, the contact person is a little bit like a goalkeeper in soccer, it is of no use to the soccer team if there is no goalkeeper. If the goalkeeper is absent from the field, no-one will be able to catch the ball. I am troubled when the explanation is simply that what is likely to happen is that the general practitioner is likely to know. They might not. Again, there might be a falling out between the patient and the general practitioner. The general practitioner may have a conscientious objection to what is happening. The general practitioner might have known the patient for a very long time and be concerned that the person is suffering from demoralisation, so the general practitioner is estranged from the patient. If the government's safety net is the contact person, that will be of no assistance if no contact person has been appointed following a revocation.

I note that under clause 81, the board will receive some information. What will the board be required to do once it has been notified by the medical practitioner under clause 81(5)?

Hon STEPHEN DAWSON: This is to help the board maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia. I think I made the point before that the information will be provided to the Australian Bureau of Statistics and be available in a de-identified form to Parliament and the community so that it can form a view about how well the legislation is operating. The role of the Voluntary Assisted Dying Board in the collection of accurate statistics and for record keeping will assist to address views espoused in public consultation, led by the ministerial panel, that it was vital that data should be maintained.

Hon NICK GOIRAN: Does clause 81 conflict with the legislative responsibility to report the cause of death under section 44 of the Births, Deaths and Marriages Registration Act?

Hon STEPHEN DAWSON: I am told that it does not conflict and that it is a separate requirement that overrides it.

Hon NICK GOIRAN: Did the government consult with the WA Registrar of Births, Deaths and Marriages in drafting this clause; and, if so, what recommendations were made?

Hon STEPHEN DAWSON: Yes, we did consult with them and the clause as it stands reflects that discussion.

Hon NICK GOIRAN: Does the clause as it stands have the support of the WA Registrar of Births, Deaths and Marriages?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: I do not necessarily need to know who the WA Registrar of Births, Deaths and Marriages is, but when were they appointed?

Hon STEPHEN DAWSON: I do not know when they were appointed and I am not sure whether the appointment date affects the bill before us, but certainly there has been continuity with the person we have been dealing with at the office. I am advised that in relation to this bill, we have been dealing with the second in charge, who has given the okay from the Registry of Births, Deaths and Marriages.

Hon NICK GOIRAN: Earlier, when I asked whether the government had consulted with the Western Australian Registrar of Births, Deaths and Marriages, really the answer should have been no, it has been dealing with somebody else subordinate within the office of that organisation. It is absolutely pertinent, because if the government, through the course of this consultation, has suddenly put in a new Registrar of Births, Deaths and Marriages in recent times, we would want to know that and whether it conflicts with any other advice that has been provided to the government. Perhaps the minister could indicate this to us: did the ministerial expert panel receive any advice from the registrar?

Hon STEPHEN DAWSON: The issue has been covered. I am not being rude; I think the concern has been covered. We consulted with the former registrar and the second-in-command. The registrar left and I am advised that the 2IC has kept the new registrar up to date.

Hon NICK GOIRAN: With that continuity, that office has consistently advised that what is being proposed in clause 81 is acceptable and supported, and no concerns have been raised by the registrar, former or current, about this particular provision.

Hon STEPHEN DAWSON: That is my advice, yes.

Hon COLIN TINCKNELL: I move —

> Page 55, lines 6 to 8 — To delete the lines and substitute —
>
> (6) The medical practitioner must state that voluntary assisted dying was the cause of death.

I am going to keep this brief, because we discussed this a lot in clause 1 and there was a reasonably good debate about this issue. I never heard anything that convinced me that we should not be doing any different. I believe that if the cause of death is assisted dying, it should be on the death certificate. I understand there were discussions about stigma and all that, but I think we are actually adding to the stigma by trying to cover up the actual cause of death. The cause of death in any sort of terms is what actually happened, and what actually happened was that the person decided to take up the option of voluntary assisted dying. Clause 81(6) states —

> The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

I just do not see how that is reflective of what has actually happened. I do not want to be responsible for any mistruths, in my opinion, on the death certificate. If the people of Western Australia and this Parliament decide to bring assisted dying into place, we should indicate quite clearly how that person's life was ended. The only way

we can do that is to say that they took the option of voluntary assisted dying, and that should be reflected on the death certificate.

Hon NICK GOIRAN: I am really troubled by the information that the minister provided earlier. I draw to the minister's attention the second last paragraph on page 88 of the "Ministerial Expert Panel on Voluntary Assisted Dying: Final Report", which clearly states —

> The Panel received feedback from the Registrar that he would have concerns …

I asked in various forms whether the Registrar of Births, Deaths and Marriages had raised any concerns. I was told, "No, we've been dealing with the second in command, and so on and so forth." Then I read at page 88, in black and white, that the registrar did raise concerns. I find that highly unsatisfactory. In addition, if we look at the final paragraph on that page, we see a very, very interesting comment. I wonder how many people have picked up on this. I would like the government to explain—not least given that it has at its disposal the chair of the ministerial expert panel—the very interesting line that says —

> There were a range of views on this topic in the Panel.

Minister, what were the range of views on this topic in the panel?

Hon STEPHEN DAWSON: My advice still stands on the conversations and the consultations that the department had with the Registrar of Birth, Deaths and Marriages. The member read comments from page 88 of the ministerial expert panel's final report. The report states —

> … the Panel recommends that in the case of a person whose death is caused by voluntary assisted dying, a separate reporting mechanism for this information be considered. The Panel recommends that the medical practitioner report this information directly to the oversight body, who in turn can report this information to the Registrar of Births Deaths and Marriages.
>
> The Panel received feedback from the Registrar that he would have concerns about such a mechanism …

It is the mechanism that is referred to in his comments. That is what that says. Certainly, my advice from the Department of Health on the drafting of this bill is that conversations and consultations have taken place, and that the office of the registrar is happy with where we have landed. Ultimately, the government accepted the ministerial expert panel's advice that maintaining a family's privacy was paramount.

In relation to the question about the differences of opinion, I am advised that some panel members were concerned that the death certificate would not disclose voluntary assisted dying as the cause of death. Some had strong views; others had different views. Certainly, where we have landed, can I say, was the view of the majority and all members of the panel reached a consensus that they support where we have landed.

Hon ALISON XAMON: I rise to indicate that I will be supporting this amendment. I have been perplexed about why this provision is included in the bill in the first place. We have other causes of death that are recorded. For example, if someone takes their life, the way that person died is recorded on the death certificate, but so is the fact that the person took their own life. That is already there and it happens regardless of whether people are concerned about stigma or perhaps families do not want to have that revealed. This decision is made independently by the coroner. The coroner does this as a matter of record. I think it is really important that we also ensure that these sorts of records are kept. We have our death records so that we have an accurate record of what has happened in people's lives and how their deaths have occurred. This is also used historically. It strikes me that this provision in the bill is a bit of a disturbing attempt at social engineering to try to hide something that I do not think needs to be hidden. One of the things we keep hearing, and we know, is that a majority of Western Australians support the capacity for people to go gently and to avail themselves of voluntary assisted dying under certain circumstances. As such, I think this provision, if anything, stigmatises something that we keep being told has broad social acceptance. I find it perplexing that if someone is murdered, it is reflected in the death certificate. If someone takes their life, it is reflected in the death certificate. I do not see why this should be treated any differently. I think it is really important that we do not attempt to try to withhold this sort of information from what should be just a standard record.

Committee interrupted, pursuant to standing orders.

[Continued on page 9728.]

Sitting suspended from 4.16 to 4.30 pm