VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 28 November. The Deputy Chair of Committees (Hon Matthew Swinbourn) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 56: Revocation of administration decision —

Progress was reported on clause 56.

Hon NICK GOIRAN: Although clause 56 rightly provides for the revocation of an administration decision by the patient, the clause is silent on what is to be done if a self-administration decision has been made and the patient has obtained and is in possession of a voluntary assisted dying substance. What is required to be done with the approved poison if the patient is already in possession of that substance and their self-administration decision is revoked?

Hon STEPHEN DAWSON: The substance must be returned. It can be returned to the coordinating practitioner, or the contact person or authorised disposer can return it.

Hon NICK GOIRAN: Where is that provided for in the bill?

Hon STEPHEN DAWSON: I am advised the issue is covered under clauses 66(1)(d) and 104.

Hon NICK GOIRAN: Clause 66(1)(d) is a reference to a contact person and clause 104 is also referenced to a contact person. Moments ago, the minister mentioned three options: it could be the coordinating practitioner, or a contact person, and I think the third category or class of person that the minister referred to was an authorised—I missed whether it was a prescriber or disposer.

Hon Stephen Dawson: Disposer.

Hon NICK GOIRAN: An authorised disposer. The two clauses that the minister just referred to me deal only with the contact person. Where in the bill are the first and the third classes of persons provided for?

Hon STEPHEN DAWSON: Clause 74 relates to "Disposal of prescribed substance by authorised disposer".

Hon NICK GOIRAN: What about the coordinating practitioner?

Hon STEPHEN DAWSON: That is in clause 76.

Hon NICK GOIRAN: If the patient's contact person is expected to return the poison after the patient's revocation of the administration decision, how will that contact person be made aware that the patient has revoked their decision?

Hon STEPHEN DAWSON: The patient may inform the coordinating or administering practitioner of the decision to revoke their administration decision and the contact person can be made aware in a number of ways—namely, in writing, verbally, by gestures or by other means of communication available to the patient.

Hon NICK GOIRAN: Clause 56(2) provides that a patient may inform the coordinating practitioner or administrating practitioner that they have revoked their self-administration decision, but there is no mention there of the contact person or the authorised disposer. The minister mentioned those three classes of people earlier; it seems as though only one of those classes is covered at clause 56(2). Can the minister clarify that?

Hon STEPHEN DAWSON: The coordinating or administering practitioner, or, indeed, the board, can follow-up with the contact person.

Hon NICK GOIRAN: There is no obligation, as I see it, on the part of the patient to inform anyone of the revocation; it is merely discretionary. They "may" let people know that they have revoked their decision. Is there any requirement in the bill for the coordinating practitioner to follow-up with a patient who has made a self-administration decision, or is the patient issued with the substance and they can store it at home for potentially months until they choose to self-administer, without any follow-up care from their coordinating practitioner? How does the bill deal with that situation?

Hon STEPHEN DAWSON: There is no requirement. Self-administration will take place at a time of the patient's choosing. Stipulating a time frame for keeping the medication at home risks coercing a patient into taking the substance sooner than they would otherwise choose to.

Hon NICK GOIRAN: Minister, I agree entirely. I have not suggested that in any way. The issue that I have is whether there will be any follow-up by the coordinating practitioner. I do not even want the patient to take the substance, but, be that as it may, that is just my view. The point is that some follow-up care should be provided by the coordinating practitioner and it is not clear that that is the case. I agree with the minister that the bill does not specify a time limit. For example, there was a time earlier in the debate when I thought to myself that the

practitioner would actually say to a patient, "You are going to die within the next six months." One part of me thinks that it is really quite improper for the patient to then take the substance seven, eight, nine or 12 months afterwards because that is an indication that the doctor got the prognosis wrong. However, there is no solution to that that I can see. I am the last person to want to suggest putting in a time limit here. As the minister says, that could coerce a patient to say, "Look, I'm getting close to the six-month mark. The doctor said I only had six months to live, so I'd better take this poison before it expires." I do not want that, so I agree with the minister. But that is not what I am talking about; I am talking about when the substance is at the patient's home and the doctor does not know what is going on once the substance has been prescribed. In order to know whether or not there has been a revocation, will the coordinating practitioner conduct a routine follow-up? This is not a simple issue because, equally, I do not want to see the practitioner also subtly coercing or encouraging the person to take the substance. It is a very complex, tricky situation of providing care for a person while making sure that there is no implied coercion. I am wondering what consideration has been given to walking that very fine line.

Hon STEPHEN DAWSON: There is no obligation in the bill to do a follow-up, but the usual doctor–patient relationship would entail following up with a dying patient. The doctor and other health professionals would have roles in the patient's care.

Hon NICK GOIRAN: Thanks, minister. I do have an amendment standing in my name, but it is after those by another honourable member, so I will wait to see what happens with those amendments before I move my amendment 88/56.

Hon RICK MAZZA: The amendments standing in my name at clause 56, being 417/56, 418/56 and 419/56, are consequential amendments. Perhaps they could be retained on the supplementary notice paper until we deal with the substantive one.

The DEPUTY CHAIR: The member's comments are noted. The proposed amendments remain on the supplementary notice paper if the clause is recommitted. The next amendment is that of Hon Nick Goiran, 88/56.

Hon NICK GOIRAN: I move —

> Page 36, after line 12 — To insert —
>
> (ea) if the patient was assisted by an interpreter when revoking the administration decision, the name, contact details and accreditation details of the interpreter;

Briefly, by way of explanation for members, this amendment is similar to the amendments that I moved to clauses 28 and 49. This amendment requires revocation forms to also include whether a patient was assisted by an interpreter in revoking an administration decision. As members will be aware, clause 160(1) provides that an interpreter can assist a patient in relation to the process for accessing voluntary assisted dying under part 4, and clause 160(2) provides for the accreditation requirements of the interpreter and mandates certain independent standards of the interpreter, such as that the interpreter cannot be a family member of the patient, a beneficiary under the patient's will, an owner or manager of a health facility in which the patient is being treated or resides, or a person directly involved in providing health services or professional care services to the patient. This amendment to clause 56 requires the name, contact details and accreditation details of the interpreter to be included in the revocation form, and I seek the support of members.

Hon STEPHEN DAWSON: I am happy to indicate to honourable members that the government is supportive of this amendment. I am of the view that it strengthens the bill, consistent with earlier agreed amendments.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 57: Self-administration —

Hon MARTIN PRITCHARD: I note that Hon Adele Farina has foreshadowed an amendment to this clause, so I just want to speak to that for a moment.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, the amendment has not been moved. Normally, we would not speak to the amendment until it has been moved, and it may not be moved by the member. The question before the chamber is that clause 57 stand as printed, not as amended.

Hon NICK GOIRAN: I have some broad questions on clause 57, before we consider some of the very significant matters set out on the supplementary notice paper. In fact, I note that there are five very significant matters on the supplementary notice paper at clause 57 and I look forward to us considering them in due course.

We know that self-administration is available in certain jurisdictions, and a debate took place yesterday about the Oregon model in particular, where self-administration is really the only way to go forward. For example, the "Fourth Interim Report on Medical Assistance in Dying in Canada" tells us that practitioner administration is the preferred method of administering medical assistance in dying in Canada. I understand from the fourth interim report that only 0.12 per cent of patients have self-administered in that jurisdiction; in other words, more than 99 per cent of patients have chosen practitioner administration. Page 8 of the report also informs us that Quebec's legislation permits only clinician-administered medical assistance in dying.

I know that the government partly funded Dr James Downar to come to Western Australia to, I think, brief the government but certainly to brief members. Did the government have an opportunity to consult with that individual on why self-administration is not permitted in Quebec; and, if so, what advice was received? Further to that, did the government also have the opportunity to ask him why self-administration rates are so low in Canada? I am interested to know why, in the Canadian experience, more than 99 per cent of patients chose practitioner administration and a mere 0.12 per cent of patients chose self-administration. This follows on from some of the dialogue that took place yesterday between the minister and Hon Aaron Stonehouse about a patient's decision to choose one method over the other. What type of advice did the government obtain from Dr Downar, whom the government funded to come to Western Australia?

Hon STEPHEN DAWSON: Dr Downar met with the ministerial expert panel and I am advised that the outcome of the discussion is reflected in the panel's recommendations in the final report. I want to make a further point and that is that it was clear from the public consultation that was undertaken that both options were wanted in Western Australia.

Hon AARON STONEHOUSE: Clause 57(7) states —

> An agent of the patient is authorised to —
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> (a) receive the prescribed substance from an authorised supplier; and
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> (b) possess the prescribed substance for the purpose of supplying it to the patient; and
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> (c) supply the prescribed substance to the patient.

Firstly, can the minister tell me who the agent is and whether this appears elsewhere in the bill?

Hon STEPHEN DAWSON: As the member has correctly pointed out, clause 57(7) of the Voluntary Assisted Dying Bill expressly provides authority to any person so selected by the patient as their agent to pick up and deliver the prescribed substance to them. Election of an agent is at the patient's discretion. "Agent" is not defined in the bill, as it is a commonly used term across the health system that denotes a person chosen by a patient to act on their behalf. In the case of the prescribed substance, the agent will pick up the substance from the approved supplier and provide it to the patient. The use of the term "agent" of a patient is contemplated under the Medicines and Poisons Act in terms of a person whom a patient asks to receive, or pick up, the medication for them and supply, or deliver, to the patient. If requested to do so by the patient, the patient's agent will collect the dispensed voluntary assisted dying medication from the authorised supplier and deliver it to the patient.

Hon AARON STONEHOUSE: The agent and the contact person could very well be the same person; I imagine that would be likely in some cases. An agent might be someone's carer, or perhaps a family member in this instance. As "agent" is not defined in the bill, unless it is defined in the Medicines and Poisons Act, I believe there is no prohibition on an agent being a family member. Under clause 66, I do not think the contact person is prohibited from being a family member.

Hon Stephen Dawson: No.

Hon AARON STONEHOUSE: I think that is appropriate. I wanted to better understand what an agent was in that context.

Hon CHARLES SMITH: I seek further clarification of subclause (7). Can an agent delegate their duties to someone else?

Hon STEPHEN DAWSON: No, they cannot.

Hon RICK MAZZA: Maybe I missed this during the debate, but can the minister define the difference between the contact person and the agent? It appears to me that they have the same functions. I do not know that the agent and the contact person are defined separately in the bill.

Hon STEPHEN DAWSON: Clause 66 sets out the role of a contact person. There are similarities between the contact person and the agent. Clause 66(1) states that the agent can —

(a) receive the prescribed substance from an authorised supplier;

That is essentially the same. Paragraphs (b) and (c) are similar. There is a difference between clause 57(5)(d) and clause 66(1)(d). Clause 66(1) states —

The contact person for the patient is authorised to —

(d) give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by section 104.

Hon MARTIN ALDRIDGE: This has also intrigued me. The contact person is obviously a person. Could an agent be used by somebody in care? The agent could be the aged-care facility or, if the patient is in the care of a public hospital, it could be the public hospital. Could the agent be an institution rather than an actual person? Who appoints or revokes that agency?

Hon STEPHEN DAWSON: The patient has to appoint somebody. The patient can choose the person. It cannot be an institution; they have to pick an individual.

Hon RICK MAZZA: I thank the minister for describing the difference. Except for clause 66(1)(d), the roles of the contact person and the agent are the same. If someone elects to use an agent and there is an unused portion of the prescribed substance, what is the agent required to do to dispose of it? At the moment, the bill provides that the contact person must give the unused substance to an authorised disposer. The bill seems to be silent for an agent.

Hon STEPHEN DAWSON: Under the bill, a patient must have a contact person if they are going to self-administer. They do not have to have an agent.

Hon ADELE FARINA: If it helps, I think that the agent arrangement arises in the event that the contact person is not able to pick up the drug—the patient is able to exercise the collection of that drug through an agent. That is what I assumed from my reading of the bill. The responsibility for getting rid of any unused substance remains with the control person. How does the authorised supplier know that the person who presents themselves and says that they are the agent for the patient is actually the agent for the patient?

Hon STEPHEN DAWSON: Under clause 70, the authorised supplier must authenticate the identity of the person who issued the prescription and the identity of the person to whom the substance is to be supplied. That could be by a letter from the patient indicating that they authorise the person to collect on their behalf, or it could be correspondence from the coordinating practitioner.

Hon ADELE FARINA: Therein lies my concern with this. In the case of the patient appointing the contact person, they need to appoint the contact person, the contact person needs to accept that responsibility, and all of that information needs to be provided to the coordinating practitioner —

Point of Order

Hon STEPHEN DAWSON: We are not dealing with the contact person at the moment.

Hon ADELE FARINA: I know; that was just part of the explanation for my question.

Hon STEPHEN DAWSON: Sure. If we were going to get into a deep conversation about the contact person, I was going to say leave it until clause 66, or whatever.

The DEPUTY CHAIR (Hon Matthew Swinbourn): There is no point of order. I give the call back to Hon Adele Farina.

Committee Resumed

Hon ADELE FARINA: I am just trying to explain the difference between the two roles. With regard to the contact person, the substance cannot actually be prescribed or dispensed until a contact person is appointed and the coordinating practitioner is aware of who it is and has a form signed by the contact person to say that they agree to take on the responsibility of contact person, so there is a clear bit of evidence about who the contact person is with the contact person's signature. It is easy enough for the authorising supplier to authenticate a signature on a letter, for example, because the coordinating practitioner will have the signature on the form that the contact person has signed.

In the case of an agent, there is no requirement for the patient to inform the coordinating practitioner that they are appointing an agent to pick up the substance. Even if the patient were to provide the agent with a letter saying, "Please supply this drug to this person who is acting as my agent", how will the authorised supplier know that that signed letter is legitimately from the patient? They will have had no contact with the patient. I think there is a bit of a gap in the bill with regard to those processes. It becomes extremely difficult for the authorised supplier to

fulfil their obligation under clause 70 of authenticating to whom they are providing the substance when that person is an agent of the patient and there has been no paperwork to establish that person as an agent.

Hon MARTIN PRITCHARD: I do not think the minister is going to respond to that, so I will move on.

Hon Stephen Dawson: That was a comment.

Hon Adele Farina: Sorry, I —

The DEPUTY CHAIR: Hon Martin Pritchard has the call; are you still seeking the call?

Hon MARTIN PRITCHARD: I will just quickly ask my question and then Hon Adele Farina can continue, if she wishes.

There is no definition or description of "agent". The contact person has to be aged over 18, but the agent obviously does not. My concern is not so much with the fact that they may be asked to collect the substance; my concern relates to clause 57(7)(b), which states —

> possess the prescribed substance for the purpose of supplying it to the patient …

Is that while they transfer the substance, or is it considered that they might actually hold onto the substance?

Hon STEPHEN DAWSON: Was the question about whether the agent could hold onto the substance?

Hon MARTIN PRITCHARD: Yes. There is no description, so they could be under 18, for instance. Is it envisaged that the agent would actually hold onto the substance with a view to supplying the prescribed substance at some later stage?

Hon STEPHEN DAWSON: The agent is essentially—I will not say a gofer; I am not being disrespectful—picking it up and delivering it to the patient. It is not about holding onto it. They are required to hand it over, whereas the contact person has a more onerous role.

Hon RICK MAZZA: If I can flesh this out a bit more, please. It would appear to me, from listening to the debate, that the agent is actually an agent for the contact person.

Hon Stephen Dawson: No.

Hon RICK MAZZA: It is not? So the agent could be the agent for the patient? The bill does not define "agent". I think Hon Martin Pritchard has pointed that out. From what I can see, the only difference in the role of the agent is the disposal of the substance. The agent, who does not have to be over the age of 18, can be asked by, let us say, the contact person or the patient, to run down to the approved dispenser, pick up the substance, take it to the patient, and actually supply it to the patient, without the contact person being there. It does not provide that the contact person must be present. The contact person could be absent from the whole process, and the agent can actually collect it, possess it and supply it. That seems contrary to why we would have a contact person, who has been defined in the bill and is required to have certain qualifications as far as age is concerned, if that can now be substituted by an agent who does not have to undertake the same duties as the contact person.

Hon STEPHEN DAWSON: Agents currently pick up medication outside of this bill, including schedule 4 and schedule 8 substances, on behalf of the patient. Schedule 4 and schedule 8 substances can be picked up by an agent of the patient in real life, outside this Parliament and outside this bill. That happens now. It could be a patient's family member. In fact, it is usually a family member to whom we say, "You're going to the shops. While you're at the shops, can you go and get my prescription?" That happens now. I am advised that the standard prescription form provides for a signature of the patient or the agent. That includes schedule 4 and schedule 8 substances.

Hon ADELE FARINA: That is all well and good in the normal world of prescribing medications. However, clause 70 of this bill requires the authorised supplier to verify the identity of the agent. That is not required for agents who collect prescriptions on behalf of a patient. I go the chemist frequently for my mum and get her prescriptions filled, but it is our local chemist down the road, they know me and they know my mum, and they know that I am collecting her prescription. Clause 70 places a legal obligation on the authorised supplier to identify the person to whom the substance is to be supplied. Without any paperwork having been completed and in the hands of the coordinating practitioner, how can that authorised supplier fulfil that requirement in the legislation?

Hon STEPHEN DAWSON: I think I have answered that in response to an earlier question of Hon Adele Farina. I said that it could be by letter or the patient could ring up and say that they are going to get somebody to collect it on their behalf. The person who hands over the substance will seek a driver's licence or some sort of identification document to verify that the person collecting the substance is indeed one and the same person as the patient advised would be doing so.

The DEPUTY CHAIR: I notice that Hon Rick Mazza has some amendments on the supplementary notice paper.

Hon RICK MAZZA: Yes, I have, Deputy Chair. I was just going to ask whether Hon Adele Farina will move her amendment first.

Hon ADELE FARINA: I am more than happy to move mine. I just wanted to make sure that everyone had finished that line of questioning. I move —

Page 36, after line 23 — To insert —

(2A) At the time of prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner must inform the patient about the following matters —

(a) the schedule 4 and/or schedule 8 poisons constituting the prescribed substance;

(b) the method by which the prescribed substance is to be self-administered;

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

(d) the expected effects of ingesting the prescribed substance;

(e) the expected time to death after ingestion;

(f) the potential risks of self-administrating the prescribed substance.

Everyone will have experienced going to the doctor and being prescribed medications. The doctor usually tells you exactly what he or she is prescribing. They will talk to you about how that will address your medical problem and about the possible side effects that you need to be aware of, and also alert you to any problems that might arise with any other medications that you are taking, so that when you are ingesting that medication, you know full well the parameters in which you are required to take that medication and the effect the medication will have on you. If something different happens, you know that you have to go back to the doctor because that was not what was intended. There is a really full discussion. It concerns me that under this bill, the coordinating practitioner will prescribe a voluntary assisted dying substance and the patient will actually not know what cocktail of poisons from schedule 4 and/or schedule 8 are actually in that voluntary assisted dying substance. I find that really unacceptable. I think that patients should be fully informed about what they are going to be ingesting, the method for preparing it if it needs to be prepared, and what they can expect to happen after they have ingested the medication. I think that is incredibly important. The bill does not actually provide for that to happen.

We also need to be aware that all of this is happening outside of a regulated system. The Therapeutic Goods Administration regulates the market in relation to therapeutic goods. The minister informed the chamber in answer to questions about clause 7 that the schedule 4 and/or schedule 8 poisons that form part of the voluntary assisted dying substance do not need to be approved by the Therapeutic Goods Administration, so they could be drugs that have not been tested for human consumption. That concerns me. Clause 7 does provide that the CEO may determine which schedule 4 and 8 poisons are to be used, but there is no obligation on the coordinating practitioner who prescribes a voluntary assisted dying substance to actually prescribe one that has been recommended or approved by the CEO. Also, there will be no offence or penalty if they choose not to. In other jurisdictions that have recommended voluntary assisted dying substances, data that has been collected indicates that a percentage of doctors still prescribe medications to their patients other than the recommended medication as a voluntary assisted dying substance, and in some cases, there have been complications as a result of that. This whole bill will bring us into a completely unregulated market. I think there needs to be some concern about what we are doing. We go to great extents to ensure that we have regulation through the Therapeutic Goods Administration so that people only ingest medications, and at doses that are therapeutic and will not harm their health. I understand that the purpose of the voluntary assisted dying substance is to kill the person, but the whole purpose of this legislation is to deliver a peaceful and pain-free death. It is impossible to do clinical testing for that effect. The only clinical testing that has been done by the Therapeutic Goods Administration is for the therapeutic use of medications. In this case, we are talking about lethal doses. Clearly, there has not been any human clinical testing, because the result of the testing would be that some of the people participating in that trial would end up dead. There have been no human clinical trials for ethical reasons. We are really working in an unknown area. People will use their best assessments, but they are only assessments. There is no guarantee that the dosages that will be selected by the clinical panel and recommended to the CEO will be effective in all circumstances. Whether members support the bill or not, I think it is critically important that at the point the doctor prescribes the substance, they sit down and have a conversation with the patient and say, "Look, this is what's in the voluntary assisted dying substance. This is what you can expect will happen to you after you have ingested the medication. These are the likely side effects." I cannot understand why we would want to withhold that information from a patient. Surely, we should all be making

decisions on an informed basis, and that is information that we should require the coordinating practitioner to provide to the patient.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of Hon Adele Farina's amendment. The subject of the amendment is already contemplated under clauses 68 and 71. It is part of the doctor's duty at common law to provide information to a patient about material risk, and this has been accepted by the High Court of Australia. Furthermore, I am told that it is good medical practice and already part of informed consent that medical practitioners deal with every day.

Hon NICK GOIRAN: Looking at clause 68, where does it indicate the matters that have been outlined in the amendment set out by the honourable member at 479/57?

Hon STEPHEN DAWSON: Clause 68(1)(d) refers to how to prepare and self-administer the substance and clause 71(2)(c) also refers to how to prepare and administer the substance.

Hon ALISON XAMON: I rise to indicate that notwithstanding the assurances given by the minister around clauses 68 and 71, I will support Hon Adele Farina's proposed amendment. I see that this value-adds to the provisions within clauses 68 and 71. As I read them, they refer generally to how to administer it and provide parameters around how the substance is to be treated, but they do not go into detail about the risks that may be inherent if the substance is not administered properly. This issue is of concern to me. I am not opposed to self-administration. If anything, I prefer self-administration to somebody else administering the substance because we can be assured that this is the will of the person who is availing themselves of this. But I think it is really critical that that person have every single piece of information available to them so that we do not run the risk of mishap. Notwithstanding that, of course, obligations apply, and often, critical information may be missed or overlooked. In this case, the implications of that could be quite dire. It is really important to prescribe this. I do not think that this takes away from anything in the bill. It simply prescribes best practice that we expect to be incorporated within this process.

Hon NICK GOIRAN: I take the point that the minister has identified in Hon Adele Farina's amendment, which is that proposed subsection (2A)(c) duplicates what the bill already prescribes at clause 68(1)(d), and I accept what the minister says. However, I make this point: just because one out of six limbs of risks that the honourable member has listed is duplicated elsewhere in the bill does not invalidate the other five limbs. If the minister wants to amend the amendment moved by Hon Adele Farina by deleting the third limb—proposed paragraph (c)—I may well support that. But that does not invalidate proposed paragraphs (a), (b), (d) and (f). The minister will quickly rise in accordance with the advice that he is given and remind us that clause 71(2)(c) indicates that advice needs to be given on how to prepare and self-administer the substance. I suspect that the minister and the minister's advisers will tell us that this is the same provision as proposed paragraph (c). The same thing applies there. I draw to the minister's attention that clause 71 states that that any information can be provided to the patient. That is duplicative. But it says it can be provided to the contact person or this "famous" agent; I would say "infamous" agent at this point. That will not provide the information and the risks to the patient. In any event, if the government objects to the third limb of the six limbs in Hon Adele Farina's amendment, I invite the government to amend that. Regardless, members should give serious consideration to the other five limbs. They are appropriate risks that should be provided not to an agent, not to a contact person, but to the person who will be taking the substance at the end of the day.

Hon STEPHEN DAWSON: I make the point that clause 26(1) is also relevant to the issue before us because it addresses some of the issues that Hon Adele Farina has raised.

Hon NICK GOIRAN: Where in clause 26 does it set out the six items of risk that Hon Adele Farina has identified in her amendment 479/57?

Hon Stephen Dawson: I did not say that it addressed all six items of risk.

Hon NICK GOIRAN: Does it identify any of the six; and, if it does, which ones?

Hon STEPHEN DAWSON: Clause 26(1)(d) identifies the potential risks. The honourable member can read it, as I can.

Hon ADELE FARINA: The information outlined in clause 26 will be provided very early on in the process. By the time the patient gets to the point of being prescribed the substance, they may have forgotten or may not fully remember everything they were told at the point that they were told, pursuant to clause 26. In any event, even if they remember it all, it is good practice to reiterate everything at the point of prescribing the substance. I do not understand why the government would have an objection to ensuring that the patient is informed of all the information that they should have.

Hon PETER COLLIER: I am receptive to this amendment. I do not think it in any shape or form impacts on the integrity of the bill or this clause and self-administration. We all know that information is power. At this point of a person's life, he or she needs to be provided with as much information as they can possibly have. This is evidently a significant decision that they will make. They need to have as much information as possible. I understand the minister's point about good medical practice, which is captured in clause 71 in how to prepare and self-administer the substance, and there is an assumption that good medical practice will prevail. But making the bill more prescriptive is not only eminently sensible, but also essential. Before I vote on this amendment, I would like to know from the minister's perspective whether accepting this amendment in any shape or form will impact negatively on the integrity of the bill.

Hon STEPHEN DAWSON: In its current form, it could.

Hon Peter Collier: How?

Hon STEPHEN DAWSON: I am advised that it is not drafted as best as it could be.

Hon AARON STONEHOUSE: If the minister would provide us with some alternative preferred wording, that would be helpful, although I assume that in presenting this amendment to the Committee of the Whole House, Hon Adele Farina has engaged parliamentary counsel.

Hon Adele Farina interjected.

Hon AARON STONEHOUSE: Okay; perhaps not. If the minister has some alternative wording, I would be interested to see it. Regarding the amendment by Hon Adele Farina, I absolutely prefer self-administration. I spoke a little about this yesterday. Voluntary assisted dying is a voluntary act, of course, and it is someone exercising autonomy and making their own choice. The best way we can be absolutely certain that somebody is exercising autonomy is if they do it themselves. There is a very clear distinction between voluntary assisted dying and voluntary euthanasia, and to stay on the voluntary assisted dying side of this issue, it is important that, whenever possible, people can self-administer. I am concerned that the bill currently provides for practitioner administration not on the basis of a medical need, but on the basis of a conversation between a patient and a practitioner. That has already been determined.

Looking at this amendment, I would be concerned if it in some way deterred people from self-administration. I do not think that is the policy intent of the amendment put forward. Proposed subclause (2A)(f) states —

> the potential risks of self-administering the prescribed substance.

That part might act as a deterrent, but if we are going to say that there are risks involved, and there are some risks involved, it would be wholly inappropriate to hide those risks from a patient just because we want them to take a certain action. All information should be provided to a patient whenever possible so that the patient is empowered to make their own choices. They should be fully informed. If that means a patient decides that they do not want to self-administer, although I would prefer that they do, that information cannot be withheld from them just to steer them to make a decision that we want them to.

It is worth noting that it would be good clinical practice for a medical practitioner to do all these things, and I suspect that they already do. I support this amendment because it merely codifies what would already be taking place and what should take place. It puts an obligation on medical practitioners to carry out their functions properly and to ensure that patients are fully informed. At other clauses of this bill, we go to a lot of effort to ensure that patients are fully informed. It is appropriate, when a patient is making an administration decision whether they want self-administration or practitioner administration, that again the patient is fully informed. On that basis, I support the intent of the amendment, but I am interested to see whether there is some alternative wording that the minister finds more appropriate. If the chamber is to agree with an amendment of this type, I want to make sure that we get the language right.

Hon JACQUI BOYDELL: I, too, am interested in whether the government has a proposed amendment to the amendment. Looking at Hon Adele Farina's amendment, I would have thought that proposed subclause (2A)(b) is covered already by clause 26(1)(f) and proposed subclause (2A)(c) is also covered by clause 68(1)(d) of the bill. I suggest that proposed subclause (2A)(d) and (e) may be covered by clause 26(1)(e). Proposed paragraph (f) of the amendment would also be covered by clause 26(1)(d). I am not sure why we would need to repeat that. If the member could explain why proposed subclause (2A) is required, I will consider support for it; otherwise, I will not support the amendment.

Hon ADELE FARINA: That was a very fair question. If members look at the way clause 26 is drafted, they will see that it refers to "a voluntary assisted dying substance likely to be prescribed". At that point, a decision about

what is going to be prescribed has not been made, so the conversation is very, very general. It is also very early on in the process. I am asking, at the point when the decision has been made to prescribe a particular voluntary assisted dying substance, or cocktail, that all of that information is relayed about what is actually being prescribed. There is quite a distinct difference between what I am proposing now and what occurs under clause 26, which relates to a more general conversation about a "likely substance" to be prescribed. That is the difference. When a doctor prescribes medication to a patient, it is not about the impact of a likely group of medications that the doctor could prescribe to the patient; it is about what is actually being prescribed to the patient, including its side effects, conflict with other medications and whether it should be taken on an empty stomach or after eating food. All of that sort of stuff occurs. I am asking for all of that to occur at the point the drug is being prescribed.

Hon MARTIN ALDRIDGE: The minister mentioned that a number of clauses are relevant to the amendment before us, which I have given some consideration to. I would like to make a couple of points. I understand the intent of what the mover is seeking to do, but I wonder whether this is the appropriate clause for it to be inserted into. For example, clause 68 relates directly to information to be given before prescribing a substance.

That may be a more relevant clause to enhance because a number of the limbs in the mover's proposed subclause (2A) are already in clause 68, and we could probably give that area some consideration, too. I have a couple of points about the amendment before us. Before we go to the limbs, it states —

> At the time of prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner must inform …

Those words suggest to me that this would require a further consultation with the medical practitioner, because the prescribing of the substance may well occur post the final request. Would the patient requesting voluntary assisted dying then be subjected to a further consultation with a medical practitioner to be informed post the final request if the prescribing of the substance did not occur at the final request? I do not think it can actually occur at the final request because there are some obligations on the coordinating practitioner that follow the final request.

I also want to raise the reference to ingestion in proposed paragraph (e). I am happy to be corrected, but I assume that references to self-administration in the rest of the bill do not refer explicitly to self-administration being ingestion. I think it is assumed that, as the bill stands today, the most likely way a person would take the self-administered substance will be by drinking something, but that may not always be the case. Certainly, that is something we might need to consider.

Hon NICK GOIRAN: I think the observations and analysis provided by Hon Martin Aldridge are good and helpful. I wonder whether clause 68 is a superior option for this very well considered amendment put by the honourable member and that we could perhaps defer consideration of this particular issue until that point. I think there is a lot of sympathy for the thrust of this amendment, including from me. Ultimately, I am somewhat ambivalent about whether it is under clause 57 or 68, but if there is an appetite for a large proportion of the substance of amendment 479/57 finding its way into the bill at clause 68, I am certainly receptive to that.

Hon STEPHEN DAWSON: I indicate that we would be happy to have a similar amendment to clause 68 that deals with the issues raised in Hon Adele Farina's amendment before us, but we would tighten up the drafting. There are a number of drafting concerns with the amendment as it stands. It is up to Hon Adele Farina, but I indicate that the government would support such an amendment to clause 68. I will have a drafted amendment for clause 68.

Hon ADELE FARINA: I thank all members who have made contributions and commented on this amendment. I am more than happy to withdraw the amendment at this stage and consider an amendment to clause 68. I just want to make clear to the minister that very much a part of my amendment is the patient being told what schedule 4 and/or schedule 8 poisons make up the voluntary assisted dying substance that they are being prescribed. I would hope that any amendment put forward by the government would include that.

Hon STEPHEN DAWSON: Member, I think that the amendment I will move to clause 68 will take into consideration that concern.

Hon ADELE FARINA: I seek leave to withdraw my amendment.

Amendment, by leave, withdrawn.

Hon RICK MAZZA: I have three amendments to clause 57 on the supplementary notice paper. The first two, at 420/57 and 421/57, are consequential, so I ask that they be deferred at this point until we have debated my third amendment, which is at 422/57.

Point of Order

Hon NICK GOIRAN: I would like to raise a point of order with the honourable member. If he is indicating that he will not be moving at this time amendments 420/57 and 421/57, I will be moving an amendment before he gets to amendment 422/57.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Can we get an indication? I will let you finish your contribution, Hon Rick Mazza, on what your intention is on those two amendments.

Hon RICK MAZZA: Thank you, Mr Deputy Chair. In light of the new information that has come forward, I ask that amendments 420/57 and 421/57 that I have on the supplementary notice paper be deferred until after we have debated amendment 422/57.

Committee Resumed

Hon NICK GOIRAN: Thank you, honourable member, and it will become apparent shortly why this is necessary. I move —

> Page 37, lines 1 and 2 — to delete ", the contact person for the patient or an agent of the patient." and substitute —
>
> or the contact person for the patient.

The DEPUTY CHAIR: After some discussion, Hon Rick Mazza, I am going to ask you to seek the leave of the chamber to postpone amendments 420/57 and 421/57 on the supplementary notice paper. If it is your intention to postpone them until later, can you formally seek the leave of the chamber to postpone those two amendments?

Hon RICK MAZZA: It is a pleasure, Mr Deputy Chair. I formally seek leave to defer amendments 420/57 and 421/57.

The DEPUTY CHAIR: Hon Rick Mazza has sought the leave of the chamber to postpone those two amendments.

Point of Order

Hon STEPHEN DAWSON: Are we just deferring these amendments until a later stage of this clause?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Yes.

Committee Resumed

The DEPUTY CHAIR: By clarification, minister, we are proposing, if it is the will of the chamber, to postpone those two amendments initially until after we have dealt with the now moved amendment of Hon Nick Goiran, which is to delete lines 1 to 2 on page 37. After having dealt with that, we will deal with amendment 422/57 on the supplementary notice paper, which deals with lines 3 to 18 of the clause, and then return to the postponed amendments. Hopefully, all members are aware of where we are going with this. Hon Rick Mazza has sought leave to postpone amendments 420/57 and 421/57.

Leave granted.

The DEPUTY CHAIR: That takes us to the amendment to clause 57 that has just been distributed under the name of Hon Nick Goiran, which states —

> Page 37, lines 1 to 2 — to delete ", the contact person for the patient or an agent of the patient." and substitute —
>
> or the contact person for the patient.

Hon NICK GOIRAN: Members, this is just concluding the debate that happened earlier this morning with regard to the use of an agent. Other members have identified—I give them full credit for doing so—that "agent" is not defined in the bill. As other members indicated earlier this morning, this undefined role of "agent" other than what is set out at clause 57(7) is already captured by the role of the contact person. This amendment will eliminate agents being used; I think that that is in the best interests of everybody, not the least of whom is the agent, because everything is undefined in this legislation. I know that there was some discussion by the minister earlier that indicated that agents are commonly used to pick up prescriptions and so on, but never for a prescription the intended outcome of which, if it is taken, is the death of the patient. That does not happen in Western Australia. This is unique. It should not be the agent who picks this up; clearly it should be the contact person. The contact person will have certain obligations under this statute. The agent will have none and this amendment will tidy up this issue.

If this amendment were to be supported by members, it is my intention at a later stage of this clause to delete lines 13 to 18 on page 37—in other words, to delete clause 57(7). But there is no point in me doing so unless this particular amendment is supported. I hope that clarifies the rationale for this amendment.

Hon STEPHEN DAWSON: I indicate that we do not support this. I have previously talked about the agent and how an agent already exists outside of this bill, if I can put it that way. The removal of the ability of the agent could limit the patient's ability to obtain the prescribed substance in a timely way. I am told that it is contrary to the common practice of allowing a person chosen by the patient to pick up the substance. It is a common delivery aid for patients at end of life already.

Hon AARON STONEHOUSE: I just want to ask a couple more questions along these lines about the role of an agent. An "agent" is sort of defined outside of this bill. It is fairly common practice currently for a patient to send somebody in their stead to collect their prescription. Is a different procedure in place between pharmacies and dispensaries and agents and patients for different types of drugs or substances? For instance, if someone sends another person to pick up their antibiotics, it is quite different from sending somebody to pick up their schedule 8 substance. I wonder whether there is any difference in the process for how those drugs or substances are handed over in those instances.

Hon STEPHEN DAWSON: No, there is no difference.

Hon MARTIN ALDRIDGE: I am trying to understand the merits of having an agent of the patient. We are sort of having the argument two ways here. We are saying that these are the usual practices that apply when we dispense drugs, but then we are saying that this is not a usual practice because we are actually supplying a voluntary assisted dying substance, and that gives rise to the need for a contact person. I draw members' attention to clause 66, which defines the role of a contact person, and they have a very limited role. Their role is to receive, possess, supply and return the drug, and, secondly, to advise the coordinating practitioner if a patient dies. They have a very limited function. When I consider the argument about why an agent might be required, I would think it would be in circumstances in which the contact person is not able to perform their function. If that is not the case, I would consider the way the patient can revoke and appoint another contact person, and that does not seem to be very arduous, apart from filling in another form and within two days providing the form to the coordinating practitioner, and then I think the coordinating practitioner has an obligation to supply it within two days to the board. I want to understand from the government why the contact person revocation and appointment process is so arduous that we then require this agent provision in the bill, when it is the job of the contact person to receive, possess, supply and return the substance.

Hon RICK MAZZA: I rise to say that I will also support this amendment, because I have some issues with the agent's role in all of this. I point out to the mover of the amendment that should my very reasonable amendment at 422/57 be successful, this amendment would become obsolete, so we will remove the reference to the contact person and agent altogether. But to futureproof it in case it does not get up, I think this is a very important amendment, so the contact person, not an agent is responsible for the substance.

The DEPUTY CHAIR: I will give the call to Hon Adele Farina in a minute. I just want to make a comment from the chair about a procedural issue. It may not have occurred to members, and I want to make this quite plain, that because Hon Rick Mazza's amendment 421/57 on the supplementary notice paper applies to page 37, lines 1 and 2, and we are currently dealing with another amendment to page 37, lines 1 and 2, there is a procedural issue in that the chamber is unable agree to an amendment and then try to change it and agree to a second amendment effectively on the same issue. There is going to be an issue here, Hon Rick Mazza, in that if the amendment by Hon Nick Goiran is agreed to, you will be prevented from moving your amendment on the supplementary notice paper. Your option at this point is to seek to amend the amendment of Hon Nick Goiran, but not to make a second attempt to amend lines 1 and 2.

Hon MARTIN ALDRIDGE: Mr Deputy Chair, can I seek your guidance on this matter? I think Hon Rick Mazza intended to defer amendments 420/57 and 421/57 pending the outcome of his substantive amendment 422/57. It would not prevent Hon Rick Mazza from pursuing his intent at 422/57 and if it is successful, in any event, it will require a recommittal of the clause. I am struggling to understand how Hon Rick Mazza would be prevented from pursuing the course of action he seeks.

Hon JACQUI BOYDELL: I am struggling a little with this amendment. I am trying to picture when a patient would appoint an agent. A patient may utilise the services of Silver Chain. Can the minister confirm that a person working for Silver Chain could be an agent? That would be a very likely scenario for self-administration. A person could be being cared for at home by a family member or, indeed, the contact person caring for the patient may not want to leave them. In this scenario, is the patient allowed to ask the visiting Silver Chain person, as their agent, to pick up the prescription? I would have thought that happens now with patients at home. I do not see that that scenario would be any different in this case. If that is the case, I will not support this amendment.

The DEPUTY CHAIR: I will get back to Hon Adele Farina. On the point raised by Hon Martin Aldridge, my advice is that the ruling will stand. The member will be unable at this point to move his amendment on the supplementary notice paper if Hon Nick Goiran's amendment is agreed to. However, he could move at the end of

debate on this amendment for this clause to be recommitted. When you raised "recommittal", you were accurate. At the end of the process following the report of the Committee of the Whole House, Hon Rick Mazza can move to recommit this clause. I hope that makes sense.

I will go to Hon Adele Farina before the minister because I put her off previously.

Hon ADELE FARINA: Alternatively, Hon Nick Goiran could also seek leave to defer, and that would enable the two to be considered at the same time after the substantive amendment, but that is another option.

I was seeking the call earlier to clarify with the minister who the authorised supplier might be. Will we expect people living in regional WA to travel to Perth to collect the voluntary assisted dying substance, because that will create a whole different complexity to the question we are considering, or will it be delivered to a pharmacy in the town from where it can be collected? I can clearly understand the situation Hon Jacqui Boydell has raised. It is one thing to leave a family member who is dying for a few minutes to go to the local pharmacy and pick up the voluntary assisted dying substance; it is quite another thing to take a trip to Perth to collect it. It also raises questions about the obligations on the contact person to return whatever is not used. It would be good to get some clarification about the location of the authorised supplier and the person who will dispose of the unused substance.

Hon STEPHEN DAWSON: I am going to take the call now before any other questions, because it is a long and growing list. Obviously, I am happy to answer all questions, but I will answer the ones that have been asked so far.

In answer to Hon Jacqui Boydell's question, yes, the patient could appoint a Silver Chain person as an agent; that would be very appropriate. In answer to Hon Martin Aldridge's question, the removal of the ability of the agent could limit the patient's ability to obtain the prescribed substance in a timely way. It is contrary to the common practice of allowing a person chosen by the patient to pick up the substance. The patient agent is a common delivery aid for patients at the end of life. The patient is likely to have someone who usually picks up their medication for them. That person may not wish to take on the onerous role of contact person but may be happy to pick up the medication. The agent allows the patient more ability to obtain the substance. Although the contact person has a legal obligation to return the substance, including a penalty for the failure to do so, the agent is an additional aid to obtain the medication in a timely way, especially at the patient's end of life. I am further told that schedule 4 and schedule 8 poisons are currently prescribed and dispensed in doses that would be sufficient to cause death if taken by the wrong person or at the wrong dose level. People in palliative care may build high tolerance to opioids and other drugs, so the level required to cause death in one person could be tolerated by another patient.

Hon MARTIN ALDRIDGE: It brings into question the role of the contact person if we are going to have agents. That may be something we will consider down the track. If an agent receives, possesses and supplies the drug or the substance, what obligation is there for the contact person to be notified that the drug has been received, possessed or supplied so that they can fulfil their function under clause 66(1)(d), which is the return of unused or remaining prescribed substances?

Hon STEPHEN DAWSON: I am going to reply to Hon Adele Farina's last question before I get on to the next one. The definition of "authorised supplier" is set out under proposed section 78(2) of the act. An authorised supplier will be a registered health practitioner—for example, a registered health practitioner at a hospital, pharmacy or medical facility who has been approved by the CEO of the Department of Health to supply a voluntary assisted dying substance for the purposes of the act. The authorised supplier will be limited to registered health practitioners authorised under the Western Australian Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. It is likely that the authorised supplier will include a public health service hospital or pharmacy with pharmacists and specialist practitioners who are also authorised under the WA Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. These registered health professionals including pharmacists are already bound by professional obligations that require them to act within their scope of practice and area of expertise. I note that it is not anticipated that the authorised supplier will be a community pharmacy.

On the dispensing of the medication, it is anticipated that a hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, for a central pharmacy service potentially based at one of the tertiary hospitals with a number of regional pharmacy hubs such as selected regional public hospital pharmacies, the central pharmacy service would likely act as a central ordering and storage point for approved voluntary assisted dying medications. It would also have governance over the training requirements and certification of any authorised suppliers—for example, pharmacists at regional hub pharmacies who are involved with the supply of VAD medications. The central pharmacy service would also receive prescriptions, dispense medications and dispose of any unused medication for metropolitan patients. It is anticipated that regional pharmacy hubs with appropriately trained and certified pharmacists would also be approved to supply medications and to dispose of any unused medications for regional and remote patients. These hubs would obtain supplies of voluntary assisted dying medications from the central pharmacy service. The hub and spoke in this model would

be authorised suppliers. In this way, an authorised supplier to the central pharmacy may supply the prescribed substance to another authorised supplier that is much closer to the recipient and will actually make contact with the recipient. This will be worked out during the implementation stage of the bill and will help to address the needs of persons in regional and remote areas of this state. In relation to Hon Martin Aldridge's question, the contact person would be advised by the patient or the agent. If self-administration, then the contact person may be the coordinating practitioner.

Hon ADELE FARINA: A problem for us when we are considering the bill is that we do not know what the hub-and-spoke model is going to look like. From what the minister said, I understood it could well be that, say, a person who lives in Nannup would be required to travel to Bunbury Regional Hospital to collect the voluntary assisted dying substance. It is possible that it might be delivered from Bunbury Regional Hospital to Nannup District Hospital, but until we see the hub-and-spoke model, we cannot assume that it is going to get to the local hospital where the person lives, particularly in small towns. We all know that a lot of towns throughout Western Australia do not have hospitals. Therefore, it seems to me, based on what the minister has told us, that there could be some travelling involved to collect the medication. In those circumstances, if the contact person is a family member, I can see the advantage of having an agent. When my dad was in his final stages of life and I had to go and get medication —

The DEPUTY CHAIR: Members, there is a fair bit of background noise—if we could keep that to a minimum, please.

Hon ADELE FARINA: It gave me some peace of mind knowing that the chemist was a minute and a half down the road. Unless there was a long queue when I arrived, I could get back fairly quickly. If I am going to be gone for half a day or a whole day to collect the substance, that is a completely different arrangement. I still have concerns that the arrangements in the bill for the appointment of the agent are deficient in terms of the obligations of the authorised supplier. Under clause 70, it needs to go through a verification process. I do not see why we do not simply have the same process in which a contact person and an agent are appointed, paperwork is provided to the coordinating practitioner and when the coordinating practitioner is writing out the prescription, they advise the authorised supplier of the person who is going to pick up the voluntary assisted dying substance. It seems pretty straightforward to me.

Hon NICK GOIRAN: As important and excellent as this debate is, I am going to propose to seek leave to defer consideration of this amendment. By way of explanation, this picks up on the proposal put to me by Hon Adele Farina. It strikes me, on reflection, that this is better considered after we consider Hon Rick Mazza's proposed amendment at 422/57, because if the honourable member's proposal is supported, what we are currently considering will become redundant. I hope it does not happen, but if the honourable member's proposal is not supported, we can come back to this important discussion. Therefore, for those reasons, I seek leave to defer.

The DEPUTY CHAIR (Hon Dr Steve Thomas): Honourable member, to make things more workable, I am going to ask you to withdraw the amendment you have moved. You have the capacity to re-move it down the track, but I do not want to have so many postponed amendments sitting here. I think it is going to confuse the debate. Therefore, if you are comfortable with that, I am going to ask you, from the chair, to seek leave to withdraw the proposed amendment. You have the capacity to re-move it at a future point.

Hon NICK GOIRAN: Thank you, Mr Deputy Chairman. I seek leave to withdraw the proposed amendment.

Amendment, by leave, withdrawn.

The DEPUTY CHAIR: Honourable members, the question before the house is that clause 57 stand as printed. Hon Rick Mazza, would you like to move the amendment standing in your name?

Hon RICK MAZZA: I move —

Page 37, lines 3 to 18 — To delete the lines and substitute —

(4A) The administering practitioner for the patient is authorised to —

(a) receive the prescribed substance from an authorised supplier; and

(b) possess the prescribed substance for the purpose of supplying it to the patient; and

(c) supply the prescribed substance to the patient immediately before the patient is ready to self-administer the prescribed substance if the administering practitioner is satisfied at the time of supply that —

(i) the patient has decision-making capacity in relation to voluntary assisted dying; and

(ii) the patient is acting voluntarily and without coercion; and

(iii) the patient's request for access to voluntary assisted dying is enduring.

(5) The patient is authorised to —

(a) receive the prescribed substance from the administering practitioner for the patient immediately before the patient is ready to self-administer the prescribed substance; and

(b) possess the prescribed substance for the purpose of preparing and self-administering it; and

(c) prepare the prescribed substance; and

(d) in the presence of the administering practitioner for the patient and a witness, self-administer the prescribed substance.

I will explain to the chamber my reasons for putting this amendment on the supplementary notice paper. We have had a lot of debate and discussion around a contact person; an agent; the security of the substance; and the ability for a contact person or an agent to go to an authorised dispenser and pick up what is, essentially, a lethal substance. That substance is able to be left around a home or in a nursing home or wherever the patient may be, so there is the issue of the security of that substance. If the patient passes away in the meantime or decides to not self-administer, there is the issue of the disposal of the substance. I have a lot of concerns about the security of that substance.

As has already been mentioned, if we are to have this legislation, self-administration is the preferable way, rather than having an administering practitioner. But I think that if someone is going to self-administer, there needs to be security and safeguards around self-administration. This amendment will require an administering practitioner to be present, along with a witness. I would like to see that because, firstly, we need to make sure that the patient is not being unduly coerced in any way. As the bill is currently drafted, the substance will be taken home and the contact person can be a family member. We do not know how much coercion might take place in the self-administration, if the method is self-administration, of that substance. If there is at least an administrating practitioner present—the administrating practitioner being the person who actually acquires and possesses the substance until such time as the patient wishes to take the substance—it will be a good safeguard.

This amendment also requires a witness, so there will at least be an independent witness present at the time, along with the administering practitioner, to make sure that those safeguards are in place and that the patient is willingly taking the substance.

A third issue is of concern to me. Debate has gone back and forth about the fact that taking the substance will not always result in the person's peaceful passing; things can go wrong. If the substance is not prepared properly, if the person does not take the substance in the way that they should take it, or if there is confusion about the delivery of the substance to the patient that the contact person or the patient cannot resolve on their own, there could be adverse results for the person taking the substance.

I get why it is done this way; there is a bit of privacy for the family when the person passes on. I get that, but I think that is far outweighed by the fact that something could go wrong, and if it does, it could be very, very traumatic for the family and the people around the person, and the person involved. At least if there is an administering practitioner there, things can be managed to make sure that that issue is minimised.

For those reasons, I have moved this amendment. I think it is a very sound amendment to put those safeguards in place and ensure that someone who has opted to self-administer will have those protections around them. At the moment, it is a very loose arrangement—a contact person and an agent; whether someone is there or not there; no witness present at the time. Therefore, I have moved this amendment.

Hon STEPHEN DAWSON: There are a number of amendments on this issue in Hon Rick Mazza's name—there are the two amendments that we have deferred; there is the amendment that is before us; and I think there is also a linked amendment at clauses 68, 71 and 72. I will make my comments on all those amendments at this stage, just to place them on the record.

Hon Rick Mazza seeks to remove the authorisation of an authorised supplier to supply the prescribed substance to the patient, and instead introduce a new authorisation that the authorised supplier must supply the prescribed substance to the administering practitioner, who must then supply to the patient and inform. The honourable member's proposal further introduces a new limitation that the supply of the prescribed substance can occur only when the person is ready to self-administer. This is part of his suite of amendments, which also seek to remove the

role of, requirements of, and information provided to the constant person in the case of self-administration and require the administering practitioner to be present when a person self-administers.

The government is not supportive of these amendments. These amendments create a fundamental shift in terms of the patient autonomy attached to self-administration. Fundamental to the model of voluntary assisted dying proposed for Western Australia is the concept of patient autonomy and choice with regard to the manner and timing of death. A patient for whom self-administration is deemed to be the appropriate course of action under clause 55 of the bill will now not have freedom of choice in the timing of self-administration and also be forced to have particular witnesses whom the patient may not wish to be there. Operationally, this may also create issues, depending on where the patient wants to self-administer. A person may want to return to their home town, and may not be able to access the coordinating practitioner at a time that fits with the notion of self-administration; for example, a time of their choosing. This is distinct from the arrangement that must occur under practitioner administration. Furthermore, to require the administering practitioner to witness is a strange scenario, particularly as this is already the considered option for practitioner administration under clause 55. The patient may request the coordinating practitioner to attend, but to require it legislatively for self-administration defeats the purpose of that option. The requirement for the administering practitioner to be present during self-administration is not required in Victoria, nor was it recommended by the joint select committee. The bill does not preclude the presence of the coordinating practitioner should this be agreed by the patient and the practitioner. Most patients at this end stage have a network of support around them, such as family, palliative care or other support workers, and it is most likely that the patient who is the subject of self-administration will self-administer at home and be supported by family. The patient's coordinating practitioner will encourage appropriate planning.

I will leave it there.

Hon NICK GOIRAN: I support the amendment that has been moved by Hon Rick Mazza and consider it to be one of the most significant amendments and safeguards on the supplementary notice paper. I note that if this amendment were successful, it would require supervision of the patient's self-administration of the voluntary assisted dying substance. I would like to draw to members' attention that this reflects the best practice guidelines in the Netherlands. The Netherlands "Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide" state at page 13 —

> During the practice of euthanasia or physician-assisted suicide, —

Remember that the Netherlands' regime has two options, as does our bill: if the practitioner is involved, it is called euthanasia; if the person takes it themselves, it is called physician-assisted suicide. It continues —

> the doctor must remain present. For the oral method (physician-assisted suicide), this can take several hours.

The guidelines go on further to say —

> Once the patient drinks the drink, the barbiturate is resorbed by the gastrointestinal tract. The faster the resorption, the higher the peak level. If the resorption rate is too slow, then a redistribution of the barbiturate will take place, resulting in an insufficient peak level. As a result, the patient fails to lapse into a coma or can come out of a deep coma.
>
> Even when anti-emetics are administered, the foul taste of the drink can sometimes cause vomiting. As a result, the whole dose is not taken. Another possible problem is that many patients use opioids at the end of their lives. Opioids result in slower gastrointestinal transit, which can mean it takes the patient longer to lapse into a coma.
>
> Due to the aforementioned unpredictability, this method is not the preferred method.
>
> The period of time between administration and the time of death varies from person to person, but in the vast majority of cases, it takes less than 30 minutes. However, sometimes it can take longer (2–3 hours). Long periods such as these can result in uncomfortable situations.
>
> It is advisable to agree a maximum period of 2 hours with the patient and any next of kin. If the patient has not died by this time, then euthanasia should be administered (intravenously). Beforehand, it is not possible to predict which patients will or will not die within 2 hours. An infusion needle should be inserted in advance as standard for every patient.

These guidelines are borne out of 46 years of experience in the Dutch regime, since the Dutch courts recognised that a doctor could lawfully shorten a person's life to prevent serious and irremediable suffering. If members do not want to take my word for that, they might give weight to the Joint Select Committee on End of Life Choices' majority report at page 152. That report from the majority of the committee notes —

> Although the Netherlands formally legislated for the practice of voluntary assisted dying in 2002, there had been a long process of incremental change prior to the introduction of the legislation.

That is what the majority report of the committee said at page 152. The honourable minister said that this was not raised by the joint select committee. What the minister did not tell everybody is that that was because the committee was silent on this issue. I note that no mention of the guidelines is made in the "My Life, My Choice" report. A committee looking at the guidelines, wrestling with the information and coming to a different conclusion is a very different thing from a committee not even looking at the guidelines in the first place. Two and a half pages of the 229 pages of the "My Life, My Choice" report are dedicated to considering the Dutch experience. There is more than 40 years of Dutch experience, but only two and a half pages were devoted to it after a one-year inquiry. The report considers the legislative background of the Dutch model and the most recent statistics on deaths under the Dutch law, but something as significant as these guidelines, including the quotes I have just read, do not even rate a mention. I encourage members to give serious consideration to this amendment at clause 57. The Dutch, with 46 years of experience in practitioner administration and self-administration, mandate practitioner attendance for all cases of self-administration. Why do the Dutch insist on that being the case? It is because of the high rate of complications even after years of clinical practice. Why would we reject the guidelines and go our own way, leaving Western Australian patients exposed to the risk of serious complications and suffering when self-administering a voluntary assisted dying substance either alone or in the presence of a distraught loved one? That is the alternative.

The fact is that the amendment moved by Hon Rick Mazza would also strengthen the principle of voluntariness central to the bill. If members look at the amendment standing in the name of the honourable member, and particularly at proposed subclause (4A)(c), they will see that it mandates that the administering practitioner has to assess the patient's decision-making capacity. We had a lengthy debate earlier on this issue, and the minister acknowledged that there is nothing in this bill that ensures that when the patient self-administers the substance, there is decision-making capacity. There is no protection for that. It is true that there is if they elect practitioner administration; that is one of the options. That is, if we like, the voluntary euthanasia option, and that is probably consistent with the model proposed by Hon Robin Chapple some 10 years ago. Under that method—voluntary euthanasia—it is true that there would be an assessment of decision-making capacity. I do not even agree with that, but that is not the point here. The point here is that we are allowing unsupervised access by Western Australians to a lethal substance with no supervision whatsoever over decision-making capacity or coercion. Members should think for a moment; if Hon Rick Mazza's amendment is not supported, what will the consequence be? The consequence will be that the person will take the poison home with them and leave it to be taken at a time of their choosing. Who is to say that that patient will take it and not somebody else in the home? Who is to say that the patient will not be coerced at that time? Who is to say that one of the carers, family members or a person who is a beneficiary under the will—any of those—will not hurry the patient along? That cannot happen under practitioner administration because the medical doctor will be supervising at all stages. All Hon Rick Mazza is asking us to agree to is for somebody to supervise this process. We keep hearing "my life, my choice"—I am still stressed about the title of that report—but for those members who believe so passionately about autonomy and have equally said that there must be safeguards, can someone please stand and explain to me what safeguards will be in place for self-administration? Why are we about to agree to a Western Australian patient taking the poison home with them with no supervision at all? This is probably the part of the scheme and the bill that distresses me the most. I urge members to give some serious consideration to this well thought out amendment moved by the honourable member.

Hon MARTIN ALDRIDGE: I have some questions I want to ask about this amendment. The amendment uses the language "administering practitioner", which is interesting because we are dealing with a clause that is about self-administration. I draw members' attention to page 3 of the bill under clause 5, where "administering practitioner" is defined as —

> (a) the coordinating practitioner for the patient; or
>
> (b) a person to whom the role of administering practitioner is transferred under section 62(2);

If members turn to clause 62(2), they will see that it refers to the transfer of the administering practitioner's role and only applies if —

> (a) a patient has made a practitioner administration decision; …

My plain reading of this would be that the administering practitioner must be the coordinating practitioner and there is no ability for that person to be appointed or referred under clause 62(2). It begs the question of why it should not just say "coordinating practitioner" rather than "administering practitioner", because I think it would confuse the reader of the potential act about the person being referred to. Under this clause, "Self-administration", the practitioner will not be administering anything. I wanted to raise that as a point for consideration under this amendment to clause 57.

I am a little concerned about the practical implication of this amendment. Keeping in mind that the minister, or one of the other speakers in this debate, talked about the patient's right to take the substance at a time and place of their choosing, I think that is something that we need to keep in mind in the context of potential new safeguards. I think this would be a significantly limiting factor—more limiting than making a practitioner administration decision. As we know, when a patient makes a practitioner administration decision, further practitioners can be appointed as the administering practitioner, including nurse practitioners, so there is a greater range of flexibility. This amendment, if adopted, would require one person and one person only—the coordinating practitioner—to be available at the time of the patient self-administering the substance. That is my reading. I am happy for it to be reviewed by others, but I think that is particularly concerning from the patient's perspective. Let us talk about it from a regional perspective. If that coordinating practitioner were in Perth on training for a few days or a week or even, indeed, enjoying a bit of holiday time, that person would have no ability to self-administer whilst the coordinating practitioner were unavailable.

I am also concerned about the burden that it might place on practitioners who are willing to be coordinating practitioners in these circumstances when they ultimately will have to be available 24/7 during the six or 12-month period of eligibility. During that period, there will be a significant obligation on the coordinating practitioner to make themselves available day and night to respond to a request by a patient, without the ability to refer that responsibility to another practitioner if the need arose under clause 62(2), which does not apply to this provision.

Another thing that Hon Rick Mazza raised that is not reflected in the amendment is something about which I have limited knowledge and something on which I did not really build my knowledge from the briefings on the bill—that is, the risks of administration. What are the likely complications? How often will they occur? Information was not easily accessible because the government does not want to talk about the types of drugs and so therefore we cannot speak specifically about the side effects or the risks. It is hard to make a judgement on whether this will be a one-in-a-million occurrence or more frequent and, therefore, we should give it greater consideration in balancing all these things.

I want to seek some technical advice from the minister. Hon Rick Mazza mentioned that the importance of having an administering practitioner, using the words in the amendment, present at the time of administration is that they have an ability to intervene if things go awry. I question the extent to which that practitioner will have the ability to intervene, other than to provide medical care and assistance. Keep in mind that this patient will have made a self-administration decision, not a practitioner administration decision. If the circumstance arose that the self-administration occurred in the presence of the administering practitioner and things were not going well, I am not sure that the practitioner can lawfully intervene and make sure that the job is finished. I think that the practitioner could intervene and provide medical care and treatment as practitioners are expected to do. I would like to know the standing of that practitioner who will be present on the occasion of self-administration and whether they can intervene in the way in which Hon Rick Mazza has suggested.

Hon STEPHEN DAWSON: In response to that last question, they cannot intervene. The member is correct in suggesting that they could provide care and support for the patient in that circumstance. In relation to an earlier point, I want to make clear again that a person would have to arrange the time to die with the practitioner in their final days. They would not have the freedom to reach a decision to face death at a time and place of their choosing. If this change occurred, it would totally undermine individual autonomy. I draw to the attention of the chamber that this whole issue was canvassed quite extensively when we debated clause 1. Some of the questions that have been asked now were asked at clause 1, so I draw that to the honourable member's attention.

Hon Nick Goiran: Who has asked questions?

Hon STEPHEN DAWSON: Some of the issues that have been canvassed now, some of the questions that generally have been asked and the comments that have been made now, were also asked as questions earlier in the debate—extensively. I draw that to members' attention. I am very happy for people to make points and talk against it, but we did canvass this earlier.

Hon MARTIN PRITCHARD: I take up one point that was raised by Hon Martin Aldridge about the administering practitioner. I think at an earlier stage, I raised an issue about the interpretation and I think the response that the minister gave at that time was that that could be any other medical practitioner, including a nurse practitioner. I ask whether that is correct.

Hon STEPHEN DAWSON: That is correct. That is for the purpose of practitioner administration.

Hon RICK MAZZA: Members might note that there is a raft of consequential amendments to this amendment on the supplementary notice paper. I just want to cover off a couple of things raised by Hon Martin Aldridge regarding the administering practitioner. I had something prepared earlier, because I asked this question of

Parliamentary Counsel's Office, which drafted my amendment. If members could bear with me a little, the document states —

> *"The administering practitioner for the patient is either the coordinating practitioner or a medical or nurse practitioner to whom the role of administering practitioner is transferred under cl. 62. So in every case a reference to the administering practitioner is a reference to the coordinating practitioner unless the role of administering practitioner has been transferred.*
>
> *Under the unamended Bill, the concept of "administering practitioner" only applies where the patient makes a practitioner administration decision. Under Mr Mazza's amendments, a patient who makes a self-administration decision also has an "administering practitioner" (see the amendments to cl. 62 which allow for the role of administering practitioner to be transferred even where the person has not made a practitioner administration decision).*
>
> *The prescription for the VAD substance would still be issued by the coordinating practitioner. This is the same as cl. 58(2) of the unamended Bill in relation to practitioner administration. However, the authorised supplier would supply the VAD substance to the administering practitioner, who is then authorised to receive the substance and (if satisfied of the relevant matters) supply it to the patient for administration in the administering practitioner's presence.*
>
> *Mr Mazza's amendments make cl. 57 consistent with cl. 58, except that the final step is not administration of the VAD substance to the patient by the administering practitioner but rather supply of the VAD substance by the administering practitioner to the patient and self-administration of the VAD substance by the patient in the administering practitioner's presence."*

Hon ADELE FARINA: I rise to support this suite of amendments. In my contribution to the second reading debate, I raised my concerns about how things can go wrong during self-administration, and there is plenty of evidence to support that in various reports from other jurisdictions. If our aim with this legislation is to ensure that the person has a peaceful and pain-free death—if that is our objective, and it is the stated objective—surely we want to ensure that a medical practitioner is on hand in the event that there are complications or adverse reactions with the administration of the voluntary assisted dying substance, to ensure that the person has a peaceful and pain-free death. I think what most people expect is the two-hour period that the Netherlands tries to hit with its medication, and that after the patient has taken the substance they will die in a very short time. The reality is that that has not always happened. I think 104 hours was the longest case—or that may be the wrong case. There was the case of David Prueitt in Oregon, which I read up on the other day. He took the voluntary assisted dying substance and three days later woke up and said, "What happened? I'm supposed to be dead." It happens, and fortunately for him he did not experience any adverse reaction during that period. He just woke up, which caused him some level of shock. He ended up dying 11 days later as the result of the disease. We need to be clear with what we are doing here. If the objective is a peaceful and pain-free death, we need to ensure that we are able to deliver this. The voluntary assisted dying substance that will be prescribed is outside the usual regulatory framework that we have in this country. In our discussions on clause 4, the minister acknowledged that it has to be a schedule 4 or 8 poison and does not need to be approved by the Therapeutic Goods Administration. That means that there have been no scientific trials to ensure that the prescribed dosage will be absolutely correct. The doctors will be making their best educated guess at that, and in most cases they will get it right, but they will not always get it right.

There are also issues about what other medication they are on and how that may impact the effectiveness of the voluntary assisted dying substance. In the report that Hon Nick Goiran read from, it also advises that the person take the voluntary assisted dying substance on an empty stomach to increase the absorption of the substance. In fact, there is some commentary in the case of David Prueitt that he had been on laxatives and that the laxatives may have interfered with the absorption of the voluntary assisted dying substance.

There are a whole lot of things to take into consideration. If our objective here is to deliver a peaceful and pain-free death, surely the best circumstance to ensure that that happens, in the event of any complications or adverse reactions, is to have a medical practitioner present. We are not saying they have to administer the medication, but in the event that something goes wrong—if there are complications or adverse reactions—they could ensure that the distress that could follow to the patient and to the family who are witnessing all of this does not occur because they are able to step in and intervene to complete that process. Surely that is the whole objective of this bill.

In relation to whether it places too onerous a risk on the coordinating practitioner, that has not proven to be the case in the Netherlands because a doctor is required to be present. Also, in the bill before us and the amendments that Hon Rick Mazza has worked out with parliamentary counsel, there is a capacity to transfer that role of administering practitioner if the person assigned as the administering practitioner cannot be available at the time of the person's

choosing. It also enables that role to be transferred to a nurse practitioner. There is heaps of flexibility in this. Surely, if our aim is a peaceful and pain-free death, this is the best way to ensure that that is the result. I do not think it is too onerous; I think it puts the protection of the patient first.

I also raised my concern that without a practitioner present, a carer or family member might administer the voluntary assisted dying substance to the patient without the patient's consent. By that stage, let me tell members that caring 24/7 for someone who is dying, day after day, by yourself, you are exhausted and you are not necessarily thinking rationally. You might rationalise in your own mind: the person has gone through the process; they have made their decision; this is what they said they want; the drug is here; now is the time that they should be taking it—that is elder abuse, and it is something we should be protecting against. I do not think these amendments are going to place too onerous an obligation; after all, it operates perfectly well in the Netherlands.

The other concern I expressed during my second reading contribution was the safe storage of the medication. Of course, there is nothing about that in the bill. It is very hard for us to make any judgements about that. We are told that it will all be sorted out during the implementation phase. Through these amendments that Hon Rick Mazza has proposed, we do not need to deal with this issue because the administering practitioner will bring the voluntary assisted dying substance with them at the time arranged for the person to self-administer it. I do not think what is being proposed is too unreasonable. It is in the best interests of the patient, which is what we should be thinking about. It is the best way to ensure that the patient has a peaceful and pain-free death.

Hon Dr STEVE THOMAS: I will briefly go where angels fear to tread. There is one person in the Parliament who has had reasonable experience with the administration of euthanasia drugs—that is me. The question as to how often untoward reactions occur and what they look like is something that I said during my second reading contribution I was not going to go into in great detail, and I do not intend to go into it in great detail today.

A question asked before was: how often do unusual reactions occur to a barbiturate administration? As someone with 30 years in the game, I think the answer to that is that somewhere between one in 20 and one in 50 of those euthanasia activities do not go exactly to plan.

Hon Colin de Grussa: Was that in humans?

Hon Dr STEVE THOMAS: No, that was not in humans. It might surprise members to know that there is a reasonable correlation between the drugs and reactions in other mammals and in humans. We like to think we are remarkably special, and it is common for the medical profession to suggest that human medicine is significantly different from everything else, but the reality is that there is a huge overlap in the drugs used and the response to the drugs. In fact, in many cases, the veterinary profession led the way for the medical profession. That is certainly the case with the particular topic that the chamber is discussing today.

Frequently, there is a significant reaction to barbiturate administration. Bearing in mind that in the vast majority of cases, when we are doing this in the veterinary profession, ideally we will give a pre-sedative so that the patient is in a fairly relaxed state and then administer intravenously a bolus of a barbiturate, particularly pentobarbitone. The bolus goes in over a second or two. If we are talking about very large animals, for which the dose rate might be hundreds of millilitres, it is obviously more complicated to get it in in that period of time. Oral administration, obviously, is much slower. It is not generally done in the veterinary profession. The equivalent of oral administration is that when a vet cannot get a vein up, they will do what is called intraperitoneal administration; that is, they will place the drug in the abdominal cavity, outside the organs, where it will be picked up in the peritoneal cavity. That process will take, generally, several minutes—not uncommonly a few minutes, but occasionally a little longer. But there is always the opportunity in this process for that to take far longer and on occasions we will get reactions that people are surprised by. I can tell members, because I have done this, that when the family is sitting around watching their beloved family pet being put down after a lifetime of service, it is not an easy thing. A lot of people end up in tears; a few vets do as well. In that process, when a vet has administered a sedative and a bolus dose of a barbiturate, they are hoping that it is not the one in 30 cases that goes astray, but if it is, when that patient sits up and howls in front of the family and the children, it is not the easiest of experiences. There are not infrequent reactions. It is the reason we are very cautious about whether people can be present. I always did; I always liked to have the family present because I think it is a good way for them to say goodbye. I would generally say to the families, "I think you should be there, but you need to be aware that not infrequently pets will have a reaction that is not the prettiest thing to watch", and people would understand that.

It is my expectation that on occasion something similar will occur. I know that will not change members' minds about whether they support this bill, but it is about the process of managing that. Hon Rick Mazza's amendment, with support from members such as Hon Adele Farina, would mean that there could be a medical doctor in place who could be required to manage that process. Again, I will not go into huge detail—I am not here to scare people—but the management of the process is important. I think the provisions in Hon Rick Mazza's amendment,

or an equivalent one, are important to manage the process when things will, inevitably, occasionally not go so well, even with all the best intent in the world and the best knowledge we have. Members have said before that dose rates vary; that is right, particularly if a person has had medications. If a person has a history of opiate usage, for example, or has used a lot of anaesthetics, they will become resistant to them and the dose rate that is required is going to vary significantly. That can be managed by a medical practitioner potentially altering that dose rate. It is not the case that it is always universally going to be a simple and beautiful process—I always wished that it was. It is sometimes like life—a little bit messy, a little bit ugly and sometimes it has to be handled as sensitively as possible. I suspect that the amendment, or an equivalent one, would assist that process.

Sitting suspended from 12.30 to 2.00 pm

Hon AARON STONEHOUSE: In considering this amendment and what value it would add to the process, I was listening to the contribution by Hon Nick Goiran, who gave the example of what is done in the Netherlands, where a medical practitioner's attendance is required. If a patient does not die from taking a voluntary assisted dying substance, the doctor is there to finish the job, so to speak. I know that it was not the member's intention, but I find that scenario rather distressing, and a rather scary idea. It is comforting to have the minister assure us that an administering practitioner would not be able to do that under this bill. An administering practitioner who is present would be able to provide medical aid, comfort and support to a patient, if they did not die as a result of taking a voluntary assisted dying substance. Looking at it in that context, and understanding that there can be complications in dosage and there can be different reactions to voluntary assisted dying substances, it certainly adds value to have a medical practitioner present at the time of taking a voluntary assisted dying substance.

It is still my preference that patients self-administer, as we can then be certain to at least some degree that it is a voluntary action; it is not a medical practitioner steering the process. The patient has taken that final action that requires the commitment for them to carry through with that action and take their own life, in that instance. I am sensitive to concerns that this would make it rather onerous, and that having to schedule an appointment with an administering practitioner just to self-administer a voluntary assisted dying substance would make it very difficult for the patients, especially those who perhaps require a greater level of care than others, or those in regional areas who may have to travel to visit a practitioner, and a practitioner is not available to do call-outs.

I am leaning towards supporting this amendment. As I see it, the greatest benefit of this amendment is that at least a medical practitioner would be present at the time to ensure that it is not a family member administering a voluntary assisted dying substance and that it is the patient who is self-administering. There is still a risk that a patient who chooses self-administration will take the substance home with them and whoever—a family member, perhaps a carer or someone close to them—is looking after their day-to-day needs is really in a position to, perhaps at the patient's request, administer; but even against the patient's wishes administer. We really will not know what goes on in that final moment. If we can mitigate that risk somehow by having an amendment like this, or similar to this, I see that there is benefit. We would be removing one of the risks that I think is present, which is when someone has the substance at home for an extended period of time and there is the potential that someone else will administer it—force them to take it or give it to them without their knowledge, or perhaps even try to help the patient take it, which, of course, would be inappropriate under this bill. I do see that there is a benefit. It would be more onerous, which is undesirable, but I think in this case the mitigation of risk might outweigh the additional burden being placed on the patient. That is the way I am leaning currently.

Hon COLIN HOLT: I must admit that I agree a fair bit with what Hon Adele Farina had to say about the purpose of this bill, which is—I will paraphrase, obviously—the safe passage of a person at the end of their life to make a choice that they have suffered enough and want to end their life. That is the purpose of the bill. If we think about the process, they will have gone through all those checks and balances to get to that very point. They will have been through a medical process and will now be coming into a much more regulated process. They will have gone through all the first and second requests and written declarations and have finally got the substance—or not got the substance under this amendment—and made the decision: "I want to end my life at the time of my choosing." That seems absolutely correct in my mind because they want to end the suffering, as dictated in the bill, which is their choice and assessment.

We get to the end point at which the patient has made that decision. I completely agree that there are risks with self-administration in a medical sense. We have had explanations. I think it comes up in clause 26, which provides that the coordinating medical practitioner has to say, "Here are all the risks of self-administration. Here are the risks with the medicine." They have to actually explain all those risks, just as they have to explain all the risks of medication now. Even in a palliative care setting, when drugs like morphine are prescribed to be administered at home, they will be told about the risks, the potential side effects and what can happen. There are explanations throughout the bill about the risks. If I were in this situation after the passage of this bill, I would probably say that I would like a doctor to be near me to minimise those risks. But that would be my choice as a patient. It would be

my choice as a patient to say that I would really like the doctor to be there, or I could go down to Lucky Bay in Esperance and decide to do it there. That would be my choice at the end of my life.

After all the processes that a patient goes through, they might say, "It's my choice. I would really like to take the substance. I know all the risks. They have been explained to me. I know all about the various stages along the way. I have weighed all that up and I accept that it is my choice." If one of my family members got into that situation, I would suggest ensuring that the doctor knew of the timing so that if anything did go wrong, they could be called and brought to the place. Again, it is about the choice of the patient. In my mind, this amendment takes away that choice. In fact, the choice of time gets taken away in some respects, because the patient has to wait for the coordinating or administering practitioner to be available to bring the substance. At that point, things are already starting to be taken out of the patient's hands. I think the underlying value of this bill is the autonomy of the patient in their decision-making—that it is voluntary. That brings autonomy. This amendment takes away some of that and there are other consequences as well. It is about a person at their end stage.

Hon Aaron Stonehouse talked about the risks of someone administering the substance to the patient, because that does not make the process truly self-administered. But let us look at the palliative care setting. In that setting my mum was in control of all the morphine that she had to give to my father whenever he needed it—absolutely. Whenever he called, she gave him some more. Although there might be some arguments that the aim of morphine is pain relief, we know what the side effects are. We are talking about someone towards the end of their life who has gone through the process and finally made a decision that the time is right for them, yet this amendment will bring one more potential hurdle into the bill. That is unacceptable. I cannot support the amendment for those reasons. I think it is about patient autonomy—let them make that decision. It is probably hard enough for them already. I would hate to think that if this amendment passed, someone could have teed up voluntary assisted dying for 10.00 am on Tuesday, have the doctor come, but the person might tell the doctor that maybe they are not quite ready and to come back tomorrow—or whatever scenario might be. There are myriad scenarios, and we have heard myriad scenarios in this debate. I come back to the fact that a person is at the end of the process, they are probably very ill, they have probably had enough and, more likely than that, they have got to their end point. I think it is for them to say when and under what circumstances they take the final step.

Hon ALISON XAMON: I indicate that I am generally torn about this amendment, because it picks up a lot of issues that go to the core of this issue. I absolutely recognise that in an ideal world, people should be able to determine the time they want to die. They should be able to have the people around them they want, and if they wish to do that privately and in a particular setting, that should be the way it is. The difficulty I have is that we are talking about a process of the state assisting in that death. As such, we have an obligation in this place not simply to create laws based on ideal scenarios, but also to foresee where things can go wrong and try to look at the best way to address that. I am genuinely concerned about the possibility of a bad reaction and someone not being there to assist. I am particularly concerned about the impact that could have on any children present. That could be extraordinarily traumatic, and it is an issue that weighs heavily on my mind. I also remain concerned about the issue of genuine consent. An idea I am attracted to is that by having someone who is independent present, there are checks and balances to determine that there is genuine consent and someone has not been coerced at the very last minute.

I have another concern, which is about protection for the families. A lot of members here talk about their experiences with what I hear as only functional families. That is great; I am really glad. Not everyone has the experience of a functional family. One of the things I do know is that when there are issues around money, wills and death, all the emotions and all the greed come out. All we have to do is go to our courts any day of the week and we will find there are disputes around estates among people who should love each either and be on the same side, but it tears families apart. I am attracted to the idea that an independent person being present will, frankly, lessen the likelihood of people being accused of murder, of having participated in the murder of a loved one. I see it as protection for the family to have, if you like, a witness present. Having said all that, I am really concerned also about the prospect of the independent witness turning up to facilitate and address all these issues, but the person who is availing themselves of the voluntary assisted dying process says, "Actually, I really don't want to go now." I would hate the presence of an independent person to be any sort of pressure on someone when they might want another five hours or even five days and have said, "I've changed my mind. I really am not ready to go yet; I want to stay."

I am also very concerned that people's capacity to access VAD will be limited by the availability of practitioners who can assist. I understand this is particularly an issue for people in the regions, but also I recognise it might be an issue just in terms of appropriate times or even places.

These matters are all weighing heavily on my mind. I am not sure that the amendment as it is drafted can address all my concerns. I am still conflicted about this. I stress again that it is my preference that people self-administer; that is far preferable to having someone administer the substance. However, we need to make sure we get the balance

right so that things do not go wrong. I am not sure that the bill unamended will achieve that, but I am not sure that the amendment in front of us can fully address the other concerns I have about access to that independent support.

The DEPUTY CHAIR (Hon Matthew Swinbourn): The honourable Di Guise.

Several members interjected.

The DEPUTY CHAIR: That is! Hon Diane Evers, my apologies.

Hon DIANE EVERS: That is all right; thanks for lightening up the situation!

I agree with Hon Adele Farina that one of our objectives of this bill is to have a peaceful and pain-free death; there is definitely no doubt about it. But another very significant part is the objective to allow the person who is dying and who is in insufferable pain and who wants to end their life to have that choice. That choice is the reason I am standing now. We believe that a person should have the liberty to decide for themselves how they would like to go. I can see a problem if there is a requirement to have an administering practitioner there. From what I can see, in an ideal world—we have had plenty of hypotheticals here—imagine a patient has invited their close friends and family around for lunch, to have a wake or memorial service while they are still there, to speak those last few words to each other. The friends and family have arrived and the patient's pain is being managed by whatever medication they are on, but the patient has told the practitioner that they intend to complete the process at half past three. The practitioner arrives and the guests are still there, having a lovely time. The patient is still enjoying their company, and it is not the right time; it does not feel like that is the right time. Time is ticking by—now it is five o'clock or maybe half past five. The practitioner is there, and they could even be a friend of the patient, but they want to get home to their own family for dinnertime or they might have to pick their kids up from somewhere. This is not the sort of pressure we want to put on a patient who is in their last few days or hours of life. It is their choice. They want to have their friends and family there; they want to be able to complete the process themselves. Remember that they are dying. Yes, miracles may happen, but, for the most part, they are dying. They are in insufferable pain. They want to be able to make that choice. Yet here we are, trying to legislate something that will put a burden on them to say, "Oh, yes, one last thing. We have to make sure that this person is here at the time that it happens." Imagine we do not pass this proposed amendment and the patient does not have that requirement. The patient had a lovely day and fell asleep with the pain relief, having had those wonderful thoughts, but they wake up at 9.30 or 10 o'clock, and their partner is with them. The patient says, "Look, we've said goodbye. It was a beautiful day. I'm ready now. Let's do this." They do not have to wait until the next morning to call up the practitioner, see if they are around still, and have them come back again.

If we want people to be free to do as they please, as long as they are not harming anyone—in this case, they are not; they are the patient; they are the one who is suffering—I would think that we would want the rights of that individual to life, liberty and property to be protected. It should be their right to be able to choose the time of their passing without any of the constraints of this proposed amendment. To say to a patient, "Before you do that, you have to make sure you've got somebody there" takes away much of what we are trying to achieve with this legislation. I think that putting such a burden on a patient would really increase their pain by giving them the responsibility of making sure that they choose to die at the time that they have organised for someone to be there. It is just unconscionable. I cannot see why we would put something like that in this bill, without even going into the issues of how difficult that might be in a regional or remote area, or if they choose to go to their favourite holiday place or to be completely on their own. Yes, I have heard all the concerns about coercion and abuse, but remember the person is dying. They are not going to be around for another two or three years. The chances are that they will not be too worried about where their property will go afterwards, because they will want that final connection with the people they love to be a feeling of goodwill, love and connection. The person is dying. It just does not make sense.

There is a concern about what would happen should the voluntary assisted dying process go wrong—should the medicine come back up or should it not be sufficient. We have already addressed the fact that the administering practitioner in this case, who has not been given the right to be the administering practitioner and complete the process, has no right to complete it should they be there and it not be final. The family would be in the same situation. The person is dying. They have pain medication around. I do not know the specific issues. We do not know yet, because things are always changing with what drugs can be used and how we can manage that. But remember, the patient is in insufferable pain already. If they were not, they would not be trying to end their life. A practitioner being there to give the patient relief after they have tried to finish their life just puts the patient back in the same place, and they would be in that place whether or not that practitioner was there. It does not actually do anything more in that respect. It does not do anything more to change their situation of being in insufferable pain and death being imminent.

Coercion and abuse—okay, fine; if I work really hard, I can imagine a situation in which a family is just desperate. They want to go on a holiday soon. They know they are going to be getting a lot of money out of the will, and

they think, "Let's knock him off a week before he's going to go anyway, in insufferable pain for that time." Wow—okay; let us make a movie out of it, too! That may happen, but that is not the point of this bill. The point of this bill is for those people who have the capacity and the desire to do this. We would put a big hole in the legislation and mess it up for many people who may not be able to manage to organise a practitioner at the right time, just to address the possibility of a really unkind family wanting to knock off a person early. Let us face it; in this world, if somebody is already in that position, there are probably more cases of them asking to be finished off than cases of families wanting to do the reverse. We have heard more cases of people asking over and over, "Please, end it for me. Put a pillow over my head", or whatever it is. Those are the cases that we are trying to look at. It is possible that it could happen the other way in some other world, or even in this world, but that is not what this is about. What we are trying to do here is create the best legislation so that the people who want to access this choice are able to, and they are able to do that with their friends present and without having to coordinate some other practitioner to be there to assist them. They want to do it on their own and at the time of their choosing. The time of their choosing may not be possible for the practitioner. The time of their choosing may not even be known to them until half an hour or 10 minutes beforehand. Those people should still have that choice. They should still have the liberty to deal with their own life and their own death in their own time, in their own manner, with the people they love around them and in the location of their choice. I think that passing this amendment would take that away from so many people, and it would just be a terrible thing to happen.

Hon NICK GOIRAN: Prior to the luncheon adjournment, I made the case that I would support Hon Rick Mazza's amendment, primarily because I put to members that the experience in other jurisdictions informs us that complications can arise as a result of taking this lethal substance. I have to confess that I did not expect to come back after the adjournment and hear the response from Hon Colin Holt, and to some extent Hon Diane Evers, that I heard to the concern that I raised about a person at the end of their life taking the lethal substance. Those members said that we need to remember that, above all else, the patient's autonomy trumps everything. If I understood the honourable members correctly, we need to remember that this is their choice. The honourable members make a compelling case.

Hon Colin Holt: I also said they needed to weigh up the risk, and I was actually responding to Hon Adele Farina.

Hon NICK GOIRAN: Absolutely—Hon Colin Holt, please do not hear my response so far as being critical of what you have said. I am simply indicating that I had not considered that position. I had not anticipated that members would say that, at the end of the day, we need to appreciate that a decision will be made by a patient who will have weighed up the risks, which will also include the risks in what I will call the Farina amendment, which is intended to be moved at clause 68 by the government. The patient will have already been told all of these risks and therefore it will be their choice—my life, my choice. I did not expect members to say that. I had intended to try to persuade members on the basis of the number of complications that can actually happen, but I concede that if a member's worldview on this issue is that it is the patient's choice, and if the patient has been told that these complications can arise and they could choke, asphyxiate or whatever the situation is at the end of life and they choose not to have a medical practitioner in attendance, then that is their choice—okay. That goes against my conscience, but I accept that a logical argument has been put by those members. I ask members to consider one thing. They talk about autonomy and "My Life, My Choice"; do they realise that at this particular point in the journey there is no requirement for the patient to have decision-making capacity? There is no requirement; we know that from the answers provided by the minister on several clauses. If the patient chooses "My Life, My Choice" and exercises their autonomy and says, "I want practitioner administration", this bill that we are going to pass will mandate that the practitioner cannot administer without there being decision-making capacity. I have not heard anyone suggest for a moment that it should be different, but suddenly we are going to take a different approach with self-administration. We are going to say to the person, "You can self-administer. Here you go. You take the poison, and we, as lawmakers, will now wash our hands of whether you have decision-making capacity or not." The amendment moved by Hon Rick Mazza ensures that somebody is supervising at the end of life to say, "This person still has decision-making capacity." To those members who have passionately made the case for autonomy and "My Life, My Choice", that is fine; I am not criticising them for having that view at all. But what follows from that is that there is no autonomy and there is no "My Life, My Choice" if the person has lost decision-making capacity. At that point it is no longer their decision. What do we do in that situation? Hon Rick Mazza fixes that. In actual fact, the irony is that if members are passionate about autonomy, it follows that they must be passionate about decision-making capacity. The only way that they will ensure that there is decision-making capacity when the person self-administers is by agreeing with the amendment moved by Hon Rick Mazza. In addition to that I wholeheartedly support the concerns raised by Hon Alison Xamon with regard to the possibility of abuse at the end of life. Again, even though I wholeheartedly support the member on that, I can already foreshadow that some members will say, "No, it's that person's choice. If they want to walk through a door where abuse is possible, that's up to them because of 'My Life, My Choice'." Okay; again, I do not agree with that, but I accept that that is a possible response. But does the person have

decision-making capacity? Before they take the poison, do they have decision-making capacity? That is the issue here. If members are of the view that it does not matter, that at that particular point in time so much has occurred that it does not matter whether they have decision-making capacity or not, they should not support Hon Rick Mazza. I do not know how they can then in all good conscience allow a bill to take place that has practitioner administration that requires decision-making capacity. I do not know why they would then support a government that has consistently said that it is fundamental to this bill that decision-making capacity trump all else. I do not know how they do that. But to those members who keep passionately asking us to support autonomy and "My Life, My Choice" I say it makes no sense in the absence of decision-making capacity. Unless they can persuade me otherwise, I will be supporting Hon Rick Mazza.

Hon DIANE EVERS: I have listened intently to Hon Nick Goiran's comments and I say we have to accept that the person has capacity, if they have gone through the process and got to the point at which they have the substance in their own home. At that point, if they have gone through that process, they have the right to do this. It is hard for me to imagine, but putting myself in the place of a person who has reached that point, they have made all their choices along the way, they know the situation and they know the risks. They know that the substance is in their home and they know that the end is near, whether by natural means or by taking the substance.

I think they have done all they need to do; are we to take that right away from them by saying that somebody has to be there to assess their capacity? They have said goodbye to everyone in their life, they are about to go to their final sleep, and we are saying, "No, wait; we still have to do a little assessment of you to make sure you know what you're doing." That is highly invasive and just seems wrong to me. I would not want that to happen to me, and a lot of people out there who are definitely in favour of this legislation going through also would not want it to happen to them.

What right do we have as a government or as a medical practitioner to tell that person in those last few moments, after they have jumped through every hoop to make sure that they do this by the book, that somebody needs to be there at the last minute to check to see whether they still have capacity? They have made that choice. They are dying.

Hon MARTIN PRITCHARD: I have not made up my mind either way, and I am listening to the debate. As an extension of Hon Diane Evers' comments, in my view, if the person lost capacity, what would most likely occur is that a relation would fulfil their last request. I am not sure whether that is right or wrong, can I say. I am trying to weigh this up. We will never get a perfect situation either way, but it seems to me fairly onerous that a member of their own family would have to make that decision. That is the most likely outcome of losing capacity.

Hon DIANE EVERS: I do not see that that is the follow-on outcome of it. Of course, the family member cannot do that of their own choice; it has to be the choice of the patient. If the patient does not say, "Yes, give that to me", it will stay in the fridge or wherever it is. Capacity is a different thing from a person being able to make the request and having the ability to do it themselves. I am not going to go any further on this, but I do not think that is the only logical outcome of it. I do not see that that all. I still see it being the choice of the patient. But that does not mean that in Hon Nick Goiran's terms that would be capacity.

Hon NICK GOIRAN: Just to clarify, member, in the absence of decision-making capacity, there is no genuine choice. The moment a person has lost decision-making capacity, the person is not making a choice. That is a matter of legality. Maybe the member thinks in her heart of hearts, "No; they're still making a choice." But, as a matter of legality, they are not making a choice. That is the issue here. The member knows that I am not agreeable with the whole bill, but at least, if I can give credit where credit is due, the bill talks about decision-making capacity. It talks about that on multiple occasions, including for practitioner administration. The one place in which it is absent is self-administration.

The final point I would make is that members may recall that there is a provision in this bill that allows for the process to be accelerated. The minimum period of time is nine days. However, there is one exception to that. It can be quicker than nine days. It can be as quick as two days—two days is the bare minimum. One of the situations in which a person can qualify for what I have referred to as the express pathway is if their doctor says, "I'm concerned that between now and the nine-day period, you're going to lose capacity." The doctor says, "I think patient X is going to lose capacity sometime in the next nine days, so I'm going to put them on the express pathway." We then continue with the rest of the process. The person chooses self-administration, because, remember, they still have capacity because they are in that nine-day period. We give them the poison to take home. At that time, there is no requirement for the person to take it in the nine days while they have capacity—no; they have taken it home—but the doctor knows that they are going to lose capacity after nine days. They could take it in 10 days, 12 days, 15 days or five months, and meanwhile the poison is at the person's home. The doctor knew that the person was going to lose capacity.

Hon Alannah MacTiernan: Balance of probabilities.

Hon NICK GOIRAN: Okay. I will take that interjection.

Hon Alannah MacTiernan: Likely to be.

Hon NICK GOIRAN: I accept that, honourable minister. Under the scenario that I am painting with regard to the express pathway, if we were going to score it out of 100, how many times is that going to happen? I accept the intent of what the minister is saying—that it is not the most likely scenario to eventuate. But the fact is that the reason we are here as the Legislative Council is to make sure that we are plugging these gaps, and one of the ways in which we can plug these gaps is by supporting Hon Rick Mazza's amendment.

Hon RICK MAZZA: Before this amendment goes to the vote, I want to make a couple of comments about the contributions that have been made. There has been some argument about the availability of practitioners who might be able to assist and be present as an administering practitioner if someone decides to self-administer. One would think that if someone has an ailment that was going to end their life, along the way they would have had consultations with medical practitioners and have access to them, whether they be a nurse practitioner or a general practitioner—whatever the case may be. I think they would have access to those sorts of people, who might be available to attend if the patient wanted to self-administer.

Hon Kyle McGinn: They might not be where they live, though.

Hon RICK MAZZA: They would have had consultations along the way.

I also have heard that there could be allegations against a family member. Hon Alison Xamon raised this issue. If someone is going to self-administer, the substance will be at home. There is no requirement about when they have to take it—whether it is two weeks or three months.

Hon Colin Holt: Some don't even take it.

Hon RICK MAZZA: Some patients may not take it; that is quite right.

But if a family member is with them, who is to say that other family members will not accuse that family member of administering the substance to the patient. Having been a real estate agent for 20 years, just at that level, I can tell members that what families will do to each other would absolutely curl their hair. To think that this will be happy families all the way and that everyone will gather around when the substance is administered is a fantasy. I have seen people rip their own families apart for financial gain. It is absolutely heartbreaking to see elderly women who are on their own have their children basically kick them out of the house. These things can occur, and I think we need to have safeguards in place to make sure that those circumstances are minimised. I think the amendment I have proposed goes some way towards that.

I get the privacy issue. I get that people would like to just go home to their family and take the substance and, hopefully, peacefully pass away. I get all that. However, in the real world, that will not always be the case, so we need to put safeguards in place. Therefore, I commend this amendment to the chamber.

Division

Amendment put and a division taken, the Deputy Chair (Hon Matthew Swinbourn) casting his vote with the noes, with the following result —

Ayes (13)

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

Noes (21)

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

Amendment thus negatived.

The DEPUTY CHAIR: Hon Nick Goiran earlier withdrew an amendment. Do you wish to still pursue that amendment?

Hon NICK GOIRAN: Yes, notwithstanding that technically we are going back to lines already passed on page 37, nevertheless, subject to whatever supplementary procedure is required, I move —

> Page 37, lines 1 and 2 — To delete "the contact person for the patient or an agent of the patient." and substitute —
>
> or the contact person for the patient.

Hon STEPHEN DAWSON: We have already addressed this amendment, albeit that Hon Nick Goiran withdrew it to allow Hon Rick Mazza the opportunity to have his amendments considered. I have indicated previously that the government is not supportive of this amendment. I hope that there is not extensive debate on the amendment, given that we have essentially debated it previously.

Hon NICK GOIRAN: To remind members, this is related but quite different from the other matter that we have just dealt with. This matter deals with the issue of an agent. Members will recall the debate earlier today when other members identified—I take no credit for this—that the bill does not define "agent". An undefined Western Australian person will be able to access this lethal medication, albeit on the part of the patient; notwithstanding that, as members identified earlier, the patient already has to nominate a contact person. There is a very significant difference between a contact person and an agent under the provisions of this bill. The contact person is defined and has roles and responsibilities. An agent is undefined and has unspecified roles and responsibility obligations. I think one of the honourable members raised earlier in the debate that this is, if you like, an unregulated aspect of the system, and I agree. The role of this undefined agent is unregulated, whereas the role of the contact person is regulated. We are talking about a person taking into possession a lethal substance. I think the minister and the government's explanation was that it is routine for agents to be used by patients to collect things. That is true, but that is to heal and care for people; it is not to take a substance that has the express purpose of the death of an individual. That is what makes this unique and that is precisely why the government has insisted in the legislation, which I support, that there needs to be a contact person who is able to do various things including account for any disposal at a later stage. For those reasons, I recommend to members that we do not leave this unregulated, undefined and frankly unnecessary aspect of the bill, which is for agents to be involved.

Hon MARTIN ALDRIDGE: I have a question for the minister. If we were to oppose this amendment and retain "agent" in this clause, is there any prohibition on the agent being a person of less than 18 years of age, which was the issue raised by Hon Martin Pritchard?

Hon STEPHEN DAWSON: There is no prohibition.

Hon MARTIN ALDRIDGE: I refer to clause 66, because it is related to this amendment. Clause 66 is "Role of contact person". Clause 66(1) simply sets out what the contact person is authorised to do, which is receive, possess, supply and return the substance. Obviously, with regard to the first three elements—receive, possess and supply—they have a similar authorisation to an agent. Clause 66(2) states —

> The contact person for the patient must inform the coordinating practitioner for the patient if the patient dies (whether as a result of self-administering the prescribed substance or from some other cause).

If the agent, who could be a person less than 18 years of age, is authorised to receive, possess and supply a voluntary assisted dying substance to the patient, how is it that the contact person under clause 66(2) will fulfil their lawful obligation to inform the coordinating practitioner when there is no obligation for the contact person to even know that an agent has been appointed?

Hon STEPHEN DAWSON: When the substance is supplied by the authorised supplier, they must notify the board, including who they supplied it to. The board would let the contact person know. The patient, upon receipt, would advise their contact person and coordinating practitioner. Conversations would take place between the practitioner and the patient prior to prescribing the substance. Further, the contact role will only be accepted by someone who has close contact with the patient and is prepared to be kept informed about the patient's state of health and decision-making capacity.

Hon MARTIN ALDRIDGE: On the point that the board would notify the contact person if the authorised supplier had dispensed the substance to somebody other than them—for example, an agent—what is the time requirement for the board to advise the contact person, and is that a requirement of the bill?

Hon STEPHEN DAWSON: Under clause 148 of the bill, it is within two business days.

Hon MARTIN ALDRIDGE: I am not satisfied that the bill requires provision for an agent. It certainly is concerning to me that an agent could be a child and that, for the purposes of this bill, a voluntary assisted dying substance could be dispensed to a child. It concerns me that there is no adequate recognition of the connection between a contact person and an agent in terms of the contact person discharging their responsibilities under clause 66 of the bill. I am also not convinced that the provisions in the bill that allow for the patient to revoke a contact person and appoint another contact person are significantly arduous to deal with the problem that is trying to be addressed by the provision of having an agent. The scope of the agent is very narrow; it is to receive, possess and supply the substance.

That is it—they cannot do anything else. If there is a circumstance in which the contact person is unable to fulfil their responsibilities, the patient would not easily be able to appoint another contact person who could do that.

Perhaps another way to do it would be to allow the contact person, with the agreement of the patient, to delegate responsibility, but it would relate directly to the appointment and the powers of the contact person. The way it has been constructed in this bill is that there is no relationship between the agent and the contact person, apart from, as the minister just said, two days after dispensing the drug, the board would make a notification. In that time, the substance could have been consumed and the patient could have died. There is no good reason—in fact, I think there is some good concern—for retaining "agent" in its current form.

Hon DIANE EVERS: I am not comfortable with the amendment taking away the right of the agent to collect the medication—the substance. This could be very difficult in regional and remote areas, where it may be that the contact person is a close family member who spends every day and every night with the person at this time and is not in a position to leave them, for whatever time it might take, to drive a significant distance to collect the substance. I can see other situations in which the contact person could be a partner who does not have a driver's licence; they may not even be able to get there. It again puts a burden on the patient that is unnecessary; as long as we address any issues regarding who the agent is and what they can do.

I seek clarification of one point. I am not sure that it can be answered here, but I would think that our Medicines and Poisons Act would say something about a person having to be 18 to be able to receive medication such as this. I do not know whether that can be answered today, but it seems to me that there would be some sort of age requirement within our poisons act. I see this as a supporting role to be able to get the substance to the person's home, where they and their contact person can use it.

Hon JACQUI BOYDELL: I have to agree with the comments of Hon Diane Evers. I think that an agent could play an exceptionally important role for the patient in managing the choices that they make at the end of their life. This is about the patient maintaining control. The patient will have their contact person. If, for some reason, the contact person cannot pick up the medication, which could occur for a whole lot of reasons, it would still be up to the patient to appoint an agent. They can do that very quickly and easily. This is about the patient's access to voluntary assisted dying. A mechanism that supports the patient being able to deliver on their decision-making is important in the process.

We have all had contact at some point in our lives with groups, such as Silver Chain, that support families in their homes during the end stages of life. I could very well see an agency such as Silver Chain taking up this role. We want to keep the family together. The contact person would probably be one of the people in the group of people around the patient who is dying. I can understand that person not wanting to leave that scenario. The patient has the right to ask someone else to simply go and pick up the substance and bring it back. That is the only role that person would play, and it is about supporting the patient. I will not be supporting the amendment as put. I think that the agent could potentially play an exceptionally important role for the patient.

Hon MARTIN PRITCHARD: I do not really have a big problem with this. I often acted in this circumstance with my parents, picking up their medications and such. I do not particularly have a problem here, but it seems to me, from the way this is drafted, that the agent is an afterthought. It has been drafted in that manner and put into the document. There does not seem to be very much continuity, as there is with the contact person, with the substance and the line of communication between the different points. The only reason I would support the amendment is that it does not seem to gel particularly well with the rest of the bill.

Hon AARON STONEHOUSE: I think it is appropriate to provide for someone other than the contact person to collect and supply a voluntary assisted dying substance. I agree with the intent of allowing agents to carry out that function. However, I am very concerned that we have just learnt that someone under the age of 18 could act as an agent. There is no prohibition on a person under the age of 18 collecting, carrying and supplying a schedule 8 poison—a barbiturate. That is potentially quite dangerous. A 12-year-old child could be sent down to the dispensary—it probably will not be a community pharmacy; we have heard that—and there is nothing stopping them from being able to do that. It may be appropriate for someone under 18 to carry out certain functions at times, but we are talking about something potentially very dangerous. It is a barbiturate that is used not only as a poison, but also recreationally in some cases. We are putting a lot of responsibility on somebody under the age of 18 in this instance.

There will also be statutory obligations for contact people that will rely upon the agent carrying out their function. We are putting a contact person potentially in a dangerous situation in which they have an obligation to return any unused voluntary assisted dying substance, but they have no control over how that voluntary assisted dying substance is delivered or supplied to the patient. The contact person has these obligations and these responsibilities under clause 66(2), but who knows what the agent is doing? The contact person obviously is over the age of 18; they have to consent to becoming a contact person, and they are a responsible person who is opting into this. They have the

option to opt out, and that responsibility can be transferred to someone else. The agent can be whoever the pharmacy or dispensary is advised will be coming to pick up the prescription. That concerns me.

There should be provision in the bill for someone other than the contact person. That is appropriate. There can be scenarios, as outlined by Hon Diane Evers, in which the contact person is the full-time carer of the patient and it is impossible for them to leave the patient, who needs intensive care, to go and collect the prescription, especially if they have to travel a great distance to do so. However, I am really concerned about what appears to be a pretty loose framework and regulation around the agent and how the agent behaves, and the requirements for an agent. I do not think it necessarily needs to be spelt out in the legislation, and it does not need to be too onerous, but the lack of an age limit concerns me. Maybe the minister can tell us more about the current practice in the Medicines and Poisons Act and how pharmacies work with agents, to help us understand how this relationship works, but based on what we have been told so far, I am very concerned.

Hon MARTIN ALDRIDGE: In response to my question, the minister said that there is an obligation under clause 148, "Board to send information to contact person for patient", for the board to notify the contact person. It reads —

> The Board must, within 2 business days after receiving a copy of a contact person appointment form for a patient under section 59(1)(b)(ii) or 65(4), send information to the contact person for the patient that —
>
> (a) explains the requirements under section 104 to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer; and
>
> (b) outlines the support services available …

That does not say that the board has to, within two days, advise the contact person that a substance has been dispensed. It says that the board has to provide information to the contact person within two days of their appointment as a contact person.

Hon AARON STONEHOUSE: I will just pile more on the minister's plate while he is preparing his answer on that point Hon Martin Aldridge raised. If the board does have some role in notifying the contact person that a substance has been collected, what information is retained by the pharmacy or the dispenser about the agent? Is the agent's identification collected? Is a contact number collected for the agent? If any information is collected and provided to the contact person, what information is collected? How is the contact person going to be able to get in contact with the agent in this case to ensure that the substance is delivered appropriately? Ultimately, the contact person is responsible at this point—they are the person with the obligation to return any unused substance and to notify the board when the patient dies. What information is retained? What requirement is there in the legislation that it is retained and passed on?

Hon STEPHEN DAWSON: There are a couple of questions floating around, so I am hopefully going to provide answers to all of them. I turn to the question from Hon Martin Aldridge. The board knows, ahead of the substance being prescribed for self-administration, that a contact person exists. This is because the substance cannot be prescribed before a contact person is appointed. If the patient's agent picks up the medication, the authorised supplier must verify who they are giving the meds to—that is, who the agent is. This information will then be on the database that will be available to the board. The board will see that an agent, not the contact person, has picked up the medication. The board will then let the contact person know, who will verify by calling the patient to check.

In answer to Hon Aaron Stonehouse's question, the issue of ages was canvassed previously. I make the point again: there is no prohibition at the moment on a 17-year-old collecting a schedule 8 or schedule 4 substance outside this legislation. It was discussed previously that many medicines, if taken incorrectly or if too much is taken, may cause death, outside schedule 4 or schedule 8 substances.

Hon Martin Pritchard suggested that it was an afterthought to include "agent" in this bill. I assure him that it was not an afterthought; it is consist with the Medicines and Poisons Act.

Going back to what Hon Aaron Stonehouse said, the patient will send a trusted person. They will have a trusted person as their agent, not a random person. The patient will not send someone they have no confidence in; they will send someone whom they understand will be able to do the task of collecting the substance and will bring it back and give it to them.

Hon MARTIN ALDRIDGE: We have established that clause 148 does not apply, but we have an understanding that the board will notify the contact person that it is not a requirement of the legislation that that occur. I do not have a problem with the idea that a contact person may not be available to do certain things, so some other person will be required to undertake those functions. My problem is that it is completely disconnected from the provisions of the legislation. I would not use the same words as Hon Martin Pritchard to say that "agent" is an afterthought,

but perhaps two ideas have been developed in isolation. Maybe that is because the government started drafting the bill before it received the ministerial expert panel recommendations. Perhaps the government's position on the ministerial expert panel recommendations and bringing it all together has resulted in some of these issues. It was interesting to hear some people's comments about the agent. The contact person may not have a driver's licence; therefore, we would need an agent to drive to pick up the drugs. I remind members that it is the responsibility of the contact person to return the unused substance. Where is members' concern that we should expand the provisions of the agent to include the return of the drug?

Hon Diane Evers interjected.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Order, members! Hon Martin Aldridge has the call.

Hon MARTIN ALDRIDGE: I am not quite sure about the relevance of that interjection.

If we are anticipating that the nominated person cannot fulfil their functions under the first limb of clause 57(7), which is to receive, possess and supply, we would think that, naturally, that would also extend to the return of the drug, which, after the fact, will be interesting. If we contemplate a nominated person not having a driver's licence—they may have some level of incapacitation or whatever the circumstances—they will need an agent. The agent will receive, possess and supply the drug, but then the patient dies. That will leave a nominated person who cannot return the drug and, according to the provision we are dealing with, the agent cannot return the drug. I do not think this has been thought through well enough.

Under clause 70, "Authorised supplier to authenticate prescription", subclause (c) provides that the authorised supplier must confirm "the identity of the person to whom the substance is to be supplied". Based on what? Unlike the contact person, an agent does not have any eligibility requirements or nomination forms. Nothing will be reported to the board on the appointment of an agent. Does somebody just rock up and say, "I'm the agent for the patient. Give us your drugs"? How does the authorised supplier identify the person as the agent of the patient? It is interesting that if we compare the powers of an agent with the powers of a contact person, the only two differences are that the contact person, additionally, is required to return the drug and notify the coordinating practitioner of the death. They are the only two differences. The contact person has two tasks to undertake after the death, whereas the agent will receive, possess and supply the substance.

Notwithstanding that, we could compare the numerous clauses that relate to a contact person's powers, how a patient appoints a contact person, the contact person appointment form, the role of the contact person and the fact that the contact person may refuse to continue. A whole range of clauses that relate to the operation of a contact person do not relate at all to an agent, who has very, very similar functions. It concerns me that although the minister has indicated that the Voluntary Assisted Dying Board will do something when they are notified within two business days that the authorised supplier has dispensed the drug, it is not a requirement of the bill that they notify the contact person. As I said before, within those two days, the substance could have been supplied and the death could have occurred.

I do not have a violent objection to having an agent; I just think that the drafting of this clause is very ill-considered. As I said before, perhaps the better way to do it would be to allow the contact person, if they were unable to fulfil their powers, to appoint an agent in consultation with the patient. Perhaps that would be a better way of dealing with it. But I agree with Hon Martin Pritchard; I think there has been a bit of a haphazard approach to the intersection of an agent and a contact person in the bill.

Hon NICK GOIRAN: I want to add, to make it clear to members, that like Hon Martin Aldridge, I do not mind if there an agent is involved in this regime, but if there is going to be an agent in the regime, it cannot be in the current form that is in the bill. If the government genuinely and passionately says that it is very important that we have an agent for the reasons that some members have said, fine, but make amendments accordingly to regulate the role of the agent so that it is at least comparable with the regulation around the contact person. Do not leave an unregulated, undefined person in the legislation. That is the issue I have. If at some later stage the government wants to move an appropriate amendment to regulate the role of the agent—obviously, I have not seen the wording yet—in principle, I would support that.

Hon RICK MAZZA: I rise to say that I will support this amendment. Listening to the previous speakers, I get the idea of an agent. I think Hon Jacqui Boydell spoke about Silver Chain maybe going into town and being able to pick up the voluntary assisted dying substance, particularly if some distance is involved, and provide it to the patient or the contact person. However, I start to have some problems with the other functions that the agent can undertake, which Hon Martin Aldridge also articulated. It is not just being able to receive the prescribed substance, bearing in mind this person could be 16 years of age or younger, but also they can possess it and supply it. Clause 71(2) refers to what the authorised supplier needs to do when providing the substance to the person collecting

it. I will not go through it, but the supplier has to advise the person who receives the substance of a whole list of different things that they can do. If that person is young and has not really been involved very much in the process for the patient, they may not be able to retain that information or understand their obligations under that clause. I think that the proposed amendment before us is actually quite a sound amendment. If there were amendments further on that the agent will be able to simply pick up the substance and then provide it to the contact person, I could live with that, but I think that the way the clause is drafted at the moment gives the agent far too much scope.

Hon ADELE FARINA: Did I hear the minister say earlier that the issue of the establishment of the agent being able to pick up medicines is actually under the Medicines and Poisons Act; and, if so, which section? I have been quickly flicking through it and I have not been able to find it. That raises the issue that even if we delete the agent from this provision, and if it is still in the Medicines and Poisons Act, the patient will still be able to appoint an agent.

Hon STEPHEN DAWSON: I am told that section 7(3)(b)(ii) of the Medicines and Poisons Act currently provides for agents to be supplied with schedule 4 or schedule 8 poisons.

Hon NICK GOIRAN: Given the wording in clause 57(4), is it the case that the authorised supplier at clause 57(4)(c) can supply the substance only for those persons listed, notwithstanding anything in any other legislation?

Hon STEPHEN DAWSON: This supersedes other acts, but we are seeking to make consequential amendments to the Medicines and Poisons Act 2014 through an amendment at clause 173(3) of this legislation to fix the inconsistency with that act.

Hon ADELE FARINA: I just had a look at that section in the Medicines and Poisons Act and it applies only if the poison is prescribed for therapeutic use. I do not know that it could be argued that the voluntary assisted dying substance is prescribed for therapeutic use.

Hon STEPHEN DAWSON: We are making consequential amendments to the Medicines and Poisons Act that will cover that. The amendment I have identified at clause 173(3) will deal with the issue at section 7(3) of the Medicines and Poisons Act.

Division

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

Ayes (14)

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

Noes (21)

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

Amendment thus negatived.

The CHAIR: We now return to the question that clause 57 do stand as printed.

Hon ADELE FARINA: Clause 57(5) refers to the patient being authorised to "prepare" the voluntary assisted dying substance. What sort of preparation will be required by the patient?

Hon STEPHEN DAWSON: They could be required to mix the substance with a sweetener to make it more palatable, or mix it with water to take.

Hon NICK GOIRAN: What would happen if the patient does not have the ability to do that?

Hon STEPHEN DAWSON: In that case, self-administration would not be the appropriate course of action; practitioner administration would be the one they should take.

Hon MARTIN ALDRIDGE: What is the mechanism for a patient to appoint an agent?

Hon STEPHEN DAWSON: They would ask someone to do it and they would have to say yes or no.

Hon MARTIN ALDRIDGE: It would be a verbal agreement between the patient and the agent. How will a dispenser verify that a person is acting as an agent for a patient?

Hon STEPHEN DAWSON: We dealt with that question earlier today.

Hon Nick Goiran: You gave one example.

Hon STEPHEN DAWSON: No; I gave the example of a letter—I gave multiple examples.

Hon Nick Goiran: What were the other ones?

Hon STEPHEN DAWSON: It could be by phone call.

The CHAIR: Order! The minister is trying to answer the question, members.

Hon STEPHEN DAWSON: I will say it again. We have spent an inordinate amount of time dealing with the same thing multiple times over the last five weeks. With great respect to the members in this place, people have to pay attention to the debate if there is any commitment to dealing with this bill. It is not fair and it is disrespectful to keep asking the same questions over and again. I dealt with this earlier today. I gave the examples that it could be by letter or it could be by phone call. Those are two examples. I do not think it is fair to continue to ask the same question, albeit after a lunch break or a day or two. It is very important that people pay attention. It is not appropriate for me to keep repeating myself.

Hon MARTIN ALDRIDGE: I take offence at the minister's suggestion that members are not paying attention to this matter.

Hon Nick Goiran interjected.

Hon MARTIN ALDRIDGE: It is a very serious issue —

The CHAIR: Order! Members, let us remember that it has been a long week for everybody—all involved. A little bit of tolerance all around is what we require at this time as we invite Hon Martin Aldridge to continue his remarks.

Hon MARTIN ALDRIDGE: Given the concerns of members about retaining the provision for the agent in this clause, which contemplates a circumstance in which a contact person is unable to travel and therefore unable to deal with the logistics of receiving, possessing and supplying the substance, why is it that the government has not given consideration in this provision to also include within the agent's powers the ability to return to the authorised disposer any unused or remaining prescribed substance?

Hon STEPHEN DAWSON: It is an undertaking that the contact person must make.

Hon MARTIN ALDRIDGE: In a circumstance in which a patient dies, the contact person cannot change and is fixed. The patient is no longer living, so can no longer revoke or appoint a new contact person. In the circumstances described by members who just voted to retain the provision for the agent in this clause, how will the substance be returned?

Hon STEPHEN DAWSON: I am advised that the coordinating practitioner can act as the contact person.

The CHAIR: Members, we are contemplating clause 57. Before we proceed, noting the two amendments on the supplementary notice paper standing in the name of Hon Charles Smith, one would presume that because they deal with matters that have been substantively dealt with, the member may not be proceeding with these. Could you confirm that, Hon Charles Smith?

Hon CHARLES SMITH: Thank you. Yes, I withdraw the next two amendments.

The CHAIR: Thanks. That gives us a scope of the work.

Hon NICK GOIRAN: At clause 57, "Self-administration", subclause (5)(d) gives the power to the patient to self-administer the prescribed substance. What should the patient do if they experience difficulty in self-administering the approved substance?

Hon STEPHEN DAWSON: They should contact the coordinating practitioner and make a new administrative decision.

Hon NICK GOIRAN: How will somebody do that when they are in the middle of taking the poison? They may have difficulties. They may be incapacitated and cannot get to a phone and no-one else is there. We just agreed that there will be no supervision. What will happen in that situation? What will the patient do?

Hon STEPHEN DAWSON: The coordinating practitioner would most likely have had this conversation with the patient and would have encouraged them to have support from family, friends or a carer when they self-administer.

In the member's example, if the person is by themselves and not with anyone else and cannot take it, the reality is that they will wait for someone else to come along to help them.

Hon Nick Goiran: They may have already started taking it.

Hon STEPHEN DAWSON: That would be a consequence of their decision and them exercising their autonomy.

Hon NICK GOIRAN: That is entirely why I remain sad about the current state of affairs, and after we have considered clause 57, I am no sadder now than I have been at any point in this debate. Minister, will it be part of the guidelines or the communication between the practitioner and the patient that they recommend that the patient call the paramedics before they self-administer?

Hon STEPHEN DAWSON: It will be part of the guidelines that the planned taking of the substance be spoken about with family or friends. The person may decide to call the paramedics, but that is not guaranteed.

Hon NICK GOIRAN: After this advice has been given to the patient that it would be excellent for them to have some family or friends present while they self-administer, and the patient then experiences difficulties, will there be any prohibition on the family or friends ringing emergency paramedics to come to the scene and provide any assistance? As a second part to that question, the minister said earlier that one of the objections, which seemed staggering to me, was that the medical practitioner would not be able to do anything if they were present other than to provide care and assistance—rightly so, I might add. It entirely disturbs me that the approach in the Netherlands is to ensure that a practitioner is present so that they can finish the job. Nevertheless, in this example—the patient has self-administered, has family and friends there as recommended by the minister, the government, the guidelines and the practitioner, has had complications arise and is suffering—will the patient's family and friends be permitted to call the paramedics; and, if they do, what can the paramedics do in that situation?

Hon STEPHEN DAWSON: In relation to the question about a prohibition on them calling the paramedics—I think that was the word the member used—there is no prohibition. If paramedics attend, I am advised that they are bound by professional obligations to provide assistance to the patient if there is medical distress.

Hon MARTIN ALDRIDGE: The minister responded to my question a few moments ago that the coordinating practitioner can act as the contact person. Could the minister advise me which clause of the bill he is relying upon for that advice?

Hon STEPHEN DAWSON: This issue was raised, and I am happy to give it to the chamber again; it is under clause 64(3).

Hon MARTIN ALDRIDGE: Clause 64(3) states —

> Without limiting who can be appointed as the contact person, the patient may appoint their coordinating practitioner, their consulting practitioner or another registered health practitioner.

The problem is that it does not automatically appoint the coordinating practitioner as the contact person. The circumstance around which I just framed the question is relevant to this clause, Mr Chair, because I am considering clause 57(7) and why the government has chosen to omit within the powers of the agent the return of any unused substance. I appreciate the views expressed by the chamber. The scenario that I put to the minister is that there could be circumstances in which a contact person will not be able to travel to facilitate the receival, possession and supply of the substance. I accept that and the chamber has agreed that we need to keep "agent". My question is whether we need to include the return of that substance. As I said a few moments ago, a situation that would be quite possible is that the patient dies and the contact person, as described by several members in this chamber, continues as the contact person. That person cannot revoke that position and a new contact person cannot be added because the patient is dead. That person has an obligation to return the substance. In that circumstance, which has been accepted by the chamber as the reason we need to keep "agent", why is it then not appropriate for us to consider including in the powers of an agent, to keep it consistent with those of a contact person, that the agent is empowered to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by clause 104? Maybe the minister can point me to some other provision that might deal with that, or he might entertain including that within an agent's role; but, what power will the coordinating practitioner have if they are not the authorised contact person, firstly, to possess the substance and, secondly, to return the substance?

Hon STEPHEN DAWSON: The contact person will commit an offence if they fail to return the substance, hence formal appointment is required. The state can facilitate medical retrieval if necessary. I will give an example. If the contact person is out of the country or is ill, they can advise that that is the case. The CEO can assist the contact person in fulfilling their obligations.

Hon MARTIN ALDRIDGE: The contact person has a lawful obligation. For those members who were concerned about helping the contact person by having an agent, would it not be helpful, to assist that contact person, to include it, or would the government accept the inclusion of a subclause 7(d) to allow the agent to return the substance? If we are allowing the agent to receive, possess and supply the substance—that is the position that has just been settled by the chamber—would that not naturally extend to its return?

Hon STEPHEN DAWSON: We would not countenance the insertion of a subclause (7)(d). Under our bill, the agent has a different role from the contact person. We are happy with the distinction between the agent's role in clause 57 and the contact person's role in clause 66(1)(d).

Hon MARTIN ALDRIDGE: This is the last time I will seek the call on this clause, Mr Chairman. I want the record to reflect that that may well be the government's position, but for those members who just stood during discussion on the clause and said, "We have great concern that the contact person may not be in a position to fulfil their functions because they may not be able to travel and may not be able to do the things required of them; therefore, that is the reason we need an agent", the agent as described in clause 57 is deficient, in my view, in line with their argument with regard to the return of the drug. The minister just said that they have a legal obligation; I think he even went as far as saying they would be committing an offence if they did not return the drug.

For those members who expressed that view in the consideration of the amendment moved by Hon Nick Goiran, if we leave this clause unamended, we are putting contact persons in the position of having a legal obligation to return the drugs and they will be committing an offence if they do not discharge their responsibility to return the drugs.

Hon NICK GOIRAN: I endorse entirely the comments made by Hon Martin Aldridge on that line of questioning. I have a final question on clause 57, subject to any supplementary questions that might arise. Will the prescribed substance have a use-by date?

Hon STEPHEN DAWSON: I am advised that all medications have a use-by date.

Hon NICK GOIRAN: What mechanisms are in this clause, "Self-administration", or any other clause, to indicate what should be done with the prescribed substance if it has reached its use-by date?

Hon STEPHEN DAWSON: The guidelines will be developed during the implementation phase, and that includes this issue.

Clause put and passed.

Clause 58: Practitioner administration —

Hon ADELE FARINA: Mr Chair, I will not be moving my amendment to clause 58. It will be dealt with as part of the government's alternative wording to clause 68.

The CHAIR: Thank you for that advice, member. The question is that clause 58 do stand as printed. Hon Charles Smith, do you have an amendment to move?

Hon CHARLES SMITH: Mr Chair, I seek to remove amendment 41/58.

The CHAIR: We will delete that amendment from the supplementary notice paper. Thank you, member, for clarifying that.

Hon NICK GOIRAN: Who is an authorised supplier under clause 58(3)?

Hon STEPHEN DAWSON: It is the same as the authorised supplier that we identified earlier. I am happy to give the member further information if required, but I believe that question was last asked on clause 57 before lunch. Does the member require information? No.

Hon NICK GOIRAN: Is the administering practitioner required to have any history of providing medical care to the patient or to have participated in any step of the request and assessment process, or might the time of administration be the first time that the administering practitioner has ever met the patient?

Hon STEPHEN DAWSON: Possibly, this could be the first time that they have met the patient, but clause 58(5) suggests that an administering practitioner needs to be satisfied at the time of administration that —

(a) the patient has decision-making capacity in relation to voluntary assisted dying; and

(b) the patient is acting voluntarily and without coercion; and

(c) the patient's request for access to voluntary assisted dying is enduring.

Hon NICK GOIRAN: Why has clause 58(5) been deemed important for inclusion?

Hon STEPHEN DAWSON: In circumstances in which practitioner administration is deemed the appropriate administration decision, it would be necessary to determine these matters. An example would be if a person is on—to use the member's language—the express pathway, to ensure that they have decision-making capacity. Also, it is important because the patient is not self-administering, and may change their mind.

Hon NICK GOIRAN: Who is eligible to witness the practitioner administration of the prescribed substance to the patient?

Hon STEPHEN DAWSON: Clauses 61(a) and (b) deal with that matter.

Hon NICK GOIRAN: Why is a witness for this practitioner administration required?

Hon STEPHEN DAWSON: We believe that the requirement for a witness during practitioner administration is another safeguard in the voluntary assisted dying process. It reflects the voluntary nature of voluntary assisted dying. It is fundamental to the WA model, and the decision to access death must be enduring.

Hon NICK GOIRAN: But it is not so fundamental that it applies to self-administration—correct?

Hon STEPHEN DAWSON: In the case of self-administration, the patient demonstrates capacity, voluntariness and enduring nature by taking the medication themselves.

Hon NICK GOIRAN: That is nonsensical. That is utterly nonsensical. There is no witness, no-one else is present, and the patient, who could have lost capacity, demonstrates the voluntariness of everything by taking the substance themselves. Did I mishear that? Does that require correction in any way?

Hon Stephen Dawson interjected.

Hon NICK GOIRAN: I heard that correctly. I note for the benefit of Hansard the furious agreement of the minister that I heard correctly.

Hon Stephen Dawson: The nodding of the minister.

Hon NICK GOIRAN: It was the polite nodding of the minister.

I find that extraordinary; is the practitioner required to remain with the patient up to the point of death?

Hon STEPHEN DAWSON: I am advised it is good medical practice.

Hon NICK GOIRAN: If it is good medical or clinical practice, is there any objection by the government to codifying that good medical practice?

Hon STEPHEN DAWSON: We would not countenance that change. I am told it is good medical practice. To make the change could undermine professional judgement. The medical practitioner may wait in the next room, because the act taking place would suggest that they need to be there and would have a concern.

Hon NICK GOIRAN: To understand it correctly then, the scenario that is being contemplated is that practitioner administration could involve the practitioner administering the substance to the patient, walking to the next room and waiting, and having no knowledge about what else is happening in the other room. Would that scenario be what we would describe as good medical practice?

Hon STEPHEN DAWSON: I am told that the patient may wish the practitioner to wait in the next room and prefer that a family member wait with them, but to get the practitioner if required. It would be unusual, though.

Clause put and passed.

Clause 59: Coordinating practitioner to notify Board of administration decision and prescription of substance —

Hon NICK GOIRAN: Clause 59(1) provides that the coordinating practitioner must provide the board with the administration decision and prescription form within two business days after the coordinating practitioner has provided a voluntary assisted dying substance. The only requirement is that the prescription has to be issued and the relevant form completed and provided to the board for notification. Where in clause 59 does it state that the board must be notified before the death of the patient?

The CHAIR: Members, noting the time and that the minister is taking advice —

Hon Stephen Dawson: There is no afternoon tea today, Mr Chair. There is obviously afternoon tea for those members who wish to partake.

The CHAIR: These are unruly interjections! As I was saying, noting the time, I will ask whether the minister wants to respond to the question.

Hon STEPHEN DAWSON: I do wish to respond; I will take advice from the advisers.

There is no requirement, honourable member, but I am advised that the information will be captured in a database that is accessible by the board.

Hon NICK GOIRAN: Will it be captured in a database before the death of the patient or could it happen after the death of the patient?

Hon STEPHEN DAWSON: It could happen after the patient's death.

Hon NICK GOIRAN: So much for board oversight. What is the board required to do with this administration decision and prescription form? Will it be received by the board pre or post death?

Hon STEPHEN DAWSON: The intent of this provision is to ensure that the board is notified progressively of the person's participation in the voluntary assisted dying process, including the outcome of each assessment to monitor that the correct process is being followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: Does the board have any oversight of the administration of the substance?

Hon STEPHEN DAWSON: Can I ask the honourable member to clarify what he actually means by that?

Hon NICK GOIRAN: In response to my last question, the minister indicated that the board can do certain things. I asked what the board was required to do with the administration decision and prescription form and the minister listed various things. I am wondering whether the board has any oversight of the administration of the prescribed substance.

Hon STEPHEN DAWSON: No, it does not.

Hon NICK GOIRAN: Clause 59(2)(b) requires that the administration decision and prescription form include only the coordinating practitioner's name and contact details. There appears to be no requirement for the practitioner's qualifications, skills or training or any of those other things to be included in the form. Why is it not required to be included in the form and is such information required in any other jurisdiction at this point?

Hon STEPHEN DAWSON: Clause 16 sets out the requirements for eligibility to act as a coordinating practitioner. The requirements have already been satisfied at this stage, but also the person has already done the training. In relation to other jurisdictions, I do not think I have that information before me, but if it comes to hand, I will provide it.

The DEPUTY CHAIR (Hon Adele Farina): To the extent that it may help the chamber, under clause 28, the first assessment report form that would be provided to the board at that time must contain a statement confirming that the coordinating practitioner meets the requirements of section 16(2).

Hon NICK GOIRAN: Clause 59(2)(f) requires that the administration decision and prescription form include the date that the prescription for the voluntary assisted dying substance was issued. For patient safety, should the board also be informed on the form about any use-by dates for that substance?

Hon STEPHEN DAWSON: I am advised that the authorised supplier may be best placed to keep a record of medication that is near expiration via the proposed database.

The DEPUTY CHAIR: Members, I note that there are some proposed amendments on the supplementary notice paper. Would members indicate whether they intend to move those amendments? Hon Rick Mazza has indicated that he will not move proposed amendment 423/59. The question is that clause 59 stand as printed. Hon Nick Goiran.

Hon NICK GOIRAN: Thank you, Madam Deputy Chair. I will definitely move the amendment standing in my name at 89/59 on the supplementary notice paper. I move —

Page 39, after line 12 — To insert —

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

Hon STEPHEN DAWSON: I indicate to the chamber that the government is supportive of this amendment for reasons given previously when similar amendments were moved.

Amendment put and passed.

Clause, as amended, put and passed.

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

Hon NICK GOIRAN: If the practitioner administering the drugs is different from the coordinating practitioner, how can that practitioner be sure of the voluntariness and lack of coercion and that the request was enduring? How exactly will the practitioner test for capacity at the point of administration?

Hon STEPHEN DAWSON: The administering practitioner will have conversations with the patient and the coordinating practitioner, and may look at the patient's history.

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