VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from 5 September.

Debate was adjourned after clause 50 had been agreed to.

Clause 51: Technical error not to invalidate request and assessment process —

Mr R.H. COOK: Madam Deputy Speaker, with your indulgence, and if members would entertain me just for a moment, a number of questions were asked by members the week before last and I undertook to provide responses in relation to some that I could not answer then. There was one question from the member for Dawesville, which, to paraphrase, was: will the details of schedule 4 and 8 drugs be able to be obtained through a freedom of information application? I am informed that any person may make a request to access documents under the Freedom of Information Act; however, the making of a request does not mean that they will be given access to the documents. Access may be denied if the documents contain exempt matter. Clause 5(1)(e) of schedule 1 of the FOI act exempts disclosure in circumstances in which it would endanger the life or physical safety of any person.

The member for Riverton asked for insight into previous budgets in relation to palliative care. The member said —

> The minister said that $206 million has been allocated over the forward estimates … Can the minister provide by way of supplementary information what was spent on palliative care in the previous … years …

Expenditure on palliative care over the past four years—that is, 2015–16 to 2018–19—totals $157.1 million. That has been broken down. In 2015–16, expenditure on palliative care was $32.2 million; in 2016–17, it was $38.7 million; in 2017–18, it was $41.4 million; and in 2018–19, it was $44.1 million. I note that that last figure is subject to finalisation. These figures do not include palliative care that is delivered in hospital settings as that activity is reported separately as part of actively-based funding for subacute services—that is, hospital-based services. Palliative care is provided in a number of different service settings—in homes, clinics, hospices, residential care facilities and hospitals. It is not currently possible to provide consolidated Western Australian data on the number of people who accessed palliative care in those years due to a range of palliative care providers being engaged in service provision both contracted through the Department of Health and undertaken directly by health service providers. The development of consolidated data is addressed as a priority by the Department of Health.

Dr M.D. Nahan: Minister, is the management of the last four years the same as the forward estimates?

Mr R.H. COOK: Yes, I understand that is the case. I have seen similar qualifications in that context.

Dr M.D. Nahan: Would you table that data?

The DEPUTY SPEAKER: Member for Riverton. We need Hansard to know who you are.

Dr M.D. NAHAN: Would you table that data?

Mr R.H. Cook: I would be very happy to.

Dr M.D. NAHAN: You read most of it out.

Mr R.H. COOK: Further, the member for Hillarys asked a question about student medical practitioners. I might talk to this later when the member for Hillarys is back in the chamber.

The member for Girrawheen asked what training curriculum is in place for Victorian doctors. I have some information on the details of the Victorian curriculum, which I seek to table.

[See paper 2720.]

Mr R.H. COOK: Finally, the member for Girrawheen asked where is the word "independent" used in relation to the two doctors. I am advised that there is no express reference in the bill to the first and second assessments by the coordinating consulting practitioners being independent; however, it is implicit. This is due to three reasons. Firstly, the coordinating consulting practitioners must separately assess whether the patient is eligible for access to voluntary assisted dying—clauses 23 and 34. Secondly, the second assessment cannot take place until the patient has been assessed as being eligible for access to voluntary assisted dying by the coordinating practitioner and a referral is made to a consulting practitioner—clause 29. Thirdly, a patient cannot be assessed as eligible for voluntary assisted dying unless both practitioners are separately satisfied that the patient meets all the eligibility criteria and understands the information required to be given to them—clause 27 and 39.

To clarify for the member for Dawesville, the following clauses under schedule 1 of the Freedom of Information Act may be relevant to VAD-related matters, including clause 5 regarding matters prejudicial to law and enforcement,

public safety, and property security; clause 6, which deals with matters revealing the deliberative processes of government; and clause 8, regarding confidential communications.

The DEPUTY SPEAKER: We are on clause 51. The question is that clause 51 —

Mr R.H. COOK: Sorry.

The DEPUTY SPEAKER: There is more?

Mr R.H. COOK: No. Deputy Speaker, I undertook to table that response for the member for Riverton. I am happy to do so now.

Mr Z.R.F. Kirkup: Are you tabling all of them?

Mr R.H. COOK: That makes sense! I should have done that at the beginning and not read them all out. I will table them all.

[See paper 2721.]

The DEPUTY SPEAKER: We are on clause 51. I will try again.

Mr D.C. NALDER: I understand the intent of clause 51; I have read the explanatory memorandum. The clause states —

> The validity of the request and assessment process is not affected by any minor or technical error …

I understand the intent, but I am nervous about how the courts will interpret this in the future. When will an error be major? I accept that there will be a problem if the form does not have a signature, but that is not clearly specified here. I want to make sure that this clause is tight enough and that it would not be open to interpretation by the courts in the future to determine what would be a minor or major technical error on the form, which includes, as it states in proposed section 50(1)(a), the first assessment report form, all consulting assessment report forms, and the written declaration. I am not clear about what would be considered a minor technical error or a major technical error, and what would constitute a failure and what would be acceptable. I note that the explanatory memorandum explains that it could be a mistaken date or a spelling mistake, those sorts of things. I get that, but I am worried about how this will be interpreted in the future and want to ensure that it is covered appropriately.

Mr R.H. COOK: The member is quite right. This clause is an administrative necessity. It clarifies that a technical mistake on a form such as a spelling error in a name or an accidental incorrect date on a witness's signature will not have the effect of invalidating a patient's entire request and assessment process. I am advised that essentially this will be up to and including those sorts of errors that do not have an operational or technical element or substantive element in relation to the detail of the form.

Dr M.D. NAHAN: I refer to the data the minister provided. When he provided it, he stated that it does not include expenditures in hospitals. Is that right? Does that include public hospitals as well as private hospitals? Does the minister have some feeling about the magnitude of palliative care —

The DEPUTY SPEAKER: I am sorry, member for Riverton. I do not think this applies to clause 51.

Dr M.D. NAHAN: I am asking for his due diligence and his understanding on this issue just to clarify it.

The DEPUTY SPEAKER: But, member, we are on clause 51.

Dr M.D. NAHAN: I understand that.

The DEPUTY SPEAKER: You cannot go back to that clause at this point. I recommend that there will be some other way to find out that information, but not this way.

Dr M.D. NAHAN: I will find some other way.

Ms M.M. QUIRK: The form proposed in this clause is exactly the same form as that provided for in the Victorian legislation. Of course, words like "technical error" have their ordinary meaning, but I am somewhat confronted about the extent to which something will be considered to be a technical mistake given that there are no forms in the schedule to this bill, which would help us understand the information that would be required. We could then explore a bit more the kinds of information that would not invalidate a request as opposed to those that would. Form 5, the "Final Review Form", is set out on pages 118–122 of the Victorian legislation. The minister said, for example, that the date on which a witness signs a document is not material, but presumably dates on which medical practitioners insert information will be material; is that correct?

Mr R.H. COOK: We have to remember that this whole process is overseen by the Voluntary Assisted Dying Board, so I guess this stuff does not happen in historical assessment. It is essentially about understanding that the actions required to take place in the voluntary assisted dying process do take place. Obviously, if it goes to an element of

whether an assessment took place and whether it was confidently carried out, that would clearly be substantive. This clause is just about making sure that administrative errors do not of themselves frustrate the process or trip up a practitioner or, indeed, more importantly, a patient due to what is essentially a technical oversight.

Ms M.M. QUIRK: I will not labour this point, but I want to emphasise the question of how we are to know when something goes from being minor to material in nature. Can the minister give us some idea, other than a spelling error or an incorrect date, of something that would not invalidate the entire assessment process? For example, doctors' writing is notoriously bad, so if we could not ascertain one of the words written by the doctor making the assessment, would that be material? I am trying to understand the required level of compliance.

Mr R.H. COOK: As the member is aware, there are a range of processes that the patient has to undertake in conjunction with the coordinating and consulting practitioner to be able to access the voluntary assisted dying process. The coordinating and consulting practitioners have to contemporaneously inform the Voluntary Assisted Dying Board of that process as they march through the steps. If the Voluntary Assisted Dying Board could not ascertain that the assessment has taken place properly or the name of the coordinating or consulting practitioner, it would be of material relevance. I think the member used the phrase "ordinary meaning" in her first question about this clause, and that is probably the correct assessment to understand it. It is about making sure that someone is not frustrated simply from a very technical and minor oversight.

Ms M.M. QUIRK: The last thing I want to clarify is that the minister said that the practitioners must contemporaneously submit the record of their decision to the board. Does the minister mean contemporaneously with them having made the decision, not with each other?

Mr R.H. COOK: That is right. It is a completely separate process. I used the word "contemporaneously" in the context of the Victorian legislation, under which those forms are not required to be lodged for seven days. In ours, it is within two days.

Clause put and passed.

Clause 52: No obligation for patient to continue after completion of request and assessment process —

Mr Z.R.F. KIRKUP: I am just trying to understand how a patient would decide not to continue once they have gone through the request and assessment process. Are they obligated to inform the coordinating or consulting practitioners at all?

Mr R.H. COOK: The patient would be making their decision known by telling the practitioners or omitting to contact them again to continue the process. This clause is obviously very important, because we want to make sure that it provides for a patient who seeks access to voluntary assisted dying to decide at any time not to proceed with the process. It is an entirely voluntary process and there is no compulsion to continue once someone has started.

Mr Z.R.F. KIRKUP: I appreciate the importance of the clause. My obvious concern is about when someone chooses not to go through with the process. In every other step along the way, the VAD board or the practitioner have been informed through some sort of data collection measure. I am trying to understand how we might ascertain why a decision was taken by a patient not to go ahead but then to decide to continue a number of days or weeks later if there is no obligation for them to inform the practitioner. We have dealt with a number of clauses so far that have ensured that there is enduring will and that an enduring decision takes place if some time passes. The clause is very important. I am just curious to understand why nothing else has been added to it to ensure that the patient informs the coordinating practitioner.

Mr R.H. COOK: As the member knows, this process can only proceed if the patient continues to make requests. Essentially the process stops if the patient ceases to make other requests. Ordinarily, we would expect the patient to make that declaration themselves because they would be in regular contact with their practitioners, but, almost by definition alone, if they fail to contact their coordinating or consulting practitioner, they are essentially communicating a decision. It might stall the process and they might come back to it, but it will not continue until the patient re-energises it, for want of a better description.

Mr Z.R.F. KIRKUP: I appreciate that, minister. My concern is that right through this process we want to make sure that as part of eligibility the person has an enduring will—an enduring decision to continue. It is probably worth us just being aware of the issue, because after going through the assessment process and to the final request, someone could, rightly so, choose not to continue, which is obviously very important. I do not take away from the importance of this clause. Perhaps as part of some of the literature furnished to the patient there should be information encouraging or obliging them to inform their practitioner somehow, because as part of the eligibility, we want to establish that there is an enduring decision. If the patient chooses not to go ahead, and they wait a month, it might not necessarily mean that they have decided. There might be two different cases, for example. There might be an individual who wants to go through with the process, but after the final request they simply pause for a month before making an administrative decision. There might then be a replication of that situation,

with the person deciding not to go ahead, but then going ahead. There is no way of assessing the situation to ensure whether there is enduring will, which is an eligibility requirement. I think that is something we should constantly be aware of. Perhaps the information furnished to the patient at the start of the process should encourage them, if not oblige them, to inform their practitioner.

Mr R.H. Cook: Thank you, member.

Dr M.D. NAHAN: My advice is that in examples overseas, particularly in Oregon, where there is this type of legislation, a sizeable portion of people never take the medicine. When that was queried, it was not clear how many had done that or why. One of the purposes of this VAD process is that it will be monitored through the collection of data. That seems to me important. I am not questioning the need for the patient not to be put off from making a final decision, but it would be very important for data collection and the soundness of this process to have a body collecting that data at the end, after the patient has made a final decision, whatever it may be, to take the medicine—or poison—or otherwise. The minister has gone to great lengths all the way to this point to provide for the collection of data, so it seems to me to be a weakness not to know of the decision. I think it would be very interesting if, as I am told occurs in Oregon, a sizeable percentage of the people who finally get the poison simply do not take it, so the question is: why?

Mr R.H. COOK: I certainly will not question the member's information from overseas, knowing the circumstances he brings to the process. However, I am informed that the Voluntary Assisted Dying Board will be informed of every step along the way, whether on the return of the voluntary assisted dying substance or the oversight of the death certificate for it. That data would be collected ordinarily as part of that process. Ultimately, the obligation is on the system to report to the Voluntary Assisted Dying Board rather than the patient themselves having an obligation to do that—that is, those participating around the patient. From that perspective, that information will be collected almost by default, albeit, the member is making the case that it will be collected because there is a gap in the information. It is obviously the role of the Voluntary Assisted Dying Board to collect that information.

Dr M.D. NAHAN: I do not see why it would be difficult. I do not think the patient should communicate with the board, but all the away along the process it is the coordinating practitioner's role to inform the board of decisions. We have gone through that. It seems to me to be relevant that if the patient passes away without taking the poison, the poison will go back, which I understand, but it would be relevant to inform the board that the patient decided of her or his free will not to take the poison —

Mr J.E. McGrath: The substance.

Dr M.D. NAHAN: — the substance; it is poison—for research and understanding the implementation of this voluntary assisted dying process. It could be done, as the minister said, by default by returning the material, so obviously it would not have been taken, or maybe taken only partially. This is for research purposes. I cannot see why it will not be done.

The DEPUTY SPEAKER: There is no question that I can hear, there.

Dr M.D. NAHAN: Why not have the coordinating practitioner report to the board why he or she is returning the substance; that is, the patient decided in the end not to take it?

The DEPUTY SPEAKER: Do you want to answer that, minister?

Mr R.H. COOK: The coordinating practitioner, and particularly the administering practitioner, have an obligation to report whether the voluntary assisted dying substance was taken. In addition, if the patient opts for self-administration, the contact person they nominate in that process has a positive obligation to report that as well.

Mrs A.K. HAYDEN: Following on from that line of questioning, because I think it is the crux of what everyone is worried about, clause 4 provides for "the request and assessment process" that has to be undertaken. It is to show that the voluntary and enduring nature of the patient is assessed. Why does the assessment stop there? I do not think the minister has answered why it stops there. Why does the assessment not continue? Surely the most important part of this step is whether someone decides not to continue. Why is that not included as part of the assessment? If a patient chooses to self-administer and takes the substance home, within what time frame will they return it and how do we make sure it is returned? More important, the reason a person changes their mind is vital feedback for anyone who is overseeing the legislation. I do not understand why the assessment stops at that point and does not continue.

Mr R.H. COOK: We will come to the role of the contact person later in the bill so I will refrain from digging into that part.

It is important that if someone wants to continue with voluntary assisted dying, they must make a positive decision, which has to be enduring and their capacity to make that decision has to be assessed. If the person feels they no longer wish to proceed, the obligation is not on that person to communicate that. There may be obligations on the coordinating practitioner or the consulting practitioner or, indeed, the administering practitioner—there certainly

will be on the contact person concerning self-administration. But from that perspective, the obligation is on someone to continue with the process, not for them to signal they no longer wish to participate in the process. We have to remember that these people are at the end of their life and they will be making a range of decisions. I do not think we should put an extra burden on the patient. Obviously, there are burdens on the consulting practitioner and particularly the coordinating practitioner, but not on the person. This is not so much a mechanism by which someone can withdraw from the process; it is simply to say that a person has the right at any stage not to participate in the process.

Mrs A.K. HAYDEN: Thank you, minister. I appreciate the minister's explanation. Can I get an understanding that if it is further on in the bill, it will be assessed and reported on if someone pulls out and that data will be collected and it will be reported on by the practitioner?

The DEPUTY SPEAKER: I think the minister has answered that already.

Mr R.H. COOK: Yes, member.

The DEPUTY SPEAKER: Member for Dawesville, do you have a different question?

Mr Z.R.F. KIRKUP: I do, otherwise I would not be standing up, Deputy Speaker.

The DEPUTY SPEAKER: That is unusual but go ahead. Thank you for the observation.

Mr S.K. L'Estrange interjected.

The DEPUTY SPEAKER: I am sorry; I did not hear that. Let us continue.

Mr Z.R.F. KIRKUP: That is fine; I appreciate that. I want to clarify two things. I take issue with two statements the minister made. Perhaps our respective views on the bill are slightly different. The minister suggested as part of his response to the member for Riverton, who I appreciate was talking about the administration decision, that at this point of the bill, we are not at the administration decision yet; we are prior to that point. The minister said that the board is informed the whole way through, but that is not true regarding this clause. The board is not informed the whole way through if the patient chooses not to go ahead at this time. That is one concern. There is no obligation on the patient to inform their practitioner, thus the board is not updated. A slight air gap exists, I suppose, whereby the board is informed the whole way through from the first request assessment and the second request et cetera. Then there is an air gap between the provisions of this clause, in that the patient has gone through the request and assessment and the board is reinformed and re-engaged at the decision-making stage and at the time the substance has been administered, and if the patient chooses not to continue. We spoke very early on concerning the consultation process about the importance of collecting data. This could be a decision point when a patient chooses not to go ahead and is making an administration decision. The patient has been assessed as allowed to access the substance but at this point they choose not to go ahead. It is surely important that the reason for that is given. We would not necessarily know because the obligation has not kicked in whereby the practitioner has to inform the board. If the person passes away before accessing the substance, we would not know because there is no obligation to report on that. They will simply be lost in the system. There is no obligation for the patient to inform the practitioner if they make a conscious decision not to go ahead with it.

I take issue with one of the points that was made—that the board is informed the whole way through. I query whether the minister believes the air gap that I have identified exists, and if that is the case, is he concerned about that lack of integrity to follow the process the whole way through?

Mr R.H. COOK: I am informed that if the patient's death takes place at any stage during the process, regardless of the extent to which they have gone through the entire cycle of voluntary assisted dying, the certifying practitioner is obliged to submit the death certificate to the board, so there is complete oversight. I understand the point the member is making, but I think perhaps this clause will not give him administrative reassurance because it is not designed to do so; it is designed to unequivocally set out the rights of the patient to make sure that it reflects the fact that it is entirely voluntary.

Mr Z.R.F. KIRKUP: I appreciate the minister's response, particularly on the coordinating practitioner's obligation to inform the board or provide the death certificate. How might that work if the patient has communicated with the coordinating practitioner only via audiovisual link?

Mr R.H. COOK: The coordinating practitioner does not need to be the certifying practitioner for the death certificate. The obligation is on the certifying practitioner to inform the Voluntary Assisted Dying Board about the death certificate.

Mr Z.R.F. Kirkup: So, the certifying practitioner being?

Mr R.H. COOK: When someone dies, a medical practitioner has to certify the death.

Mr Z.R.F. KIRKUP: How might the certifying practitioner know that that person has gone ahead with the VAD process?

Mr R.H. COOK: At this stage, the patient would have family members, a contact person or an administering practitioner who would already have been engaged in the process. The patient will not be making this decision in isolation so that everyone sits around wondering what went wrong; it will be in the context of the ongoing care that that patient is under. For instance, the patient might be sitting in a wheatbelt town, surrounded by family and supervised by the general practitioner, but the general practitioner may not be the administering or consulting practitioner; they might just simply be a member of the medical community in that town. So even though there has been audiovisual contact between the patient and the coordinating and consulting practitioner, a general practitioner is obviously competent for the certification process.

Dr M.D. NAHAN: To follow on from the member for Darling Range, my understanding—maybe the member for South Perth can back me up on this—is that, particularly in the Oregon experience, a sizeable proportion of the people who have the substance do not take it. That is actually a very important part of this, because when people first get a diagnosis of a death sentence, they go into, as we call it, existential stress. Access to the substance can give them a backstop to feel more comfortable about waiting for a period before making a decision. All I am interested in is whether, down the track, we will collect this data and the assessors and researchers into this process will have access to the decisions of people who have acquired the substance but have decided not to use it. If it is not used, it might provide them some backstop just to know that they have it if, in fact, they were to decide in the end to do it.

Mr R.H. COOK: Yes, that information would be collected, and we will obviously go through that in detail when we talk about the voluntary assisted dying substance and its management.

Mr Z.R.F. KIRKUP: I appreciate the information the minister gave in his previous response, which was that at this point in the process, the person might have a contact person or an administering practitioner nominated. I do not want to verbal the minister, but if that is what he actually said, there is actually no obligation on the patient at that point of the process to appoint either one of those at all, so I am not entirely certain that that would be the case. I am simply identifying what I think is an air gap, and I appreciate that it might be dealt with as part of the information that is furnished to the patient. The minister made the point that the certifying practitioner will provide the death certificate to the Voluntary Assisted Dying Board because they might have a contact person or an administering practitioner identified, but there is no obligation on the patient to have done either of those steps at this point in the process, as best as I can read the legislation.

Mr R.H. COOK: Obviously, there is an obligation on the coordinating practitioner. In the event that the patient dies, the coordinating practitioner will be obliged to contact the Voluntary Assisted Dying Board. There will also ultimately be a death certificate in that process, so there will not be that information gap.

I stress again that clause 52 does not relate to an administrative process; it essentially sets out the rights of the patient and communicates that the entire process must be driven by the patient. The patient is not obliged, even after the completion of the request and assessment process, to take any further action in relation to access to voluntary assisted dying. It is a clarifying clause that really underpins the principle that this is an entirely voluntary process for the clinician, the practitioners and the patient.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I apologise for my frustration at this point. I do not disagree with the importance of the clause and the rights that it confers on the patient to not proceed with this. My point is that if the patient dies along the way, before making an administrative or contact person decision, or any part like that, we will be stuck at the point at which the patient has been assessed and they will not know whether that patient has died, especially if they have been with a coordinating practitioner in an audiovisual sense. The practitioner will not know whether that patient has died, so there is no way —

Ms A. Sanderson: They have a relationship.

Mr Z.R.F. KIRKUP: But there is no obligation on the patient to inform them; that is exactly the point, member for Morley. There is no obligation —

Ms A. Sanderson: They've died.

Mr Z.R.F. KIRKUP: I understand that; they have died, or something has occurred. We just do not know, if the patient does not choose to proceed, and there is no obligation on the patient to tell —

Ms A. Sanderson: You're stabbing in the dark at crazy hypotheticals, member, and they have a relationship.

Mr Z.R.F. KIRKUP: Okay, I appreciate that they might have a relationship. I am just making the point that I think there is an identified air gap and I think there is a concern.

Clause put and passed.

Clause 53: Eligibility to act as administering practitioner —

Dr D.J. HONEY: I refer to clause 53(1)(a)(ii) with regard to the nurse practitioner. How do we know that there will not be coercion in this process? I have mentioned before that hospitals are extremely hierarchical. Typically, the specialists are not questioned by anyone, and doctors in hospitals have considerable seniority over nurses. Nurses may feel too intimidated to challenge a doctor. How do we make sure that a nurse is not coerced into being involved in this process when they really do not wish to be involved in it, but they do not feel able to reject the doctor requesting them to help with administration?

Mr R.H. COOK: I am not going to enter into a discussion about the workplace culture of a hospital. I remind the member of clause 10(1), which states —

> A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.

Clause 10(2) states —

> Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

It will essentially be malpractice for a nurse practitioner to participate in this process by way of coercion. The legislation sets out very clearly the obligations of the administering practitioner. From that perspective, I understand what the member is saying in the context of the theory that medical practice sometimes gets to a dark place. Nowadays, particularly in relation to nurse practitioners, it is a highly professional qualification and, ultimately, falls under the rigour of national and local laws.

Dr D.J. HONEY: I am not implying any lack of professionalism by nurses. My concern is specifically around coercion on a nurse practitioner from a more senior person in a hospital, not out of some dark purpose, but simply because they believe this process should go ahead and they need an assisting practitioner. I am particularly thinking about small country practices. For example, Kojonup Hospital may have a handful of nurses, and only one medical practitioner who has agreed to participate in the process, and a nurse could feel compelled to be involved in it. It was really a question around that: is there any check and balance against coercion? It is a bit like sexual harassment in a workplace. There are very strict laws around sexual harassment, but we know that sexual harassment occurs very broadly in workplaces despite the numerous laws, rules and regulations, and severe penalties for that. The concern is about what processes will be in place to make sure there is not coercion, but I am not sure that the minister can give me any more of an answer than he has already given me.

Dr M.D. NAHAN: What about in rural areas such as the Kimberley if a patient decides to go through the process and self-administer the substance or have it administered at home? Is the minister confident that he will be able to get one of the eligible administering practitioners to every facility in our large state?

Mr R.H. COOK: The member has summed up very succinctly the challenge of providing health care in Western Australia. It is a challenge; there is no doubt about that. One of the suggestions or recommendations from the ministerial expert panel was that nurse practitioners be able to participate in the voluntary assisted dying process for that very reason. We have lots of nurse practitioners in Western Australia, so the aspiration is that that will make it more available to people in remote communities. It will simply be a challenge that the WA Country Health Service and others will have to overcome, and they do that every other day. Ultimately, it is a challenge.

Dr M.D. NAHAN: I cannot remember, but will this stage of the process be facilitated through video services? There are two issues here. The administering practitioner may not necessarily have to do anything if the substance is to be self-administered, as the patient will be able to take care of it in their own time and at their own place, but if the administering practitioner is required to be there, could they do that via video? My concern is that, as we just discussed, it will be a challenge to get people who meet the criteria under clause 53 to every possible place that they might be called to in this state. The minister will have to give a guarantee to those people that he will put in the resources that are required to make sure that an administering practitioner will be there if required at the time that the voluntary assisted dying substance is taken, if that is required under this legislation. If the administering practitioner needs to administer the substance, they will have to be there and sometimes that is not possible.

Mr R.H. COOK: Obviously, if the administering practitioner is to carry out a role in voluntary assisted dying, they will have to be there. It underpins the challenges in country health. It is just one of those things that the WA Country Health Service deals with every day.

Dr M.D. NAHAN: This is a new and very important one—somebody is being assisted in dying. We heard a couple of weeks ago that a number of wheatbelt centres had no doctors. This is a challenge for us. This is not a criticism of this government; every government has faced the same situation in trying to get medical practitioners to various areas. This is an additional special requirement. All I am seeking is a commitment from the government that what needs to be done will be done irrespective of the cost.

Mr R.H. COOK: Again, it is a challenge. We have 248 nurse practitioners in WA, 43 of whom are practising in WA country health regions, so the member can see why it is important to have them potentially involved in the process. The member is right; in some places, doctors are like hen's teeth. Like everything else we do in country WA, this is just something that we are going to have to endure.

Ms M.M. QUIRK: Can the minister remind us what qualifications and training a nurse practitioner has generally? Then I want to explore the specific training for specific nurse practitioners.

Mr R.H. COOK: A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must be a registered nurse first and then complete an approved post-graduate master's degree. In Australia, the registered nurse must have 5 000 hours of advanced clinical experience before they are eligible to be endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia. A medical practitioner or nurse practitioner must have successfully completed the approved training for voluntary assisted dying before they can be an administering practitioner.

Ms M.M. QUIRK: Under clause 53(2), the requirements for nurse practitioners to be administering practitioners will be approved by the CEO. Can the minister let us know what requirements are contemplated to be necessary for that approval to be forthcoming?

Mr R.H. COOK: During the implementation period, the Department of Health will develop a means by which interested medical and nurse practitioners may pre-register to check whether they meet the necessary eligibility criteria to act as a coordinating, consulting or administering practitioner and to receive the approved training. The CEO will approve the training for the various roles in relation to obligations under the voluntary assisted dying legislation. Ultimately, a nurse practitioner would be required to have had some experience in the area in which the patient is located and would obviously need to have the necessary clinical experience to fulfil the role of administering practitioner.

[Quorum formed.]

Ms M.M. QUIRK: I am not sure whether the minister or one of his colleagues explained the other night that there had been discussions with the Royal Australian College of General Practitioners about training modules and components. Presumably, independent discussions are going on about nurse practitioners. With whom are those discussions being conducted, and does the minister expect that the training will be on a par with that given to medical practitioners?

Mr R.H. COOK: The Australian College of Nurse Practitioners was consulted about nurse practitioners playing a role in this process, as was the Royal Australian College of General Practitioners. Obviously, they will be consulted again about the training modules. In relation to general practitioners, the college has offered to oversight and accredit the course to make sure that it contributes to overall professional standing.

Ms M.M. QUIRK: The minister raised the issue about the nurse practitioners having some expertise in the areas that they would be expected to deal with in the capacity of administering practitioner. Am I to understand, for example, that a nurse practitioner who principally undertook midwifery would not be appropriate, or would they be considered appropriate if they have had the necessary training?

Mr R.H. COOK: The nurse practitioner would need to register with the chief executive officer to take part in the training and, obviously, the assessment of that nurse practitioner's experience would be relevant to whether they are registered. For instance, some nurse practitioners take a management stream in their careers. They are obviously highly qualified clinicians, but ultimately they have decided to specialise in leadership and management. Clearly, they would not have the day-to-day clinical knowledge that would be expected of someone who is still practising on the wards. It is an acknowledgement that nurse practitioners and, indeed, doctors come from a range of different backgrounds, specialisations and experience in their careers, and this is about making sure that the chief executive officer has oversight of this important role.

Ms M.M. QUIRK: I think the minister has pointed out that this is not the path that Victoria has gone down, because it does not have the same issues with remote and regional areas as Western Australia. There is a subtle ethical difference between nurse practitioners and physicians that I do not think this provision has necessarily picked up, and I am not confident that the CEO will even address it. I am not by any means diminishing the skill

of nurse practitioners, but there is not the same history involving an ethical framework. As I understand, there have only recently been discussions about an ethical code for nurse practitioners, and nurse practitioners very much see their role as advocates for the patient. There could be some conflicts about their perceived obligations to advocate for the patient, as opposed to maybe having the independence to balance the ethical complexities in a fraught area such as this. I raise that as an issue that concerns me. At least, at the end of the day—the minister has been saying this throughout consideration in detail—there is a well-established ethical framework for medical practitioners. Although I recognise that nurse practitioners operate professionally, there is not that same consensus about ethical obligations and to whom they are owed.

Mr R.H. COOK: I appreciate the member's observations. The development of the nurse practitioner qualification has been a huge benefit to the health community. They are highly qualified and highly experienced, and many in the medical fraternity often make the observation that they would trust a nurse practitioner over a GP any day. Notwithstanding that, the member made the observation about the differences between Victoria and Western Australia. As it happens, the nurse practitioner field has been particularly well developed in Western Australia, as opposed to Victoria. Victoria may have gone down this route, but I think you can count the number of nurse practitioners in Victoria on the fingers of one hand. It is a particularly well developed health practitioner field in Western Australia, and, as the member observed, we also have a very large area in which to operate.

Mr Z.R.F. KIRKUP: I am keen to understand whether an administering practitioner could have a commercial arrangement or relationship with a coordinating or consulting practitioner.

Mr R.H. COOK: It is technically possible, but the assessment still has to be independent.

Mr Z.R.F. KIRKUP: I imagine there might be some issues in relation to ethical guidelines, but could the administering practitioner be a related family member, or something like that, to the patient? I imagine it would be like other practitioners, but this is a bit different from normal practitioners.

Mr R.H. COOK: I think that would be captured under the malpractice arrangements. I do not think that would be possible, but it is important to be vigilant with these things.

Mr Z.R.F. KIRKUP: My next question is in relation to subclause (2) about the publishing of the information that is required. There is a lot of reliance on the website of the department to be providing various bits of information that are required. I imagine that this is all going to be found in the same place or in a relatively consolidated manner and very easy to find.

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: I note that nurse practitioners will already be in communities, and I want the minister's assurance that, as part of their training, they will receive some cultural training on this issue. They no doubt know the communities in which they live, but obviously there are special issues surrounding death for Aboriginal communities, for example, that I think should be included in that training.

Mr R.H. COOK: I can most certainly make that commitment. It was a key recommendation from the ministerial expert panel. I do not have it directly in front of me—I can just see a photocopy from a distance—but I think it is even part of the Victorian training module. But the member is absolutely right; it is a very important consideration.

Clause put and passed.

Clause 54: Application of Division —

Mrs A.K. HAYDEN: Clause 54(a) states that this division applies if —

> the request and assessment process has been completed in respect of a patient; and

The coordinating practitioner will have two days within which to lodge the completed final review. Once the final review has been completed, the patient will be given access to the administration of the voluntary assisted dying substance. Is there a chance that the patient will have access to the substance prior to the Voluntary Assisted Dying Board being notified?

Mr R.H. COOK: Upon reaching that stage, the patient must make an administration decision. Obviously at that stage, it has been confirmed that the patient has decision-making capacity, and that their request is enduring. The patient would then need to make an administration decision, and that would involve the appointment of an administering practitioner, or a contact person. Therefore, it is highly unlikely that in that intervening period, the Voluntary Assisted Dying Board would not have been told. I guess it is technically possible. Under this legislation, there is a capacity to reduce the nine-day period in the event that the coordinating and consulting practitioners were of the view that the patient would die within those nine days. It is technically possible, but ultimately it would be extremely rare.

Mrs A.K. HAYDEN: We have gone to the final assessment, and the board is not aware of it. Does the minister not believe we should make sure that the board is aware and is notified before the substance is administered? The board is overseeing everything and ticking off on the lot. We need to remember, as the minister has said, that the people who have gone down this path just want to end it as quickly as possible. They may be able to get the substance as soon as the following day, and the board is not notified. We have done all this work to ensure that the board is part of the process, but we are keeping the board out of it at the end. I know that the minister is not open to amendments, but maybe we should add that the substance cannot be administered until the board has been notified.

Mr R.H. COOK: I understand the point the member is making. The relationship ultimately is between the coordinating practitioner and the patient. Clause 54(b) states —

> the final review form in respect of the patient certifies that the coordinating practitioner for the patient is satisfied of each of the following —

It then outlines each of the final stages. That will ultimately be the final review process for the coordinating practitioner. The patient will have to go through a process by which they will get the voluntary assisted dying substance. As we have already discussed, that will primarily be through a hub-and-spoke model, closely controlled by the chief executive officer. I understand the point the member is making. We have deliberately created a process whereby the relationship will be between the coordinating practitioner and the patient, oversighted by the Voluntary Assisted Dying Board. The Voluntary Assisted Dying Board in that context is not a police officer; it is an oversight panel. I understand the point the member is making, but, from that perspective, we do not believe it is necessary in the context of this stage of the process.

Mrs A.K. HAYDEN: Clause 54(b) states —

> the final review form in respect of the patient certifies that the coordinating practitioner for the patient is satisfied of each of the following —

It then lists subparagraphs (i), (ii) and (iii). Does that mean that the approved substance could be administered by a medical practitioner or nurse practitioner who has not been part of the prior assessment?

Mr R.H. COOK: The way it will work is that this will be the final review stage by the coordinating practitioner. At that point, the coordinating practitioner will have gone through the assessment process and will be convinced that the patient's decision-making capacity endures, and that their decision to access voluntary assisted dying endures. It will then go through to the administration phase. Under the administration phase, it will be up to the patient to make the decision. That is covered in clause 55, and we will have a closer look at that when we get to that clause.

Ms M.M. QUIRK: I raise this issue now because the minister has raised it. The minister made the assertion that the Voluntary Assisted Dying Board is an oversight board. It is an information-collecting board, and a board that ensures that the process has been complied with, but that oversight may well occur after the patient is dead.

Mr R.H. COOK: The roles and functions of the board are well and truly set out in clause 117, so I will beg the member's patience in digging deeply into that. The function of the board will be to monitor the process. It is certainly more contemporaneous than the Victorian model, but it is not at the bedside, for want of a better description. Perhaps we can deal with that in more detail when we get to clause 117.

Mr S.K. L'ESTRANGE: I draw the minister's attention to clause 54(b)(ii), in case I missed this at some point during the debate when we were last in session. It states —

> that the patient in requesting access to voluntary assisted dying is acting voluntarily and without coercion;

How will that be assessed?

Mr R.H. COOK: The member is right; we did traverse this territory fairly extensively earlier. Obviously it is the role of the coordinating practitioner, armed with both their medical experience and their mandatory training in the voluntary assisted dying process, to make that call. Part of the training process will be to examine and be able to detect issues around coercion and things of that nature. If either the coordinating practitioner or the consulting practitioner is in any way in two minds and not absolutely convinced, they must seek further advice.

Mr S.K. L'ESTRANGE: What I am about to ask is in no way a reflection on our medical practitioners. I just want to pose this question so that it is on the record and we are all aware of it. If a medical practitioner was incredibly supportive of voluntary assisted dying as a medical option for a patient, and if, by virtue of another clause in this bill, they were able to introduce into the conversation between themselves and the patient the option of voluntary assisted dying, how would that be assessed or tested to determine whether opening up that conversation was in and of itself a form of subtle coercion?

Mr R.H. COOK: This is the matter of bedside conversation, and this is what our medical workforce is there to do—discuss people's options at the end of life. This is the reason that we place so much trust in our medical workforce.

Mr S.K. L'ESTRANGE: I certainly get what the minister was implying—that there is a bedside-manner aspect to this. I suppose that I am looking at this from the perspective of somebody who might have been diagnosed with a terminal illness six months out, as per the legislation, in which case they might be sitting in a chair in a doctor's office. I think we had an example about this from the member for Armadale the last time we sat. The patient might be relatively clear of thought and able to think for themselves, but they might be influenced by the authority or expertise of a doctor. In that sense, although they are not deeply in pain and suffering at this point in time, they are six months out from that fate. How do we know whether, at that point, the advice they will be getting is not a form of coercion?

Mr R.H. COOK: At this point, the patient will have had two assessments, one by the coordinating practitioner and one by the consulting practitioner, who each have to come to a separate assessment of the patient's decision-making capacity, that they are not being coerced, that they are acting entirely voluntarily and that their decision is enduring. It is in that context. That is a hallmark of the assessment process. I understand the context in which the member for Armadale raised that particular issue, but, ultimately, the patient will have undergone a rigorous process to test their will in relation to this. The patient will have made a written declaration by this point as well, which will have been witnessed by two witnesses who do not stand to benefit financially in any way from the patient's death. We can see that a range of people will have been involved in the process, each of whom will obviously have formed a view on potential coercion.

Mr S.K. L'ESTRANGE: Thanks for that, minister. As I said, my line of questioning was not actually to do with anybody getting a financial gain or anything like that; it was purely about getting medical advice. I wanted to make sure that was fully understood by the minister. Thank you.

Ms M.M. QUIRK: I refer to capacity, which comes under clause 54(b)(i). I think we have already established and are in fierce agreement that capacity can wax and wane throughout the process. How long is there between the administration decision and the actual administration? I ask that because there could be some issue in the interim, between the final review form and the certification and the actual delivery and administration of the drug.

Mr R.H. COOK: There is no specific time frame, but the member is right; decision-making capacity has to be enduring. The administering practitioner will have a similar role in terms of that capacity. One of the great limitations of this legislation is that it will not assist people who do not have that enduring capacity. Some people have criticised the bill for that, but I think the member for Girrawheen and I would share a concern that that has to be there.

Ms M.M. QUIRK: I think we are agreeing on this, minister. Really, until the time of administration, the administering practitioner will have an ongoing professional obligation to make an assessment about capacity, even though there is no formal requirement to do so in the bill.

Mr R.H. COOK: There is no specific time frame. Obviously, the patient's decision must be enduring. I guess that in some respects, we do not want coercion to go the other way either—that is, to talk the patient out of it. As we have observed, the patient's decision-making capacity will have to be present throughout the process. Indeed, even the administration decision will have to be clear and unambiguous. From that perspective, I think we have provided the right framework to make sure that the patient has that capacity throughout the process.

Ms M.M. QUIRK: This probably relates more to clause 55, but the minister did just mention number 38 in the hit list of protections; that is, the medication administration method decision must be clear and unambiguous. Are those words in the bill itself?

Mr R.H. COOK: Yes. I am sure we will come to that shortly.

Clause put and passed.

Clause 55: Administration decision —

Ms M.M. QUIRK: Effectively, in Western Australia, a patient will be able to choose between a self-administration decision and practitioner administration decision, but it is the coordinating practitioner who will advise the patient when a practitioner administration decision can be made. My view is that clause 55(2) places too much power in the hands of the practitioner and takes power away from the patient. I would like the minister's views on that.

Mr R.H. COOK: As clause 55(2) states —

> A practitioner administration decision can only be made if the coordinating practitioner for the patient advises the patient that self-administration of a voluntary assisted substance is inappropriate …

I understand the member's perspective, but I respectfully believe that too much power is not placed with the coordinating practitioner.

Ms M.M. QUIRK: We can differentiate between this requirement and the requirement in Victoria, where physician administration of the drug is possible only when a patient physically cannot do it themselves. One could argue that the provision is much broader in Western Australia. I want to know why that is.

Mr R.H. COOK: We had clear advice from the expert panel on this. It was thought that the Victorian provision was far too restrictive. I am advised that consistent with good medical practice, the coordinating practitioner will provide the patient with advice that the patient is able to consider in order to make an informed decision about the method of administration. That the patient's decision is well-informed is fundamental to the proposed model for voluntary assisted dying in WA. Practitioner administration may occur only upon advice from the coordinating practitioner that self-administration is not appropriate, having regard to one or more of the following reasons: the person's ability to self-administer the substance; the patient's concerns regarding self-administration; and the administration method suitable for the person. A person may still access practitioner-administered voluntary assisted dying when they are physically capable of self-administering a voluntary assisted dying substance. This is because a person's ability to access practitioner administration should not be dependent on their physical ability alone, but rather a number of factors that both the practitioner and a patient consider salient when deciding the administration method. For example, a physically capable person may still have an inability to self-administer due to concerns about incorrectly administering the substance or having an allergic reaction to the medication. This position is different from Victoria, where only physically incapable people may access practitioner administration. To quote that legislation —

> … the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance; …

That is from section 46 of that act. However, the ministerial expert panel was clear that such a limitation should not apply in Western Australia.

Ms M.M. QUIRK: Why?

Mr R.H. COOK: I think I have just made that clear; it is because it was considered too restrictive. Ultimately, the ministerial expert panel wanted patients to be able to access voluntary assisted dying and that their capacity to self-administer, whether physical or otherwise, should not be an impediment to access the voluntary assisted dying process.

Mr P.A. KATSAMBANIS: There are different regimes in different places and some of them have had time to embed themselves. There has been a parliamentary inquiry and an expert panel inquiry into this legislation, so can the minister indicate to the chamber what percentage of people he expects will choose self-administration as opposed to practitioner administration?

Mr R.H. COOK: No, I cannot. Welcome to the debate.

Mr P.A. Katsambanis: I have been here a long time.

Mr R.H. COOK: Earlier, I tabled a response to one of the member's questions. I just wanted to make sure that he got it.

Mr P.A. Katsambanis: I got that.

Mr R.H. COOK: I can inform the member that, for instance, 95 per cent of patients in Canada have chosen a practitioner-administered voluntary assisted dying substance. That might potentially give the member an indication. I am not sure.

I just want to say that I was not being critical; I just wanted to put it on the record.

Mr P.A. KATSAMBANIS: No; sure. There are a million things going on in this place at the moment, for all of us.

I do not want to put words in the mouth of the minister, but in the choice between self-administration and practitioner administration, the Canadian regime seems to be closer to the regime that is being proposed here than the regimes in other jurisdictions—for instance, Oregon and Victoria. Based on that figure of 95 per cent practitioner administration decisions in Canada, would the minister accept that it is more likely than not that practitioner administration will become the administration of choice in Western Australia?

Mr R.H. COOK: I do not think we are in a position to be able to make that call. I am perusing some notes in front of me to see whether they will assist me—no. Ultimately, Western Australia will have to plough its own path on this. We are in not a position to provide further advice on what we think the division might be between self-administration or practitioner administration.

Mr S.K. L'ESTRANGE: I am trying to work through clause 55. Clause 55(2)(c) states —

> the method for administering the substance that is suitable …

But that is all based around subclause (2), which states —

(2) A practitioner administration decision can only be made if the coordinating practitioner … advises the patient that self-administration … is inappropriate …

I am wondering why paragraph (c) is there?

Mr R.H. COOK: Some patients may not be able to swallow a voluntary assisted dying substance and some might be able to swallow but would not be able to ingest or digest the substance. Some medical limitations in the process may inform the nature of the administration.

Mr S.K. L'ESTRANGE: Is the answer that the minister just gave not covered by subclauses (2)(a) or (2)(b)?

Mr R.H. COOK: No. The ability of a patient to self-administer the substance may refer to their physical capacity to undertake the task. The patient's concerns about self-administering the substance also go to the point about the patient's views or attitudes to the process. The third is the medical limitations that are associated with that.

Ms M.M. QUIRK: As the minister rightly pointed out, the criteria in Victoria is narrower. I am a bit concerned that a medical practitioner will be somewhat assertive and insist on practitioner administration. The minister would accept that there is always an unequal power relationship between doctors and patients, even for those who are assertive and educated, and that people tend to bow to the advice of their doctor. I wonder whether for that reason it might be appropriate to require a witness to be present when an administration decision is made. It seems to me that that would be a way to alleviate some concerns.

Mr R.H. COOK: I am informed that this is considered to be a medical decision. A range of issues will impact on the decision. From that perspective, it is not a question of oversight and having a witness vouch for the integrity of the decision. A patient has to make the decision with the advice of and in conjunction with their practitioner. From that perspective, it is not appropriate that it needs to be witnessed because by its very nature it is a medical decision and, therefore, the patient must make their decision in conjunction with and based on the advice of the coordinating practitioner.

Ms M.M. QUIRK: Can the minister confirm—I am not a full bottle on this by any means—that in Oregon the majority of, if not all, cases are by self-administration?

Mr R.H. COOK: I understand that that is correct.

Mrs A.K. HAYDEN: The minister said that he would answer a question I asked during debate on clause 45 under this clause. That question was whether a decision could be made during the final review that a practitioner who was not part of a patient's personal process could administer the substance.

Mr R.H. COOK: Thanks for reminding me to come back to this point. The coordinating practitioner can delegate the task of an administering practitioner, but the administering practitioner, regardless of whether they are the coordinating or administrating practitioner, must still be convinced of those three elements—that is, the decision-making capacity in relation to voluntary assisted dying; the patient's request to access dying is voluntary and without coercion; and that the patient's request to access voluntary assisted dying is enduring. As we discussed earlier under clause 53, the administering practitioner must also have met the requirements approved by the CEO and have undertaken the mandatory training.

Mrs A.K. HAYDEN: Does the administering practitioner have to go through the same elements that the minister just referred to?

Mr R.H. COOK: That is correct.

Dr M.D. NAHAN: In essence, this is a third check. There is the coordinating practitioner, the consulting practitioner and the administering practitioner. All three must decide that the patient is free and capable of making such a decision and that there is no coercion—that is, they are of sound mind and there is no coercion. There will be three vetting checks by medical experts along the line to quantify that.

Mr R.H. COOK: That is the case. Obviously, if the coordinating practitioner is also the administering practitioner, there are not three people involved in the process, but the member is quite correct that there is that three-stage process.

Dr M.D. NAHAN: The coordinating practitioner is generally administering; how can that be in very isolated areas?

Mr R.H. COOK: That is correct. In an isolated situation the member can understand that the coordinating practitioner is unlikely to be the administering practitioner, so it is an extra check and balance. That should provide members with more assurance because extra eyes and minds are applied to the process.

Dr M.D. NAHAN: One of the objectives of the process is for it to be expedited because the person is generally on the pathway to death. I understand if the coordinating practitioner is the administering practitioner, but if they are not and if they are new to the patient, which could be the case in isolated areas in particular, how are they going to make decisions about the consciousness of the person and, particularly, the issue of coercion? Their main role

is basically to oversee the administration of the substance; that is what their basic role is. The patient has already been vetted twice, but if they are new to the process, how can they possibly be really careful, particularly about coercion, when it is not the patient, but the people around the patient who are the major concern?

Mr R.H. COOK: At this stage, of course, the patient has undertaken two assessments, it has been made sure that their decision-making capacity is enduring and they have made a written declaration witnessed by two people. The administering practitioner would be talking to the patient about their decision and would have regard to the decisions of the coordinating and consulting practitioner. It would obviously be an element of the training process for the administering practitioner to be able to make sure that they are satisfied with those three elements.

Dr M.D. NAHAN: What happens if after the patient has gone through this lengthy two-stage process of the coordinating practitioner making the decision that they are eligible, the administering practitioner, who is an expert, has been trained and gone through the process, makes a decision that something is up and they are not going to do it? Where do we go from there?

Mr R.H. COOK: In the first instance they would go back to the coordinating practitioner and express a view that they do not think the patient is eligible. Indeed, they would also make reference to the Voluntary Assisted Dying Board, because at that point they are essentially stopping the process.

Dr M.D. NAHAN: That is interesting. It would be extremely frustrating to the patient for them to have gone through this process and then all of a sudden for the person whose real role it is to facilitate a decision that has already been made to decide not to go through with things. This is actually a third check in this process that I do not think the minister has emphasised enough. In Oregon a lot of the deaths take place at home or at a place of the person's choosing, which is a good idea. When the substance is administered, the family and relatives will be around the patient, and the administering practitioner might get a view that the coordinating practitioner never had—they might; we do not know. If the administering practitioner says that they are not confident and they cannot sign off on a lack of coercion, and the matter goes back to the coordinating practitioner, do things start all over again or does the coordinating practitioner get another administering practitioner who is more aligned to the coordinating practitioner's views? Are we stuck in a do-loop going around with very sick people?

Mr Z.R.F. Kirkup: What is a do-loop?

Dr M.D. NAHAN: That is before the member's time. It is a computing term. It is being stuck in a circle going around and around that cannot be got out of.

Mr R.H. Cook: A vicious circle.

Dr M.D. NAHAN: Yes, a vicious circle.

Mr R.H. COOK: The member could appreciate that if the administering practitioner is of the view that the patient has lost capacity, the process stops and has to go back to the coordinating practitioner. As we have discussed in earlier clauses, the patient ultimately has the capacity to go to the State Administrative Tribunal and say that they do have decision-making capacity. The situation would require an administering practitioner to be of the view that the patient does have the capacity. It is an element and another restriction, or safeguard if you like, to the process, and I think it is an important one.

Dr D.J. HONEY: I know this is covered later, but I might as well deal with that here. I refer to clause 55(2)(c), which states —

> the method for administering the substance that is suitable for the patient.

Could the minister outline what those methods are? Just to pre-empt the answer little bit, do they include injection, intravenous drip or assisted ingestion? What methods are anticipated for the administration of the substance?

Mr R.H. COOK: Obviously, the method depends on the patient's circumstances, as I mentioned in my response to the member for Churchlands. It will depend upon the patient's physical capacity to absorb or take the drugs. The member mentioned a number of ways that could happen and yes, they would be included. Kerry Robertson, the woman who accessed voluntary assisted dying in Victoria, took the substance orally, but other patients may need to have it administered by injection or IV drip. I am advised that the likely methods of death may include self-administration, which would be oral medication in liquid or tablet form administered by the patients themselves, or practitioner administration, which would be the administration of the substance by the administering practitioner—for example the coordinating practitioner, another medical practitioner or nurse practitioner—in the form of a liquid or tablet, or via injection, oral tube, nasal tube, intravenous line or stomach peg. I am not saying that is an exhaustive list, but it gives an idea.

Dr D.J. HONEY: I am not trying to be cute here, but if someone opted for oral self-administration, they changed their mind and the practitioner decided that the only alternative was a lethal injection, I assume it would require a different substance, or form of it, and there would be some delay in the process until that substance was accessed.

Mr R.H. COOK: I am conscious that I am a layperson answering a question from someone who I think has a PhD in chemical engineering, so I am going to be very careful what I say. I assume that it would be a different substance, depending on the nature or method of application.

Mr Z.R.F. KIRKUP: I have a number of issues I would like the minister to look at concerning the administration decision. As part of the administration decision and the conversation the patient would be having with their coordinating practitioner, and they decide on self-administration, there is no requirement for them to nominate a location where they might take the substance. Am I reading the bill correctly?

Mr R.H. COOK: Yes, member, that is my understanding. We come to self-administration in clause 57.

Mr Z.R.F. KIRKUP: I appreciate that. Clause 55(1) provides for the consultation they will have with their coordinating practitioner. Is that consultation about what decision they want to make and there are no other circumstances around that? Will the practitioner have a conversation with the patient at that time to discuss the options they have and what it will look like if it falls through?

Mr R.H. COOK: This clause deals with the administration decision which, as the member can see, has a very specific legal application in relation to the voluntary assisted dying process. The member can understand that at this time a range of conversations are going on between the patient and the coordinating practitioner about their pain and a range of circumstances. Clause 55 deals with the nature of the decision around self-administration or practitioner administration.

Mr Z.R.F. KIRKUP: I appreciate that, minister. One of the concerns that was raised with me as part of the town hall contact I had in my district was that a lot more people in my district indicated their preference for an administration practitioner. The onus here obviously is reversed; it is self-administration unless one of those three concerns are raised there, individual concern or the like. Is there any reason the default option is not provided together with the administration decision with the practitioner as part of this legislation?

Mr R.H. Cook: Is the member suggesting that they do not have to have the same checks and balances in the event it is self-administered?

Mr Z.R.F. KIRKUP: A lot of concerns raised with me in my district was that the default position be practitioner administered rather than self-administration. People who raised this issue with me felt they do not necessarily like having the conversation, "I have some concerns about the self-administration so here is the practitioner." A lot of people would feel safer knowing that the legislation reflected practitioner-administered decision by default, and wondered why that was not the case.

Mr R.H. COOK: I do not agree with the characterisation of it as a default mechanism one way or the other. I believe this is, essentially, a decision the patient would make after many discussions with the coordinating practitioner. Obviously, clause 55(2)(a), (b) and (c), are all elements that will inform that decision. Ultimately, this is a decision they will come to with and on the advice of the coordinating practitioner for the patient. I do not think we default one way or the other. We are saying there are two pathways and they need to take one or the other.

Mr Z.R.F. KIRKUP: I appreciate that. A lot of the concerns raised with me, and it was my view, were that in light of subclause (2), patients have to meet a certain number of requirements to reach the practitioner rather than having to work back from it being taken as a given that the practitioner administers it. The patient has to prove that they can self-administer. I appreciate that it is not in the legislation; it was a concern raised a number of times in my district by people who felt that the practitioner should have that role. I appreciate that the minister has already answered that to provide some clarity.

Clause 55(3) states that an administration decision "must be clear and unambiguous". I appreciate the requirement there also for the audiovisual. I am keen to understand more about that if administration is ultimately proven not to be allowed to occur because they cannot make a clear and unambiguous decision in person. Does the minister see any other option? I assume the minister is quite confident that the audiovisual element will remain the same.

Mr R.H. COOK: I am confident about the audiovisual. The member will also see in subclause (4) that the patent may make an administration decision verbally or in another way, for example, by gestures, so it contemplates the circumstance in which the patient has lost the capacity to speak and is very frail. Obviously, there will be a range of communication protocols in place for that. My advice is that the patient's administration decision must be clear and unambiguously made by the patient either in person or by means of audiovisual technology either verbally, by gestures or by other means of communication available to the patient. This is to prevent discrimination against

people on the basis that they cannot speak. As long as their request is clear and unambiguous, this will suffice. Examples of alternative means of communication include sign language, and the use of a communication board or an iPad communication aid. Such strategies are often established with the person by a speech pathologist.

Ms M.M. QUIRK: I think the minister has answered the question. I wanted to know what the words "in another way" meant. Obviously, that is broader than gestures. I think the minister referred to the use of an iPad. Would that be the kind of use he contemplates coming under the definition of "in another way"?

Mr R.H. COOK: Yes, member. I hope that description satisfies the member's concerns about subclause (4). Obviously, it is important that just because a patient has a physical incapacity they are not disadvantaged in the process and cannot participate.

Mr S.K. L'ESTRANGE: To follow up on the member for Girrawheen's point about using gestures or an iPad in the administration decision or "in another way", can the minister clarify who will be in the room? Who will they be making the decision to?

Mr R.H. COOK: This goes to the question of the administration decision. Technically, it can be the coordinating practitioner and the patient. If it is via audiovisual, some assistance will be required with that. That is why it is important to have a line of sight, particularly in utilising gestures or some other form of communication.

Mr S.K. L'ESTRANGE: If we are talking gestures, it is hard to define what the gestures might be by people with different levels of incapacitation. We do not know, but, obviously, the medical practitioner present will have to interpret what they are seeing—if it is hand signals or whatever. Is there any safety mechanism in place to make sure a gesture is not misinterpreted? In these circumstances does there need to be more than one medical practitioner present so that the consensus view is that it is exactly what the patient wants?

Mr R.H. COOK: Does the member mean in person or specifically around the audiovisual?

Mr S.K. L'ESTRANGE: Either. Because, essentially, the medical practitioner will be trying to interpret the administration decision of the patient. Is that correct in this instance?

Mr R.H. COOK: Yes.

Mr S.K. L'ESTRANGE: Therefore, I am asking: how is a medical practitioner protected from not making a mistake in how they interpret those hand signals or whatever?

Mr R.H. COOK: This again comes down to the training for that. I stress that the requirement is that the request has to be clear and unambiguous. If it is a hand gesture or something like that—remember, this comes at the end of a long process—existing protocols will be in place regarding the way the patient communicates. If the patient has lost speech capacity or speech is challenged, a speech pathologist or some allied health professional would have been engaged. It again comes down to the issue that the way the patient communicates the decision has to be clear and unambiguous. We have left it like this for the reason that we anticipate that there will be situations in which a patient has to communicate other than by way of verbal communication.

Mr S.K. L'ESTRANGE: My take on why clause 55(4) exists is that it is for those people who cannot communicate as clearly as would normally be the case. All I am asking is: why would the minister not consider there being a witness present—a medical practitioner witness—so that there are at least two people with expertise to actually listen to or observe that request in whatever form it might be? As we have seen, clause 55(4) contains the words "or in another way". "Or in another way" could mean any number of things, so all I am suggesting is that it might be a good safeguard to have a witness present who has a medical background to make sure that not just one person is interpreting, but two, at the very least.

Mr R.H. COOK: I appreciate the member's concern. I guess ultimately it is a question of balance. This is about empowering the patient to be able to make a decision to positively access the process, so from that perspective we are confident that protocols are in place to allow that patient to be able to make the necessary decision. I draw the member's attention to the fact that there still has to be a witness in the practitioner administration process, so obviously it is not a process that takes place away from other folk. In communicating the decision, clause 55(4) simply allows or anticipates that there will be those who need to communicate in a way other than verbally. It is not necessarily the case that the way in which that is communicated will be unambiguous, so if there is ambiguity, obviously other measures would have to be put in place. I take the member's point that he wants a witness because he thinks there might be ambiguity. If there is ambiguity, other measures have to take place because the decision made has to be clear and the request has to be clear and unambiguous. If they cannot be clear and unambiguous, they clearly are not fulfilling that clause of the bill.

Mr S.K. L'ESTRANGE: Is what the minister just said—if it is determined to be ambiguous—captured in the bill? How is that captured in the bill?

Mr R.H. COOK: Clause 54(3) states —

> An administration decision must be —
>
> (a) clear and unambiguous; and
>
> (b) made in person before the coordinating practitioner for the patient or, if that is not practicable, in accordance with section 156(2)(a).

That refers to the audiovisual provisions.

Ms M.M. QUIRK: I am reluctant to raise this, given the minister's learned adviser, but there is always an issue about leading questions. I am a bit concerned about how things are phrased. I do not want to make the process more problematic for those requesting it, but if they are relying on gestures, surely they cannot say something that will not really elicit a meaningful response. For example, if the medical practitioner is raising the various substances that might be used and the different kinds of responses or reactions that may take place, I am not quite sure how that conversation would take place. I understand that people with motor neuron disease who do not have speech, for example, are in a particularly difficult position. I do not want to diminish their right to exercise their choice in these matters, but they might say, "If you would you like X substance administered by me, blink", or, "If you want it done at home, no blink". From that, do we infer that the patient would like the drugs administered by a physician? As part of the training, is there going to be some issue about how those questions are put so that any response that is in a gesture form will in fact be meaningful and will communicate the full nuances, if you like, of intention?

Mr R.H. COOK: Yes, in the context of the training, they would canvass issues around how they ask these questions in a sensitive matter. Ultimately, it is a binary question. At this stage, the patient has been assessed by two practitioners, made a written request, made the final review and communicated a range of things over a period of time, as I mentioned in reply to the question from the member for Churchlands. If people have some incapacity in being able to verbalise their particular perspective, obviously a speech pathologist would be involved. For the purposes of clause 55, the patient has to make a binary decision and it is either administered or self-administered. We could anticipate that it would be in the manner that the member described.

Ms M.M. QUIRK: Another issue comes up frequently in the context of the Aboriginal community. We are all familiar with situations in which people have been wrongfully charged and even convicted based on faulty police interviewing techniques. Again, I just want to raise that as an issue. I anticipate that that will be considered down the track at the implementation stage, but there is always the concern that those being questioned want to be agreeable; that is a cultural aspect that we need to be particularly mindful of.

Mr R.H. COOK: I completely agree, member.

Mr Z.R.F. KIRKUP: There are a number of references to gestures throughout the legislation, and I think reference was made to an iPad in relaying information. By the sound of it, I imagine that there is probably going to be some sort of application developed for that iPad. As the minister said, there will have to be a decision between two different administration decisions, for example. As part of this, when such a decision has to be made perhaps by gesture, is the department looking at making or developing any such application? I am keen to see what that looks like, because it might not be such a bad idea to have something like that.

Mr R.H. COOK: Not that I am aware of. We might anticipate that in the context of the legislation, but, more importantly, I think we would anticipate a whole range of applications utilising an iPad or some sort of device like that for communicating with people, whether it is on this issue or others.

Clause put and passed.

Clause 56: Revocation of administration decision —

Mrs A.K. HAYDEN: Clause 56 deals with the ability to revoke the decision, which we discussed at clause 54. Without going over that again, can the minister explain to me the process of returning the substance if the patient decides to go down the voluntary assisted dying path, opts for self-administration and then changes their mind?

Mr R.H. COOK: I will be very happy to do just that on division 4, which deals with prescribing, supplying and disposing of the voluntary assisted dying substance. It begins on page 45 of the bill.

Mrs A.K. HAYDEN: I do not want to move on from this clause only to have the minister tell me that I should have asked the question on this clause, so I am happy for him to direct me to another clause. If the substance is stored at home—again, this might be dealt with in division 4—is there a period within which it needs to be returned? Can the patient keep it and not record that they have changed their mind, because they want to delay it? If they want to delay the decision, do they need to revoke it? Is there a time period that changes it from a delay to a revocation of the decision?

Mr R.H. COOK: To a certain extent, I can respond to this by saying that delaying is not a revocation of the self-administering decision. Again, what will happen with the voluntary assisted dying substance is dealt with extensively in division 4. The clause essentially provides that the patient may at any time revoke an administration decision. The patient may inform the coordinating practitioner or the administering practitioner of the decision to revoke in a number of ways. Clearly, this is about stopping the process; it is not about delaying the process.

Mrs A.K. HAYDEN: If I am the patient and I have decided to self-administer and euthanase myself, I can do this and then say, "I'm not doing it today." Is there a time frame in which I have to administer it? Will the substance still be valid? Does the substance have an expiry date? I understand that the minister said that a delay is a delay and revoking is a different issue. I could take the substance home and administer it tonight, tomorrow or next month, but could I do it in six months or a year down the track?

Mr R.H. COOK: I can assure the member that, by definition alone, they would not delay it by a year. The short answer is no. The long answer is that we will deal with that in division 4. The revocation of the administration decision means that the patient may at any time revoke a self-administration decision by informing the coordinating practitioner for the patient that the patient has decided not to self-administer a voluntary assisted dying substance or revoke a practitioner administration decision by informing the administering practitioner for the patient that the patient has decided not to proceed with the administration of a voluntary assisted dying substance. This is about the revocation of the decision made under clause 55.

Mrs A.K. HAYDEN: The difference is that I have changed my mind and I have to hand it back. The minister will tell me what that process is when we get to division 4. But if I choose to delay it, that has nothing to do with revoking.

Mr R.H. Cook: Correct, yes.

Dr M.D. NAHAN: If a patient decides to self-administer it, they can revoke that decision, or they can change the decision to have it administered by an administering practitioner or they can say that they do not want it altogether. It is one of those options.

Mr R.H. Cook: Yes.

Dr M.D. NAHAN: I do not want to harp on this, but I think it is very important for us to have data on this. This is a very controversial process, as the minister well knows. Under clause 56(4), a lot of data on the revocation decision must be supplied to the board. That is great and I understand that. However, a patient may decide not to take the substance and they may not officially hand it back but keep it for a while and then pass away without using it. That is a very important piece of data that I do not think will be explicitly collected. I understand the revocation form; that is good. But from the discussions I have had with people, the substance has a potentially therapeutic aspect because it allows people to have, let us say, insurance if things get too painful. I think it is very important to have an explicit set of data that the board and other people acquire. One of the themes of this bill is for data to be collected at every step of the way, which is good, but this seems to be an omission. The member for Darling Range asked what would happen if they kept it for a year. There are many cases of people being diagnosed with a disease that will kill them in six months but they live for two years. We have heard it in this room. It could happen. We will deal with the treatment of the substance when we get to division 4. Again, there appears to be a gap in collecting data about people who have it in their possession and will use it if they need to, but decide not to.

Mr R.H. COOK: If a patient decides to self-administer, the contact person is required to return either the unused portion or the entire portion for disposal by an authorised disposer. In that context, the Voluntary Assisted Dying Board would have oversight of that process and would obviously be in a position to record that. The revocation of an administration decision will be provided in a revocation form to the Voluntary Assisted Dying Board, as the member observed. Ultimately, if a patient has gone through the process but not used the voluntary assisted dying substance, there would be a record of that from either the coordinating practitioner or the contact person, and that would be by way of either communication or the return of the substance.

Mr Z.R.F. KIRKUP: Under subclause (2), the patient may inform the coordinating practitioner or administering practitioner of the patient's decision in writing, verbally or in another way—for example, by gestures. Why was "may" used, not "must"?

Mr R.H. COOK: It is because there are alternatives. They could do one or the other. Obviously, if they are going to revoke, they have to do what is outlined in either paragraph (a) or (b) of subclause (1), but that decision is theirs. It is about empowering them. We had this dialogue with the member for Girrawheen—in some instances, the CEO "must" and in other instances the CEO "may". This is a "may" situation.

Mr Z.R.F. KIRKUP: I refer to subclause (3). The member for Darling Range spoke about the lack of a time frame for informing the coordinating practitioner of the revocation. There should be a requirement that that information is very quickly discussed, and that the practitioner is informed. Is there a reason why there is no particular time constraint on that?

Mr R.H. COOK: This empowers the patient to change the nature of the administration of the substance. The only constraint on that is that they make that decision before the substance is administered. Essentially, this is about the patient deciding not to take the medication or have the medication administered today or tomorrow. The day after that they might say, "Actually, I've decided to take it myself" or "I don't want to take it myself; I want it to be practitioner administered." In that sense, there is not a time frame or a specific limitation on when they make that decision.

Mr Z.R.F. KIRKUP: Clause 56(3)(c) states —

> within 2 business days after the revocation, complete the approved form … and give a copy of it to the Board.

Will the revocation form be published or provided anywhere else, because I do not believe that it is defined at this point in time? I obviously appreciate that it would not be defined in the legislation, but will it be published as normal? How will it be provided, and what does it look like in terms of how it is stipulated?

Mr R.H. COOK: As the member can see, subclause (4) provides detail about what is in the form. The form itself would be available on the website, for instance, for download. I can imagine that, at this point in the process, there is quite a lot of documentation sitting around the patient, and I would imagine it would be part of the pack that the patient would be issued with. Obviously this would be subject to implementation.

Mr Z.R.F. KIRKUP: My concern about the revocation form was the need for it to be easily accessible.

Mr R.H. Cook: "Give me that form; give me that form!"

Mr Z.R.F. KIRKUP: That is right. I raised with the Attorney General when he was at the table previously the issue of the lack of location on these forms—where those decisions were made. Given that the minister is here now, and we are able to go through it in a bit more detail, is there any reason why the location in which each decision was made has not been included? I imagine that that would be helpful, perhaps for review purposes or something like that. Is there any reason, in particular, that that has not been included? I appreciate the Attorney General's limitations, but I asked him whether that would be helpful for any investigative or review purposes. His view was "not necessarily", which is not to verbal him, but I am keen to understand why that would not be included. I think it would be helpful, perhaps, for us to be able to review the decision made at this location, and all that sort of stuff—just to track the process as part of that journey.

The ACTING SPEAKER (Mr R.S. Love): Members on my right—member for Wanneroo, member for Morley, and minister—keep it down, please.

Mr R.H. COOK: Just to clarify, the form is filled out by the coordinating practitioner, in answer to the member's last question, but we have included in the form what we consider to be the bare minimum. I can imagine the chief executive officer or the Voluntary Assisted Dying Board would want to have other information in front of them, but this is the very bare minimum as required under the legislation.

Mr Z.R.F. KIRKUP: Effectively, it helps with the point that the member for Riverton made about data collection. My view is that we would want as much exhaustive data as possible, particularly about the location if it is a regional issue, but I appreciate that this is the bare minimum. My final question refers to subclause (5), which states —

> The revocation of an administration decision does not prevent the patient from making another administration decision under section 55(1).

I assume that that has been included because effectively the revocation does not take away the patient's enduring will. Is that correct?

Mr R.H. COOK: That is correct.

Mr Z.R.F. KIRKUP: Minister, I may as well just keep on.

Mr R.H. Cook: You said that was your final question.

Mr Z.R.F. KIRKUP: Yes, I did, but is there a reason there is no time constraint on that particular element, in revoking an administration decision, for some time to pass before the patient can go back and make another one? Is there any reason why more constraint was not applied to the patient making another decision? I imagine the patient would be asked whether they wanted to continue, and is just revoking that particular one—that sort of decision-making.

Mr R.H. COOK: Member I can confirm that this is about empowering the patient. We did not want to put any limitations or pressure on that decision-making process.

Ms M.M. QUIRK: It is probably evident to most people, but I am having a little trouble with clause 56(4)(c) in contemplating circumstances in which a revocation may occur. The coordinating practitioner does not fill in the form,

but someone else does. Is that a situation in which, say, the patient might communicate with a nurse or something, and the form goes to the board having been completed by someone other than the coordinating practitioner?

Mr R.H. COOK: Yes, I guess it would take place in a clinical environment. It could be the administrating practitioner as well for that matter. It is essentially there just for the purposes of completeness.

Ms M.M. QUIRK: I know we have been concerned about coercion in other contexts, but it seems to me that this could be a situation in which family members bully the patient, who, then, under some duress, tells the nurse, "No, I've made a decision but I no longer want to do this", and we do not effectively have the supervision of the coordinating practitioner to clarify that position.

Mr R.H. COOK: I am informed that under subclause 4(c), once the person has made the revocation decision, they then have to go and make another administration decision, so they would go back to then making a self-administration decision or a practitioner-administration decision. At all times, the coordinating practitioner would be involved in the process and, ultimately, as we referred to earlier, the administration decision must be clear and unambiguous.

Ms M.M. QUIRK: With reference to subclause (4)(c), I understand the minister's last answer, but I would not mind if he would give me an example in which the circumstances contemplated in this subclause might occur.

Mr R.H. COOK: One example would be when a coordinating practitioner has delegated their role to an administrating practitioner, so the person by the bedside or close to the patient at that point in time may be the administrating practitioner, and the patient has formed a different view.

Clause put and passed.

Clause 57: Self-administration —

Dr D.J. HONEY: Subclause (2) refers to a voluntary assisted dying substance that is of a "sufficient dose" to cause death. Is there any guidance about what that amount will be? To short-circuit the discussion, will there be any limit on the amount? I have heard that in other jurisdictions, sometimes a double dose is prescribed in case the person who was self-administering the liquid regurgitated it and another dose was required to be administered. Could the minister explain what limit will be placed on the amount, and whether it would be possible to prescribe a double dose to ensure that the patient would ingest a sufficient quantity?

Mr R.H. COOK: I am advised that the choice of lethal medication will be a clinical decision made by the coordinating practitioner from an approved list of schedule 4 and 8 poisons only. That is covered under clause 7. The chief executive officer of Health will have the authority to approve schedule 4 or 8 poisons for inclusion on the approved list. It is intended, as part of the implementation of the bill, that a clinical panel be convened to determine the schedule 4 and 8 medication protocols suitable for voluntary assisted dying in Western Australia. The clinical panel will also inform the operational requirements for supplying, dispensing and ensuring the safe management of these medications. It is expected that this clinical panel will include appropriate representation from pharmacy, medical and nursing experts from a Department of Health and clinical perspective. I should say also that all persons who will perform a function under the bill will be subject to the Medicines and Poisons Act and the Misuse of Drugs Act. There are obviously very strict protocols for the prescription and management of those medications. The decision would be undertaken in full sight of the clinical training that goes with that, and ultimately there would be advice from the panel about the amount and things of that nature.

Dr D.J. HONEY: I hear that explanation, but that is in the future. Is it possible or likely under this clause that a double dose could be prescribed?

Mr R.H. COOK: There may be malpractice, I guess, in that context. Is the member saying that they would want to make sure there was enough of the medication, not that they would administer it twice?

Dr D.J. HONEY: My understanding is that in other jurisdictions, a double dose is sometimes prescribed, because people may have difficulty ingesting the substance the first time and regurgitate it, and they want to ensure that they receive an adequate dosage.

Mr R.H. COOK: I thank the member for the question. I now understand what the member is trying to ask. This goes to the important discussion that takes place between the coordinating practitioner and the patient about whether the patient will self-administer or the practitioner will administer. Clause 57(2) states —

> The coordinating practitioner for the patient is authorised to prescribe a voluntary assisted dying substance for the patient that is of sufficient dose to cause death.

In that context, it is not about topping it up, so to speak. It is about a clinical decision. Part of that clinical decision is the way in which the drug will be administered. The member has raised—pretty impressively—a number of different ways in which that might occur.

Mr Z.R.F. KIRKUP: I refer to the requirement to "prepare" the prescribed substance. Can the minister explain why that has been included? I assume the substance could be a singular pill, or something like that; I do not know what it will look like. Will this preclude a patient from being able to consume a single pill? To me, "prepare" means all the types of processes that the member for Cottesloe has outlined. Why has preparation been enshrined in the bill? If in the future a single pill were to be developed, would a patient be precluded from simply taking that?

Mr R.H. COOK: I am advised that this is to enable the clinical panel to have available to it the full range of substances that might be brought to bear. The member is quite right. I guess that ultimately a pill would need to be prepared. However, I assure the member for Cottesloe that we could imagine a range of different ways in which the substance could be prepared, or combined with other substances, in order to take it in a manner that was appropriate for the particular patient.

Ms M.M. QUIRK: I want to raise a couple of issues. I intend to move an amendment, but, prior to that, I want to talk about subclause (4) and the words "authorised supplier". That is defined earlier in the bill. As I understand it from clause 78, an authorised supplier is a person who is on a list authorised by the CEO. As the minister would say, we will get to that in due course. Subclause (4) provides that the authorised supplier is authorised to —

(a) possess the prescribed substance …

(b) prepare the prescribed substance; and

(c) supply the prescribed substance to the patient, the contact person for the patient or an agent of the patient.

Will authorisation be required for conveyance of the substance, or does that come within the definition of "supply" in paragraph (c)?

Mr R.H. COOK: Yes. The language is consistent with the language in the Medicines and Poisons Act.

Ms M.M. QUIRK: I know that we will get to this in clause 78, but does the minister contemplate that pharmacists in public hospitals will be on the list? Will private pharmacists be on the list? What will be the scope of people who will be authorised suppliers?

Mr R.H. COOK: I am advised that authorised suppliers will be limited to registered health practitioners authorised under the Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons. It is likely that authorised suppliers will include a public health service hospital or pharmacy with pharmacists and specialist practitioners who are authorised under the Medicines and Poisons Act 2014. 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. As I mentioned earlier, we contemplate that we would probably have a hub-and-spoke system. It would certainly not be the case that the medicines would be available from the corner pharmacy. It would be a carefully delegated and authorised process, overseen by the chief executive officer.

Mrs A.K. HAYDEN: I asked about this earlier and the minister said we would deal with it later, so I am wondering whether it comes under this clause as well. It is in regard to preparing a prescription for the substance. With the preparation and handing over of the substance, will there be a use-by date, and is there a storage requirement for this substance?

Mr R.H. COOK: In relation to the dates, I am advised that that would obviously depend on the medication itself. Ultimately, that would come down to the advice provided by the authorised supplier to the contact person or agent of the patient. Storage of the medication is covered in subsequent clauses, so we will come to that fairly shortly.

Mrs A.K. HAYDEN: The use-by date obviously cannot be determined at the moment because we do not know what the substance will be. If there is a use-by date for the substance, what requirement will there be for the substance to be used prior to that expiration date or returned once it has expired?

Mr R.H. COOK: As I said before, it would depend on the medication. Obviously, there will be an obligation to return any unused portion of the medication. In the event that it expired for whatever reason, there would be a requirement to return it. We would not put a time line on the patient themselves. I am sure the chemist does not want to be in the position of saying, "Here's a voluntary assisted dying substance. Make sure you use it inside a fortnight", because that would obviously be a very unfortunate set of circumstances. We will need to carefully craft the circumstances and the conversation that will take place with the authorised supplier, but of course that will be subject to training.

Mrs A.K. HAYDEN: I thank the minister for that. I am not at all asking for that to occur, so I totally agree with the minister. My concern is more to the point that we do not know what the substance will be, so we are making it up as we go along at the moment. Let us just say that the substance has only a three-week lifespan for 100 per cent potency. I am concerned about a situation in which it expires and the potency level drops, or the substance is not

as effective as it is meant to be. The minister's answer, if I understood him correctly, is that nowhere in this bill does it say that if there is an expiry date on the substance, it needs to be handed back on that expiry date. The last thing we would want is for someone to do this and for the substance to not work because it has expired. That would be tragic.

Mr R.H. COOK: There is obviously a great deal of information that needs to be provided by the authorised supplier to the patient or their representative. That would clearly be part of it. I just draw the member's attention to my earlier remarks about the clinical panel. Obviously, it would not have as one of the voluntary assisted dying substances a substance that was so unstable that it would have to be used within a very time-limited period, because that, of itself, would be counterproductive in terms of the process.

Mr S.K. L'ESTRANGE: I am still dealing with clause 57(5), which the minister started to talk about with the member for Darling Range. I am just looking at paragraph (b) that says —

> possess the prescribed substance for the purpose of preparing and self-administering it; …

Has any contemplation been given to the maximum amount of time that that substance can be held by the person?

Mr R.H. COOK: No.

Mr S.K. L'ESTRANGE: We can also look at subclause (5)(d), which states —

> self-administer the prescribed substance.

I will just give an example of what could happen. A person goes and collects the substance or poison—whatever we want to call it—and takes it home. Let us say they live at home alone. Nobody then knows the time line within which this person is going to use the substance. If they use it straightaway and nobody knows this person, outside of the person who issued it, does that mean the body will be left in the home for some time? Is there any follow-up on that? If they are not going to use it at that point in time, is there any security around the substance itself? If there is no maximum time frame for the substance being kept in the home, there could be safety issues and issues with just looking after the person after they have deceased. What I am getting at is that I think time frames probably are an important practical aspect of this legislation, as well as a safety aspect.

Mr R.H. COOK: The self-administration will be at a time of the patient's choosing. If they choose to self-administer, they will have to appoint a contact person under division 3, and that contact person will have a range of obligations in terms of the process. Under division 4, we will come to the management of the voluntary assisted dying substance in terms of responsibilities around storage and things of that nature. They are like any other schedule 8 poison or drug—the person has obligations for the storage of it. As I said, we can come to that. I am further advised that the legislation includes all the existing safeguards of the Medicines and Poisons Act—I think I have said that a number of times—for the safe and secure storage of the substance, and also provides for the closed-loop safe and appropriate prescription, supply, storage and disposal of any unused voluntary assisted dying substance. In addition to other statutory labelling requirements for prescription medicines, the authorised supplier will label the package or container with warnings about the purpose and dangers of administration of the voluntary assisted dying substance, and information about safe and appropriate storage of the substance. The member for South Perth made the observation that people probably keep more dangerous materials in their laundry than necessarily any of the voluntary assisted dying substances, but we can come to that in division 4. In relation to the member's question around whether the person will be able to take it home and sit in a dark room by themselves, the answer is no; they have to appoint a contact person. The obligations and responsibilities of the contact person are covered under division 3. To go to the member's initial question, there is no time line in relation to when a person has to exercise their right under the legislation.

Mr S.K. L'ESTRANGE: We will get to division 3—I thank the minister for directing me to that section. With regard to the time frame for the patient to administer, how does it work in other jurisdictions? Is this something that has been taken from somewhere else?

Mr R.H. Cook: Great question.

Mr S.K. L'ESTRANGE: Does the minister have any evidence of how it works? I note the minister's point that poisons are held in households already—cleaning, gardening and rat poisons and whatever. I get that. Putting that to one side, this particular poison has a particular task and purpose, which can be achieved very efficiently. As the minister would know, those other ones can be quite clumsy, whether taken accidentally or on purpose. This is quite a direct-purpose poison. It will probably have instructions that go with it. I just park that as being separate to the other things held in the home.

Mr R.H. Cook: You are asking what is the practice elsewhere.

Mr S.K. L'ESTRANGE: Yes. How do other jurisdictions in Australia, such as Victoria, or elsewhere in the world approach this aspect?

Mr R.H. COOK: My attention is drawn to page 137 of the ministerial expert panel report. It provides a comparison between eight different jurisdictions and their medication management. None stipulate a time line for the process.

Mr S.K. L'Estrange: This is all self-administered?

Mr R.H. COOK: No. I think Oregon has it in only limited circumstances. I believe all of them have a capacity for self-administration; none stipulate a time line. Obviously, as people have observed, our legislation is largely modelled on the Victorian legislation; it does not have a time line either. Have a look at it.

Ms M.M. QUIRK: I foreshadowed that I would move an amendment to clause 57. The reason for this amendment is that there is a widely held misunderstanding about the oversight nature of the Voluntary Assisted Dying Board. In particular, some of the so-called safeguards that are listed state, firstly —

> 98. The Voluntary Assisted Dying Board is to monitor voluntary assisted dying in Western Australia under the Act

That is ex post facto and therefore needs to be explored in more detail. Secondly —

> 99. The Voluntary Assisted Dying Board has quality assurance and improvement functions

That is certainly true after the event. Then the safeguards state —

> 100. The Voluntary Assisted Dying Board is to refer breaches or matters requiring review to the appropriate authority (e.g. Commissioner of Police, Coroner, Registrar Births Deaths & Marriages, Department CEOs, AHPRA, HaDSCO)

Those so-called safeguards effectively will come into operation after a patient has died. My amendment will clarify and make absolutely unambiguous the role of the board. Therefore, I move —

> Page 36, lines 19 and 20 — To delete the lines and substitute —
>
> (1) This section applies if —
>
> (a) the patient has made a self-administration decision and has not revoked it; and
>
> (b) the Board has given the coordinating practitioner for the patient a notice of no objection under section 117A for the self-administration decision.

I apologise at the outset. On Sunday, I settled this amendment with Parliamentary Counsel and had hoped that it would appear on the notice paper. However, I was told only today that Tuesday's notice paper is finalised on Friday. Copies of my amendments have been distributed.

I must explain to members that I propose to introduce a new clause 117A. It will provide for a notice of no objection—in other words, in the course of an application, assessment and approval, forms would have to be sent to the Voluntary Assisted Dying Board. Consequently, the board would have to issue a notice of no objection under proposed new clause 117A. I make no apologies for this; that is a de facto permit. I know the amendment will be rejected by the government in part because the government says the regime under the Poisons Act is different from that which applies in this bill. Nevertheless, as I said, I am concerned that there is a misunderstanding about the role of the board. This amendment seeks to clarify that role.

Mrs A.K. HAYDEN: I rise to support the amendment put forward by the member for Girrawheen. By way of background, as we have been discussing today and previously, there is a gap here. The board is not involved to the extent that it could be—the notifications, the delay. Clause 117(a) states that the board will "monitor the operation of this Act". To do that properly, the board will need to monitor every aspect of the legislation, not just the bits and pieces that the government chooses. Clause 57 refers to "revoked" and a "substance". We do not know what that substance is. We do not know whether it will have an expiry date. We do not know how it will be stored. We do not know how long it could be kept for. They can delay it. To me, there are too many gaps. The board is not being informed in a prompt fashion to avoid any mistakes. What we are simply trying to do here is put in the required safeguards. We know the government has the numbers to pass this bill in the lower house. Our only job is to improve the bill and to put in any additional safeguards that we believe will protect people at the end of the day. I make no apologies for supporting the amendment. I stand here and say the board needs to be involved. The idea of the board is to monitor the operation of the act. Let us make sure it is able to monitor every aspect of this piece of legislation.

Mr R.H. COOK: I thank the members for their contributions. I understand what the member for Girrawheen is trying to do here. Essentially, she is right—it needs to be read in the context of her proposed new clause 117A. I understand what she is trying to do. It is about extra oversight. I appreciate the sentiment with which the amendment has been brought forward. However, I think it will add an extra burden on the patient when accessing voluntary

assisted dying. In this context, the patient would have already gone through a rigorous process of assessment, written requests, and enduring decision-making capacity and interest in moving forward. This amendment would essentially make the board an additional coordinating practitioner. I think that the member for Girrawheen is right: it is a de facto permit system like that which exists in Victoria. I understand that the member for Darling Range has been pursuing this line of inquiry and, therefore, this amendment probably suits her purposes. However, I respectfully submit that it does not improve the legislation. I think that it would be an extra obstacle for the patient who by this stage would have already undergone a very rigorous process. This goes to the point about how people conceive the board's role. As I have said on a number of occasions, the board is there to monitor the act; it is not there to police or stand by a patient's bedside and provide an extra opinion. That is the role of the coordinating practitioner, with the assistance of the consulting practitioner. I appreciate the sentiment with which the amendment has been brought forward and respectfully disagree with the amendment.

Mr P.A. KATSAMBANIS: I state at the outset that I think this amendment improves the bill by improving the safeguards in the bill. Interestingly, the government and the minister have spent a lot of time talking about safeguards. However, when an amendment is introduced by the member for Girrawheen to produce such a safeguard, one that would provide real-time monitoring of this radical and revolutionary procedure in our legislation, the minister labels it an obstacle. It is not. I think the amendment is intended in good faith. Other regimes around the world have given their supervising boards the capacity to supervise the process rather than act as a postbox and collector of documents. That is the intention in this amendment. I think it is a good amendment. If we are to legislate for a regime such as this—I have stressed this in other contributions throughout this consideration in detail—we need to ensure the strongest possible protections are in place to protect not only the patient who wishes to access this, but also, at times of potential future litigation, the medical practitioners or nurse practitioners, and the general community. That is particularly the case in this clause, which we are seeking to amend now. I am talking about a whole series of amendments.

Sitting suspended from 6.00 to 7.00 pm

Mr P.A. KATSAMBANIS: As I was saying before I was interrupted by the break, we are dealing with the amendment to clause 57, but this is one of the clauses for which the proposed amendment really relates to new clause 117A. I do not intend to discuss the principles of what is being introduced by new clause 117A at every stage of the process, but I think this is a fitting stage to discuss them very briefly. I think they were well outlined by the member for Girrawheen, who moved the amendment, and also by the member for Darling Range in her contribution. This is about providing an extra safeguard. It is not an obstacle. It is a very important safeguard, because, as I said earlier, it helps the patient, it safeguards the practitioners and it also safeguards other people who might be involved in any debate or discussion after the event. It gives the board that has been created under the legislation a bit more of a supervisory capacity. The minister said the board is there to administer the legislation, but the board has no supervisory capacity in relation to all the paperwork that needs to be filled out for an act of assisted dying under this legislation. It is really a postbox to receive the documentation. It is more a matter of filing notices than anything else. The object of the proposed amendment is to give the board one final look at things before a patient moves to the final stage, and I think that is fair and reasonable. In some ways it is essentially what happens in other jurisdictions such as Oregon or Victoria. I think it would add one more significant safeguard and alleviate a lot of the concerns out there about the possibility of bad practice creeping in. It was interesting that in one of the earlier discussions today the minister mentioned the word "malpractice", and there is always a fear. I do not knock our medical profession in any way. I think our medical professionals are absolutely world class—totally committed professionals—but amongst all professions there are those one or two bad eggs, no more than that really, and we need to guard against those people. That is why we bring in prescriptive rules for all professions, whether it is the legal profession, the medical profession, the nursing profession or the accounting profession. Those rules are unnecessary for 99.9 per cent of practitioners who act ethically and morally, but we still bring them in. In this case, we are dealing with a patient who is being put to death one way or another, either at their own hand or by an assisted procedure; they are being put to death by medication. We are introducing this extra safeguard of an independent board to supervise the process and a final check-off. It is interesting that the wording used in proposed new clause 117A is not that the board must issue a notice of objection; it is a notice of no objection. It is predicated on the basis that it is far more likely that the board will look at this stuff and, everything having been done right, will say, yes, it has been done right and we can move to the next step. It is almost couched in terms of it being highly unlikely that the board will intervene and say, "No, do not do it", but we are dealing with that one in a thousand or one in a million. We are dealing with the externality. One fatal error in this regime is one too many. I know the government and the minister have indicated they do not want to accept amendments, but I urge them to consider this as one more important safeguard.

Dr M.D. NAHAN: I stand in support of this amendment for a couple of reasons. First, it will ensure that the board is informed prior to the taking of the substance. Most of the board's actions, to the extent that it takes action, can

only take place, if this is not done, after the death, which is too late. Importantly, the government has sold the legislation on the basis of 102 safeguards, and there are a number of safeguards we have gone through. However, many of those claimed safeguards are reports to the board, and the board really is not a safeguard unless it has powers to act as a safeguard before the action is taken. If the board is just an ex post facto assessor, decision-maker or reviewer if the process is drawn out, it does not have any teeth. The board has been promoted by the government as one of the major—I think the major—source of safeguards, and this amendment would allow it to be a safeguard with teeth. One of my concerns is that if the board is set up to react to expedite a request, and the legislation is designed to ensure quick action because the majority of people considering this will be on the pathway to death and speed can be a very important factor for them; in fact, the only amendment to the Oregon legislation to date has been to allow the process to be undertaken more quickly, and that amendment was brought on by the demands of the potential users of the process, so I worry about the board reacting quickly. As the member for Hillarys pointed out, if everything is going according to plan, the board will just tick and flick; it will say, "No issues here." But there may be some cases in which information has not been adequately provided by the coordinating practitioner or all the other people who are supposed to report to the board, or the board may find some anomalies. Clearly, we would want the board to act before the death, and this amendment would allow that to be done. I stand in support of it and I urge the government and the minister to consider it as something that will not undermine the legislation, but will strengthen it for both the community and potential users.

Division

Amendment put and a division taken, the Deputy Speaker (Ms L.L. Baker) casting her vote with the noes, with the following result —

Ayes (11)

Dr D.J. Honey	Mr S.K. L'Estrange	Ms L. Mettam	Ms M.M. Quirk
Mr P.A. Katsambanis	Mr R.S. Love	Dr M.D. Nahan	Mrs A.K. Hayden *(Teller)*
Mr A. Krsticevic	Mr W.R. Marmion	Mr D.C. Nalder	

Noes (38)

Ms L.L. Baker	Mr M. Hughes	Mrs L.M. O'Malley	Mrs J.M.C. Stojkovski
Dr A.D. Buti	Mr D.J. Kelly	Mr P. Papalia	Mr C.J. Tallentire
Mr J.N. Carey	Mr Z.R.F. Kirkup	Mr S.J. Price	Mr D.A. Templeman
Mrs R.M.J. Clarke	Mr F.M. Logan	Mr D.T. Punch	Mr P.C. Tinley
Mr R.H. Cook	Mr M. McGowan	Mr J.R. Quigley	Mr R.R. Whitby
Ms M.J. Davies	Ms S.F. McGurk	Mr D.T. Redman	Ms S.E. Winton
Mr M.J. Folkard	Mr D.R. Michael	Ms C.M. Rowe	Mr B.S. Wyatt
Ms J.M. Freeman	Mr S.A. Millman	Mr P.J. Rundle	Ms A. Sanderson *(Teller)*
Ms E.L. Hamilton	Mr Y. Mubarakai	Ms R. Saffioti	
Mr T.J. Healy	Mr M.P. Murray	Ms J.J. Shaw	

Amendment thus negatived.

Ms M.M. QUIRK: The minister, being a supporter of lots of physical activity, will of course be pleased that some of his colleagues got up a few extra steps in that division.

I had one last question on clause 57 about subclause (5)(a), which relates to an agent receiving the prescribed substance. What sanctions will be in place if the agent takes off with the prescribed substance and does not supply it to the patient?

Mr R.H. COOK: All persons who perform a function within the legislation are subject to the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1971. Obviously, penalties would be associated under those two acts. Clause 57(7) states —

> An agent of the patient is authorised to —
>
> (a) receive the … substance from an authorised supplier;

If they act outside this legislation, they would not be so authorised, and so they would also be acting contrary to this legislation.

Mrs A.K. HAYDEN: I refer to clause 57 and self-administration. I am not sure whether this falls under subclause (5), which starts "The patient is authorised to", but in the Netherlands, a doctor is required to be present during the time of self-administration until death occurs, to ensure that the poison is taken by the patient, administered correctly and that death occurs. If that does not happen, the doctor is present to administer more of the substance to ensure that the patient is successful in passing away. Why did the minister not consider putting such a provision into the bill?

Mr R.H. COOK: I am advised that this is ultimately a decision for the patient to make. If they want a practitioner with them, they can have one. In division 3 we describe the role of the contact person who has a role to participate under self-administration. Obviously, it is the responsibility of the medical practitioner to ensure that the voluntary assisted dying substance is adequately prescribed. We decided that it was not necessary for a self-administering patient to have a medical practitioner there. This is similar to the process that happens in Victoria. The member will remember the description of Kerry Robertson, who died at her home with her two daughters there, taking the voluntary assisted dying substance as prescribed, which produced the desired effect. Obviously, that comes down to the important decision made under clause 55, "Administration decision". It is, I guess, a decision for the patient to make.

Mrs A.K. HAYDEN: I apologise if I missed it in clause 55, but with all due respect, everyone in this place has spoken about a peaceful, dignified death, yet when self-administration is about to take place, no-one is there as a backup to make sure that no unintended consequences occur. The person taking the substance might be unable to swallow or whatever in the way they will take the drug—we do not know that yet. If they are unable to administer it correctly, there is no backup to make sure they are going peacefully and there are no side effects. A doctor will not be there to make sure the patient's dying wish is fulfilled, excuse the pun. I am really concerned for the family who may be there with them, witnessing the situation. It will not be a very pleasant sight if it does not work, and the person could be in pain. In all honesty, I do not understand why that is not in the bill as a safeguard.

Mr R.H. COOK: As we have mentioned in numerous places, this is about a patient-centred focus, if you like. From that perspective, I guess we are honouring the wishes of the patient who may wish to do this in the privacy of their own home not surrounded by medical practitioners. They will have come to the end of their life and gone through the voluntary assisted dying process and will be at the point at which they will self-administer. From that perspective, it is for the patient to make the decision about the nature of that self-administration process, not for us to make that call. I think we have the balance right here. Again, we are informed both in design of the law and from the emerging experience in Victoria around the patient in that scenario. I take the point the member has made that a person could potentially find themselves in that situation, but, again, that is why clause 55 is important, which is the administration decision, to make sure the patient has all the information necessary to carry out the act.

The DEPUTY SPEAKER: Member for Darling Range, a different question.

Mrs A.K. HAYDEN: It is the final question on this. Let us say the substance does not work. What process would the patient undergo? They are at home and have taken it, but it did not work. What will be the process then?

Mr R.H. COOK: Obviously, they would make contact with the coordinating practitioner or their general practitioner. They would seek further assistance with the process. That decision would be for them to make. I am also informed that it is likely that the type of schedule for a poison that will be approved for the use in the voluntary assisted dying process will not have any other side effects for the patient. In the event that the medication does not result in the patient's death, evidence indicates that the patient will awaken without otherwise being affected. That is the nature of the sedatives or things of that nature that ultimately will be used. These are issues for the clinical panel and the chief executive officer to consider in the context of the implementation.

Mrs A.K. HAYDEN: One last question, if I may. The minister is saying that it is likely there will be no side effects and we do not know what they will be, but there is the patient's mental position and the family around them to consider. Is the minister telling me that once this legislation is passed, it is his intent that there will be guidelines around a list of what the family is to do if it is not successful?

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: I refer to the issue of "agent" in clause 57(5)(a) and (7). Who does the minister contemplate will be an agent? The agent is someone other than a contact person. The agent is not defined in the legislation. What quantity of drugs are we dealing with? I know that a range of prescribed substances could be given to the agent, but I am anxious to know what quantity or volume we are talking about to get some idea of possible criminal sanctions. If it will help the minister on that latter point, we can probably deal with the quantity issue at clause 71.

Mr R.H. COOK: Yes, I was going to refer to that, member. Thank you very much.

Obviously, in ordinary circumstances, we would anticipate that the contact person will be the agent—that is, the person who would have further obligations due to being officially nominated for the role they will play under division 3. As I said, I would ordinarily contemplate that the agent would be the contact person, but it does not necessarily have to be the contact person. It will be simply someone acting on behalf of the patient to take the voluntary assisted dying medication to the location of the patient.

Dr D.J. HONEY: That gives me a little cause for concern. Once poisons used to be quite freely available. As the member for Churchlands pointed out, I appreciate that we can look at other substances in houses, but I know of specific poisons that people could take to kill themselves. In my old world of cyanide when I was a lad, there used

to be big bottles of sodium cyanide in laboratories. Now it is strictly controlled and we cannot access it without permits and the like. Even qualified scientists cannot access that without a special permit. All the other positions are well defined, and there is a lot of rigour around choosing those persons. I wanted to go a little further down this path. I am not going to do this exhaustively; I just want to get some idea about the qualifications for the agent. I picked up on something the minister said just then—that normally it would be the contact person. There are very strict qualifications for the contact person. Would it not be prudent to make them one and the same and say that the contact person is the agent? I appreciate the aim here is to be flexible, but my concern is that in this process, we have a person receiving a poison that is designed to kill someone, and that person could have no qualifications at all. I see this as a deficiency in the legislation, whereas a lot of effort has been made to ensure that people in other positions meet some basic criteria. I guess the nub of the question is: What are the qualifications for the agent? Would it not be more prudent to say that the agent is the contact person? I am not going to ask another question after that.

Mr R.H. COOK: Thank you, member. Picturing a patient who is at the end of their life, they would have had a very robust interaction with the health system and would be on a range of medications to manage a range of symptoms; therefore, in practicality, they would already have a pretty robust relationship with the health system. Ultimately, the name of the agent would be recorded by the supplier and potentially would be the husband or wife of the person involved, who may not be the contact officer, but might be someone who would ordinarily undertake these sorts of tasks. From that perspective, it could be the contact person, but not necessarily. I remind members that the Misuse of Drugs Act, which applies to schedule 8 poisons and some schedule 4 poisons, contains offences relating to the manufacture, sale, supply and possession of prohibited drugs, paraphernalia and so on. We have significantly robust regulations and laws for the protection and proper management of these sorts of medications. From that perspective, the member characterises it as creating too big an opportunity for the mismanagement of those medications. Part 7 of the bill deals with offences by the agent for unauthorised supply or possession. Ultimately, this clause deals with the proper carriage of the substance from the authorised supplier to the patient.

Clause put and passed.

Clause 58: Practitioner administration —

Mr Z.R.F. KIRKUP: Clause 58(2) refers to "sufficient dose to cause death". I realise that we have not prescribed what that dose looks like, because there might be a range of different medications and things like that. This clause refers to "sufficient dose to cause death". I note that in some other jurisdictions, significantly more than the sufficient dose is provided in order to bring about death. Is there any reason that this clause is specific as to the dosage? Obviously, I appreciate a quantity of the substance has to be provided to bring about someone's death. I am curious about why that would not be provided as part of the usual prescription process and why it is defined here as "sufficient"?

Mr R.H. COOK: Obviously, the intent here is as described, but what is prescribed would depend on the patients themselves. The intent here is to outline that for this patient, with this condition, of this particular weight, and with their capacity to consume the voluntary assisted dying substance, the coordinating practitioner must prescribe a sufficient amount that will cause death for that particular patient in their particular circumstances. It is simply to be explicit about that. We do not want a little bit left over; we do not want there not to be enough. Essentially, we want the patient to take the substance and for that substance to have its effect.

Mr Z.R.F. KIRKUP: This will be via practitioner administration, so they will not take it.

Mr R.H. COOK: That is correct, yes.

Mr Z.R.F. KIRKUP: Under clause 58(4), the administering practitioner for the patient is authorised to receive the prescribed substance from an authorised supplier, and then there are a range of other aspects to that. Is my reading of the legislation correct—that the authorised administering practitioner will not have an agent; there will be no intermediary? Is there a responsibility on the administering practitioner to get it from the authorised supplier directly? Can they delegate that responsibility to somebody else? I could be wrong, but I could not see that in there.

Mr R.H. COOK: Member, the way an administering practitioner would take carriage of the medicine would be very different from the way a member of the public would. Obviously, it would be delivered to their rooms or the clinical environment in which they are operating, rather than the practitioner going to a chemist or a hospital, for instance, to get it. Maybe if they work in that hospital, it would be from that particular perspective. It is different from the self-administering regime.

Mr Z.R.F. KIRKUP: Just to clarify that a little bit more, if I can, let us say the administering practitioner is not in a hospital environment. Would they have to go and get that from the authorised supplier, who I imagine would be a pharmacist involved in the prescription and supply of that medication substance, like every other? Would they themselves have to go to the pharmacy to retrieve the substance or not?

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: Can they not send someone as a delegate? I appreciate that in some other circumstances there might be an agent or a courier who delivers it. I cannot find it in the legislation, but I could be wrong. This is a good process to go through to clarify whether or not the administering practitioners have to go themselves directly to retrieve it. If they do not have to do that, is there any other part of the legislation that empowers a third party to be the courier?

Mr R.H. COOK: Yes, I think I understand. I am advised that it would be under the current arrangements under which a medical practitioner would get supplies of medications, so, again, it is very different from the punter in the street. It will be through the usual measures—a medical courier or whatever is authorised under the Medicines and Poisons Act for the carriage of those medicines.

Mr Z.R.F. KIRKUP: I appreciate that, minister, because, of course, in the normal circumstance, practitioners themselves are not usually in receipt of the medication. They write the script; they give it to the patient; the patient goes and retrieves it. The clinic itself does not necessarily have custody of any medication in a normal environment—not in all environments, I appreciate. Just to clarify, would it be like a flu injection process, or something like that, when the medication is delivered directly to the office of the clinic; is that right?

Mr R.H. COOK: Yes, that is right. I am sure we will come to the clause eventually, but my understanding is that the prescription itself will not go into the hands of the patient or the member of the public.

Mr Z.R.F. KIRKUP: I am going to clause 58(5), if I can, which states —

> The administering practitioner for the patient is authorised, in the presence of a witness, to administer the prescribed substance to the patient …

Are there any requirements for the witness themselves? Are there any constraints on that witness? Could they be anybody—a family member or an employee of the practitioner? Is that defined later in the legislation?

Mr R.H. COOK: Clause 61 deals with the witness to the administration of a prescribed substance and we will come to that shortly.

Ms M.M. QUIRK: I have an amendment to this clause also. I am moving it for the similar reasons that applied to my amendment to the previous clause. I need to correct something that the minister said. He said that the insertion of the process that we recommend under proposed section 117A will make it more onerous for the patient. We would contend that it is not more onerous because it is the coordinating practitioner who must apply for the no objection certificate. Yes, it means that there would be a delay of up to two days but, as I said beforehand, it assuages the concerns of many people who believe that under the bill as it is currently drafted, the board would not be acting as a real-time monitor. We will talk a bit about that when we get to those clauses in the bill.

It is for that reason that I move —

> Page 37, lines 20 and 21 — to delete the lines and substitute —
>
> (1) This section applies if —
>
> (a) the patient has made a practitioner administration decision and has not revoked it; and
>
> (b) the Board has given the coordinating practitioner for the patient a notice of no objection under section 117A for the practitioner administration decision.

Amendment put and negatived.

Ms M.M. QUIRK: Following on from what the member for Dawesville said, I can appreciate the witness being a family member; that makes eminent sense because most patients would like a family member present. This is down the track so we do not need to deal with it now, but I wonder whether the minister might consider at clause 61 that the proprietor of a nursing home should be an ineligible witness? We have talked about this before. In the case of a lonely patient who has no family around, there are very sound reasons for the witness to be independent.

Mr R.H. COOK: I am happy to deal with that under clause 61.

Clause put and passed.

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

Ms M.M. QUIRK: My question on clause 59 runs along the same theme that I have been pursuing today. It states —

> **Coordinating practitioner to notify Board of administration decision and prescription of substance**
>
> (1) Within 2 business days after prescribing a voluntary assisted dying substance for the patient, the coordinating practitioner for the patient must —
>
> (a) complete the approved form …

Again, my concern is that this is seen as a safeguard but it does not necessarily have to be contemporaneous with when the substance was administered because it can be done two days later. Again, this clause emphasises that the board is nothing more than, if you like, a postbox for receiving and dealing with these various forms within the fullness of time.

Mr R.H. COOK: This has come up a few times throughout the debate. In practice, when the administering or consulting practitioners lodge these forms, they will be done electronically. It would essentially be done at the same time, but I understand what the member is saying about the two business days. It is certainly much more contemporaneous than the Victorian model, but it is simply an opportunity for the Voluntary Assisted Dying Board to oversee and monitor that the act is running according to plan and, from that perspective, this is another part of the process that is carried out by the Voluntary Assisted Dying Board.

Mr P.A. KATSAMBANIS: My concern with clauses 57 to 60 is about the prescribed form that needs to be filled out and delivered to the board after the death of a patient. Clause 59(2) states —

> The administration decision and prescription form must include the following …

It then includes a list of things, and what really surprises me is that nowhere either in that list or in the preceding clauses that we have dealt with is a provision outlining how the practitioner has to certify what happened to any of the remaining medication or whether all of the substance was used—I hesitate to use the word "medication". Can the minister indicate how the board will oversee what happens with any substance that is left over? Regardless of whether there are provisions later on for that, one of the useful safeguards in these forms that are delivered to the board would be to have some form of certification that either the entirety of the substance was consumed in the process or, if not, a way of indicating what has happened to it and where it has been delivered to or deposited. We know that in the wrong hands this substance could have devastating and unintended consequences. I seek some clarification from the minister around that. Without that certification there is a gap. Although it is not listed in the clause, could the minister make an undertaking to see that it could be included in the prescribed form that the CEO will eventually create? That would at least create a little certainty around the possibility that any remaining substance may inadvertently or deliberately be misused.

Mr R.H. COOK: The member is quite right. It is dealt with in clauses 76 and 77, the latter of which refers to the practitioner disposal form.

Clause put and passed.

Clause 60 put and passed.

Clause 61: Witness to administration of prescribed substance —

Ms M.M. QUIRK: We previously talked about the witnesses to the administration of a prescribed substance. Clause 61(2) states —

> … a person is an ineligible witness if the person —
>
> (a) is a family member of the administering practitioner for the patient; or
>
> (b) is employed, or engaged under a contract for services, by the administering practitioner for the patient.

Why is that considered necessary?

Mr R.H. COOK: As this is the final act in the voluntary assisted dying process, we thought that it was important that that person be independent, and the requirement for a witness during a practitioner administration is yet another safeguard in the voluntary assisted dying process. It reflects that the voluntary nature of the voluntary assisted dying process is fundamental to the WA model and that the decision to access death must be enduring.

Ms M.M. QUIRK: Again, we have this issue about independence. The intention is that there be some independence from the medical practitioner, but that is not explicit in that clause. Earlier, I asked why a proprietor of a nursing home where a patient might be would not also be an inappropriate witness.

Mr R.H. COOK: Sorry, ma'am. Could you clarify that you are saying that an administrator of a nursing home should not be eligible to be an independent witness?

Ms M.M. QUIRK: Yes. They might have some financial interest, or whatever.

Mr R.H. COOK: This is one of those clauses that are important for protecting everyone involved in the process. It is about protecting the patient to make sure that there is a witness to that process. It is also about protecting the administering practitioner. From that point of view, I think we have captured the level of independence required in this, and, obviously, it is important to have that level of independence. I do not appreciate the sensitivity that is necessarily excluding someone who is an administrator of an aged-care facility, or something of that nature; but

I understand the point that the member is making. Ultimately, what we are doing, though, is simply trying to make sure that this person is at arm's length to the person who is administering the voluntary assisted dying substance. From that perspective, that is the key outcome that we have achieved here.

Mr P.A. KATSAMBANIS: In relation to the witness that is required under clause 61, I have two very simple questions: Can the coordinating practitioner be a witness for the purposes of clause 61; and, if the coordinating practitioner cannot be a witness, where in the bill is that coordinating practitioner precluded from being a witness?

Mr R.H. COOK: No, it would not. Clause 62 deals with the transfer of the administering practitioner's role. Under this clause, when the administering practitioner for the patient is no longer able, for any reason, to administer the prescribed substance to the patient, the role of the administering practitioner may be transferred to another person. By definition, if the coordinating practitioner is in the room with the administering practitioner, the coordinating practitioner is in a position to administer the voluntary assisted dying substance. Therefore, it could not, by definition, be there.

Mr P.A. KATSAMBANIS: That is not the question I asked, though. My question was very simple. There are two prohibitions on a witness in clause 61. The first prohibition is that they are a family member of the administering practitioner, which is pretty simple. The second prohibition is that they are employed or engaged under a contract for services by the administrating practitioner for the patient. Those are the only two limiting factors. In reading this clause, it is very, very clear that if the coordinating practitioner was not the administering practitioner, even if the administering practitioner was a nurse practitioner under the employ of the coordinating practitioner, by the bare reading of clause 61, the coordinating practitioner would be a witness. My and the community's fear around these sorts of procedures is that closed-loop that we have talked about. Yes, we accept that in the main the vast majority of people involved in this process will be honourable and ethical—absolutely. However, in closed-loop situations in which independence is called into question, it needs to be absolutely beyond doubt. We are dealing with administering a lethal substance that will take a person's life, and I am not satisfied by the minister's answer that clause 62, which deals with the transfer of an administering practitioner's role, will in any way stop the coordinating practitioner from being an eligible witness to the administration of the lethal substance.

Several members interjected.

The DEPUTY SPEAKER: Excuse me, members! The minister is on his feet.

Mr R.H. COOK: Thank you, Deputy Speaker, and thank you, member. I disagree with the member's interpretation. A coordinating practitioner can only transfer their role as the administering practitioner if they are unable to administer it. Therefore, if they are in the room with the patient, they, by definition, could administer the voluntary assisted dying substance.

Mr P.A. Katsambanis: Maybe they're still unable. Maybe their arm is broken.

Mr R.H. COOK: Member, there may be a whole bunch of other scenarios. I just think the member's interpretation of clause 62 is incorrect.

Dr D.J. HONEY: One of my general concerns with this bill is in people being required to be involved in this process when they otherwise would not. One of my concerns about the witness is that it may be convenient for an administering practitioner, who comes into a hospital that they do not work at, to say to a nurse or physiotherapist or some other staff member, "Listen, I want you to come over and be a witness for that." Is it the case that if it is being done in a hospital setting, the administering practitioner could simply require someone else who works in the hospital to come over and be a witness? What restrictions are there on someone being a witness in that situation?

Mr R.H. COOK: I am familiar with the member's sentiments around the coercive or corrosive nature of the potential hospital environment. As the member will see under clause 61(2)(b), they cannot be engaged under a contract for services by the administering practitioner for the patient. Therefore, from that perspective, it would not be allowed that there be, in effect, an employer–employee relationship or a manager–employee relationship. But, again, I think from that perspective, there are the appropriate checks and balances in the context of governance around clinical practice in a hospital environment, which would ensure that these things should not take place.

Dr D.J. HONEY: I want to clarify that I do not generally regard the hospital environment as a corrosive environment, but I do know that medical hospitals are very hierarchical environments. I want that to be clear for *Hansard*, because people will read this. It was really that concern about someone being coerced into it; I do not think the minister is going to give me an answer past that. Clause 61(3)(a) states —

> the patient's request for access to voluntary assisted dying appeared to be enduring;

How does the witness ascertain that? Do they interrogate the patient? I wonder whether subclause (3)(a) is almost redundant. Certainly, subclause (3)(b) is reasonable.

Mr R.H. COOK: They would have to bear witness to essentially the patient continuing to seek voluntary assisted dying. Obviously, at that stage the patient has gone through an exhaustive process to reach that point. In the normal use of the word, the witness simply has to be satisfied that the patient's wish to access voluntary assisted dying appears to be "enduring". The witness plays an important role in supporting the administering practitioner, but from that perspective simply has to bear witness to that enduring request for access.

Ms M.M. QUIRK: I would like to pursue that point. If we look at clause 58, "Practitioner administration", at subclause (5)(c) we see that the administering practitioner must be satisfied that —

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

We are now dealing with a clause that states "appeared to be enduring". We know, for example, that the witness does not need training in assessing capacity or whatever. I wonder why the words "appeared to" have suddenly appeared in this clause, especially when we look at the equivalent provision in the Victorian legislation—I think I have the Western Australian legislation here—which has "appeared to be enduring" as opposed to "enduring".

Mr R.H. COOK: Under section 65(2)(a)(i) of the Victorian act, the witness has to certify that —

> the person at the time of making the administration request appeared to have decision-making capacity …

From that perspective, it is a similar notion. Obviously, what we would expect from our medical practitioners is very different from what we would expect from a witness, who essentially could be an ordinary member of the public. From that perspective, we have a much higher level of burden on the medical practitioner than on the witness.

Ms M.M. QUIRK: Safeguard 44 states that a witness must also be present for the practitioner administration. I thank the minister for referring me to section 65 of the Victorian legislation. Section 65(1)(b) states a witness must be "independent of the co-ordinating medical practitioner". That is specifically stated in the Victorian legislation. It is not stated in this legislation, although it is in the explanatory memorandum. Section 65(2) states —

> The witness who witnesses a person making an administration request and who witnesses the administration … must, in a co-ordinating medical practitioner administration form—
>
> (a) certify in writing that—
>
> (i) the person at the time of making the administration … appeared to have decision-making capacity …
>
> (ii) the person in requesting access to voluntary assisted dying appeared to be acting voluntarily and without coercion; and
>
> (iii) the person's request to access voluntary assisted dying appeared to be enduring;

The Victorian legislation uses the same language, but it also refers to "coercion" and "decision-making capacity", which are absent from this clause, and I ask why.

Mr R.H. COOK: We did not think it was appropriate. This person is a witness to a medical practitioner undertaking a procedure. We do not expect them to have the same expertise as the medical practitioner; therefore, we do not expect them to be able to provide the same level of authority in their observations. From that point of view, subclause (3) deals appropriately with the obligations that we think are appropriate for a witness.

Ms M.M. QUIRK: It is possible for a layperson to ask, "Do you remember what you had for lunch?" If the patient could not answer that question, the witness would then not have any confidence that necessary capacity was there or that the request was enduring. All I am saying is: yes, I appreciate that a layperson might not have the same level of training, but that is all the more reason to put in other subclauses that deal with coercion and capacity.

On the independence of witnesses, I give the minister this scenario. Say the proprietor of a nursing home had someone occupying a bed, for which there is much demand in Western Australia; I think we are 3 000 beds short. He had someone in the room who was on a pension, but he had the capacity to have someone in that room who would pay full odds for the room and was not entitled to any concessions. Something like that would mean that the proprietor of a nursing home may well have a financial interest and would not be an appropriate independent witness.

Mr Z.R.F. KIRKUP: I have listened to a number of my colleagues ask questions about the witness and I am slightly concerned about the relationship that coexists. I appreciate the minister has provided a response on that. If I were a witness, how might I go about establishing whether someone is being coerced? What role would I have as a witness to intervene in the process, if at all? What would my role look like? If I believe that beyond that point in time I must certify that the substance has been taken, am I legally obligated to intervene in any way to stop the process? Can I do that legally? Aside from providing certification, what is my role as a witness? I take the member for Girrawheen's point: we are empowering an individual, who could be anybody. I understand that person needs

to be accessible, but what role would they play if they have a concern about coercion? I am keen to understand that role, aside from the certification, which is what the clause appears to refer to from my reading of the legislation.

Mr R.H. COOK: Clause 61(3) states —

> The witness to the administration of a prescribed substance to a patient must certify in the practitioner administration form for the patient that —
>
> (a) the patient's request for access to voluntary assisted dying appeared to be enduring; and
>
> (b) the administering practitioner for the patient administered the prescribed substance to the patient in the presence of the witness.

The person has borne witness to the administration of the substance and they have remained convinced that the patient's request for voluntary assisted dying appeared enduring. If they cannot certify it, the administering practitioner would be acting outside the scope of the legislation and, as the member will see later in the bill, there are some very harsh penalties for doing that.

Mr Z.R.F. KIRKUP: If the witness refuses to certify that because they believe that the patient has been coerced, for whatever reason, and they witnessed the administration by a practitioner that has ultimately brought about that person's demise—they have effectively borne witness to an illegal act—would they be obligated to try to stop that act in any way, shape or form?

Mr R.H. COOK: A very serious act would have occurred. Like any other citizen, the witness would be required to contact the police, I would have thought. The Voluntary Assisted Dying Board would certainly engage in an investigation because an activity has been undertaken under the act that is contrary to the act. The member can imagine that there would be a range of remedies that the witness could undertake, such as speaking to the administering practitioner or coordinating practitioner, or, to the very extreme, referring it to the police.

Mr Z.R.F. KIRKUP: I imagine that if someone were about to perform a dangerous act on a person that would harm them in some way, I, as a citizen, would be obligated to stop that occurring or to do something. We would expect citizens to step in if they witness a situation like that. I realise that the legislation will stop there being any liability on the witness for not performing a lifesaving act—that is later in the legislation—but I worry that as the role of the witness is defined, the steps that they can take, aside from the lack of certification, have not been outlined. I appreciate the minister's response and where we are at with that but I place my reservation on the record. There is the ability to witness someone's death and believe that they have been coerced, but all they can do is not certify it or tell the police or the board. We would want somebody to step in before that occurs.

Mr M.J. Folkard: Dial triple zero!

Mr Z.R.F. KIRKUP: I appreciate that interjection. Maybe the witness will.

Ms M.M. Quirk interjected.

The ACTING SPEAKER (Mr S.J. Price): Members!

Mr Z.R.F. KIRKUP: I am trying to bring up that we are moments away from death, in all likelihood. I am trying to imagine a situation in which that would occur. To witness something like that would be very difficult. Not to labour the point, but I have some concerns about the role of the witness. I would appreciate some definition in the legislation about the role the witness can play to try to stop the process, if at all. I appreciate that that is not in the bill. On the other side, it is interesting to consider a hostile witness who might not agree with the process. They may suggest that the patient was being coerced, and it is only themselves and the practitioner in the room.

Ms A. SANDERSON: Before the minister responds, I wonder if in his response he could provide any examples of whether this has possibly occurred in other jurisdictions in the 25-years' worth of evidence that we have from those jurisdictions, and, given that we have to make decisions based on evidence and not wild hypothetical scenarios, whether there are any examples of a so-called hostile witness to a process impeding the process or whether someone has witnessed so-called harm being done to a terminally ill person.

Mr R.H. COOK: I was not going to respond to the member for Dawesville's comments, but I am happy to provide that to the member.

Several members interjected.

The ACTING SPEAKER: Members!

Mr R.H. COOK: Around the table here, we have not heard of any action that may have taken place in that manner, but in any situation, if there are —

Ms M.M. Quirk interjected.

The ACTING SPEAKER: Member for Girrawheen!

Mr R.H. COOK: If there are unlawful acts, people respond to them in different ways. The legislation has penalties for acting outside the act, and that is appropriate. How a conviction of someone under this act may roll out will be the subject of court proceedings in the normal manner of events.

Dr M.D. NAHAN: I will not delay things, but the member for Girrawheen raised clause 61(3), and I would like the minister's response. We have always been concerned about two issues in this process. One was the voluntary nature of the decision. Clause 61(3)(a) deals with that adequately and uses "appeared". I accept that the witness will not be a real practitioner and will therefore have to go on appearance, but why did the government leave out the section that the Victorian legislation has on coercion? The government could use "appear" if it wished to use that word, and I think the Victorians used "appear". The witness's function is not just to witness the signing and the death, but also to make a final check that it is kosher. The two issues we are worried about is whether the person is conscious and wants the decision. The second is that there are no signs of overall coercion. It might be said that in 99 per cent of cases there will not be, and I accept that, but we are dealing with death. I am not clear why the government has left that out when it has included it everywhere else in the long process it has gone through. I cannot see why the government has left that out.

Mr R.H. COOK: Under clause 58, the administering practitioner's role calls on their training and their authority under the act to make a declaration about coercion. The purpose of the witness is to bear witness to the final act. From my perspective, it is important that the patient's request for access to voluntary assisted dying is enduring. The witness would not have the skills or the training to be able to certify in relation to coercion.

Dr M.D. NAHAN: So —

The ACTING SPEAKER: Member for Riverton, before you start, as you referred to, the member for Girrawheen had already asked the previous question you asked. If you continue asking the same question —

Dr M.D. NAHAN: I am not. This is an important issue. The minister is not pushing back.

The ACTING SPEAKER: No, but he is giving you the same response that you have already heard.

Dr M.D. NAHAN: I am just trying to find out what the role of the witness will be.

The ACTING SPEAKER: It has been answered.

Dr M.D. NAHAN: I accept what the minister just said, that, essentially, the administering practitioner will assess whether there is coercion. The question I have is: the administering practitioner, when trying to elicit that it is voluntary and the person has the wherewithal to make the decision, will have the training, but will the witness have that training also? Will they have to go through the same process that the administering practitioner will in terms of communication? There are a number of subclauses that state that the administering practitioner has to be able to elicit the response from the patient. This legislation asks a witness to make a decision that it appears to be enduring. If the patient cannot communicate other than in certain ways to the administering practitioner, how will the witness make a bona fide assessment?

Mr R.H. COOK: At the end of the day, it will probably be someone who is known to the patient, and they will simply undertake to ask the question. From that point of view, they will be able to form a view. I have answered this extensively to the member for Girrawheen. I have entertained questions from the member for Dawesville on this clause and several questions from the member for Riverton. I think we have covered this clause adequately.

Ms M.M. QUIRK: At the risk of repeating myself, what were the specific drafting instructions for this clause? Was there a specific drafting instruction to the effect that it should depart from the Victorian model?

Mr R.H. COOK: The member would understand that I will not be disclosing Parliamentary Counsel's advice. The drafting instructions were best practice for Western Australia, being informed by the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying.

The ACTING SPEAKER: Member for Girrawheen, the minister has responded to your question, which you have already asked multiple times; slightly variegated each time. Can we just move on? If you are going to continue down this same line of questioning, the minister does not have to respond.

Ms M.M. QUIRK: I wish to place this question in *Hansard*: can the minister please disclose the government's intention to exclude a reference to coercion and capacity?

Mr R.H. COOK: I think I have answered the member's question.

Clause put and passed.

Clause 62: Transfer of administering practitioner's role —

Mrs A.K. HAYDEN: Clause 62 relates to the transfer of the administering practitioner's role. Can the minister explain to the house under what circumstances this may occur?

Mr R.H. COOK: Under this clause, when the administering practitioner for the patient is no longer able for any reason to administer the prescribed substance to a patient, the role of the administering practitioner may be transferred to another person. The ability to transfer the role ensures that a person is not disadvantaged due to unforeseen circumstances such as the original administering practitioner being no longer able to perform the role due to illness, injury or other reasons. The transfer may occur only when the patient has made an administration decision for practitioner administration and the coordinating practitioner has prescribed the voluntary assisted dying substance for the patient.

Mrs A.K. HAYDEN: I thank the minister for that. The minister said "other reasons". Can he tell us what the other reasons may be?

Mr R.H. COOK: No, member.

Mrs A.K. HAYDEN: Does the practitioner to whom the role is passed have to go through anything to make sure that they have the same understanding as the original practitioner—that the decision was made under all the criteria that we have discussed? I do not want to labour over those criteria again.

Mr R.H. COOK: The person to whom the role of administering practitioner is transferred must meet the eligibility requirements set out under clause 53. Clause 5 defines "administering practitioner" in relation to a patient to mean the coordinating practitioner for the patient or a person—medical practitioner or nurse practitioner—to whom the role of administering practitioner is transferred under clause 62(2).

Mrs A.K. HAYDEN: Because the minister read that out quite fast, I ask him to confirm, so that I understand him correctly, that if the role of the administering practitioner is transferred to a different practitioner, the process will start again; that is, the practitioner needs to go through the same regulations and the checklist so they are 100 per cent certain that the patient has not been coerced or the like.

Mr R.H. COOK: Yes, in the administration role. They do not obviously perform the role of the coordinating or consulting practitioner, but in the administration role, yes, they would have to start afresh.

Mrs A.K. HAYDEN: Can this occur if the administering practitioner has decided that they have simply changed their mind and they do not want to proceed with this administration?

Mr R.H. COOK: It is the ability to transfer in the event that they are unable to fulfil the role of the administering practitioner.

Mrs A.K. HAYDEN: Just to clarify, the minister said "or any other reason" but could not indicate those other reasons. Could a reason be that they just changed their mind?

Mr R.H. COOK: They could have family obligations or they could be out of the country. There could be other reasons they cannot do it.

Mr P.A. KATSAMBANIS: When an administering practitioner is appointed, this clause foresees circumstances in which that practitioner would want to transfer the role. That makes some sense for the reasons that the member for Darling Range and the minister articulated. This clause requires that within two business days after the acceptance of the transfer, an administering practitioner transfer form needs to be both completed and given to the board. My initial question is: is it possible for the transfer to occur and the lethal substance administered prior to the board being informed of the transfer of administering practitioner responsibilities?

Mr R.H. COOK: Yes.

Mr P.A. KATSAMBANIS: Again, the minister can take this as a comment: I consider that to be another failure of the drafting of this bill. I think it is a significant concern that there are transfers of very onerous duties. Be that as it may, that is what the minister and the government wants.

In the transfer that occurs under clause 62, what provision is made so that the person accepting the transfer and becoming the new administering practitioner is bound by all the provisions that are contained in division 2 of part 4 of the act?

Mr R.H. COOK: They become the administering practitioner so they have to discharge all of their duties consistent with the act, not just at the point that they have received them. This is the same question that I answered from the member for Darling Range.

Mr P.A. KATSAMBANIS: Let us start working through the practicalities of this so we can understand the limitations and also the obligations. The administering practitioner has to fill out a practitioner administration form and send it to the board within two days of filling it out. That was set out in clause 60. If that form is not sent to the board before the transfer—within that two-day period, obviously, because there can be a transfer within the

two-day period—who is obliged to fulfil the duties and obligations under clause 60? Is it the original practitioner or is it the substituted or transferred practitioner, or is the obligation on both of them?

Mr R.H. COOK: If they are to become the administering practitioner and the certification by the administering practitioner following the administration of the prescribed substance has already occurred, I am not sure what role the member would have them play because, by then, the process is complete. Is that what the member is suggesting?

Mr P.A. KATSAMBANIS: That was not my question at all. That was a previous question that the minister answered. I am saying that under clause 60, someone who has accepted to be the administering practitioner has to fill out a practitioner administration form. Under clause 62, there is the circumstance of transferring that responsibility. If the practitioner administration form, the original form, has not been lodged with the board at the time of transfer—they are allowed two days and the transfer could take place within those two days—whose responsibility is it to lodge that form under clause 60? Is it the original practitioner or the practitioner who has acquired the role under clause 62? Is the obligation on both of them? Do they each need to fill out a form?

Mr R.H. COOK: I think the member is confused. Under clause 62, an administering practitioner transfer form is lodged. We have the new administering practitioner, who would then undertake administration of the prescribed substance under clause 60, which would then require the practitioner administration form. There is no point in transferring the role of the administering practitioner if the voluntary assisted dying substance has already been administered. Just because it goes from clause 60 to clause 62 does not mean that things take place in that order. They simply capture different activities under the legislation. It is not in chronological order.

Mr P.A. KATSAMBANIS: I was attempting to refer to the form in clause 59, which is the administration decision and prescription form. The minister said that all this needs to be done afterwards rather than beforehand. Do all the obligations of the administering practitioner to inform the board occur after the administration of the substance and not before? Does the administering practitioner have any obligations to the board before the administration of the substance?

Mr R.H. COOK: Clause 59 points to the role of the coordinating practitioner, who is the only one who can prescribe the voluntary assisted dying substance. Under clause 59, the administration decision and prescription form would have been lodged by the coordinating practitioner. Only then will the coordinating practitioner be in a position to transfer the role of the administering practitioner to another medical practitioner, who would then be bound, obviously, by the administration decision. The prescription will be completed, and it will be the role of the medical practitioner who becomes the administering practitioner to fill out the administering practitioner form and complete the practitioner administration form.

Mr P.A. KATSAMBANIS: I think the answer to the last question I posed is effectively yes. There are no obligations on the administering practitioner to inform the board prior to the administration of the substance. This simply reinforces some of the previous debate—this is a comment, minister—that an entire administration process, including the possible transfer of the administration process, will happen completely outside of any information provided to a supposedly independent board—I assume it will be independent, more than supposedly. Again, it is just a safeguard that seems to be missing here. It is obviously a deliberate decision by the government. It weakens the protections available under the proposed legislation.

Mr Z.R.F. KIRKUP: My question relates to clause 62(5), which states —

> If the original practitioner has possession of the prescribed substance when the role is transferred …

I am trying to understand the practicalities of how that will occur. I am trying to imagine a situation in which there has been a change in practitioner due to a patient's location or whatever reason. The substance transfer, as I will call it, that occurs as part of subclause (5) suggests to me that the practitioners old and new will have to meet and effectively exchange the substance. Is that correct? Is there any capacity for the new practitioner to acquire the substance from somewhere else; and, if so, what will happen to the original substance? I imagine it will have to be disposed of. Under this legislation, will the practitioners effectively have to meet and swap the substance? I flag that I have another couple of questions about this.

Mr R.H. COOK: In the normal course of events, a medical practitioner would have means and ways in which the transfer of medicines takes place. It is covered under section 22(1) of the Medicines and Poisons Act 2014, which states —

> A person who stores, handles, transports or disposes of a poison other than in accordance with regulations made under subsection (2) commits an offence.

Obviously, they would be required to undertake the transfer of the substance in a way that is consistent with the Medicines and Poisons Act.

Mr Z.R.F. KIRKUP: I appreciate that response, minister. That is not inconsistent with how the practitioner might receive the substance in the first instance. Obviously, a logistical chain already exists. If they cannot get that substance for whatever reason, is there any capacity for the new practitioner to access the substance, or a new substance? From my reading of the legislation, they cannot. They cannot go back to the start and prescribe a new vial or whatever it might be of the substance; they have to take the one that has been prescribed. I am trying to imagine a remote or regional setting in which a terminally ill person has a number of days to live. I know that the minister does not like to deal with wild hypothesis, but I am trying to understand the practicalities if someone moves and how this clause will come into effect. Is there any capacity for the new administering practitioner to access a new substance?

Mr R.H. COOK: Only the coordinating practitioner can write the prescription. That would have to be managed under the normal regime that we would expect under the Medicines and Poisons Act. There might be a circumstance in which they could ultimately, but under the Medicines and Poisons Act, the practitioner would have to account for that store of medicines at the time that they produce a new one. It would have to be consistent with the act.

Clause put and passed.

Clause 63 put and passed.

Clause 64: Patient to appoint contact person —

Mr S.K. L'ESTRANGE: Clause 64, "Patient to appoint contact person" states —

> (1) The patient must appoint a person as the contact person for the patient.

The eligibility under subclause (2) states that they need to be 18 years of age, and subclause (3) states —

> Without limiting who can be appointed as the contact person …

I want to focus on that bit, because it provides some examples of who can be appointed and it also leaves it open to anybody else. I acknowledge the seriousness of the role of the contact person, and I know we are not yet at clause 66, as the minister knows, clause 66 states —

> (1) The contact person for the patient is authorised to —
>
> (a) receive the prescribed substance …
>
> (b) possess the prescribed substance … and
>
> (c) supply the prescribed substance … and
>
> (d) give the prescribed substance …

It is a pretty serious role. Was any consideration given to what a minimum standard, for want of a better word, should have been for the person who will hold the position of contact person?

Mr R.H. COOK: Essentially, this discussion would be between the patient and their carer, whether that would be the local doctor or their coordinating practitioner. The role of the contact person involves some clinical process, and they will have a role to play in the process, but at the same time it will also be a very intimate role, because this person will be intimately involved in the person's end-of-life decision. Again, we are making this a person-focused exercise, and from that point of view understand that we do not want to limit it, as such, but we are anticipating that it might be the coordinating practitioner or another medical practitioner who has been involved in the process.

Mr S.K. L'ESTRANGE: I understand the personal focus, but there will be situations in which language barriers are involved. The person who the patient wants to be their contact person might not be a strong reader, for example. This person will be handling the prescribed substance and will be giving the prescribed substance. Through that, we would expect they may have to read instructions on how to give that prescribed substance. I would have thought that as a minimum there might be some sort of literacy standard for the contact person, irrespective of the relationship that that person has with the patient, given their role.

Mr R.H. COOK: Yes, member, and the contact person must accept the nomination for that role and they need to undertake that with the understanding that there are some obligations under this legislation, in particular to return any unused portions of the voluntary assisted dying substance. They will not necessarily be the person who will be holding the patient's hand at the end of the process and they will not necessarily have to be a family member or someone like that, but it will have to be someone who is able to act competently under the provisions of the legislation.

Mr S.K. L'ESTRANGE: Should there be a provision in the legislation to make sure that that contact person, whoever it is, is competent to carry out their role?

Mr R.H. COOK: Not necessarily, member. Obviously, the contact person is something that would be discussed with their medical practitioner or coordinating practitioner, in this case in particular, and in that context they would talk about what is required for the role. The contact person has a role to play, but it is not one in which they will be necessarily making any sort of medical or other skill-based related decision; they simply have a role to play.

Mrs A.K. HAYDEN: Following on from that but going to a different step, in the explanatory memorandum under clause 64, the last paragraph states —

> The intent of appointing a contact person is to ensure that once supplied, a voluntary assisted dying substance can be monitored and safely disposed of (if unused).

Under this legislation, is there any provision for training or information that will be required to be provided to that contact person to enable them to fulfil their role to monitor the assisted dying substance but also to dispose of it if it is not used? We will be giving this person quite a lot of responsibility, and I agree that they have agreed to be that person, so they are taking on this task, but is any training or information required under this bill that will be passed on to that contact person so that they can fulfil the requirements as outlined in the explanatory memorandum of the bill?

Mr R.H. COOK: I draw the member's attention to division 9, clause 148, which explains what the board does when it receives an appointment form in relation to the contact person. In the implementation phase we would anticipate that a range of materials would be provided or developed to support the contact person carrying out their role. Clause 104 provides one of the key roles of the contact person, which is to give an unused or remaining substance to the authorised disposer. From that perspective, I think we have anticipated exactly what the member believes a contact person would need.

Mrs A.K. HAYDEN: It says under clause 148 that the board must send information within two days of receiving a copy of the contact person appointment form. Does the contact person appointment come before passing out the administrative drug? As we have established already, that could take place before the board is notified.

Mr R.H. COOK: The coordinating practitioner cannot even fill out the prescription without the contact person's details being provided in that form.

Mrs A.K. HAYDEN: Just to clarify, the contact person will—the minister said, "More than likely"—receive a guideline or booklet or something for them to follow, that will be in regulations or whatever happens after the passing of this legislation. Will that definitely be included? The minister said, "More than likely". Is it definitely included that they will be given that or not?

Mr R.H. COOK: Yes, member. Clause 148(b) contemplates that very thing.

Mr S.K. L'ESTRANGE: To follow on just from my previous line of questioning, I want to confirm that other than being 18 years of age, there is no other restriction on who can be appointed as a contact person as it currently stands. Is that correct?

Mr R.H. COOK: Yes.

Mr S.K. L'ESTRANGE: Would the minister see merit in having, at the very least, some restrictions placed on who could be selected? For example, if someone had a criminal history, possibly even relating to poisons, or any other criminal history that suggests they are not a decent citizen, would the minister think that, as a safeguard in this act, we could at least have some restrictions on who could be appointed as a contact person, given the nature of the duties of the contact person?

Mr R.H. COOK: Member, I am informed that, no, it is not necessary. There is no evidence overseas of a person who is a contact person undertaking a misuse of that role, or misuse of the substances involved. This is simply making sure that there is a single person who has responsibility for carrying out the acts in this part of the bill.

Dr M.D. NAHAN: Why do we have to have a contact person? Why can the patient not do it? In many circumstances, they will not be able to; I understand that. However, in some circumstances, the patient may want to do this himself or herself. My reading of the bill is that the patient must appoint a person as a contact person. Can they appoint themselves?

Mr R.H. COOK: Because the contact person has responsibilities after the voluntary assisted dying substance is consumed, or not, if they die naturally.

The ACTING SPEAKER (Mr S.J. Price): Do you want to say more?

Mr R.H. COOK: No, the member for Riverton is nodding furiously, so I think I got my point across.

Mr Z.R.F. KIRKUP: I am going to assume that the minister's answer to my question will be that this is patient-centric legislation, which we do not want to constrain too much. Why is it that under clause 64(6) we have not provided a time requirement for a patient who wants to revoke their contact person to inform the person of the revocation?

In all other places throughout the legislation, there are a lot of time frame constraints of two business days. In this clause, there is no time constraint on the patient to inform the contact person that they have revoked their appointment, as best as I have read it. Why is that the case? I suspect the answer is probably at the start of my question.

Mr R.H. COOK: I am informed that the patient may revoke the appointment of a contact person. Following such a revocation, the patient must notify the person of the decision, whereupon the person ceases to be the contact person. We do not have the same regime of two days' notice to the Voluntary Assisted Dying Board because that is an obligation of the medical practitioners who are involved, whether coordinating, consulting or administering. It is not an obligation of the patient. If a patient has revoked the appointment of a contact person, the patient must nominate another contact person in accordance with the act. This is to ensure that the voluntary assisted dying substance is monitored and disposed of as required by the act. The contact person also provides a clear contact point for the Voluntary Assisted Dying Board.

Mr Z.R.F. KIRKUP: I appreciate the minister's response. Clause 64(6)(a) says that the patient must inform the person of the revocation. The patient obviously has to inform the coordinating practitioner, but the coordinating practitioner does not have to inform the person who was previously assigned to be the contact person. My question is: Why is there no time frame constraint? If I have appointed a contact person and I decide to revoke that, why is no time frame applied to me on when I must inform them? I appreciate the role of the coordinating practitioner, but why is it that, as a patient, I am not required to inform the person within a set period of time that they have been revoked as my contact person?

Mr R.H. COOK: Member, again, this is around empowering the patient to make sure that things move forward in the way that they wish. Obviously, a new appointment has to be made, subject to section 64(1), and under that process, once that form has been completed and sent to the Voluntary Assisted Dying Board, the process will run on itself. The Voluntary Assisted Dying Board will then contact the new person. I suspect, in real life, the Voluntary Assisted Dying Board will say, "We now have two forms; we will go back to the coordinating practitioner and find out what is going on here." But, obviously, one would revoke the other.

Ms M.M. QUIRK: We had some discussion about the difference between an agent and a contact person. Can the minister confirm that a contact person is under certain requirements to return drugs that have not been used, but there is no such requirement on an agent?

Mr R.H. COOK: Member, both the agent and the contact person have obligations under the Medicines and Poisons Act. Regardless of what role they play, they have obligations under that act in terms of the misuse of drugs and making sure that various aspects of that law are adhered to. The contact person, in addition to that role, also has obligations under this act. This sets out those obligations.

Ms M.M. QUIRK: We will get to this in due course, but I will just let the minister know that there are obligations under clause 104 that relate solely to a contact person and not to an agent. That seems to be problematical.

Mr R.H. COOK: No, it is not, member, but we will come to it.

Clause put and passed.

Clause 65: Contact person appointment form —

Mr Z.R.F. KIRKUP: I have a couple of questions on this clause. I will start with clause 65(1). Similar to other concerns about forms, if the full details of the contact person are not set out on the form, does that invalidate the form? We have the details there—the name, date of birth and contact details of the contact person. In all previous questions I have asked about forms, if we do not have the full address of someone, their full date of birth or whatever, it has not stopped that form from progressing. Is that still the case when it comes to the contact person?

Mr R.H. COOK: No, member, it does not invalidate it; however, as I mentioned before to the member for Darling Range, there are obligations that the Voluntary Assisted Dying Board has in relation to contacting the contact person, so the form obviously has to provide enough information for it to be able to contact the contact person.

Mr Z.R.F. KIRKUP: In clauses 65(1)(d) and (e), the contact person has to provide a statement consenting to their appointment—I appreciate that—and a statement that the contact person understands their role under the act and their requirements under section 104 to return any unused portion of the substance.

Mr R.H. COOK: Correct.

Mr Z.R.F. KIRKUP: How do they have to express that? Will the prescribed form include the question, "Do you understand your obligations", tick, or whatever that might be, or do they have to physically write that out? Will the CEO issue that as part of the pack of forms, or will the contact person physically have to write out "I understand my obligations" et cetera?

Mr R.H. COOK: Obviously, there will be a declaration that they have to sign. Of course, this goes to the heart of what the member for Churchlands was saying. If this person understands what their obligations are and can carry them out, then, under clause 148, information will be provided that will continue to inform the person of their capacity to be a contact person.

Mr Z.R.F. KIRKUP: I will make a statement on subclause (1). My concern about the contact details is that all the information we have previously canvassed around contact details on forms allows for that partial information. At the moment, an email address would meet the legislative capacity for contact details. Obviously, the contact person plays a really important role, but there is no way to verify who the contact person is. For example, there is no identification requirement or a requirement for that person to be a citizen of the state. If a person provides an email address they could just be —

Ms M.M. Quirk: In this country they are called a resident. There is no such thing as a "citizen of the state".

Mr Z.R.F. KIRKUP: They are a resident. Sorry, member for Girrawheen. I appreciate the member disabusing me of that notion. There is no requirement to ID the contact person or for them to be a resident. Additionally, the contact point could also be an email. I am flagging a concern that to provide an email address is not as rigorous, for example, as all the other requirements that a person has to go through. For example, a patient has to meet with their coordinating or consulting practitioner. I have some concerns about that, but I appreciate that it is unlikely to change at this point in time.

The ACTING SPEAKER (Ms J.M. Freeman): The question is —

Mr Z.R.F. KIRKUP: I am continuing, if I may, Madam Acting Speaker.

The ACTING SPEAKER: I thought you were wrapping it up.

Mr Z.R.F. KIRKUP: Subclause (2) states —

> If the patient is unable to complete the contact person appointment form, another person can complete the form on behalf of the patient.

Could that person conceivably be the contact person; and, if so, does that represent a conflict of any sort?

Mr R.H. COOK: It could conceivably be the same person who takes on that role, but they would still have to be signed or declared by the patient.

Mr Z.R.F. KIRKUP: I appreciate that. Thank you, minister. Subclause (3) states —

> The patient or the contact person for the patient must give the contact person appointment form to the coordinating practitioner for the patient.

Is there a particular reason for not having a time frame on that, such as two business days or something like that?

Mr R.H. COOK: The only reason, member, is that if the patient is not in a rush, then neither are we. From that point of view, they are in control of the process. Immediately after it is given to the coordinating practitioner, the coordinating practitioner has to get it to the Voluntary Assisted Dying Board inside two days. But again, this is up to the patient.

Mr Z.R.F. KIRKUP: My final question is on subclause (6). In picking up the point that the minister just made, I appreciate that a person cannot be moved through the process to prescribe until the contact person appointment form is provided. Does the minister envisage any capacity, as part of the implementation process, whereby the practitioner might be able to verify the contact person? The practitioner would probably want to make sure that the contact person listed is who they say they are. Does the minister imagine that in any part of the implementation process something like that might be done?

Mr R.H. COOK: Yes, as the member can see throughout the legislation, the coordinating practitioner has a pretty onerous and important role to play in guiding both the patient and other medical and health practitioners through the process. From that perspective, one would expect that they would want to make sure that the contact person is able to function under the act.

Mrs A.K. HAYDEN: The member for Dawesville asked most of my questions, so my remaining question will be quite brief. What happens if the patient cannot find a contact person?

Mr R.H. COOK: As we observed under the previous clause, the coordinating practitioner, the consulting practitioner or another registered health practitioner could play that role.

Clause put and passed.

Clause 66: Role of contact person —

Mr P.A. KATSAMBANIS: Clause 66 outlines the role of the contact person who is authorised to receive the prescribed substance, to possess it, to supply it to the patient and then to give whatever is left over to the authorised disposer as required under clause 104. They are onerous tasks obviously, but all relatively simple. 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).

I have a few process questions around that. There is no actual obligation for the contact person to be present for the self-administration, as I understand it, so how would the contact person firstly inform themselves so that they can inform the coordinating practitioner? If we assume that that has occurred, then lots of forms need to be filled out. There is no indication of a required form that the contact person needs to fill out that would include things such as where the death took place, how the death took place, and whether it took place as a result of self-administration or some other cause. Why has that been left out? Why was there not one more form? I would have thought that given that this could broaden out to a range of people beyond just the practitioners involved—it could be a lay person in some circumstances or in many circumstances for that matter—some sort of authorised or prescribed form would be seen to be a positive thing. I know that the government has shied away from using prescribed forms, but it could be an approved form to make it simple for the contact person. There are two elements to that question. Firstly, how do they inform themselves? Secondly, why would they not be given a form to make it easier for them to provide the information to the coordinating practitioner?

Mr R.H. COOK: We are just trying to make it easier for the contact person. No, the contact person does not have to be there. The patient may want to undertake the process alone. Secondly, the contact person has an obligation under the process to monitor the voluntary assisted dying substance. They would be in regular contact with the patient. In fact, I would say that they would be in almost constant contact with the patient.

Clause put and passed.

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

Mr S.K. L'ESTRANGE: Sorry, I was still thinking about the minister's answer on clause 65, and then, Madam Acting Speaker, you just absolutely rushed through clause 66. This is a serious bill.

Ms A. Sanderson interjected.

Mr S.K. L'ESTRANGE: I know the member is in a hurry, but some of us actually want to critique this bill.

Ms A. Sanderson interjected.

Mr S.K. L'ESTRANGE: We were paying attention. We were listening to the minister's answer and going through it in the bill.

The ACTING SPEAKER: Member, take a seat. The question is that clause 67 stand as printed.

Mr S.K. L'ESTRANGE: No. I will refer the minister in my questioning of clause 67 to some of the information in clause 66, which relates to some of the information in clause 104, which gets back to the concerns we all have about not having any restrictions placed on who the contact person can be. The Attorney General with his legal background would understand that if we are going to the trouble in clause 104—which is referred to in clause 66 and which leads to clause 67—to imprison somebody for 12 months if they do not do what they are asked, then we are putting in place a prison sentence to make sure that people do the right thing. Our concern is that there is no restriction on who that contact person can be and, notwithstanding that flaw in this bill, under clause 66(2) no time limits are attributed to that contact person for informing anybody of when the patient died. How is the minister going to ensure that this contact person, before they refuse to perform the role under clause 67, is the right person for the job?

Mr J.R. QUIGLEY: I could ask that as a rhetorical question: whom would you want near you when you come to die? We would want someone we trust. Therefore, this chosen contact person is someone the patient trusts. They do not need a medical degree, member, nor will the person who will wipe our brow or hold our hand as we take our last breath. It will be someone we have chosen, just as someone the dying patient will have chosen.

Mr S.K. L'ESTRANGE: The Minister for Health was in charge of the bill before the Attorney General came into the chamber, so the Attorney General would not have heard the minister's answers. The minister indicated to us that the bill has been drafted so that that person can be a primary carer, as an example. I am putting that to one side, because nowhere in the bill is it stipulated that that needs to be the case. What if somebody were to choose a contact person who might have—this is what we mentioned earlier to the health minister—issues around reading, and there are instructions that go with the substance that has to be administered? What if they did not fully understand their obligations under the bill because they are not an educated person? They might be known by the

patient, closely or not. It does not matter. They just have to be 18 years of age. We are quite concerned that the government is not taking the appointment, whatever appointment is made, seriously. Clause 67 relates to clause 66 because the patient can still make another appointment, but there is no requirement for, or restrictions on, the appointment. Notwithstanding the Attorney General's point, 99 per cent of the time we would expect that the person standing next to the patient would be somebody who is close to them. We would expect that. All we are saying is that in the event that that is not the case, this person can just be selected by the patient. The only requirement for a contact person is that the patient select them. There is no other requirement. They just have to be 18 years of age and they must be appointed by the patient. That is it. What if there were somebody who had a track record—for example, a criminal record—in which they might be very close to, and do everything right by, the patient, because they are close to that patient, but they may have another life outside that and they are handling this substance that could put the community at risk? All we are asking is: why is there no restriction on who can be appointed under clause 67(2)(c)—because we missed clause 66—when the patient must make another appointment? We are simply asking the question: does the government not think that there should be at least some minimum standard for whom the contact person should be?

Mr J.R. QUIGLEY: May I answer that with a rhetorical question. Should the person whom the member wishes to accompany him as he draws his last breath have some prescribed minimum standard under a government regulation or should he be able to choose someone whom he wants near him as he dies?

Mr S.K. L'ESTRANGE: I will answer that rhetorical question. If I were in the situation, I would want that person to be somebody close to me, exactly as the Attorney General described. But that, actually, is not my question. I am hoping that that person will be with me regardless of whether they are the contact person. If we look at clause 66(1) on page 44 of the bill, we see that the contact person has the role of receiving the prescribed substance, possessing the prescribed substance, supplying the prescribed substance, and then giving the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer, as required by clause 104. Under clause 104, that has to occur within 14 days, and if none of that is followed properly, they can go to jail for up to 12 months. Therefore, absolutely, the person I would want with me would be somebody close to me who cares for me, but that would not have to be the contact person. I am suggesting that two people could be there if the person close to me did not qualify. However, in this instance, they would qualify because they have only to be 18 years of age. Does the government not think that some due consideration could be given to making sure that the contact person has some minimum standard of acceptability under the bill?

Mr J.R. QUIGLEY: At least the member has planted his flag in the mound. Come his day, he will not even be considering VAD and he will not even be considering a contact person; he will go the full distance. He has made that clear, and all pain to him. He has made that clear. He is against these contact people. He is against people handling this drug, so at least in the presence of the Lord he has said, "This is not for me. I will go the full distance."

Mr S.K. L'Estrange: I said none of that. You are verballing me.

Mr J.R. QUIGLEY: Do not use your weasel words now; God was listening. Do not use your weasel words now.

The next thing is, as far as criminality goes —

Several members interjected.

Mr J.R. QUIGLEY: I do not want interjections.

The ACTING SPEAKER: Just answer the question, minister.

Mr J.R. QUIGLEY: As far as criminality goes, already under the Medicines and Poisons Act, criminals can be prescribed schedule 4 and schedule 8 drugs, which are lethal. That is already in the poisons act. The member said that a patient might choose a contact person who had a criminal record. That might likely be the case in Indigenous communities, which the member does not care about. That might well be the case.

Several members interjected.

The ACTING SPEAKER: Minister, answer the question. Members, stop interjecting!

Mr J.R. QUIGLEY: It might well be the case in Indigenous communities that the person wants their son as the contact person and that son may have a criminal conviction and have been to jail under the former government's mandatory sentencing laws, but they can still handle and still be prescribed schedule 4 and schedule 8 drugs. There is no limitation on prescriptions under the medicines act, as the member well knows. In relation to treating patients with a history of substance abuse, persons with a history of substance abuse within the previous five years, or recorded as oversupplied or drug dependent, can be authorised to receive schedule 8 medicines. Even though they have a history of drug abuse, under the medicines act, they may be prescribed schedule 8 medicines. Therefore, the point is rejected.

Ms M.M. QUIRK: I want to clarify one point the Attorney General made, and that is whether the contact person even needs to be present when the substance is administered. The contact person's role is quite limited and the patient can have whomever they like with them, and it does not need to be the contact person.

Mr J.R. QUIGLEY: Correct.

Mr S.K. L'ESTRANGE: The Attorney General just said that they do not have to be present. Does anybody have to be present?

The ACTING SPEAKER: No, minister. Just answer the question.

Mr J.R. QUIGLEY: Sorry?

The ACTING SPEAKER: Answer the question, minister.

Mr J.R. QUIGLEY: I appeal to the umpire. I have not said a word. I got 50 metres and I had not said a thing!

The ACTING SPEAKER: Come on! Come on!

Mr J.R. QUIGLEY: Does anyone have to be present when the member dies —

The ACTING SPEAKER: Member!

Mr J.R. QUIGLEY: — or can he have his choice? This patient will have their choice, the same as he will have his choice when it comes to drawing his last breath. This government will not pass a law regulating who must be present or whether the person can die in peace and solitude. That is their choice, the same as the member has.

The ACTING SPEAKER (Ms J.M. Freeman): Can we get to the clause; it is clause 67. Member for Dawesville.

Mr Z.R.F. KIRKUP: Acting Speaker.

Mr J.R. Quigley: My friend from Dawesville.

The ACTING SPEAKER: I gave you the call, member for Dawesville.

Mr Z.R.F. KIRKUP: I appreciate that. It is always good to have the Attorney General here. I always appreciate it when the Attorney General is at the table, because, hopefully, I will get some relevant answers at some point.

The ACTING SPEAKER: Member, ask the question.

Mr Z.R.F. KIRKUP: If a coordinating practitioner receives two forms, which are dated, but perhaps in the morning the patient made a decision, signed the form, dated it, appointed the contact person and sent it off to the coordinating practitioner —

The ACTING SPEAKER: Sorry, member, are we on clause 67?

Mr Z.R.F. KIRKUP: Yes, clause 67, "Contact person may refuse to continue in role". Clause 67(2)(c) states —

> the patient must make another appointment under section 64(1).

I am curious about the date on the form. Obviously, the coordinating practitioner is obligated to try to find out from the patient who is the most relevant contact person. How might that practically occur?

Mr J.R. QUIGLEY: Of course, they would sort out which was the valid one. Yes, I agree.

Ms M.M. QUIRK: Under clause 67, a contact person may refuse to continue in the role. That might occur, for example, because the person is provided with information about what they are required to do in that position and they might baulk at that. Alternatively, English might be their second language and they do not fully comprehend their role and for that reason say, "This is all too hard. I don't want to do it." Is it prescribed in the legislation what exactly is instructed to the contact person and will that be available in languages other than English?

Mr J.R. QUIGLEY: That is all covered in clause 66. When the bill becomes an act and comes into force, the Department of Health will hand out information to the contact people. I know the member has studied the bill very closely and she would be well aware of clause 148, "Board to send information to contact person for patient", which stipulates —

> 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 —

Conjunctively —

(b) outlines the support services available to assist the contact person to comply with the requirements referred to in paragraph (a).

That completely answers the member's question.

Ms M.M. QUIRK: It does not actually, Attorney General, but that was a good effort. Clause 148, which the Attorney General referred to, requires information to be provided to the contact person, but not necessarily in another language. What I am saying is that that might be the cause of a person refusing to be a witness. They get official-looking documents and they do not quite know what their role is, whereas, in the Victorian legislation, there is provision for some certification that the contact person understood and that information was provided to them in another language.

Mr J.R. QUIGLEY: The bill provides for the use of interpreters when required. Furthermore, Western Australia adheres to the state government's Western Australian Languages Services Policy 2014. The person is not providing information to someone in the language of this chamber, which I have heard this evening—a person is not providing information if they are talking double-dutch. The information has to be provided in comprehensible English or translated into a language that that person adheres to. There is not a problem there.

Ms M.M. QUIRK: I am not going to flog a dead horse, but clause 160 relates to the use of interpreters for patients, not contact persons.

Mr J.R. QUIGLEY: The contact person has to provide information to the patient. The department will be supplying the contact person with information in an inappropriate language. If the member wants to make a mountain out of a molehill on this, she should keep on going, but it is pretty straightforward; it is not rocket science. This is about giving information to someone who does not use English as a first language.

Ms M.M. Quirk interjected.

The ACTING SPEAKER: Thank you, Attorney General.

Mr J.R. QUIGLEY: I thought my time was still ticking. It is not rocket science to transmit information to someone whose first language is not English; we do it every day.

Clause put and passed.

Clause 68: Information to be given before prescribing substance —

Dr D.J. HONEY: Clause 68(1) states that the coordinating practitioner must "inform the patient, in writing, of the following". I assume that provision is there so that the patient is fully informed of the process. Why is it specified as having to be in writing? In the case of someone who is quite ill, for example, they could be vision impaired and unable to read. Should there be a broader requirement to make sure that if someone is vision impaired or has some other difficulty, they can receive that information?

Mr J.R. QUIGLEY: I will paint a scene, member. Prostate cancer—I hope the member does not have it—has metastasised and the pain is immense. It is throughout a person's bones, liver and kidneys. I know the member will not because he is voting against voluntary assisted dying and he will go the full distance—all power to him—but the person elects to access VAD. The doctor comes in with information to be given before prescribing the substance. The patient is in bed in agony and the doctor has to give them this information, and the member is asking why it has to be in writing. This poor person is in a wretched state and dying—I have been in a chemo lab; it felt like a chemo lab—in a chemo room and a doctor comes in and gives them the information outlined in paragraphs (a) to (f) and they are meant to retain it at all. They are meant to say, "Yes, I understand all of that. When my rellies come to visit me, I will be able to regurgitate that and tell them what went down." No; it has to be in writing so that the person can ask their daughter, their dad, or whomever when they come what are the requirements. There it is in writing. It is called risk management. We know that the medical practitioner has given the information because there, in writing, is the information. It is risk management for the doctor and protection for the patient and their family, because they will know all the procedure.

Dr D.J. HONEY: It may be that the patient cannot take in that information. Might I say that I suspect the great majority of patients will not be writhing in agony, but regardless of whether they are, rather than prescribing it specifically in writing, surely there should be a requirement that it is communicated in a way that is appropriate for the patient's condition, not simply in writing. I appreciate what the Attorney General has said about writing—that we can trust only what we see written down and all that. However, it may be that a patient cannot possibly understand that because of an affliction. Surely there should be a requirement that the information be communicated to the patient in a patient-appropriate form, not simply in writing.

Mr J.R. QUIGLEY: What is being postulated is that a patient who is non–compos mentis might not be able to understand the writing. If they are non–compos mentis, they would not qualify as a voluntary assisted dying candidate—end of story.

Dr D.J. HONEY: I am having trouble getting through to the Attorney General. I did not imply that the person was non–compos mentis, but simply that they may have an affliction that means that they cannot read the material. Surely there should be a requirement that it be communicated to them in an appropriate form. For example, they may be blind.

Mr J.R. QUIGLEY: If they cannot read, it would not be appropriate for them to self-administer. They might not be able to read the label on the bottle. They might want to take the substance, but instead swallow two aspirins because they could not read the label. This information will be in writing. Their visitors, mum or dad, or contact person will be able to read it. This is for the protection of the patient, and management of risks for the doctors.

This is, to me, a further example of the filibuster being carried on by certain conservative members of this chamber to slow this bill down as much as possible. When clause 68 is read, it will be seen that there is nothing controversial in it. But it is an opportunity for those members to dig in and bog down the progress of this bill—and so shall they be judged!

Dr D.J. HONEY: I do not think that lecture offered much insight. I am trying to assist —

Point of Order

Mr M.J. FOLKARD: Under standing order 97, this is irrelevant.

The ACTING SPEAKER (Ms J.M. Freeman): We are not there, member for Burns Beach. Member for Cottesloe, ask your question.

Debate Resumed

Dr D.J. HONEY: Thank you very much for your guidance, Ms Acting Speaker.

I am trying to assist the minister. I have not asked a question for some considerable time because I did not see the need for it.

The ACTING SPEAKER: Let us move it on. Ask the question.

Dr D.J. HONEY: Ms Acting Speaker, I had what I would say are insults from the Attorney General as opposed to an answer before. I am trying to assist —

Point of Order

Mr J.R. QUIGLEY: Where is the question?

The ACTING SPEAKER: Sit down, Attorney General. Member for Cottesloe.

Debate Resumed

Dr D.J. HONEY: The question is that it surely would assist in making sure that a potential patient was fully informed if the bill included "or in a patient-appropriate manner". I do not expect any more sense out of the Attorney General on that and have not had any so far. It is a genuine attempt to help to make this system more relevant to the broader range of patients other than those people who will access this process and will be full-sighted at the time.

The ACTING SPEAKER: I will take that as a comment. Member for Dawesville.

Ms M.M. Quirk interjected.

Mr Z.R.F. KIRKUP: We are not doing that.

I echo the concerns of the member for Cottesloe about the requirement to be provided in writing. I know that in circumstances in which someone might be visually impaired, information cannot be provided to them in writing. As part of all of this, is there any requirement that the information has to be acknowledged by the patient?

Mr J.R. Quigley: Sorry. I got the good part—the preamble. I did not get the question.

Mr Z.R.F. KIRKUP: I will continue the question. The question is whether there is any requirement at all for patients to acknowledge that they have received the information that has been given to them; and, if not, why not?

Mr J.R. QUIGLEY: We do not want to go throwing legal requirements upon the patient. The patient is dying. We do not want to load the patient up with a whole lot of legal regulations. The patient has put their hand up and asked

for VAD, and then gone to another doctor and asked for VAD. They have been ticked and ticked again. I remember when jack the dancer gave me a little visit —

Mr Z.R.F. Kirkup: I don't know who that is.

Mr J.R. QUIGLEY: Cancer. When I went to the hospital of Peter MacCallum, and before they would administer the stuff, because it was a trial, the waiver of liability form was about an inch thick. I had to go up and see Craig Bennett, my mate from uni, whom I used to drink with. He said that it was going to be a horrible death and he had watched Paul Eddington go in St John's Hospice in London. I had to go through all that because I was going onto an experiment. I was healthy, alert and, I would like to think the chamber would agree, sane.

Mr J.E. McGrath: Back then you were!

Mr J.R. QUIGLEY: Thank you, member, and long may I remain.

It was very burdensome. If a person is far more advanced than I was and is, dare I say, knocking on heaven's door, should we tell them to sign legal forms of receipt to acknowledge all this? It is an unfair burden on a dying person. We want to make the burden as light as possible. They are going through the worst —

[Interruption from the gallery.]

Mr J.R. QUIGLEY: That was good! Someone does not come from a theatre family, because people from theatre families do not whistle inside, do they? Did the member for Dawesville know that?

Mr Z.R.F. Kirkup: I didn't.

Mr J.R. QUIGLEY: It is because in the Victorian theatres, the props were worked by whistles. When someone whistled, they would pull it up or down, and if anyone else whistled, the wrong prop would come down. I do not know who was whistling from the gallery, but they do not come from a theatre family.

The person has already been thoroughly briefed on the process by not only the coordinating doctor, but also the consulting practitioner. They have gone through all this. How many hoops do we want to force a dying person to crawl through? How many hoops? This government is about not throwing burdens on the dying person, but building a fence of 102 safeguards around the process.

Mrs A.K. HAYDEN: Before I receive a lashing from the Attorney General, I want to say that the Minister for Health asked me to raise this in division 4, so I am asking this now, as the minister requested. In clause 68, "Information to be given before prescribing substance", subclause (1)(c) states —

> … the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;

Obviously, we do not know what the substance will be, but will that be to keep the medication at the right temperature and so forth to make sure that it will be able to deliver what is intended, or will storage also include it being in a safe locked box out of harm's way—if the Attorney General was listening to the second part of the question?

Mr J.R. QUIGLEY: Let us go back to subclause (1), which states —

> (1) The coordinating practitioner for a patient who has made a self-administration decision must, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following —
>
> …
>
> (c) that the substance must be stored in accordance with the information provided by the authorised supplier who supplies the substance;

The doctor has to tell the patient to store the substance as the supplier says and not to be like the Attorney General, who has glaucoma and was told to store his medication in the fridge but he keeps it in his pocket. I use it to drop my eye pressure. I am not following the directions of Professor Morgan down at the Lions Eye Institute—sorry about that, professor—because I have it in my pocket. Professor Morgan told me where to store it. I was noncompliant. In this situation, the coordinating doctor is required to tell the patient to obey the directions on the bottle. If it says to store it in the fridge, the patient should store it in the fridge. If it says to store it in the AG's pocket, they should store it in the AG's pocket. The patient needs to follow the directions given by the supplier. That is what the doctor has to tell the patient.

Mrs A.K. HAYDEN: There was a second part to my question. I will repeat it. Is there anywhere in this bill that advises that this substance, once obtained and taken home, will be put in a safe place and locked away from harm's way?

Mr J.R. QUIGLEY: I choose not to answer that question. It will be covered in clause 71, as the member knows in detail, so I will wait until clause 71.

Mrs A.K. HAYDEN: Further to that, this clause does not seem to inform the patient of any complications that might arise. Is there a reason that has not been included in the information to be given before prescribing substances?

Mr J.R. QUIGLEY: The patient will already have been informed of those possibilities by the coordinating practitioner and the consulting practitioner. Under the Medicines and Poisons Act 2014, that is a further requirement when prescribing schedule 4 and schedule 8 drugs.

Mr A. KRSTICEVIC: Following on from the Attorney General's answer about his personal medication, obviously we are talking about a very serious substance in this case. He made the comment that he did not follow the instructions and he is doing the opposite to what he was told. In this situation, what consideration has been given to a patient who has the same attitude as the Attorney General; that is, they are not interested in what they are being told and they want to do it their way? They may contravene all the requirements of how to store the substance or give access to it or say where it is kept and they are happy to say that up-front. What guarantees are there that, firstly, people understand this and, secondly, that they will follow the instructions implicitly? More importantly, if they are not going to follow those instructions and are blatantly saying that they will do what they like and they do not really care what they are being told, what safeguards are there to ensure that they are not given that medication?

Mr J.R. QUIGLEY: If I might be permitted to say so, that is a very Liberal conservative question; that is, we will now police patients. We could perhaps anticipate an amendment from the member so that if a patient does not follow the instructions on the bottle, we can inflict a mandatory term of imprisonment. That is what the Liberal Party can do. It wants to go around policing patients. The Labor government is not in the business of policing patients. The Labor government is in the business of supporting patients who are dying and who wish to avail themselves of a substance that will relieve them of their burden. We are not in the business of allowing the health department to kick down their door and open their fridge and, if the substance is not at the right temperature, prosecute them. For heaven's sake!

Mr A. KRSTICEVIC: I do not think we were talking about the medication being at the right temperature. We understand that the patient is following the procedures, especially from a safety perspective, to make sure that the medication does not end up in the wrong hands, it is administered properly and, after the event, the contact person returns the unused substance in the appropriate way. The contact person may already have a track record of not being the most honest person or may have a criminal record relating to substance abuse or some other record. It is really about making sure that they understand the procedures and they will follow them. If they say that they will not or there is no confidence that they will and things may be done inappropriately, there needs to be safeguards in that situation. The Attorney General cannot just say that the government is not in the business of monitoring a substance that can kill people and it does not really care how that person deals with it once we give them that substance. As long as they have the instruction booklet, all it cares about is giving them that pamphlet and whatever happens after that happens, and it will trust them to do the right thing and not take any responsibility beyond that point. That is a totally flippant answer. I think the Attorney General needs to give a more serious and concrete response so that the public can be confident that this substance will be looked after and managed properly and the right procedures and processes will be followed.

Mr J.R. QUIGLEY: I get the picture entirely of what the member is proposing. He is proposing that if the patient does not keep the substance in the manner set out on the bottle, instead of sending an ambulance to the house, we should send a police car and take the patient to the lock-up and prosecute them. We will not need VAD; they will be down at the lock-up. What a ridiculous proposition!

Mr A. KRSTICEVIC: What an absolute load of rubbish that answer is.

The ACTING SPEAKER: Member, you do not get to determine the answers; you just have to ask the questions.

Mr A. KRSTICEVIC: There was so little information of substance in the Attorney General's reply that I was not able to link it to the question that I asked.

The ACTING SPEAKER: Just ask your question, member, and do not make it repetitive.

Mr A. KRSTICEVIC: I do not understand how the Attorney General keeps referring back to the bottle and the instructions. It is about a lot more than the instructions on the bottle. It is about where the patient has to store it and how they have to deal with it before, during and after the event. The Attorney General is an example of someone who does not follow the instructions he was given for a less serious medication. What happens if the same attitude is taken with serious medication—in this case, medication that can end someone's life? I do not understand what the process or procedures would be in a situation like that if a patient decides that they do not want to follow the instructions and makes up their own rules and processes. How can the Attorney General say that that is okay and that no consideration will be given in that situation?

Mr J.R. QUIGLEY: If the member does not like it, he can go down to the morgue and prosecute the person because they will be deceased. We are not picking on patients who are dying. We have no intention of policing or prosecuting dying people. We intend to support them in their death. We have no intention of prosecuting them or enforcing procedures against them. Most members in this chamber would have poisons in their house. I do not want to kick in the member's garden shed to see how he keeps his Roundup, but the bottle is clearly marked "poison". A lot of people have schedule 4 or schedule 8 poisons around their house and they deal with it every day. The member can keep asking questions. This is as much as I want to contribute on this subclause.

Clause put and passed.

Clause 69: Prescription for substance —

Mr P.A. KATSAMBANIS: A lot of this clause is routine. The definition of "medication chart" is included in clause 69(1). There is a prohibition in subclause (4), which states —

> The prescription cannot be in the form of a medication chart.

Why is there that prohibition? I think I can guess the answer but I reckon it would be more useful if it were on the record.

Mr J.R. QUIGLEY: It is as though people here have not been to hospital! They are such a healthy bunch that they have never been to hospital. There is a medication chart at the end of a patient's bed. Every time a nurse takes a patient's temperature or gives them an aspirin, they pull out the medication chart and fill it in. Never ever does a nurse pick up the medication chart and hand it to the hospital pharmacy, because it is not a prescription. The only person who can prescribe is a medical practitioner. In this case, it is a medical practitioner who has had voluntary assisted dying training; sans that, they cannot write a prescription. However, a nurse or nursing assistant enters what substances a patient is taking on their medication chart. Today it might be Panadol, tomorrow it might be morphine and the next day it might be something else. It will be recorded. The board will have to report all these deaths to the coroner and it will want to know—"Give us a look at the medication chart"—bang, done. It is not a prescription.

Mr P.A. KATSAMBANIS: That certainly was not the answer I was expecting. I do not think there is much point in examining this if the Attorney General is going to take this attitude. I will ask a different question around the same issue. If, as the Attorney General said, a medication chart cannot be a prescription, why is subclause (4) necessary?

Mr J.R. QUIGLEY: It cannot be used for VAD purposes. A medication chart cannot be used as a prescription for a voluntary assisted dying substance. It is impossible under the legislation.

Clause put and passed.

Clause 70: Authorised supplier to authenticate prescription —

Mr P.A. KATSAMBANIS: I am trying to get a sense of how this will work. These are not loaded questions. Clause 70 places an obligation on the authorised supplier to confirm —

> (a) the authenticity of the prescription; and
>
> (b) the identity of the person who issued the prescription; and
>
> (c) the identity of the person to whom the substance is to be supplied.

As the I understand it, and as the Minister for Health previously outlined, this will happen in a closed loop. It will not be in the form of a piece of paper that is given to a patient who runs down to the pharmacy. It will be delivered directly from the coordinating practitioner to the authorised supplier, I assume, by closed-loop technology of some form or other. What authentication steps are envisaged here? What in practice will a supplier have to do when they receive a prescription in their inbox that purports to be from someone who has the right to make that prescription, a coordinating practitioner? What will those steps be so that everyone is clear about the obligations on the authorised supplier so that they do not fall foul of the legislation?

Mr J.R. QUIGLEY: As the Minister for Health said, it will be a closed VAD loop. The only people who will have access to that loop will be certified VAD doctors. It will not be contained in a paper prescription whereby a person can pinch someone else's prescription and run around pharmacy shopping. It will be in a closed loop. The authenticity of a prescription will be verified by the prescriber number of the VAD doctor. The identity of the person who issues the prescription, once again, will be confirmed electronically, because, as the member knows, he has already voted for electronic lodgements in the Supreme Court. How do we know that it is the plaintiff lodging the document? Because it is authorised under the legislation. All prescriptions for voluntary assisted dying medications will be sent directly from the coordinating practitioner to the authorised supplier only on a unique voluntary assisted dying medication prescription. We have already covered this in clause 69(6). This is irrespective of whether self-administration or practitioner-administration is chosen. This means there is no opportunity for the prescription to be taken to any other pharmacy.

Mr P.A. KATSAMBANIS: Again, we are trying to put information on the record to assist the users of the legislation. From what I heard the Attorney General say—I do not want to verbal him or put words in his mouth—receipt of the authorised prescription by the authorised supplier within that closed loop will prima facie be taken to be authentication of the prescription. Is that correct or will the authorised supplier need to take additional steps outside of accepting the fact that it was received within the closed loop?

Mr J.R. QUIGLEY: The contact details on the prescription, the details of the coordinating practitioner and the telephone number of the patient will enable the authorised supplier to make the necessary checks to confirm the matters aforementioned. The Western Australian Medicines and Poisons Regulations 2016 outline a number of requirements for prescriptions in part 4, division 1, regulation 10, which include the details of the prescriber; the details of the patient; the description, quantity, dose strength and form of the medicine; the directions for use; and other relevant supply directions. The authorised supplier will have to check by driver's licence number or some other identifier that the prescription has been written for that person. When I say "written", I mean electronically on a closed portal in which no-one can shop around.

Clause put and passed.

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

The ACTING SPEAKER: Member for Dawesville.

Mr Z.R.F. KIRKUP: Thank you very much, Madam Acting Speaker.

Mr J.R. Quigley: This will be better.

Mr Z.R.F. KIRKUP: Thank you. The Attorney General has thrown me.

Are there penalties if the supplier, recipient or agent does not follow what is contained in subclause (3); and, if so, are the prescribed penalties contained at the back of the legislation or are the penalties prescribed in other acts?

Mr J.R. QUIGLEY: Clause 70 deals with an authorised supplier having to authenticate the medication. Clause 71 deals with information to be given when supplying the prescribed substance. If the recipient is not the supplier, the authorised supplier must, when supplying the prescribed substance, advise the recipient the information provided under proposed subsection (2) to the patient. That is a requirement of the legislation. If a pharmacist issues the drug without supplying the information in proposed subsection (2), that will constitute an offence of misconduct and they will be prosecuted by the Pharmacy Registration Board of Western Australia. I have conducted those prosecutions. It is the only time that I have been a prosecutor. I went home feeling really lousy because I got a chemist struck off and I thought, "That's the end of it." Regulations in that industry are tightly administered by the pharmacy board. I appeared there and this guy was struck off. I went home thinking, "How's he going to pay his mortgage?" I felt terrible. The board is very strict. Although it is not an offence under this legislation, it is an offence under pharmacy regulations and it is professional misconduct.

Mr Z.R.F. KIRKUP: Would the Australian Health Practitioner Regulation Agency have a role in investigating that and then possibly disbarring the practitioner? Would that be the case and would it be AHPRA?

Mr J.R. QUIGLEY: The Pharmacy Board of Australia is under AHPRA, so it would be investigated and prosecuted if there was any suggestion that the pharmacist had issued this without going to subclause (2). I thank the member very much for his assistance.

Ms M.M. QUIRK: The Attorney General has read out portions of clause 71(2). In circumstances in which the recipient is an agent rather than a contact person, as I understand it under paragraph (d), somehow the agent needs to contact the contact person, who still has the obligation to give the substance to an authorised disposer. Is that a correct interpretation?

Mr J.R. QUIGLEY: The agent is of course not the contact person. The agent is someone who has been appointed to receive the substance. The contact person has a whole host of obligations to which we have already referred and will be referring further. The contact person has a completely different set of legal obligations from an agent. The agent could be a local delivery service or something like that, someone who is authorised to pick the substance up from the airport and transport it to the contact person, but the contact person has onerous obligations once they accept that responsibility.

Ms M.M. QUIRK: Under subclause (2)(d), if a patient decides not to self-administer, they would still have the substance. Somehow, the contact person might not be around. The agent or the recipient would have to make sure that the contact person contacts the authorised disposer. I am trying to ascertain the sanctions, if the recipient or agent does not contact the contact person.

Mr J.R. QUIGLEY: It is the interplay between clause 71 of this legislation and the Medicines and Poisons Act and Misuse of Drugs Act. There will be offences under the Misuse of Drugs Act for someone who improperly

deals with a schedule 8 drug, as there is already for any other schedule 8 drug, and this is what the agent would be laying themselves open for—a very, very serious misuse of drug prosecution.

The ACTING SPEAKER (Ms J.M. Freeman): We will now have a short break and I will leave the chair.

Sitting suspended from 10.03 to 10.19 pm

Mr A. KRSTICEVIC: I refer to clause 71(3), which states —

> If the recipient is not the patient, the authorised supplier must … advise the recipient to give the information provided under subsection (2) to the patient.

Does the authorised supplier have only to advise but not make sure that the information is passed on? Is there no requirement for the recipient who picks up the substance to sign something that says they will do that or confirm they have done it? What will happen if the patient is not advised at all?

Mr J.R. QUIGLEY: It is between the patient and the agent. If the recipient is not the patient, the authorised supplier must—it is compulsory—when supplying the prescribed substance, advise the recipient to give the information provided under subsection (2) to the patient. The authorised supplier must pass on the information that the authorised supplier has given to the recipient.

Mr A. KRSTICEVIC: Obviously, it says the supplier must advise the recipient to give the information to the patient. It requires the supplier only to advise the recipient to give the information to the patient. It does not say that the recipient must give the information to the patient. They must only advise the patient that this information might be worth giving to the patient. The bill does not require that the recipient must give the information to the patient. How can it be confirmed that the recipient has given it to the patient? After the recipient has given the information to the patient, is there a requirement to confirm with the supplier that they have given the information to the patient? Would it not be a breakdown in the chain of communication if the patient is not given information on how to store the substance or how to prepare and self-administer. There is no way to confirm they have received that information because only one person has said to another person, "By the way, you might want to give them instructions when you get there; that's all you need to do. You do not have to confirm that you have done it. There is no requirement for you to advise anyone you have done it. We'll just assume that now that I've given it to you, you will do the right thing." Can it be confirmed even at the start that the authorised supplier has told the recipient they have been given the instructions? Does the supplier then get a signature from the person picking up the medication, stating, "I sign that I've picked this up, you've given me all the instructions, I will give it to the patient when I get there at the end of the process, and I will confirm that when I get back"?

Mr J.R. QUIGLEY: In Utopia, it would be lovely to have a requirement that members actually read the subclause before asking a question. In a Utopian parliament, that would probably be happening. However, here, of course, this is not about the recipient or the patient. This is about the authorised supplier. It is an obligation put upon only the authorised supplier of what the authorised supplier must do. Not the recipient; not the patient.

Mrs A.K. HAYDEN: I asked this question when we were debating clause 68(c). The Attorney General told me to raise it in clause 71, which we are now debating, which is titled, "Information to be given when supplying prescribed substance". Clause 71(2)(b) states —

> how to store the substance in a safe and secure way;

Can the Attorney General give an example of that?

Mr J.R. QUIGLEY: Sure—out of reach of children.

Mrs A.K. HAYDEN: Is that it?

Mr J.R. QUIGLEY: Is that it?

Mrs A.K. HAYDEN: Yes.

Mr J.R. QUIGLEY: Well, we would not want children to get it! That is it. The member wanted an example; I gave her one.

Mr A. KRSTICEVIC: I go back to the previous answer about reading the clause, I know we are talking about the authorised supplier here, but the authorised supplier is giving the medication to someone who is not the patient. When they supply the medication, they need to advise the recipient and give them the information. What guarantee is there that the patient at the end of this process has actually received the information that the authorised supplier has given to the recipient if the recipient is not the patient? That is the question. This is important information that the patient must receive, because it contains the instructions on a whole range of very critical issues. I would think that it would be incumbent on the patient being able to confirm somewhere in this process somehow that the

recipient has given them the instructions. The Attorney General talked about a closed loop, whereby there is a requirement at the end of the process for the patient to potentially phone either the authorised supplier or the consulting physician to say, "I have received the medication, I have received the instructions, I understand there are 20 points on this"—or however many there are—"and I understand them." Therefore, we know that the loop is now closed, the patient has received the information in the prescribed way, and the patient has received the instructions that the authorised supplier must give to the recipient, if the recipient is not the patient; therefore, we know that everyone is fully informed of what their obligations are, and there is no way that the wrong procedures can be followed. It is a very simple question. It cannot be that hard for someone to make a phone call, sign a document, send an email or go into this closed loop and tick a box, or something to say that the patient has received the medication and the patient has received the information on how to use the substance and what to do with it. At this stage, all I am hearing from the Attorney General is that, well, the authorised supplier has given it to the recipient, and we will just assume that it has all happened, because that is what is supposed to happen in the natural course of events. The process will be obvious, nothing can go wrong, the process is perfect, and human nature or human processes do not fall down, even though the Attorney General has given us a perfect example of him not following the right process with his own medication. That is nowhere near as important —

The ACTING SPEAKER (Ms S.E. Winton): Member for Carine, can we get back to a question?

Mr A. KRSTICEVIC: It is a very important part of the question, because —

The ACTING SPEAKER: I appreciate that, so can you ask a question?

Mr A. KRSTICEVIC: The Attorney General has put on the record that he does not follow his medication, so now his physician will know and will have that information when he reads *Hansard*, but how will we know in this case that the patient has received the information? It cannot be that hard. This is a very serious piece of legislation. Someone could get to the end of this process and have no way of confirming that they have received the information they need. The Attorney General is saying, "It doesn't really matter. As long as the authorised supplier's done their bit and given it to whoever the person is who's picked it up, the rest is irrelevant. Who cares? We just assume that the patient has got the information. We don't really care if they have or haven't. We just assume that they have and that's good enough for me." I just do not think that is good enough. I would like the Attorney General to tell me how we can guarantee that the patient, at the end of this process, has received the information. How do we know 100 per cent that the patient has received this very important information, given that this is a very serious piece of legislation that has consequences that cannot be wound back? We need to make sure. It cannot be that difficult. By the time they have gone through the process to get to this point, to say to someone, "Well, you need to make a phone call or you need to sign a document or send an email or do something" is an insignificant step, but it is a critical step relative to all the other steps that have been laid out in this piece of legislation. I just want the Attorney General to give us confidence and assure us that we know 100 per cent that the patient, at the end of the process, has received the medication and the information.

Mr J.R. QUIGLEY: Clause 71(3) does not deal with the patient; it deals with the authorised person. The answer I gave to the member stands as before. I have no further comment.

Mr A. KRSTICEVIC: I know the clause relates to the authorised supplier, not the authorised person, just to correct the Attorney General. It deals with the authorised supplier, so I hope we are talking about the same process. The authorised supplier is the one who must provide the information to the recipient, if the recipient is not the patient. We all know it is the authorised supplier. That is not in dispute here. We are not talking about how the process starts; we are talking about how the process finishes. How do we know that the patient has received the information that the authorised supplier may have given to the recipient, if the recipient is not the patient? More importantly, at the point when the authorised supplier gives the information to the recipient, is there some way to confirm that the authorised supplier has actually given the information to the recipient? If the recipient is not the patient, they may not even have been given the information, unless they can confirm or sign a document or do something to say, "Yes, I have received this. I will sign this. I have received the medication. I have received information. I have signed a receipt." If a courier comes to bring a phone attachment, one has to sign on the electronic document to say, "I've received this parcel." This is not exactly a parcel in that respect; it is a much more serious delivery that is coming than a part for an iPhone or a computer or something. I just want to make sure that the patient, at the end of this process, has received the information that the authorised supplier has given to the recipient, when the recipient is not the patient. How do we know the recipient has the information and, more importantly, how do we know whether the patient has the information? It is important to make sure that both those people are given the information so that, at the end of the day, the patient knows the processes, procedures and instructions that they need to follow.

Mr J.R. QUIGLEY: It is the same answer as before, but I also invite the member to read clause 73, which we will get to presently.

The ACTING SPEAKER: Member for Carine, do you have a new question?

Mr A. KRSTICEVIC: This is not a very difficult question.

The ACTING SPEAKER: Member for Carine, do you have a different question?

Mr A. KRSTICEVIC: The Attorney General has not answered the question. He refuses to answer the question. It is a very simple question. It says here —

The ACTING SPEAKER: Member for Carine, the Attorney General has given you an answer. Do you have a different question to ask? He has given you his answer twice now; I do not think he is going to give you a different one. Unless you have a different question, I would like to put the clause.

Mr A. KRSTICEVIC: I will ask the question in a different way. I really do not understand. The clause is very self-explanatory. I have not heard anybody else dispute the question I have asked, apart from the Attorney General. It cannot be that hard to answer this question and to tell me in very simple terms —

The ACTING SPEAKER (Ms S.E. Winton): Member for Carine, are you asking a new question?

Mr A. KRSTICEVIC: — how do we know that the information provided has been provided to the patient? It is a very simple question.

The ACTING SPEAKER: Thank you. Attorney General, would you like to answer again?

Mr A. KRSTICEVIC: It cannot be that hard.

The ACTING SPEAKER: Thank you, member for Carine.

Mr A. KRSTICEVIC: I know that the Attorney General does not want to answer the question. Perhaps he does not know the answer and the Minister for Health can answer it.

The ACTING SPEAKER: Member for Carine! You have asked your question so let the Attorney General answer it again.

Mr A. KRSTICEVIC: He is not answering the question at all.

Ms M.M. QUIRK: Before our break I was inquiring about an agent who is the recipient, and in particular clause 71(2)(d), which states —

> … if the patient decides not to self-administer the substance, their contact person must give the substance to an authorised disposer for disposal;

I asked a question, and to be fair the Attorney General did answer it but not with enough specificity so that I can find out what the particular sanction is. In those circumstances, the contact person may not even know that the patient has decided not to self-administer. He does not know that he is under an obligation. What sanctions are on the agent in relation to his role and, for example, notifying the contact person that the substance is not going to be used?

Mr J.R. QUIGLEY: As stated before, there are pretty heavy sanctions under the Misuse of Drugs Act.

Ms M.M. QUIRK: Perhaps at some stage the Attorney General could supply me with the section involved. I have had a bit of a look and I am not quite sure where to find it. Given that the contact person has authorisation for possession of the same, what is his obligation to notify the contact officer?

Mr J.R. QUIGLEY: Under this legislation, they are authorised to supply the drug to the patient. If they supply it to anyone else or fail to supply it to anyone else, then they are not authorised under the act and any such—I was going to say "dealing" but that implies a monetary thing—passing on of that drug to any person other than the contact person for the patient would not be covered by the act and be an offence under the Misuse of Drugs Act and the Medicines and Poison Act as well.

Ms M.M. QUIRK: I will risk the wrath of the Acting Speaker at the moment. Can I ask what sections —

Mr J.R. Quigley: The member can ask anything she wants to; it is the Parliament of Western Australia.

Ms M.M. QUIRK: What are the sections of the legislation supplied by the Attorney General? I will give the Attorney General a specific example. The contact person is out of the jurisdiction. He or she has gone on holiday. The patient appoints someone as an agent to collect the substance from the post office or the chemist or wherever it is. The agent then goes to the patient, gives them the drug and the patient, for whatever reason—irrelevant for present purposes—decides not to self-administer. The agent goes on his or her way. The contact comes back from

holidays and does not know that any of this has occurred but is nevertheless under an obligation to give the substance to an authorised disposer.

Mr J.R. QUIGLEY: It is all to do with the concept of knowledge—criminal law 101, mens rea. If the contact person does not even know that the patient has received the drug, there is no obligation on the contact person. It is beyond their knowledge and we cannot prosecute people for things that happen without their knowledge. If a drug is delivered to a patient by the agent and the contact person is not there and does not know about it, the contact person does not know about it.

Ms M.M. QUIRK: I am asking about the obligations of the agent. Also, I am still waiting for advice on what sections of the Misuse of Drugs Act and the Medicines and Poisons Act the Attorney General believes may possibly be in play.

Mr J.R. QUIGLEY: The agent does not have any legal relationship.

Clause put and passed.

Clause 72: Labelling requirements for prescribed substance —

Mr Z.R.F. KIRKUP: Clause 72 is relatively straightforward, so I will ask a series of clarifying questions in one batch. The container will have a statement that warns of the purpose of the dose of the substance, states the dangers of administration of the substance and states that if it is supplied for self-administration, it must be stored in accordance with advice and the like. I understand that that needs to be affixed to the container, or however the substance is provided, in some way, shape or form. Under subclause (1)(a), the purpose of the dose is to cause death, so I assume that that has to be stated quite clearly. Can the Attorney General confirm that? I assume that under subclause (1)(b), the dangers of administration of the substance would be death, but it might also cover side effects other than death. If that were the case, what would they be?

Mr J.R. QUIGLEY: Yes; it depends on the substance. I agree with the member.

Mr Z.R.F. KIRKUP: I assume that it is substance specific; is that the case, Attorney General? Of course, we are aware of other jurisdictions where there have been some adverse reactions to something like that. I assume that that would be stated, but it would be according to the substance that has been prescribed; is that the case?

Mr J.R. Quigley: Yes.

Mr P.A. KATSAMBANIS: The protections in this clause are wise and good. The container must have a label that warns of the purpose of the dose, states the dangers of administration and, if it is to be self-administered—so, it is given to the non-medical patient—states how the substance is to be stored and that any unused or remaining substance must be given to an authorised disposer. That is all well and good and I think it is important. It will be on an approved form, so I think that is good too. The authorised suppliers will not be freelancing; there will be an approved form. The question I have is based on the fact that right now we do not know the range of substances or what the delivery package will look like. If the delivery package looks like the boxes I got for my typical tuberculosis treatment from Sir Charles Gairdner Hospital, the label could be printed in 32-point Times New Roman and it would fit perfectly on the box. If the container is the size of the one that the Attorney General pulled out of his pocket before the suspension, which I think he said was his glaucoma medication and was quite a small bottle, it would be very difficult to fit that sort of information on the label. Would the approved form require the labelling that is necessary under clause 72 to be in a particular size or could it be shrunk to the tiniest possible size to fit on the container? I see the one that the Attorney General has in his hand now, but he would know, having been in the Peter MacCallum Cancer Centre, how some phials could be even smaller than that container. I ask for a little bit of clarity. We know that for people who will use this substance, obviously it will cause death.

Mr J.R. Quigley: Hopefully.

Mr P.A. KATSAMBANIS: That is their intention, and that is fine and good. But if it is mixed up with other medication in a household, it could fall into the wrong hands. The other problem that we could face if the typeface is too small is that the person who is self-administering, who chooses to do it on their own, because they can, might not be able to read the label and end up taking the wrong medication, so I seek a little bit of clarity around that. I am not trying to be tricky or sneaky or cute. I just want to know what the approved form is going to look like.

Mr J.R. QUIGLEY: Yes, certainly. Clause 72 states that the label must be attached in writing to the relevant package or container. If it is a little tiny vial, it is okay to attach it to the package. I returned to my seat in the chamber to get the medication to which the member refers. Members will see that it is a very small bottle with the label being a little tag attached to the very small bottle—even a person of my age with glaucoma can read it quite well—and that will happen with this material. It can either be on the box if it is a little, weeny vial with a very potent subject, or it can be attached to the actual container containing the potion. The label will clearly identify

that it is a VAD substance and distinguish it from other medications, and it is not intended that the ingredients of the substance be provided on the external packaging for obvious safety reasons.

Mr P.A. KATSAMBANIS: That last point, in particular, has been emphasised in the rest of the debate. Will there be a stipulation for a minimum font size? That answer is all I want to seek for clarity.

Mr J.R. QUIGLEY: It has to be in an approved form. To be approved, it has to be readable. It has to be legible.

Mr Z.R.F. KIRKUP: Attorney General, is the approved form that is referenced there approved by the CEO? Is that likely to be made public, or is that going to be decided as part of the implementation process? Why is it that we do not decide to define that more now?

Mr J.R. QUIGLEY: I take that the member has asked that question on behalf of the chamber, because I know the member knows the answer to that, and that he is asking that on behalf of the other members. It is the old principle of the barrister: you never ask a question you do not already know the answer to. I respect that member and he would not ask a question that he did not know the answer to. The problem is we cannot prescribe the size of the label and the size of the print on the label because the substances, which we are not going to reveal, will come in various-sized containers. If it is a little, weeny container with a very potent potion inside of it, the labelling might be on the box in larger print than it would be if it were on a small bottle with the label attached to the bottle. I am heartened. The member is nodding in consent. He did know the answer all the while, but I thank him for asking on behalf of the other members who did not think of this point. Due to the variation of the containers and bottles et cetera, we cannot prospectively prescribe the font, the size of the font or anything. It will be legible and intelligible and in accordance with the law.

Mrs A.K. HAYDEN: Attorney General, previously, I asked a question about labelling requirements under clause 57 to the Minister for Health, and I was asked to bring it up in division 4. There does not seem to be a need for an expiry date. Can the Attorney General tell me whether current substances that are being used in other jurisdictions have an expiry date, or are these substances able to be used forever and a day?

Mr J.R. QUIGLEY: It is the same as any other poison or substance that is prescribed. The manufacturers prescribe the expiry date. It will expire the same as a bottle of milk. The manufacturer puts the last date the milk should be drunk by on the bottle, and it does the same with its other products. Or if the member buys pre-wrapped meat at the butchers or the Independent Grocers of Australia, it will have a use-by date.

Mr J.E. McGrath: Farmer Jack's.

Mr J.R. QUIGLEY: Farmer Jack's Supermarkets—Freddy Fairthorne is my old schoolmate. The manufacturer will put the expiry date on it.

Ms M.M. QUIRK: I want to explore whether, given that the drugs will be going to remote communities, any thought had been given to having some pictorial notifications. In the old days, it used to be the skull and crossbones, I think, on things like Ratsak or what have you. I am wondering whether there is any possibility of having a pictorial representation as well.

Mr J.R. QUIGLEY: The labelling will be consistent with the Medicines and Poisons Act 2014. This is a poison, and it will be consistent with the Medicines and Poisons Act. There might well be, optionally, a skull and crossbones or something like that on it. I am not joking—they put that on placards on trucks to say that something is dangerous. But apart from that, it will be —

Mr P.A. Katsambanis: They do that with some of the substances you buy at hardware stores.

Mr J.R. QUIGLEY: That is right—they put a skull and crossbones on them. I was not being flippant. That signals to the population that this substance is dangerous, but the rest of it will comply with the information provided in the act.

Mrs L.M. HARVEY: I refer to clause 72(1)(c), which reads —

> states that, if the substance is supplied for self-administration —
>
> (i) the substance must be stored in accordance with the advice given by the authorised supplier; and
>
> (ii) any unused or remaining substance must be given to an authorised disposer by the patient to whom it is supplied or their contact person.

How are we going to be sure that the substance is actually stored in accordance with the advice given by the authorised supplier? Will somebody check on that? Do we just take people on good faith, hoping that the contact person fully understands their responsibilities? I seek the Attorney General's advice about what kind of compliance effort might be put into ensuring that these substances will be stored and secured in the appropriate way. That is the first question. The second question I have is: is it likely that the substance is going to have the person's name and other details on the label, like any other prescription?

Mr J.R. QUIGLEY: The first question—I make no criticism, implied or otherwise by this—was answered earlier when the member was not in the chamber. Many members were not in the chamber. I am not making any particular criticism, but I am just going back to this point. This government is not in the position of wanting to prosecute dying people. If a dying person fails to store the substance for self-administration in the manner instructed, this government has no intention of sending the police around to kick in their door and arrest them for not complying with the act. This is a dying person whom we are supporting by giving an option. There will be strict enforcement against coordinating doctors, consulting doctors, authorised suppliers et cetera, but there will be no enforcement, but rather support for a dying person, if that dying person has failed to keep the drug in the manner in which he or she was directed to store it. They can be safe from prosecution by a Labor government.

As to the second point, that deals with the prescribing of drugs under the Medicines and Poisons Act. The drug will have to bear the name of the person for whom it is prescribed. I have never seen any drugs—like these things I have in my pocket to keep my eyeballs straight—that do not bear the name of the patient. Forget about a VAD drug—I cannot go down to the pharmacy and pick up any drug without my name being printed on it. I am talking about drugs that do not require a prescription, member for Hillarys.

Mr P.A. Katsambanis: They have cough medicines and the like behind the counter, and you have to ask for them and give details.

Mr J.R. QUIGLEY: But they are not prescribed. Anything a person puts a prescription down on the counter for, the pharmacist goes away and types it all up on their little computer these days and by the time it is taken to the cashier, there is a label on it bearing the person's name and the directions for the drug.

Mrs L.M. HARVEY: I heard the Attorney General's earlier answer about it obviously not being in the public interest for police to prosecute a dying person. It would be a nonsense and is not what I am trying to understand. The contact person will be involved as well. They will have a wide range of responsibilities under this legislation and will play a very important role. What kind of compliance effort will be put into chasing up the contact person to ensure that they are looking after the security of the substance and making sure that it is being stored appropriately? If the patient is very sick and bedridden, they may not be able to get up to check that the substance is stored in a cupboard, but I expect that the contact person would be able to. I do not think it is unreasonable to expect that some kind of effort might be put into that. Perhaps it could be an SMS to their mobile phone asking them to give assurance that the substance has not been used, is still intact, and is being stored appropriately—I do not know. That is just an option, but I think some assurance is needed from the Attorney General that there will be some kind of compliance effort put into ensuring that the contact person, who will ultimately have custody of any portion of the substance that is left after an individual who has accessed voluntary assisted dying has passed away, does the right thing. Who will chase them up? What effort will be put in? How will we make sure that the contact person is keeping the substance safe from other people in the household?

Mr J.R. QUIGLEY: Here are two scenarios. While the patient is still alive, there will be no obligation on the contact person at all.

Mrs L.M. Harvey: Even if the patient is incapacitated?

Mr J.R. QUIGLEY: If the patient is alive, there will be no obligation on the contact person. The contact person will be a hand-holder. There will be no obligation on the contact person—end of story! However, if the patient has passed away as intended but has not consumed the whole of the substance, there will be an obligation on the contact person because they will be the person in the room with the drug who is still alive. Those obligations are set out in clause 104 of the bill, and include imprisonment of up to 12 months. We can deal with that clause when we get there.

Do not forget that this person will be dying. The coordinating practitioner—the doctor—will be able to check at any time that their patient is properly storing the drug in accordance with how they have been directed. There will only be an obligation on the contact person if the person whose brow they have been wiping and whose hand they have been holding dies. That will obviously extinguish the obligation of the patient, because they will be dead, but will enliven an obligation on the contact person to dispose of the excess drug in accordance with clause 104 of the bill, on pain of imprisonment if they fail to do so properly.

Mrs L.M. HARVEY: I have one further question on this. Does any responsibility shoot back to the coordinating practitioner with respect to the storage of these substances, or is it only the contact person in the event that the patient has expired?

Mr J.R. QUIGLEY: We have to bear in mind that the contact person might actually be the coordinating practitioner. There is nothing to stop the patient from choosing their doctor as their contact person, so there would

be an obligation in that. But the coordinating practitioner does not have to go around kicking in the door of the dying patient to check that they are complying with directions given.

Mr J.E. McGrath: But if they are their doctor, they might have an interest in making sure that everything goes right.

Mr J.R. QUIGLEY: Correct, if they are the contact person as well. I will tell members about another drug. I had my knee chopped out and they gave me this stuff called oxycodone.

Mr J.E. McGrath: It's very good.

Mr J.R. QUIGLEY: I would not take it. There is a box lying around the house somewhere. I would not take it because I read in *The New York Times* that it is very addictive, so I stuck with Panadol, but they give people this stuff to take home. Every medical procedure is now meant to be without pain, according to the population, so they dish out these opioids. But in this particular case, this is a very powerful drug. It is up to the patient to be responsible for its storage, but if they die, the contact person has an obligation enlivened under clause 104 of the bill.

Mrs A.K. HAYDEN: I have two questions, but the first one follows on from the question asked by the Leader of the Opposition. From what the Attorney General just said, the contact person has no responsibility whatsoever for looking after the substance.

Mr J.R. Quigley: That is not what I said.

Mrs A.K. HAYDEN: Under clause 66, the contact person can be authorised by the patient to receive the prescribed substance from the supplier, possess the prescribed substance for the purpose of supplying the prescribed substance to the patient, and give the prescribed substance or any unused portion back to the authorised disposer.

Mr J.R. Quigley: That is correct.

Mrs A.K. HAYDEN: I am glad, because I am reading it from the bill! For example, a contact person is authorised by a patient to go and collect the substance and is told how to store and keep that substance. The patient is not told that, because the contact person went and collected the substance. But there is no obligation on the contact person to ensure that that substance is stored correctly.

Mr J.R. QUIGLEY: It is not their drug; it is the dying patient's drug. The dying patient will have an obligation to store the drug, not the contact person. Remember, the script is written out for a patient who is dying. Once that script is filled, the drug is not owned by the contact person; it is owned by the patient. What the member has described relieves the contact person, who receives the drug and gives it to the patient, from any criminal liability under the Misuse of Drugs Act. It is the patient's drug and they are responsible for storing it, until they are no longer of this world, at which point an obligation is enlivened in the contact person under clause 104.

Mrs A.K. HAYDEN: On that note, if the instructions say that the substance must be kept at a certain temperature or the substance will not be maintained, and the patient uses a substance that has not been kept at that temperature—we do not know what it is—and its quality is not maintained, we could have a problem with that substance not doing what it is meant to do because it was not stored as prescribed by the supplier. The contact person is the one who collected it. The contact person is the one who has the information, because the person who is not well, who is ill, is not up to reading the instructions. They are trusting their contact person. That is why they have them. All of a sudden, the contact person, who is the only person who understands how this substance is meant to be kept, is not obliged to make sure that that is done so it is effective for the purpose it is to be used for.

The DEPUTY SPEAKER: The question is that clause 72 stand as printed.

Mrs A.K. HAYDEN: Am I getting an answer to that or not?

The DEPUTY SPEAKER: The Attorney General is not standing, so I assume not.

Mrs A.K. HAYDEN: Deputy Speaker?

The DEPUTY SPEAKER: Do you want to ask another question, member for Darling Range?

Mrs A.K. HAYDEN: I had two questions. My second question refers to the question I asked earlier about the expiry date. The Attorney General said that as per the Medicine and Poisons Act, the expiry date and information about whatever the substance is and whatever is required for it will be on the label. My question is about the expiry date. We do not know what it is; we do not know what its lifespan is. I did ask a question that did not get answered: in other jurisdictions are there any substances with expiry dates? I am trying to find out how long this substance could last. If it has only a short lifespan, will there be a requirement that that substance be returned and not used after the expiry date?

The DEPUTY SPEAKER: The question is clause 72 stand as printed.

Clause put and passed.

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

Mr Z.R.F. KIRKUP: Thank you, minister; it is good to see you. Clause 73(3) states —

> Within 2 business days after supplying the prescribed substance, the authorised supplier must give a copy of the completed authorised supply form to the Board.

That could conceivably take place after the substance has been taken; is that correct? I would like that clarified. It is obviously not a concern about the board's time constraint or responsibilities for monitoring the application of the act.

Mr R.H. COOK: Technically, yes. The member will observe that "within 2 business days" is the standard language used in the context of professional obligations.

Clause put and passed.

Clause 74: Disposal of prescribed substance by authorised disposer —

Mr Z.R.F. KIRKUP: Clause 74(3) states —

> The authorised disposer must dispose of the prescribed substance as soon as practicable after receiving it.

This triggered me to go down a weird rabbit hole on the destruction of medications and things like that. Is there any particular reason that a time frame is not specified? Most of my understanding about how medication is destroyed, certainly in hospital settings, is that it is done in batches, effectively. Is there any reason that the bill does not prescribe that it has to be done within a certain time? I would have thought it would have been relatively practicable to prescribe, say, two business days, as the minister pointed out. I am curious why that is not stated clearly in the legislation.

Mr R.H. COOK: No. I am advised this is the usual manner. An authorised disposer must dispose of prescribed substances as soon as practicable after they receive the substance. Currently, most pharmacies accept unwanted medicines from consumers and dispose of them in RUM—Return Unwanted Medicines—bins. RUM is a national not-for-profit program funded by the commonwealth government to address the safe disposal of medicines. It is a free and safe method for the disposal of unwanted and expired medicines.

Mr Z.R.F. KIRKUP: One of my questions was going to be about RUM, which is one of the things I discovered when I was following this through. It is a good thing that it exists. I was curious about whether this would apply, but of course as for every other schedule 8 substance, they have to deal with that already—right?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: I assume that transport is not taken into account in the obligations that exist for hospitals or for an authorised contractor to take the medication from where it might be received at site A to the destruction point. I know the state has transport contracts in place to move medication to be destroyed. I assume that the medication gets to the facility and has to be destroyed there within a practical time line; is that right?

Mr R.H. COOK: That is right. All Return Unwanted Medicines bins are securely transported to an Environmental Protection Authority–accredited high-temperature incinerator facility where the sealed RUM bin is destroyed, ensuring that no traces of any medicine remain. The EPA-approved incinerators are the most efficient and environmentally friendly option for removing unwanted or expired medicines from the community.

Mr Z.R.F. KIRKUP: This question probably relates to subclause (4). Could the minister provide us with some more information? If someone who is charged with the disposing of a substance fails in their duty to do so, what penalties apply? I assume the legislation is the Medicines and Poisons Act 2014, but I was curious whether the minister might have on hand what those penalties might be. If the minister has that information, do any time constraints apply to those parts of the act? Does it have to be done within seven days or 21 days or anything like that?

Mr R.H. COOK: There are two facets to this. If the person does not comply with the provisions of this legislation, particularly clause 10, professional misconduct or malpractice provisions may impact on them. In this context I am thinking of a pharmacist. If there is a contravention of the Medicines and Poisons Act, part 2, "Offences", and particularly section 22, applies. Section 22(1) states —

> A person who stores, handles, transports or disposes of a poison other than in accordance with regulations made under subsection (2) commits an offence.

The offence is covered in section 115 and is a penalty of a $45 000 fine and imprisonment for three years.

Clause put and passed.

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

Mr Z.R.F. KIRKUP: I refer to subclause (1), which states that once the prescribed substance is disposed of, the disposer must immediately complete the approved form. I assume the form will be part of the suite of forms issued by the CEO.

Mr R.H. Cook: That is correct.

Mr Z.R.F. KIRKUP: Again, is that immediately? There are probably many authorised disposers around the state. I presume they go through their own processes as per the Medicines and Poisons Act, which from my reading does not require an immediate notification. I imagine disposers go through volumes of prescribed medications that are destroyed. Why is there now an immediate requirement rather than two business days? Is there any particular reason for that?

Mr R.H. COOK: It is still two business days; they must immediately complete the form. Under subclause (3), it is within two days. That is at the top of page 51.

Mr P.A. KATSAMBANIS: There is a list under clause 75 of the things that the authorised disposal form must include. I note that the type of substance that has been received or returned and the quantity that has been returned is not required to be included. Is there a reason that is not required to be included? I would have thought, simply to complete the cycle, when all the paperwork went back to the board, knowing that the same substance that was prescribed was returned and having some idea over time, simply for statistical purposes if not for anything else, how much gets returned, might be useful information to include on such forms.

Mr R.H. COOK: As we have observed before, this is the bare minimum that will be required. It may be that the chief executive officer of the Voluntary Assisted Dying Board will want to have extra insight into that. Ultimately, we do not want the sort of information that needs to be recorded to be too onerous on the authorised disposer. I assume that the member is asking whether what is left over might be material as some sort of insight into how the medication is used. We cannot obviously get much insight simply from the amount that has been returned, other than to be satisfied that that amount was returned. I take the point that the member is making, other than to say that this is the bare minimum that we would anticipate. There is potential that the chief executive officer might want to include other information on the form.

Mr P.A. KATSAMBANIS: I ask this for a number of reasons, and I think the first one around what substance is returned is self-evident. We want to know that what is going out is coming back, but as far as quantity is concerned, there is probably a number of things. Firstly, how much is being left over? Secondly, perhaps some of this medication could be extremely costly, so if over time we are finding that an amount is being returned, there might be a better quantity prescribed in the first place that could reduce the cost to the public purse or to the people undergoing these treatments. I think for a multitudinous number of reasons, we could see that having a complete trail might be rather useful, as well as a protective mechanism.

Mr R.H. COOK: The intent of this provision is to record the details relevant to the disposal of the prescribed substance and to ensure that the Voluntary Assisted Dying Board is progressively notified of the person who has participated in the voluntary assisted dying process, including the outcome of each assessment. That will be to monitor that the correct process has been followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation of the voluntary assisted dying process. Regarding the actual disposal, it is, I guess, pertinent that we understand that a portion has been disposed of. That there is half left or all of it left may be information that the Voluntary Assisted Dying Board would wish to inform itself of later down the track, but it is not necessarily material to what we are trying to achieve with this clause.

Mr Z.R.F. KIRKUP: One part of the disposal process that the minister spoke about was the Return Unwanted Medicines program, RUM. I am trying to understand a bit more about RUM. I understand that in a pharmacy setting—my mother works in a pharmacy—RUM is literally a yellow tub that sits in the pharmacy. That tub is then taken into the logistics chain—someone picks it up and takes it to the authorised disposer. Within it would usually be some schedule 4 and possibly already some schedule 8 drugs. As part of the implementation, has Health anticipated how a VAD substance versus a non-VAD substance might be identified as being in a RUM bin? As best as I understand it, the pharmacist notes it, then it is dropped into the bin and they then provide that bin to the transport company. I am keen to understand the logistics of how that goes at the other end. If the supplier does something wrong, they are possibly liable for a $40 000 fine and a couple of years in jail.

If there is a massive tub and one small container that is meant to be the VAD substance, how is it distinguished if it is mixed in with everything else? Have we anticipated what that might look like?

Mr R.H. COOK: Under the Medicines and Poisons Act, for the disposal of any drugs, there is a range of obligations on everyone involved in the supply chain from manufacture right through to disposal. In that sense, these poisons, like myriad other poisons that sit in the Return Unwanted Medicines bin, have the same level of scrutiny around them.

It may be of interest that smaller portions of the same drug could be for other patients although in different amounts performing very different functions. It is simply appropriate that we capture all these schedule 4 and schedule 8s that sit within that. The RUM bin process is fairly robust and is one we have some experience of now. No extra safeguards are needed on top of the process that is already very secure. Does that answer the member's question?

Mr Z.R.F. KIRKUP: I think so. I absolutely agree. I think the process is inherently safe. As I understand it, usually the bin is handed over with a log. How is it distinguished given that within that tub there is a schedule 8 or schedule 4 returned medication that might have been used for VAD? The minister is quite right: a small portion of the substance could already be in the RUM bin but how will they know it was for the VAD? I do not know how that will be noted.

Mr J.E. McGrath: Why do they need to know?

Mr Z.R.F. KIRKUP: There are obligations on the disposal form. My concern is: how will people know there is a VAD drug in there given they will need to fill out the form? I want to best understand how that will be practicably described.

Mr R.H. COOK: There are no extra obligations with these schedule 8 drugs over any other. Clause 75 provides information to the Voluntary Assisted Dying Board so it has oversight of or can monitor the full process. Filling out the form, I guess, is as much completing the loop with that information process.

Mr Z.R.F. KIRKUP: As part of the disposal process, I suspect the pharmacist might have an additional obligation to provide an indication to the eventual end-point disposer that there is VAD medication in there; that is all.

Clause put and passed.

Clause 76: Disposal of prescribed substance by administering practitioner —

Mr Z.R.F. KIRKUP: Clause 76(2) states that the administering practitioner is authorised to dispose of the prescribed substance. I assume that refers to the Return Unwanted Medicines process. Is that right?

Mr R.H. COOK: Yes.

The DEPUTY SPEAKER: The question is that clause 76 stand as printed. All those in favour say "aye".

A government member: Aye.

Mr Z.R.F. KIRKUP: Sorry.

The DEPUTY SPEAKER: Yes, be quick. Go ahead, member for Dawesville. Sorry, I mean to be quick to get up.

Mr R.H. Cook: Make it snappy. Come on, onto your feet. Leap to your feet.

Mr Z.R.F. KIRKUP: I appreciate the rush, but I am here.

The DEPUTY SPEAKER: Jump up and ask for the call.

Mr Z.R.F. KIRKUP: Thank you very much, Deputy Speaker.

The DEPUTY SPEAKER: I am going as slow as I can.

Mr Z.R.F. KIRKUP: I thought you and I had a connection already and you knew I was getting up.

The DEPUTY SPEAKER: Perhaps we should not talk about that in the house, member!

Mr Z.R.F. KIRKUP: We will keep moving forward, minister. Subclause (3) states —

> The prescribed substance must be disposed of by the administering practitioner as soon as practicable …

There are not two business days or anything like that, as best as I can understand it. It is not addressed later in the legislation.

Mr R.H. Cook: That's right.

Mr P.A. KATSAMBANIS: I want to understand this. The administering practitioner is effectively also authorised to dispose. There is no need to hand the substance on to an authorised disposer. How does that interact with a nurse practitioner? Do nurse practitioners ordinarily deal with the disposal of schedule 4 and schedule 8 medications in their practice? How would nurse practitioners be dealt with? In practice, would there be any difference from what a medical practitioner would do in the same circumstances?

Mr R.H. COOK: There would be no difference.

Mr Z.R.F. KIRKUP: If administering practitioners have the ability to dispose of the substance, do they have to dispose of it through the prescribed disposal contractor, or can they incinerate it themselves? I want to clarify that.

Mr R.H. COOK: In effect, member, they become the authorised disposer. They still have to go through the process using the Return Unwanted Medicines bins and things like that.

Mr Z.R.F. KIRKUP: They are not incinerating it in their backyard.

Mr R.H. COOK: No, that is right.

Mr P.A. KATSAMBANIS: I was going to ask this question when we debate clause 78, but since the minister mentioned it, I will ask it now: the administering practitioner in effect becomes the authorised disposer, but—correct me if I am wrong—they do not need to obtain authorisation as an authorised disposer under clause 78. Just for clarification, is it correct that they do not need to obtain a separate authorisation as a disposer under clause 78?

Mr R.H. COOK: Under clause 76(2)(b), the administering practitioner is authorised to dispose of the prescribed substance.

Ms M.M. QUIRK: I refer to clause 76(6), which the member for Dawesville has already referred to, which states —

> The unused or remaining substance must be disposed of by the administering practitioner as soon as practicable after the patient's death.

How long is a piece of string when we use the words "as soon as practicable"? Given that there are stringent time frames up until the patient's death, what does the minister envisage "as soon as practicable" means in that subclause?

Mr R.H. COOK: The reason we use the phrase "as soon as practicable" is that it would be within the clinical boundaries of an administering practitioner, so they already have in place all the mechanisms to keep medicines secure, the protocols in relation to the handling of those medicines, and things of that nature. The time lines are not as crucial as they would be if the medicines were sitting in a patient's home, for instance.

Ms M.M. QUIRK: Given the provision in clause 76(2) that administering practitioners can dispose of the prescribed substance themselves, why can we not use the term "immediately"? I do not understand why the words "as soon as practicable after the patient's death" need to be there.

Mr R.H. COOK: Again, the member will remember that an administering practitioner is working in the context of a practice and, in that sense, already has protocols in place. The words "as soon as practicable" are consistent with subclause (3) at clause 74, "Disposal of prescribed substance by authorised disposer". From that perspective, I think it is perfectly appropriate. In the same way as an authorised disposer would have all those protocols, management regimes and arrangements in place for their practice, an administering practitioner would have the same arrangements as part of their practice.

Ms M.M. QUIRK: It just seems to me to be a different scenario. In clause 74(3) there is an authorised disposer, so it is a question of when that person receives it. There may be delays along the way. In the case of someone who has actually administered the drug, I cannot see why terms like "forthwith" or "immediately upon the patient's death" could not be used. I do not understand why we would have the same time line there as we do when someone is relying on a third party to supply the drugs to them.

Mr R.H. COOK: We are treating the authorised disposer and the administering practitioner in the same vein, in this sense. They are both health practitioners and both working within a particular practice or service centre with protocols in place. Once the authorised disposer has received the unused portion of the medications, they must dispose of it within a practicable time, and an administering practitioner must do the same. An authorised disposer must immediately fill out the form; an administering practitioner must do the same. We are essentially treating them on a par. Both are caught under the same obligations and the same time lines, with the same sense of urgency. They are treated the same for the reason that we know that they will both have the same protocols, frameworks and rules in place for the management of those medications.

Mr P.A. KATSAMBANIS: I just want to clarify something. Again, I am not trying to be obtuse or difficult. I just want to clarify, in a practical sense, when the actual disposal occurs. This is important in the context of reading clauses 76 and 77 together, because as the minister rightly said in his previous answer, the administering practitioner needs to complete the approved form immediately upon disposal and then notify the board within two days. As I understand it, medical practitioners have a bin or a receptacle, if you like, a secure bin, where they dispose these types of medicine within their practice. Then, at some point in time, a contractor of sorts will come along, take the bin and dispose of it in a particular way. The average garden-variety practitioner does not have an incinerator in the backyard to do that. Is the disposal point the process of putting the substance into the approved bin and it remaining within the practice, or is it when the contractor comes along and takes the bin away? In some circumstances, that could happen some considerable time after the substances have been placed in that bin.

Mr R.H. COOK: It is the return of unwanted medicine bin. The administering practitioner would have the RUM bin; the pharmacist would have the RUM bin. They would chuck it in the RUM bin, seal it, fill out the form, and the form goes off.

Clause put and passed.

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

Mr Z.R.F. KIRKUP: I note that under clause 77(2) the requirements for the practitioner disposal form are quite detailed, and I think rightly so—the details that the board will be furnished with. Part of this provision deals with the date on which the patient has died. I am curious to understand why we would not include something like the location. Is that something the minister imagines the board might seek? I realise that we have asked questions like this previously and the minister has suggested that it is the bare minimum. Does the minister imagine that location might be identified in time?

Mr R.H. COOK: Yes, member, I would anticipate that that information would be sought. These are the very basics that the board would need under the legislation.

The DEPUTY SPEAKER: The question is that clause 77 stand as printed.

Mr R.H. Cook: Welcome back, member for Cottesloe!

Dr D.J. HONEY: Thank you very much. I told the minister that I would come in only when I needed to.

The DEPUTY SPEAKER: Member for Cottesloe.

Dr D.J. HONEY: Thank you very much, Deputy Speaker.

The DEPUTY SPEAKER: Members, I know it is late, but it is helpful if you can mention when you are on your feet. I am trying to keep my eyes on the member for Girrawheen as well, so if I am looking over there, I might not see you. Go ahead, member for Cottesloe. I know you are tall and she is short! Go ahead, member for Cottesloe, now we have that sorted!

Dr D.J. HONEY: I could have asked this question on any of the clauses. Is there any intent to have any sort of audit process to check compliance? As the minister knows, we have talked a number of times about the diversity of human behaviour. Some people hang onto things because they like to for whatever reason. If I was looking at this in a manufacturing sense or as a process that I was in charge of, I would have some sort of process to follow up and audit to make sure that the material really had been disposed of. Will there be some requirement for photographic evidence or will there be some process of audit so that compliance is periodically checked rather than simply relying on someone signing a form?

Mr R.H. COOK: Under the health act, the Medicines and Poisons Act and the Misuse of Drugs Act, the chief executive officer has all kinds of powers of inquiry, and that is ultimately delegated through officers who act on his or her behalf. This would be captured under the same regime. It would not ordinarily be an audit of everyone, but it would basically be a process of keeping an eye on the landscape and inquiring into any anomalies that came up from time to time. We do hear that from time to time; for instance, there was a pretty in-depth inquiry into the disappearance of schedule 8 drugs from Fiona Stanley Hospital at one time, which was conducted by the chief executive officer under his powers. It would be captured under the same regime, remembering of course that the Voluntary Assisted Dying Board will also be able to engage with the chief executive officer and request that that person undertake an inquiry on its behalf.

Dr D.J. HONEY: Just to follow up—I will not labour the point—are there audits for other drugs such as opioids and the like? Are there periodic audits, for example, of hospitals and the like that would be a template for this?

Mr R.H. COOK: Yes, that is right. We are getting better at this sort of stuff all the time. For instance, nowadays Perth Children's Hospital has highly digitalised systems whereby drugs can be taken out of a drawer only if it is authorised by two people and things of that nature. That stuff gets tightened up continuously, and not before time.

Mrs A.K. HAYDEN: The form will have all the other details required. I am guessing here, because I have not seen a disposal of poisons and medicines form before. Is there one form for all poisons and medicines or will this be a separate form just for this substance and will that be labelled on the form when it is submitted?

Mr R.H. COOK: Yes, it will be a different form. Obviously, there will be obligations under the Medicines and Poisons Act and the Misuse of Drugs Act. This will not escape that. This just understands that it is a voluntary assisted dying substance, so there is an extra level of accountability.

Mrs A.K. HAYDEN: The clauses that we have debated so far provide for the board to collect all these forms. What will happen with that? Will there be a check and balance to say that so much has been dispensed, so much has been used and so much has been returned? What will happen with all these forms that are provided to the board?

Mr R.H. COOK: Member, I doubt it would have the granularity of portions and size of that matter. But, certainly, all of these forms are collected for two things: first, so that the Voluntary Assisted Dying Board can monitor the process to make sure that the system is operating as it is anticipated; second, so that it can continue to collect data about what is going on and make sure that the improvements that can be made are done so; and third, to provide an annual report, under clause 154, on the operation of the act and any issues of interest about that.

Mr Z.R.F. KIRKUP: Minister, the point that the member for Darling Range raised was about the volume of the substance. I appreciate the minister's response. I am interested in hearing a little bit more. I imagine that the board would perhaps want to understand how much has been returned in terms of volume. If we imagine a situation in which a little bit or a significant amount has been returned, that is possibly within the oversight of the bill and the board may be interested in it; although, I appreciate that it is not the granularity in the legislation, as the minister pointed out.

Mr R.H. COOK: Potentially, that could be the case, member. I can imagine the board could be interested in knowing, for instance, whether the substance was returned at all because it would want to know who passed away without using the substance and the circumstances around that. If any substance is left over—we cannot account for spillage in the home, but there will be that level of interest in it.

Mrs A.K. HAYDEN: How will the board know what was left if we do not have a quantity on the form?

Mr R.H. COOK: As I have explained before, member, these are the very basics that would be required in terms of the accountability under the act. The board may be interested in other information and it could include that in the form.

Clause put and passed.

Clause 78: Authorised suppliers and authorised disposers —

Mr Z.R.F. KIRKUP: Minister, I assume that authorised suppliers mean pharmacies. Would that be an appropriate summary?

Mr R.H. COOK: Member, I am advised that an authorised supplier will be a registered health practitioner at a hospital, pharmacy or medical facility who has been approved by the CEO of Health to supply a voluntary assisted dying substance for the purposes of the act.

Mr Z.R.F. KIRKUP: In anticipation of a couple of questions about this, would an authorised supplier exist in a community pharmacy setting, rather than a hospital pharmacy?

Mr R.H. COOK: No, I think it is highly unlikely. The authorised supplier will be limited to registered health practitioners who are authorised under the Medicines and Poisons Act to supply schedule 4 and 8 poisons. It is likely that the authorised supplier will include a public health service hospital or pharmacy, with pharmacists and practitioners who are also authorised under the Medicines and Poisons Act 2014. These registered health professionals, including pharmacists, are already bound by professional obligations, which require them to act within the scope of practice in the area of expertise.

Mr Z.R.F. KIRKUP: To clarify, is it basically only in a hospital or clinical environment; is that the case?

Mr R.H. COOK: Yes, that is right, member. The protocols in a hospital pharmacy are much higher than in a—I do not mean this disrespectfully—corner store, basically.

Mr Z.R.F. KIRKUP: I am trying to imagine a situation in a regional or remote context that will, obviously, present some challenges. What do those circumstances look like in the north west or the Kimberley, for example, where the hospital pharmacy might not be easily accessible for the practitioner or the person's agent? Is there any other mechanism that the CEO might be able to grant approval for?

Mr R.H. COOK: It is anticipated that the hub-and-spoke model may work best for Western Australia as a way of balancing appropriate access with appropriate control. For example, a central pharmacy service, potentially based in 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 the central ordering and storage point for approved voluntary assisted dying medications and also have governance over the training requirements and certification of any authorised suppliers, such as pharmacists at regional hub pharmacies who are involved in supplying voluntary assisted dying medications. We may anticipate that, potentially, Sir Charles Gairdner Hospital might be considered as the central pharmacy, but it may liaise with Broome Health Campus for distribution from there.

Mr Z.R.F. KIRKUP: Just to confirm my thinking there, it is not dissimilar to Victoria where there is a singular hospital pharmacy. Obviously, the patient goes and picks it up, or whatever it might be, but the idea is that there is a centrally tasked hospital pharmacy that provides this. I appreciate the hub-and-spoke model, but is the government

effectively envisaging that there might be a tertiary hospital? Does the minister imagine that there will be a single one, or more than one in the early stages? Do we have any insight into what that might look like?

Mr R.H. COOK: I can confirm that Victoria uses one—it is such a small, dinky little state, so it probably needs only one.

Mr P.A. Katsambanis: It is not in a very easy to get to spot, either.

Mr R.H. COOK: What, Victoria?

Mr P.A. Katsambanis: No, the hospital. I am not sure whether it is publicly known. I know where it is, but I am not sure whether it is publicly known.

Mr R.H. COOK: It is anticipated that we would have a hub-and-spoke model, based upon one single central pharmacy, but obviously it is for the chief executive to determine in the implementation stage.

Mr Z.R.F. KIRKUP: One last question —

The DEPUTY SPEAKER: You said that a minute ago.

Mr Z.R.F. KIRKUP: Yes, but the minister has opened up a little bit more.

The DEPUTY SPEAKER: Come on. You said one more—bundle them.

Mr Z.R.F. KIRKUP: Will the up-to-date list of authorised suppliers mentioned in subclause (6) specifically state, using the Sir Charles Gairdner Hospital model that the minister spoke about, that the pharmacy within that hospital would be the authorised supplier? Would it have the name of the pharmacist themselves? What does that look like?

Mr R.H. COOK: It would be the name of the health services, not the individual pharmacists.

Mr Z.R.F. KIRKUP: Obviously, there are some protections for pharmacists who are conscientious objectors who choose not to participate in the dispensation of these substances, and, additional to that, if the authorised disposer is a contractor, would that contractor's information be provided, and why is it necessary that that information be published on the website, just out of interest? Why is that considered to be important public information?

Mr R.H. COOK: An example would be if someone wants to take some medication to the authorised disposer, and cannot find the coordinating practitioner. If they really want to get rid of the stuff, they can source an authorised disposer.

Mr Z.R.F. Kirkup: And it is the same for a conscientious objector?

Mr R.H. COOK: I am nodding to that one, yes. They can conscientiously object.

Mrs A.K. HAYDEN: The member for Dawesville touched on this. Subclause (2) states —

> A person who is authorised under subsection (1) is an ***authorised supplier***.

In Victoria, they are using the term "pharmacist". Can someone other than a pharmacist be an authorised supplier?

Mr R.H. COOK: As I said before, an authorised supplier will be 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 the voluntary assisted dying substance for the purposes of the act. The member will recall from earlier that "health practitioner" has a wide definition. In this context, these are the people who will be authorised to supply.

Mrs A.K. HAYDEN: So that I can understand, an authorised registered health practitioner may not be a pharmacist. If they are not a pharmacist, I am a little confused about how they will have the authority to prepare the substance. Could the minister explain that and explain why the government has chosen to go with "authorised supplier" instead of "pharmacist", as Victoria has?

Mr R.H. COOK: Authorised suppliers will be limited to registered health practitioners authorised under the Medicines and Poisons Act 2014 to supply schedule 4 and schedule 8 poisons.

Mr P.A. KATSAMBANIS: I am seeking some clarification. The minister indicated that for authorised suppliers the current intention is that there will be a central point, most probably located in a public hospital in Perth, and there will be a hub-and-spoke model that will utilise—I do not want to put words in the minister's mouth but I heard this—public hospital sites around the state. Is it envisaged that authorised suppliers outside the public health system—that is, private pharmacists or pharmacy technicians or the like—may be involved in the system as authorised suppliers? If so, in what circumstances is that envisaged?

Mr R.H. COOK: It will not be so much about whether it is a public facility, but whether it has a public contract. It could potentially be a private facility that operates under a public contract, as, I have just been informed, takes place in the Kimberley. But it would not be a community pharmacy.

Mr P.A. KATSAMBANIS: It is important to have on the record that it will not be a community pharmacy, or that is not the intention anyway.

Mr R.H. Cook: That's correct. Ultimately, the CEO will be responsible for implementing the program.

Mr P.A. KATSAMBANIS: I understand that, and the drafting leaves it open, so it could be in some circumstances. We are just looking at intention here. I refer to the authorised disposer. Is it envisaged that a similar model would apply for authorised disposers, or are we likely to have a broader range of authorised disposers? Again, for completeness, will the authorised disposers likely be within the public health system or will the initial point for the authorised disposers be a bit more distributed and in the private system as well?

Mr R.H. COOK: The authorised disposer will be a registered health practitioner—for example, a registered health practitioner in a hospital, pharmacy or medical facility, who has been approved by the CEO of the Department of Health to dispose of a voluntary assisted dying substance for the purposes of the act.

Dr D.J. HONEY: I refer to the suppliers. Is there any anticipation of how many people will be authorised as suppliers for this purpose?

Mr R.H. COOK: No. I do not have a sense of how many folk would be involved. In the first instance, it will be up to the chief executive officer to get the appropriate governance in place, have a central hub and make sure that they develop the protocols and the workforce that can manage that, then grow it beyond that to make sure that we have properly trained authorised suppliers in regional health facilities.

Dr D.J. HONEY: My understanding, from answers to earlier clauses, is that the state will pay for this material. What mechanism is in place to make sure that there is adequate cost control over the price of the material? Is there going to be a fixed price or is there going to be a free-market approach and we will pay whatever the market wants to charge? Obviously, where I am heading with this is whether we will end up with a monopoly supplier or duopoly suppliers, which could effectively gouge the state government for the cost of these materials.

Mr R.H. COOK: I seem to recall that Dr Grube made the observation that Hawaii actually specified the drug involved and the value of that drug went from $50 to $7 000 overnight. That is one of the reasons the state would obviously want to play its cards close to its chest. But the state is a big purchaser of drugs and it would come in the context of its overall supply arrangements. In that sense, one of the key responsibilities of the CEO of Health, as the member would know, is to keep costs down, because it makes the Treasurer very nervous when he or she does not.

Dr D.J. HONEY: I am not trying to put words in the minister's mouth, but I take it that part of that strategy may be to make sure that there is certainly more than a couple of potential suppliers so that there is an intrinsic mechanism driving a lower price.

Ms M.M. QUIRK: I just want to follow on from the member for Cottesloe. I am curious. Is the CEO the only one who will make the decision about who is an authorised supplier? In other words, will it go through the normal procurement protocols in the department or will there be preferred suppliers? I am just trying to work out whether this is a subset of what normally occurs for the acquisition of drugs.

Mr R.H. COOK: As I have said previously, it is likely that an authorised supplier will include a public health service, hospital or pharmacy with pharmacists and practitioners who are also authorised under the Medicines and Poisons Act. They will be internal to the system. It will not be a process of going out and seeking a private provider beyond what we already provide within the system.

Ms M.M. QUIRK: Can the minister confirm that under clause 78(3), the CEO's authorisation will just be an administrative matter and not subject to delegated legislation?

Mr R.H. COOK: That is correct.

Clause put and passed.

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

Mr Z.R.F. KIRKUP: Subclause (2) states —

> The coordinating practitioner for a patient cannot direct an authorised health professional to supply a prescribed substance to the patient, the contact person for the patient or an agent of the patient, unless —
>
> (a) the authorised health professional is an authorised supplier; and
>
> (b) the direction is in the form of a prescription for the prescribed substance given directly to the authorised supplier.

If the coordinating practitioner fails to comply with a particular element, what penalties will apply? The penalty clause had a general $10 000 fine. Is that what that is? I would not mind some clarification of that.

Mr R.H. COOK: As the member observed, this clause prohibits the coordinating practitioner from directing an authorised health professional to administer a prescribed substance to a patient. I am informed this clarifies that. Under the Medicines and Poisons Act, other people can prescribe various schedule 8 and schedule 4 drugs. For the purposes of this act, it is made clear that notwithstanding the authorisation under the Medicines and Poisons Act, a practitioner must be specifically authorised under the Voluntary Assisted Dying Act to prescribe these medications.

Mr Z.R.F. KIRKUP: Therefore, if a practitioner does not comply, the penalty is a $10 000 fine; is that right? I realise there is the Australian Health Practitioner Regulation Agency side to that as well, but what is the specified monetary fine, and is there an imprisonment element to the penalty? What would that look like if it is incorrect? I imagine there would be a severe breach if that were done wrongly or fraudulently.

Mr R.H. COOK: It is consistent with section 115 of the Medicines and Poisons Act, which is a fine of $45 000 and three years' imprisonment.

Mr Z.R.F. KIRKUP: The minister said that it is a $45 000 fine or three years in jail. Clause 79(3) states —

> The coordinating practitioner or administering practitioner for a patient cannot direct an authorised health professional to administer a prescribed substance to the patient.

Can the minister clarify why that was inserted in the clause?

Mr R.H. COOK: My understanding is that subclause (3), in a similar way to subclause (2), overrides the Medicines and Poisons Act in relation to authorisation. Under the Medicines and Poisons Act, for instance, a practitioner can authorise another practitioner to administer a particular medication. But this makes it crystal clear that in this context the only person who can undertake this task is the coordinating practitioner or the administering practitioner or the patient themselves. Regulation 15 further constrains them.

Mrs A.K. HAYDEN: Following on from the member for Dawesville's question, did the minister say that 115 were listed under authorised health professionals in the Medicines and Poisons Act?

Mr R.H. COOK: It is in section 115 of the act, which specifies the penalties in relation to this part of the Voluntary Assisted Dying Bill.

Mrs A.K. HAYDEN: In that list I assume there is a wide range of things; I do not have it in front of me. Is a veterinarian listed under this and is that what this is meant to avoid? Is it to make sure that a veterinarian is not able to become an authorised supplier?

Mr R.H. COOK: I cannot speak for the veterinary surgeons, but they are certainly not captured by this clause. This specifically refers to regulation 15 of the Medicines and Poisons Regulations, which relates to a direction by a prescriber to administer medicine that is a schedule 4 or 8 poison. It is a further constraint to make sure that it is crystal clear that that regulation cannot be relied upon in the context of voluntary assisted dying.

Clause put and passed.

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

Mr Z.R.F. KIRKUP: Subclause (2) states —

> A person cannot issue a structured administration and supply arrangement in relation to the administration or supply of a medicine for the purpose of voluntary assisted dying.

Is this to ensure that there is not a consistent supply arrangement in place or something like that? I would just like some clarity about that subclause.

Mr R.H. COOK: Not dissimilar to the previous clauses, this is to override the Medicines and Poisons Act so that that particular aspect of the act cannot be utilised in the context of the Voluntary Assisted Dying Bill.

Mr P.A. KATSAMBANIS: I just want to try to get some clarity on this. The way I read this, and I would like the minister's comment, is that it is to make the administration of the prescribed substance under this legislation a standalone procedure that is not combined with any other treatment or groups of treatment being undertaken by the patient. Is that correct? It is just one standalone process separate from all the other treatments.

Mr R.H. COOK: The member could anticipate that a patient at the end of life has already been administered a range of medications and things of that nature that, in the normal course of events, would all be administered under the Medicines and Poisons Act, so this is to ensure that those medications that the patient accesses—that is, the voluntary assisted dying substances—are captured by these extra clauses that essentially divorce these provisions from the Medicines and Poisons Act.

Mr P.A. Katsambanis: Okay, I am good with that.

Clause put and passed.

Debate adjourned, on motion by **Mr D.A. Templeman (Leader of the House)**.

House adjourned at 12.09 am (Wednesday)