

## JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

### *Statement by President*

**THE PRESIDENT (Hon Kate Doust):** Before I give the call to Hon Colin Holt, I remind members that yesterday the chamber agreed to suspend standing orders to enable the member to table the report from the Joint Select Committee on End of Life Choices and that that member would be able to provide a statement of up to 20 minutes and that each other Council member of that committee would also be able to make a statement for 10 minutes.

Given the nature of the matters that will be canvassed as a result of this report, I ask that people listen to each speaker in respectful silence.

*First Report — “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices” — Tabling*

**HON COLIN HOLT (South West) [10.11 am]:** I am directed to present the first report of the Joint Select Committee on End of Life Choices entitled “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices”.

[See paper 1670.]

**Hon COLIN HOLT:** I begin by thanking the house for allowing me and my fellow committee members to make a contribution on the tabling of this report. The report is a result of a 12-month inquiry into a sensitive, controversial and very personal issue. The committee received nearly 700 submissions and held over 80 hearings. The committee visited a number of organisations and communities, including travelling to the great southern and the Kimberley. Committee members entered the homes and hospital wards of people who were gravely ill—people who asked their own questions of what their end-of-life journey would be. For some submitters and others whom we met during the course of this inquiry, their life journey is already at an end. As a committee we are incredibly grateful to those who came forward to tell their stories—brave people who wanted to share insights of their illness or the illnesses and end-of-life experiences of their loved ones. What struck me most about these stories and the evidence we gathered is the strong will to live—the strong desire for life. People will go to extraordinary lengths to extend life by any means possible to squeeze out that last drop, and with the assistance of great medical care many do indeed get a great deal longer to enjoy their lives. But we also read and heard many personal stories about end stages of life when pain and suffering was common and the best medical treatment was unable to give relief.

How we die has changed over the last 60 years. Medicine and the law have not kept pace with this change, nor the changes in community expectations. Many of us are familiar with the deaths of grandparents or other elderly relatives who passed away peacefully in their sleep, often at home. This is now not the common experience. Modern medicine has given us greater longevity but has also delivered longer periods of dying. People now survive a lot longer than they did in the past, sometimes with debilitating symptoms, and there was also a clear message to the committee that in the final stages of life, when living becomes unbearable, there is a desire by many to have a quick, peaceful and painless end surrounded by loved ones.

In addressing the terms of reference, the committee made a number of findings and recommendations. Palliative care was the single largest issue examined during the inquiry. Palliative care aims to provide treatment to alleviate symptoms from diseases and illnesses that cannot be cured. Over the course of the inquiry we met with many dedicated medical professionals involved in palliative care and we were consistently impressed with their commitment and dedication to their patients. Although Australia is ranked as one of the best in the provision of palliative care, it became clear during the inquiry that much work is needed to ensure that palliative care services are able to keep pace with growing demand and growing community expectations. The committee found that Western Australia has the lowest number of publicly funded inpatient beds per capita of all Australian states and access to specialist palliative care is limited and varies greatly across the state. Generally, those living in metropolitan Perth have good access to specialist palliative care. The home and community palliative care model, currently delivered by Silver Chain in the metropolitan area, provides a valuable and high quality service allowing critically ill patients to be at home in familiar settings, surrounded by their family. It should be expanded. This service and many others are limited by available resources. There are obvious gaps in palliative care in Perth, with limited inpatient or hospice care, especially in the northern suburbs. This needs to be addressed. Generally, access to specialist palliative care is greatly limited in regional areas and almost non-existent in remote regions. I say generally, because as the committee found on its visit to the great southern, specialist palliative care, including access to a community hospice, is available in Albany. However, travelling to nearby communities we found access to this speciality health service is dramatically reduced. There was a marked difference between Albany, Denmark and Mt Barker.

Our visit to the Kimberley reinforced yet again the challenges of delivering health care in remote areas of our state. The delivery of palliative care in home settings is an even greater task. In an extraordinary admission, the WA Country Health Service told us in its submission —

General Practitioners (GPs) provide a substantial proportion of the palliative care provision in WACHS and also engage in end of life conversations with patients and carers. There is limited support from Palliative Care medical specialists and this gap is filled to some extent by the senior palliative care nurses. There is no medical oversight, coordination or governance of medical palliative care services across WACHS and a state-wide approach would be of some benefit coupled with a comprehensive auditing program to ensure that contemporary standards are maintained. Policy is also somewhat lacking and developing strong policy approaches is a pre-requisite for improving and maintaining standards.

To me, that is a cry for help from the very people delivering palliative care into regional Western Australia. This cry for help, together with the barriers to access to palliative care in metropolitan Perth and across the state generally, must be urgently addressed by the state government.

Multiple health conditions and co-morbidities mean individuals may have more treating specialists and less overarching coordination of care and advocacy. This results in gaps in care, particularly when patients move from different palliative care settings, such as in the community to hospital. The need for better coordination and integration of palliative care services was raised by many witnesses.

Dementia is now one of the most common terminal illnesses in Australia and the number of people affected is rapidly increasing. Around half a million people have been diagnosed as living with dementia. This is a challenge of monumental proportions for policymakers and governments and is reflected by demands from individuals that their health care wishes be honoured once they have lost capacity. This was a strong theme amongst submitters. This report does not claim to have the answers to this complex area but it does direct the government to carefully examine the question of dementia and advance healthcare planning.

As one of the terms of reference, the committee inquired into advance healthcare directives and what role they play in the planning for future care options. Advance care plans, goals of patient care and statutory advance healthcare directives are valuable tools to help individuals plan for future care needs but, as the committee found, there is widespread evidence that the community and health professionals do not have a clear understanding of healthcare planning. We all need to have conversations about how our own end-of-life wishes are to be respected and we need to communicate these wishes to our loved ones, our general practitioners and relevant health practitioners. The earlier these conversations take place, the better. The committee found a particularly low uptake of the legally binding advance healthcare directives, with many health professionals preferring less statutory documents. This needs to be investigated further and a system put in place by which discussions of future health care between health professionals and their patients, especially when it comes to the final stages of life, are standard practice. The recording of patient wishes as the result of such discussions either as an AHD or a health plan needs to be streamlined. There also needs to be improvement in the identification of and access to patients' healthcare plans, especially given that medicine has become more specialised, with no single practitioner having responsibility for overall patient care.

It is clear from the evidence that, even with access to the best quality palliative care, not all suffering can be alleviated, and that too many Western Australians are experiencing profound suffering as they die. Palliative care physicians themselves acknowledge this. Many life-limiting conditions that cause profound suffering cannot be completely palliated. The committee heard from individuals and health professionals about the terrible effects of some of those illnesses, such as motor neurone disease, Huntington's disease, dementia, Parkinson's disease and many cancers. Evidence received from one witness, a young lady of 39 years, relayed her experience of being born into a family with a history of Huntington's disease. Her transcript makes difficult reading. At the age of six years, she lost her biological father. He had Huntington's disease and he took his own life. She lost her brother as a young man when he developed juvenile Huntington's. His death was slow and in her words it "was heart-wrenching to watch". After that, she lost two half-brothers, who were both gene positive for Huntington's disease. They were diagnosed in their mid-30s, and one of them attempted suicide twice. To quote her directly —

Considering all of that, I think I lead a pretty happy existence and I am full of life and I enjoy life, but come the time—I was diagnosed as gene positive when I was 25; I have Huntington's. This is my greatest fear, to have to die in pain, because I have seen that and I do not want to go through that. That is why I am here today.

According to national coronial data about suicide, around 10 per cent of suicides in Western Australia are by people with a terminal or debilitating illness. This figure is similar to estimates for other jurisdictions, including the United Kingdom and the United States. These people often die lonely and violent deaths—including through helium asphyxia, carbon monoxide poisoning, self-inflicted gunshot wounds and hanging. When faced with a conscious decision to end their life, the refusal of medical treatment and the refusal of food and water, as well as suicide, are currently the legal choices for Western Australians. A competent individual's absolute right to refuse food and water, and to refuse medical treatment is clear in law. At the end of life, those refusals are not suicide. Health professionals providing palliation for those who choose this difficult path are not aiding a suicide; they are

providing good palliative care. The committee concludes that the current lawful options available to people experiencing grievous and irremediable suffering at the end of life are inadequate.

The report notes that there has been a cultural shift across the community away from “doctor knows best” to individuals wanting more say over their medical treatments. The principle of patient autonomy emerged during the 1970s and is now a critical feature of modern medical ethics. This principle means that competent patients are free to make their own medical treatment decisions. The committee recommends that the government legislate for an assisted dying scheme in Western Australia. The recommendation responds to the unnecessary suffering experienced by too many people at the end of their lives, and acknowledges community expectations regarding individual autonomy. The committee recommends that the bill be drafted in consultation with a panel of experts including health and legal professionals and health consumers. The panel will provide a means for government to undertake careful consultation with key stakeholders for the development of the bill.

This report sets out a recommended framework for a voluntary assisted dying bill. The framework builds in safeguards and rigorous processes that will be critically important to the safe functioning of any scheme. Establishing eligibility by ensuring decision-making capacity and the absence of coercion, together with non-discrimination, are critical elements of the framework to be considered by government. A participant must be aged 18 years or over and a resident in Western Australia. In the course of the inquiry the committee found that a predicted time frame until death as an eligibility criteria can result in some individuals being unfairly excluded and may not be clinically justified. People with progressive chronic or neurodegenerative disease may experience intractable suffering for months or years before they die. The committee has chosen not to ignore the suffering of these individuals. The committee has recommended that those who are eligible for voluntary assisted dying must be experiencing grievous and irremediable suffering related to an advanced and progressive terminal, chronic or neurodegenerative condition that cannot be alleviated in a manner acceptable to that person, where death is a reasonably foreseeable outcome of the condition.

A person’s decision to end their own life in the face of terminal illness that is causing grievous and intractable suffering can be a rational choice. It is not necessarily a medical decision, but in some circumstances it may require the assistance of a medical professional. Assisting someone facing hopeless circumstances to die peacefully with friends and family in a setting of their choosing is a humane and compassionate act that is fully in keeping with modern medical ethics and community expectations. The committee acknowledges that some health professionals will not want to be involved in the process, and, accordingly, recommends that there should be no compulsion for individual health professionals to participate.

The committee also reviewed other jurisdictions that have legislated for some form of voluntary assisted dying. There are volumes of peer-reviewed research and data on the various models, some of which have been operating for more than 20 years. We heard evidence about the dangers of a so-called slippery slope that has occurred in other jurisdictions. Proponents of this argument contend that once a scheme is introduced, it will inevitably lead to expansion to include vulnerable groups such as children and those with mental illness. The committee finds no evidence that this has occurred in any of the jurisdictions that have legislated for voluntary assisted dying. Each jurisdiction has its own unique legal framework resulting from considered legislative processes and court rulings in those countries. The Oregon legislation, for example, has never been amended in its 20 years of operation. However, the committee has rejected aspects of these overseas models. The model that our Parliament is asked to consider is in line with the expectations of our community and reflects the values and safeguards we deem appropriate.

There are a wide variety of views on the issue of voluntary assisted dying. There are those who fundamentally oppose the introduction of any laws, and, of course, there are those in full support. All these views should be respected in any community or legislative debate that follows the tabling of this report. Members will see references to these alternative views in the report and the publicly available submissions and hearing transcripts, including the inclusion in this report of a committee member’s minority report.

As Deputy Chair of the Joint Select Committee on End of Life Choices, I once again extend the committee’s thanks to all those who gave evidence either through submissions or at hearings. Thank you for sharing your stories and thank you for allowing us to visit your homes or stand beside your hospital beds. This inquiry was an enormous undertaking and would not have been completed without the great assistance of the committee secretariat. The committee sincerely thanks Marion Huntly, Michele Chiasson, Mathew Bates, Pam Clarke and Dr Jeannine Purdy. Their dedication to the inquiry is admired. Finally, I would genuinely like to thank my fellow committee members for the many hours dedicated to reading submissions, listening to testimony and talking to the community of Western Australia, and for the many hours of committee discussions and deliberations. I commend the report to the house.

**HON ROBIN CHAPPLE (Mining and Pastoral)** [10.29 am]: Hon Colin Holt has encapsulated extremely well what we went through. I say “we went through”, because in terms of what we had to deal with, we had our very

souls shaken. We listened to the many issues presented to us by people in their hospital beds; in many cases people with a great deal of passion to continue living but in a situation where their prognosis was not good. We heard of passion, fear, conviction, despair and the inalienable right to pursue a good life and, indeed, a good death. Like Hon Colin Holt, I commend our report to the house.

I would also like to briefly pay my respects to a gentleman called Tex. He was one of the many people whom we visited with Silver Chain. We actually went to the coalface in many cases and met with people. Tex was an old truck driver from the Pilbara—a worker from up there. I built a bond with Tex. Unfortunately, Tex, like many of the people we met, is no longer with us.

I come back to some of the key issues. Again like Hon Colin Holt, I wish to thank all the members of our committee. Regardless of differences at different times, we worked well as a committee. It was a good outcome. I also thank the staff: Mathew Bates, Michele Chiasson, Marion Huntly and Dr Jeannine Purdy.

I want to go back just briefly to where we came from. From my respect and the respect of this chamber, it has been a very long journey with many milestones. Norm Kelly, the WA Democrats member, tried three times to introduce voluntary euthanasia legislation into this very chamber, the first being in October 1997 by way of a referendum. Unfortunately, it did not pass. His last attempt was in October 2000. My first attempt to introduce legislation to provide some dignity at the end of life was in 2002. Interestingly enough, it was Jim McGinty in 2008 who introduced and achieved the eventual passage of healthcare directives, which was a brand-new level of support for people at the end of their lives. My second attempt to introduce legislation again failed in 2010. It was really quite interesting that in the lead-up to the last state election, my colleague and now minister Alannah MacTiernan, Tony Simpson, the then member for Darling Range, and I gave a commitment that we would try to see the introduction of voluntary assisted dying legislation during this term of Parliament. The establishment of this end-of-life choices committee a year ago by Amber-Jade Sanderson has led us to this place today. This is not the end; this is probably the start of the last chapter of a journey that has been taken by many people.

Externally, the committee met with a number of different organisations. We had 81 public hearings. We took evidence from more than 130 witnesses. I have to say that many a tear was shed as we listened to some of the presentations before us. On both sides, passion was there. We visited many establishments—Brightwater Care Group, Bethesda Hospital and, as Hon Colin Holt has said, the hospital and hospice in Albany. We went to the Kimberley and met with the Derby Aboriginal Health Service, which was really quite interesting. They had developed their own advance healthcare directive system to cater for an Indigenous community. There was a lot of goodwill out there. But it was those people who presented to us who touched us deeply. I do not think there were many members who had a good night sleep after certain meetings we held. It touched us deeply.

It is important at this time to note that maybe we would not be here without the persistence, to a large degree, of what we used to call the WA Voluntary Euthanasia Society but is now called Dying with Dignity Western Australia. In so many ways over many years it has stimulated debate on this subject. As we know from polling, WA, both in the regions and the metropolitan area, has the highest level of support for compassion at the end of life.

I do not want to labour this discussion any further. I really encourage every member to spend some time reading what I think is an incredibly good report. Thank you, Madam President.

**HON DR SALLY TALBOT (South West)** [10.35 am]: This inquiry has been a long and intense process. In welcoming the tabling of the committee report, I want to start by paying tribute to my seven colleagues who sat on this inquiry. We did not always agree, as is evident in the minority report submitted by one member, but we treated each other throughout the year with kindness and respect—qualities that are not commonly encountered in the hot contest of political ideas. I also pay tribute to the staff who went on this journey with us. Dr Jeannine Purdy gave us a strong and solid start. I have an immeasurable amount of respect and regard for the work of Mathew Bates, Michele Chiasson and Marion Huntly, whose work as research officers was exemplary. They helped us take the evidence gathered from hundreds of hours of hearings, thousands of pages of written submissions and the wealth of material published in books and journals and craft it into the narrative, 52 findings and 24 recommendations that make up the report being tabled today. It is fair to say that if our efforts as members of this Parliament to improve the quality of life for Western Australians have any degree of success, it is in large part because we are supported by people with the intellectual integrity and application of Marion, Michele and Mat—it has been a real privilege to work with them.

But the real heroes of this story are the people who had the courage and conviction to provide the evidence on which the report findings and recommendations on voluntary assisted dying and palliative care provision are based. I know I am not speaking only for myself when I say that the evidence we heard from Dr Robert Edis about the experiences of his patient Melanie was unforgettable. When life with motor neurone disease became unbearable for Melanie in a nursing home high-dependency unit, she repeatedly called 000 until an ambulance arrived and agreed to take

her to a hospital, where she could have a conversation about how to die. I reckon that Melanie knew how to change the system, even in the most desperate circumstances. I think we have much to learn from Melanie's story.

Nigel Haines shared with us the diary he kept while he spent many years watching his wife, Suzie Haines, die of Alzheimer's. Suzie Haines spent her final three years in what her husband calls a vegetative state. He visited her regularly for years —

... sometimes for only a minute, but enough time for me to kiss her, apologise for not doing anything to end her suffering and tell her I loved her.

Nigel Haines lived through what he calls a gut-wrenching living nightmare that went on for years. His request that we change the laws relating to voluntary assisted dying cannot be dismissed.

William Philip's wife was a nurse, so she knew what it would be like to die of the particular cancer she contracted. She decided to kill herself by overdosing on her prescription painkillers. She did not succeed, and after four days the withdrawal symptoms were so bad that Mr Philip had to call for help to manage her. She asked her husband, "Why didn't you smother me while I was unconscious?" She died a couple of years later, literally drowning in what Mr Philip described as terror. I have some specific memories that I cannot describe here because they relate to a closed hearing. We have shared in the report some of the evidence that was given by this witness, but nothing can convey the quality of the presentation the witness gave us and her graphic portrayal of her mother's suffering. Incidentally, her mother, like Ms Philip, was a nurse whose wish not to have her life prolonged was based on her professional understanding of the course of her cancer. According to this witness, at the end —

*My mum knew what was going on, and her teeth were chattering and she was choking, but I swear she said my name. [...] That killed me, knowing that she could have been aware of what is going on in those final hours.*

We heard passionate testimony from groups and individuals who argued that we should not change the law in Western Australia to enable people with certain conditions and with grievous and irremediable suffering to choose assisted dying. Chief Rabbi David Freilich made a deep impression on me and I urge people to read his evidence. Although his arguments moved me, I deeply disagree with his conclusions. To him and others who base their opposition to choice on moral principle, I say that modern ethical thinking has taught us that in understanding human thought and action, it is a mistake to rigidly separate motive and outcome, or intention and consequence. When we are able to hold those two aspects of ethics together, it becomes much clearer how we might distinguish between acts that arise from fear and hatred and those based on love and care. As lawmakers, we can never, by definition, prevent people from acting outside the law. We can, however, put safeguards in place to protect vulnerable people and ensure that the law and its application are crystal clear to those who have recourse to it and to those who enforce it. The report tabled today provides a framework of considerations for what that law and those safeguards should look like. This framework is based on solid evidence, all of which was meticulously researched and meticulously cited and reviewable by anyone who cares to ground their argument on facts that are based on empirical evidence rather than on slogans and rhetoric. It is the hope of all of us who served on this inquiry that this report will help inform the debate on end-of-life choices in this state, because the simple fact is that we must make changes to current policies and practice. We cannot continue to criminalise the choices people make to bring pain and suffering to end. We cannot continue to pretend that the unregulated use of opiate overdosing is an acceptable practice in the twenty-first century. And, although there are some superb palliative care services and practitioners in this state, we cannot continue to ignore the fact that our system of palliative care funding and service provision needs radical scrutiny and reform.

I will end with the words of two magnificent women who attended our hearings in Albany last March. Kathleen Trendall and Patricia Marshall certainly met their own criteria as —

... articulate seniors who have given serious and considered thought to choices which will most directly affect them ...

The selected extracts of their evidence that appear in the minority report do not, in my opinion, do justice to their heartfelt plea for change. Here is their opening statement —

The need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices is applauded. However, the terms of reference need to be broadened to include the views of articulate seniors who have given serious and considered thought to choices which will most directly affect them in the not-too-distant future. End-of-life choices are not only about pain and terminal illness; the medical model of managing the end of life when experiencing chronic or terminal illness and the role of palliative care is an insufficient model for many seniors. The questions of loss of self-autonomy and human dignity, conscious awareness of physical or mental deterioration and the realisation that meaningful participation in life has come to an end are very important considerations for the elderly and should be included in any discussion of end-of-life choices. The process of ageing brings an increasing

awareness of one's own deterioration and detachment from what is perceived as a complete life. It is only when this process is directly experienced that it can be fully understood; therefore, it is necessary for those making decisions to change the law to take some advice from those who may choose a voluntary and dignified end to their life when they perceive it to be complete.

With that strong and powerful witness statement, I commend the report to the house.

**HON NICK GOIRAN (South Metropolitan)** [10.44 am]: It has been a privilege, it has been costly and it has been important for me to serve on this committee for the last 12 months. It is always a privilege to serve on any committee of the Parliament of Western Australia but the past 12 months has been personally very costly to not only me in the time that I invested in the work of the committee, but also, in particular, my family and staff, both of whom have now become accustomed to me working on what we referred to as a "secret project". It is sometimes very isolating to be working on a committee with no capacity to talk with family, friends and staff about matters other than what is in the public domain.

It has been important for me to serve on the committee. When we were looking to form the committee, some people asked why I would bother going on the committee. I was determined to put myself forward to go on the committee because I did not want a situation in which, once the committee had done its work, I would raise concerns and some committee members would say, "Look, with all due respect to you, member, you haven't actually served on the committee. We looked into that particular issue and what we found is not consistent with your view." I now have the benefit of having served on the committee for the last 12 months and, indeed, I am the only member who attended every meeting and every hearing over the last 12 months. The outcome is that I felt compelled to submit a minority report, which I commend to members. Its title is "The safe approach to End of Life Choices: License to Care not Licence to Kill".

The committee was given four terms of reference by the Parliament of Western Australia. One was to look into advance health directives, enduring powers of attorney and enduring powers of guardianship. I have spent no time on that in the minority report, because the work of the committee on that term of reference was satisfactory. One of the other terms of reference was for the committee to look into palliative care. The committee has done some good work on that particular term of reference. However, it is disappointing to me as one of the two co-chairs of Parliamentary Friends of Palliative Care that the committee has not provided any analysis on the recommendations provided to it by the peak palliative care body in Western Australia, Palliative Care WA. It provided a letter dated 15 May 2018, which I commend to members, that can be found in appendix 1 of my minority report, which is in the final pages of this weighty tome. The committee has provided no analysis of the recommendations on palliative care, which is why I have devoted the first chapter of my minority report to current end-of-life practices in Western Australia, including palliative care, in that particular appendix.

Another of the committee's term of reference was to consider legislative change. Members will see when they read the report that the committee put together a framework. In my view, that framework is a recipe for one of the world's least safe regimes. But whatever one's view on that, one of the things that the Parliament of Western Australia asked the committee to do was to examine the impact of federal laws on state legislation. A scholarly assessment of the committee's report will score it zero out of 10 on that ground because the committee made no assessment of how federal laws may impact state legislation. The most compelling reason for me to put together a minority report was because the committee was asked in one of its terms of reference to review legislation in other jurisdictions. Although the committee made reference to legislation in other jurisdictions, the committee report makes no mention of the abuses and failures that have occurred in other jurisdictions. I found that quite unusual because I have been involved in debates and writing and discussions on this particular issue for the last 10 years and normally the debate goes something like this: opponents of assisted suicide will say, "We can't do that because of what's happened in the European jurisdictions. In Europe, they have euthanasia for children and those with mental illness." Normally a proponent will then say, "Don't worry about the European model. We're not proposing the European model. Can we provide for your consideration the model in Oregon, where there has been no legislative change for 20 years?" Then an opponent will say, "With regard to Oregon, have you considered the consistent medical errors that happen on prognosis? Have you considered the consistent practice of doctor shopping? Have you considered that the suicide rate in Oregon has increased?" That fact was put to the committee by the chief proponents in the world, Dignitas, from Switzerland, during the course of the last 12 months. Normally, in more recent times, proponents will then say, "Look, forget about all that; just look at the Carter decision in Canada. That will tell you that there's been no abuse in any jurisdiction." Interestingly, the committee has made reference to the Carter decision in its report, but it makes no reference to the High Court decision in Ireland on the Fleming case, which concluded the exact opposite of the Carter decision. That is normally what happens when we have these types of debates.

The greatest encouragement I can give to members in this instance is to consider the lived Australian experience. We have the benefit of the experience in the Northern Territory and we know that when it was legalised in the Northern Territory, four deaths took place under that legislation. I do not have the time today to unpack all those

for members, but, rather, I commend to them the minority report. However, I will give one example of what happened in the Northern Territory. This is how the safeguards work when we have assisted suicide. In one case in the Northern Territory a patient was diagnosed with mycosis fungoides. Philip Nitschke was the doctor. Two doctors were required because that was an important safeguard in the Northern Territory legislation. Dr Nitschke arranged a second doctor who was an orthopaedic surgeon. That is important because the legislation stated that the second doctor needed to have some qualification in or experience with the illness in question. But Dr Nitschke obtained a second signature from an orthopaedic surgeon. If that was not bad enough, the dermatologist and the local oncologist both said that the illness was not terminal and, particularly distressing, that person was being treated for depression. That is how safeguards work, members, when it comes to assisted suicide. We are not talking about the Netherlands, Belgium, Oregon or anywhere else; we are talking about the Australian experience in the Northern Territory. I commend members to consider all those examples outlined in the minority report.

In the last few minutes that I have, I will leave the final words to some of the witnesses who appeared before the committee. The Chief Psychiatrist of Western Australia on 14 December said —

But the stakes go up when you are saying that someone is going to die.

The Director of Public Prosecutions in February this year said —

There is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem ... at the end of the day it is one person's say-so ... the patient, of course, is deceased.

Professor David Kissane, from whom the committee never took evidence, said —

The clinical experience observed during the brief life of the ROTI Act [euthanasia legislation in the Northern Territory] could be regarded as an experiment in which the legislation that supported the practice of euthanasia can be examined for its effectiveness. This [clinical experience] ... demonstrated the inadequacy of provisions of the ROTI Act and suggested that the vulnerable cannot be safely protected by such legislation.

The final word I will give is to Marshall Perron, the former Chief Minister of the Northern Territory, who brought in the legislation. He appeared before the committee, and in written supplementary evidence to the committee said —

There is no redress for family or friends in the event that a death was hastened and one or more of the eligibility requirements was not met. Obviously one cannot be brought back from the dead.

Assisted suicide is bad public policy. I commend the report to the house, in particular the minority report, and I thank the members for the privilege of serving on the committee for the past 12 months.