



Voluntary Assisted Dying Bill 2021

**Report No. 10, 57th Parliament
Health and Environment Committee
August 2021**

Health and Environment Committee

Chair	Mr Aaron Harper MP, Member for Thuringowa
Deputy Chair	Mr Robert (Rob) Molhoek MP, Member for Southport
Members	Mr Stephen (Steve) Andrew MP, Member for Mirani
	Ms Ali King MP, Member for Pumicestone
	Ms Joan Pease MP, Member for Lytton
	Dr Mark Robinson MP, Member for Oodgeroo

Committee Secretariat

Telephone	+61 7 3553 6626
Fax	+61 7 3553 6699
Email	hec@parliament.qld.gov.au
Technical Scrutiny Secretariat	+61 7 3553 6601
Committee webpage	www.parliament.qld.gov.au/HEC

Acknowledgements

The committee acknowledges the assistance provided by the Department of Justice and Attorney-General and the Department of Health.

All web address references are current at the time of publishing.

Contents

Chair’s foreword	vi
Recommendations	viii
1 Introduction	1
1.1 Role of the committee	1
1.2 Inquiry process	1
1.3 Policy objectives of the Bill	1
1.4 Explanatory notes and the Queensland Law Reform Commission Report	2
1.5 Stakeholder views on the Bill in its entirety	2
1.6 Alterations by regulation	4
1.7 Should the Bill be passed?	5
2 Background to a voluntary assisted dying scheme in Queensland	6
2.1 Community views on voluntary assisted dying	10
2.1.1 Support for voluntary assisted dying	10
2.1.2 Opposition to voluntary assisted dying	15
3 Overview of the Bill	19
3.1 Key elements of the Bill	20
3.2 Eligibility criteria to access voluntary assisted dying	20
3.2.1 A person must have an eligible disease, illness or medical condition	20
3.2.2 A person must have decision-making capacity	26
3.2.3 Voluntary assisted dying request must be made voluntarily and without coercion	31
3.2.4 A person must be at least 18 years old	34
3.2.5 Residency requirement	35
3.2.6 Committee comment	37
3.3 Voluntary assisted dying assessment and substance administration processes	37
3.3.1 The process for accessing voluntary assisted dying	37
3.3.2 Administration of a voluntary assisted dying substance	48
3.3.3 Committee comment	54
3.4 Additional safeguards	54
3.4.1 Initiating a discussion about voluntary assisted dying	54
3.4.2 Prescribing, supplying and disposing of voluntary assisted dying substance	59
3.4.3 Voluntary Assisted Dying Review Board	61
3.4.4 Offences	64
3.4.5 Committee comment	71
3.5 Operational matters	72
3.5.1 Protections from liability	72
3.5.2 Conscientious objection	74
3.5.3 Practitioners’ qualifications and experience	89
3.5.4 Review of eligibility decision by the Queensland Civil and Administration Tribunal	93
3.5.5 Voluntary assisted dying is not suicide	97

3.5.6	Notification and certification of death	99
3.5.7	Impact of the <i>Criminal Code Act 1995</i> (Cth)	100
3.5.8	Statewide Pharmacy Service	105
3.5.9	Committee comment	106
3.6	Palliative Care	107
3.6.1	Committee comment	111
3.7	Equity of access to voluntary assisted dying	111
3.7.1	Committee comment	115
4	Compliance with the <i>Legislative Standards Act 1992</i>	116
4.1	Fundamental legislative principles	116
4.1.1	Rights and liberties of individuals – right to privacy regarding personal information – information sharing and disclosure	116
4.1.2	Rights and liberties of individuals – right to freedom of conscience and belief and right to freedom of expression	117
4.1.3	Rights and liberties of individuals – proportionality and relevance of penalties (crimes and misdemeanours)	119
4.1.4	Rights and liberties of individuals – proportionality and relevance of penalties (maximum penalty of 100 penalty units)	122
4.1.5	Rights and liberties of individuals – general rights and liberties – ordinary activities should not be unduly restricted	123
4.1.6	Rights and liberties of individuals – general rights and liberties – administrative power	124
4.1.7	Rights and liberties of individuals – natural justice	125
4.1.8	Rights and liberties of individuals – power to enter premises	127
4.1.9	Rights and liberties of individuals – immunity from proceedings	129
4.1.10	Rights and liberties of individuals – immunity from proceedings	130
4.1.11	Institution of Parliament – delegation of legislative power	132
4.1.12	Institution of Parliament – scrutiny of the Legislative Assembly	133
4.2	Explanatory notes	135
5	Compliance with the <i>Human Rights Act 2019</i>	136
5.1	Human rights compatibility	136
5.1.1	The right to life and the right not to be arbitrarily deprived of life	136
5.1.2	The right to freedom of expression	142
5.1.3	The right of recognition and equality before the law, right to privacy and reputation, right of the child, right to health services – consideration in relation to eligibility criteria	146
5.1.4	The right to freedom of thought, conscience, religion and belief	157
5.1.5	Other potentially rights engaging clauses	161
5.2	Statement of compatibility	163
	Appendix A – Submitters	165
	Appendix B – Officials at public departmental briefing	233
	Appendix C – Witnesses at public hearing	234
	Statements of Reservation and Dissenting Reports	239

Abbreviations

ACC	Australian Christian Churches
ACL	Australian Christian Lobby
ACNP	Australian College of Nurse Practitioners
ADA Australia	Aged and Disability Advocacy Australia
Ahpra	Australian Health Practitioner Regulation Agency, which administers the National Health Practitioner Regulation Law in force in each Australian state and territory
ALA	Australian Lawyers Alliance
APS	Australian Psychological Society
Bill	Voluntary Assisted Dying Bill 2021
Board	Voluntary Assisted Dying Review Board
chief executive	Chief executive of Queensland Health
CRC	Convention of the Rights of the Child
Criminal Code (Cth)	<i>Criminal Code Act 1995 (Cth)</i>
Criminal Code (Qld)	<i>Criminal Code Act 1899</i>
CPSP	Certified Practising Speech Pathologist
DADC	Doctors For Assisted Dying Choice
department	Department of Health
DJAG	Department of Justice and Attorney-General
DPP	Director of Public Prosecutions
DWDQ	Dying With Dignity Queensland
DWDV	Dying With Dignity Victoria
GPs	general practitioners
HCQ	Health Consumers Queensland
HRA	<i>Human Rights Act 2019</i>

ICCPR	International Covenant on Civil and Political Rights
LSA	<i>Legislative Standards Act 1992</i>
Medicines and Poisons Act	<i>Medicines and Poisons Act 2019</i>
MIGA	Medical Insurance Group Australia Pty Ltd
NZ	New Zealand
NSW	New South Wales
OHO	Office of the Health Ombudsman
PCQ	Palliative Care Queensland
PJCHR	Parliamentary Joint Committee on Human Rights
PSA	Pharmaceutical Society of Australia
QAI	Queensland Advocacy Incorporated
QCAT	Queensland Civil and Administrative Tribunal
QCU	Queensland Council of Unions
QHRC	Queensland Human Rights Commission
QLRC	Queensland Law Reform Commission
QLRC Report	<i>A legal framework for voluntary assisted dying, Report No. 79, May 2021</i>
QNMU	Queensland Nurses and Midwives' Union
RACFs	residential aged care facilities
SA	South Australia
SARC	Victorian Scrutiny of Acts and Regulations Committee
SPA	Speech Pathology Australia
STEP Queensland	Society of Trust and Estate Practitioners Queensland
the disability convention	Convention on the Rights of Persons with Disabilities
the former committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the 56th Parliament
UN	United Nations

VAD	Voluntary Assisted Dying
VALE Group	Voluntary Assisted Life Ending Group
WA	Western Australia
White and Willmott Model	Professors Ben White and Lindy Willmott, Submission No. 1199 to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying</i> (24 April 2019) attachment 'Voluntary Assisted Dying Bill 2019' and 'Explanatory Notes'

All Acts are Queensland Acts unless otherwise specified.

Chair's foreword

As Chair of the Health and Environment Committee, I am deeply humbled to present the committee's report on the Voluntary Assisted Dying Bill 2021.

This historic report follows on from the extensive work of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (former committee) of the 56th Parliament who undertook a significant inquiry to understand the views of the Queensland public on voluntary assisted dying. That work resulted in 21 recommendations including one to introduce Voluntary Assisted Dying legislation. The former committee's recommendations were considered by the Queensland Law Reform Commission, who must be commended for their work, including further extensive consultation, and for developing the legal framework for a voluntary assisted dying scheme in Queensland and the Voluntary Assisted Dying Bill 2021.

We are proud to have completed this journey, culminating in the consideration of the Voluntary Assisted Dying Bill 2021, which will soon be debated in the Parliament for the first time in its history.

During the committee's inquiry process, we heard the views of over 6,000 people and organisations through submissions and 5 public hearings in regional and south-east Queensland. This was in addition to the more than 4,700 submissions received and evidence heard from 502 invited witnesses at 34 public and private hearings in the inquiry into aged care, end-of-life and palliative care and voluntary assisted dying undertaken by the former committee.

Importantly, 98 per cent of submissions considered by the former committee commented on voluntary assisted dying, with the majority of those submissions indicating support for the introduction of voluntary assisted dying legislation in Queensland.

Some observers have said the work of the former committee and this committee must have been a heavy burden, listening to or reading thousands of deeply personal stories of loved ones suffering terribly with a terminal illness at end of life. As Chair I say, we were all privileged to have had the opportunity to hear from so many and whilst it was at times a challenging and emotional journey, it is nowhere near the burden of those dear souls facing end of life due to a terminal illness.

I can say with great confidence we have listened to and heard from Queenslanders on the issue of voluntary assisted dying and on the Bill, which at its very core is aimed to give choice to people suffering at end of life in a kind, compassionate, safe and practical way.

After hearing from so many Queenslanders, who told us of their support for a voluntary assisted dying scheme, I can report, we are recommending the Bill be passed.

Such an emotive and sensitive subject will result in divergent views. As a democratic society, we must respect that some will be opposed to a voluntary assisted dying scheme for a variety of reasons that are important to them. From the outset, I wanted this to be a respectful process and we were able to achieve that outcome.

I want to thank every single person who contacted us or came before us, you have helped us shape a Bill that will finally provide a choice for those suffering at end of life.

I would like to commend the following people and organisations who helped the committee come to the conclusion that the Bill be passed. These people have been passionate and dedicated to the cause to allow people choice at end of life for those terminally ill people we heard were suffering in intolerable pain: Dying with Dignity Queensland, The Clem Jones Group, Doctors for Assisted Dying Choice, Nurses for Assisted Dying, VALE, Andrew Denton and Go Gentle Australia, QNMU, United Workers Union, the late Peter Simpson, Electrical Trades Union, Penny Toovey, Stuey Trail, Everalld Compton, Gang of Four, Marjorie Lawrence, Joan Musmucci, and Professors Ben White and Lindy Willmot, for their expertise in providing evidence-based research in relation to voluntary assisted dying.

To the many others who stayed the course in their desire to see this Bill passed to address needless suffering of loved ones. Your hard work and passion for change is almost completed.

I cannot finish this work without mentioning our dear friend and colleague, the former Member for Stretton, the late Duncan Pegg who bravely stood before the Parliament and reminded all of us to listen to those who have a terminal illness and are facing end of life. We listened Duncan.

As Chair, I would like to thank all of my fellow committee members and former committee members from the 56th Parliament for the way they have worked together during these inquiries. On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill or appeared before the committee. I also thank our Parliamentary Service staff, the secretariat of the Health and Environment Committee, and officers of the Department of Justice and Attorney-General and Queensland Health.

It is my firm view that the issue of voluntary assisted dying is above politics and religion, this is about people.

I commend this report to the House.



Aaron Harper MP

Chair

Recommendations

Recommendation 1 **5**

The committee recommends the Voluntary Assisted Dying Bill 2021 be passed.

Recommendation 2 **106**

The committee recommends that the Commonwealth Government amend the *Criminal Code Act 1995* (Cth) by inserting a definition declaring that ‘suicide’ does not include voluntary assisted dying carried out lawfully pursuant to a law of a state or territory.

Recommendation 3 **107**

The committee recommends that as a matter of urgency the Commonwealth Director of Public Prosecutions issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the *Criminal Code Act 1995* (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws.

1 Introduction

1.1 Role of the committee

The Health and Environment Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 26 November 2020 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.¹

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Environment, Great Barrier Reef, Science and Youth Affairs.

The functions of a portfolio committee include the examination of bills and subordinate legislation in its portfolio area to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles
- matters arising under the Human Rights Act 2019 (HRA)
- for subordinate legislation – its lawfulness.²

The Voluntary Assisted Dying Bill 2021 (Bill) was introduced into the Legislative Assembly and referred to the committee on 25 May 2021. The committee is to report to the Legislative Assembly by 20 August 2021.

1.2 Inquiry process

On 28 May 2021, the committee invited stakeholders and subscribers to make written submissions on the Bill. The committee received 1,360 submissions in addition to 4,767 form type submissions. (See Appendix A for a list of submitters.)

The committee received a public briefing on the Bill from Queensland Health (the department) and the Department of Justice and Attorney-General (DJAG) on 14 June 2021 (see Appendix B for a list of officials).

The committee received written advice from the department in response to matters raised in submissions.

The committee held public hearings in Townsville on 12 July 2021, Rockhampton on 13 July 2021, and in Brisbane on 14, 15 and 16 July 2021 (see Appendix C for a list of witnesses).

The submissions, correspondence from the department, and transcripts of the briefing and hearings are available on the committee's webpage.³

1.3 Policy objectives of the Bill

As set out in the explanatory notes, the main purposes of the Bill are to:

- give persons who are suffering and dying, and who meet eligibility criteria, the option of requesting medical assistance to end their lives
- establish a lawful process for eligible persons to exercise that option

¹ *Parliament of Queensland Act 2001*, s 88 and Standing Order 194.

² *Parliament of Queensland Act 2001*, s 93; and *Human Rights Act 2019* (HRA), ss 39, 40, 41 and 57.

³ Parliament of Queensland, <https://www.parliament.qld.gov.au/work-of-committees/committees/HEC>.

- establish safeguards to ensure voluntary assisted dying is accessed only by persons who have been assessed to be eligible; and protect vulnerable persons from coercion and exploitation
- provide legal protection for health practitioners who choose to assist, or not to assist, persons to exercise the option of ending their lives in accordance with the Bill
- establish a Voluntary Assisted Dying Review Board and other mechanisms to ensure compliance with the Act.⁴

1.4 Explanatory notes and the Queensland Law Reform Commission Report

The explanatory notes draw heavily on the report of the Queensland Law Reform Commission *A legal framework for voluntary assisted dying, Report No. 79* (QLRC Report), as the QLRC was tasked with developing ‘an appropriate legislative scheme for voluntary assisted dying’ and preparing ‘draft voluntary assisted dying legislation to give effect to its recommendations’.⁵ Consequently this report references the QLRC Report, in addition to the explanatory notes, to clarify the rationale for the inclusion of particular provisions.

1.5 Stakeholder views on the Bill in its entirety

There was strong support for the Bill.

David Muir from the Clem Jones Group argued:

We have a VAD bill in front of us today because solid evidence led us here following the previous committee’s inquiry. The bill, like other VAD laws, does not offer automatic access to voluntary assisted dying, but it allows people to seek access in line with legislative criteria and safeguards. Like other VAD laws, it accommodates the position of opponents 100 per cent with one single word: voluntary. This law will allow both sides of the argument their choice. A voluntary assisted dying law will never impact someone who does not want to choose VAD. Nobody should impose their views by denying that choice to others. Above all, let us all remember one very simple fact: under any VAD law there will not be a single extra death but there will be a lot less suffering. That is why we urge the committee to recommend the bill before us to the parliament unchanged.⁶

Dying with Dignity Queensland (DWDQ) stated:

DWDQ commends and fully supports the proposed Queensland Voluntary Assisted Dying legislation as well drafted, carefully thought out and balanced in its approach. It is conservative in that it has many safeguards and strict eligibility criteria.⁷

Gang of Four, a group comprising three terminally-ill women and a retired Palliative Care Nurse Specialist, stated:

We endorse and embrace the draft Qld Voluntary Assisted Dying Bill 2021 released by the Qld Law Reform Commission. We believe it has been well considered and clearly demonstrates that many voices and opinions have been taken into consideration. It also takes into consideration the legislation of other states who have already passed Voluntary Assisted Dying laws.⁸

⁴ Explanatory notes, p 4.

⁵ Hon Stirling Hinchliffe MP, Acting Attorney-General and Minister for Justice, Acting Leader of the House, Minister for Local Government, Minister for Racing and Minister for Multicultural Affairs, *Terms of Reference, Queensland’s laws relating to voluntary assisted dying*, 21 May 2020, https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0018/661113/VAD-Amended-Terms-of-reference-12-Jan.pdf, p 4.

⁶ Public hearing transcript, Brisbane, 16 July 2021, p 22.

⁷ Submission 278, p 2.

⁸ Submission 32, p 1.

Dying With Dignity Victoria (DWDV) argued:

In our opinion this Bill provides the best set of options and controls of the three cases of VAD legislation we have seen to date, and we commend the authors for their work.⁹

The Queensland Nurses and Midwives' Union (QNMU) considered:

... that a person experiencing intolerable suffering caused by disease, illness or medical condition [has] the right to choose to die in a manner acceptable to them and shall not be compelled to suffer beyond their wishes. The draft law for voluntary assisted dying provides those with life limiting conditions the choice about how, when and where they die.¹⁰

Marshall Perron stated:

Commendably the Bill has been drafted after consideration of the laws passed in Victoria, WA and Tasmania and the history of practice in Victoria. The Queensland bill presents a sensible, pragmatic, and safe regime avoiding a number of problematic issues identified in Victoria and in previous Australian Bills.¹¹

In contrast, submitters opposed to voluntary assisted dying had moral, conscientious or religious objections to the Bill.¹² The Australian Christian Churches (ACC) QLD stated:

As a faith community, obviously we have great concern about this proposed legislation due to our values and beliefs in relation to the value and sanctity of life... however we consider that particular elements of this legislation as it currently stands, are inherently weak and provide inadequate professional standards, insufficient protections for individuals and organisations, and lack a holistic approach to a matter of such serious gravity.¹³

The State Committee for Queensland of the Christian Medical and Dental Fellowship stated their reservations about the legalisation of voluntary assisted dying and concerns about the potential for wrongful deaths and unintended consequences of this legislation.¹⁴

A number of professional associations highlighted the diverse opinions held by their members and therefore did not comment on their support or otherwise for the Bill.¹⁵ The Royal Australasian College of Physicians stated that its members are not unanimous in their support for, or opposition to, legislative change.¹⁶ The Australian and New Zealand Society for Geriatric Medicine stated:

The ANZSGM acknowledges the wide range of perspectives and ethical views held by people living in Australia and New Zealand of all ages on Voluntary Assisted Dying (VAD). Likewise, ANZSGM members hold differing views in good faith and the views of all members are respected.¹⁷

Similarly, Palliative Care Queensland (PCQ) argued:

Palliative Care Queensland is neutral on VAD. It is up to society and politicians to create laws. We firmly believe that VAD is not part of palliative care practice, but, just as we coexist with curative treatments, we can coexist with VAD.¹⁸

⁹ Submission 1056, p 2.

¹⁰ Submission 937, p 6.

¹¹ Submission 429, p 2.

¹² For example, see submissions 79, 1054, 1150, 1309.

¹³ Submission 1052, p 1.

¹⁴ Submission 1226, p 1.

¹⁵ Submission 1106, 1320; Ms Herrald, STEP Queensland, public hearing transcript, Brisbane, 15 July 2021, p 14.

¹⁶ Submission 1042, p 2.

¹⁷ Submission 1320, p 1.

¹⁸ Ms Mills, public hearing transcript, Brisbane, 15 July 2021, p 42.

Some submitters warned against weakening the Bill with ad hoc additions to safeguards. Professors White and Willmot argued against any temptation to consider each safeguard or process individually, and to add numerous safeguards to voluntary assisted dying legislation causing subsequent policy drift by a thousand cuts:

... the Queensland Bill is a safe and measured law that has been written in a logical and coherent way by experts. We urge the Queensland Parliament to avoid the situation that other states have experienced where safeguards are awkwardly added to already sound law in an ad hoc way. This leads to the VAD law being incoherent or inconsistent in important ways.¹⁹

Similarly, DWDQ argued that the Bill should be considered in its entirety and the Bill's integrity should not be weakened by amendments:

DWDQ agrees with the QLRC's statement that the proposed legislation be viewed as a whole. DWDQ advises Members of parliament not to become focused on one aspect and not to make amendments that would damage the overall integrity of the bill... DWDQ advises members of parliament to view this historic legislation as a whole and be wary of making changes that would break that balance.²⁰

Ms Fiona Jacobs, a nurse practitioner, submitted:

I implore you - EMPATHISE, understand, try to relate to the person who is suffering - can you walk in their shoes? If so you will vote YES for this incredibly important legislation - in its entirety and in its original form as presented by the QLRC.²¹

1.6 Alterations by regulation

Given the significance of the proposed legislation, the committee queried the extent to which the scheme could subsequently be altered by regulation. The department clarified that the Bill provides for a number of detailed, technical matters to be prescribed by regulation, including:

- labelling of the voluntary assisted dying substance (clause 71)
- storage of the voluntary assisted dying substance (clause 74)
- disposal of the voluntary assisted dying substance (clause 75)
- statistical information about request for, and provision of, voluntary assisted dying that the Review Board is required to record and keep (clause 117).

The Bill also includes a general regulation-making power (clause 167). This provision states that the Governor in Council may make regulations under the Act.²²

The department stated that any regulatory changes would be subject to parliamentary scrutiny:

The process of making and amending subordinate legislation includes Parliamentary checks and balances through the Executive Council process, including:

- the subordinate legislation must be within the power of the Act;
- Governor in Council consideration and approval of the Regulation;
- justification of fundamental legislative principles in the Explanatory Notes to the Regulation;
- tabling and disallowance; and
- portfolio Committee scrutiny.²³

¹⁹ Submission 906, p 5.

²⁰ Submission 278, p 2, p 6.

²¹ Submission 5, p 3.

²² Queensland Health, correspondence, 22 July 2021, p 2.

²³ Queensland Health, correspondence, 22 July 2021, p 2.

Professors White and Willmott argued that the substantive provisions in the Bill, relating to safeguards and the eligibility criteria, could not be changed by regulation:

We do not believe that regulations could be used to widen the operation of the VAD Bill including, for example, by expanding the eligibility criteria. A regulation is only valid insofar as it does not exceed the power conferred under the authorising law (in this case, the VAD Bill)

...

In this regard, we further note that none of the substantive provisions in the VAD Bill (e.g. provisions relating to eligibility or safeguards) provide that regulations could alter the nature or scope of those provisions.

We therefore conclude that there is no scope for the regulations to the VAD Bill to be made pursuant to the *Statutory Instruments Act 1992* that would alter the eligibility or safeguards underpinning the VAD Bill.²⁴

1.7 Should the Bill be passed?

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

The committee heard the views of over 6,000 people and organisations. In Rockhampton, the committee heard from Ms Faye Tomlin, an experienced nurse practitioner specialising in palliative care, who had witnessed well over 500 deaths. Ms Tomlin told the committee:

I have seen the very best of people and I have experienced the very worst. I understand the complexity of living until you die. I certainly recognise the difficulty of living with a life-limiting illness for everybody involved, not just the person who may die from the illness but also their family. For me it is very simple: every person deserves the right to make their own choice. I hope this does not sound a little callous, but it is irrelevant to me how a person dies in that I wish it to be on their terms, their choice. We all have that right as a human being. It is our human right to make our own choice.²⁵

The committee also received many submissions similar to that of Julie Watson, who argued:

I firstly want to thank the Qld government for moving forward on this promise! Thank you for removing religion out of this Health issue. I have watched two family members die with unnecessary prolonged suffering, it was devastating to witness. I am a firm believer that I should have the right to choose my own peaceful death! My body My choice! It should be that simple.²⁶

In considering all the evidence to this inquiry, to the inquiry by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the 56th Parliament (the former committee), as well as the QLRC Report, the committee has formed the view that this Bill should be passed without amendment.

Recommendation 1

The committee recommends the Voluntary Assisted Dying Bill 2021 be passed.

²⁴ Professors Willmott and White, correspondence dated 21 July 2021, p 1.

²⁵ Public hearing transcript, Rockhampton, 13 July 2021, p 32.

²⁶ Submission 120, p 1.

2 Background to a voluntary assisted dying scheme in Queensland

On 14 November 2018, the Legislative Assembly referred an inquiry into aged care, end-of-life and palliative care and voluntary assisted dying to the former committee. That inquiry's terms of reference included that the former committee report on Queensland community and relevant health practitioners' views on the desirability of supporting voluntary assisted dying, including provisions for it being legislated in Queensland and any necessary safeguards to protect vulnerable persons.²⁷

The former committee conducted a public awareness campaign that included the publication of an Issues Paper.²⁸ Copies of the Issues Paper were distributed to Queensland public and private hospitals, residential aged care facilities, Members of Parliament and other stakeholders. It also provided information about the inquiry to over 4,000 groups and individuals registered to receive regular email updates about the former committee's work. In addition, it advertised the inquiry and called for submissions in major newspapers and placed further advertising to raise awareness of each of the public hearings and forums for the inquiry.²⁹

The former committee received and considered 4,719 submissions as part of the wider inquiry and heard evidence from 502 invited witnesses during public hearings held across regional centres along the east coast of Queensland as well as Mount Isa, Longreach, Mossman and Palm Island.³⁰ In addition, it visited a cross section of residential aged care facilities, hospices and palliative care facilities during the inquiry.

The former committee provided its report to parliament (Report No 34 Voluntary Assisted Dying) on 31 March 2020. The report reflected the views of the majority of Queenslanders who made thousands of submissions and spoke of personal, tragic stories of seeing loved ones suffer at end of life.

The former committee found, consistent with trends in other jurisdictions, a significant number of Queenslanders facing terminal and debilitating illnesses were choosing to take their own lives.³¹ It also found that some Queenslanders experienced profound suffering as they die, in part due to the challenges of accessing palliative care and that even with access to the best quality palliative care, that sometimes not all suffering can be palliated.³²

The former committee reported:

... the strong desire expressed by submitters and witnesses for people to be able to exercise choice about the timing and manner of their death. If there is a choice between a death accompanied by prolonged suffering and a death that is without such suffering, it appears from the submissions and other evidence presented to the committee that most Queenslanders would choose the latter.³³

That committee acknowledged the strong community views in relation to feelings and attitudes on voluntary assisted dying but found overwhelming community support for Queenslanders to have

²⁷ Queensland Parliament, Record of Proceedings, 14 November 2018, p 3,477.

²⁸ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 2.

²⁹ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 2.

³⁰ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 2.

³¹ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 11.

³² Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 42.

³³ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 40.

access to a voluntary dying scheme in this state. It also highlighted the results from recent opinion polls that voluntary assisted dying is supported by a majority of Australians, and that voluntary assisted dying law reform has high level support in Queensland.³⁴

In relation to the evidence it received, it concluded:

After considering the evidence presented in submissions to the inquiry, the testimony of expert witnesses and others with opinions, and the expert advice provided by legal, medical and other stakeholder groups, and considering the experiences of governments and citizens with voluntary assisted dying schemes operating in other jurisdictions, the committee considers that, on balance, the Queensland community and health practitioners are supportive of voluntary assisted dying and for it to be legislated in Queensland.³⁵

As such, the former committee recommended that the Queensland Government develop a legislative scheme for voluntary assisted dying in Queensland. The report made 21 recommendations as to how a voluntary assisted dying scheme might operate.³⁶

On 21 May 2020, the Hon Stirling Hinchliffe MP, Acting Attorney-General and Minister for Justice, Acting Leader of the House, Minister for Local Government, Minister for Racing and Minister for Multicultural Affairs referred the development of an appropriate legislative scheme for voluntary assisted dying for Queensland and the preparation of draft legislation to the QLRC, pursuant to section 10 *Law Reform Commission Act 1968*.³⁷ The terms of reference provided:

The provision of compassionate, high quality and accessible palliative care for persons at their end of life is a fundamental right for the Queensland community.

The Queensland Law Reform Commission is asked to make recommendations about an appropriate voluntary assisted dying scheme and to prepare draft voluntary assisted dying legislation to give effect to its recommendations, with particular regard to:

1. the best legal framework for people who are suffering and dying to choose the manner and timing of their death in Queensland;
2. identifying who can access voluntary assisted dying;
3. process for access to voluntary assisted dying to be initiated, granted or denied;
4. the legal and ethical obligations of treating health practitioners;
5. appropriate safeguards and protections, including for treating health practitioners;
6. ways in which compliance with the Act can be monitored;
7. timeframes for implementation of a scheme in Queensland, if progressed.

In preparing draft legislation, the QLRC should also have regard to the following:

- A. The Parliamentary Committee's Report No 34 Report, Voluntary assisted dying, including the draft legislation in Appendix A of the Report (VAD Report) and Information Paper No. 5, Summary of the Findings and recommendations from Report No. 34 on Voluntary assisted dying (Information Paper No. 5);

³⁴ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 62.

³⁵ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 105.

³⁶ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, pp x-xii.

³⁷ Hon Stirling Hinchliffe MP, Acting Attorney-General and Minister for Justice, Acting Leader of the House, Minister for Local Government, Minister for Racing and Minister for Multicultural Affairs, *Terms of Reference, Queensland's laws relating to voluntary assisted dying*, 21 May 2020, p 4.

- B. The Parliamentary Committee's Report No 33 Report, Aged care, end-of-life and palliative care (AEP Report);
- C. Consultation with stakeholders and the community that occurred during the Parliamentary Committee's consideration of the matter;
- D. Views of experienced health and legal practitioners;
- E. Views of the Queensland public;
- F. Legislative and regulatory arrangements in other Australian and international jurisdictions.³⁸

The QLRC provided its final report including a draft bill to the Minister on 10 May 2021.³⁹ The Hon Shannon Fentiman MP, Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence, tabled the QLRC Report in the Legislative Assembly on Tuesday 18 May 2021.

The QLRC aimed to develop a draft law for Queensland that is 'compassionate, safe and practical'.⁴⁰ It made 197 recommendations for a voluntary assisted dying scheme in Queensland and the draft bill gives effect to the recommendations.

In formulating its recommendations, the QLRC undertook extensive research, analysis and consultation and considered the voluntary assisted dying schemes and experiences of other Australian and overseas jurisdictions. The QLRC also considered a voluntary assisted dying bill compiled by Professors White and Willmott of Queensland University of Technology (the White and Willmott model).⁴¹

The committee notes that most of the recommendations of the former committee were given effect in the QLRC draft bill.⁴²

On 25 May 2021, the Hon Anastacia Palaszczuk MP, Premier and Minister for Trade, introduced the Voluntary Assisted Dying Bill 2021 (the Bill) and referred the Bill to the committee for its consideration.

In terms of implementation of the Bill if passed, the explanatory notes to the Bill advise:

In line with the Government's election commitment, the Bill incorporates the QLRC's draft Bill and updates the commencement provision to 1 January 2023 to reflect the Government's commitment to commence the scheme 15 months after assent of the Bill.⁴³

The diagram below depicts the Queensland Parliament's consideration of voluntary assisted dying, which commenced in November 2018.

³⁸ Queensland Law Reform Commission, *A legal framework for voluntary assisted dying, Report No. 79*, May 2021, p 685 (QLRC Report).

³⁹ QLRC Report, Appendix F, p 741.

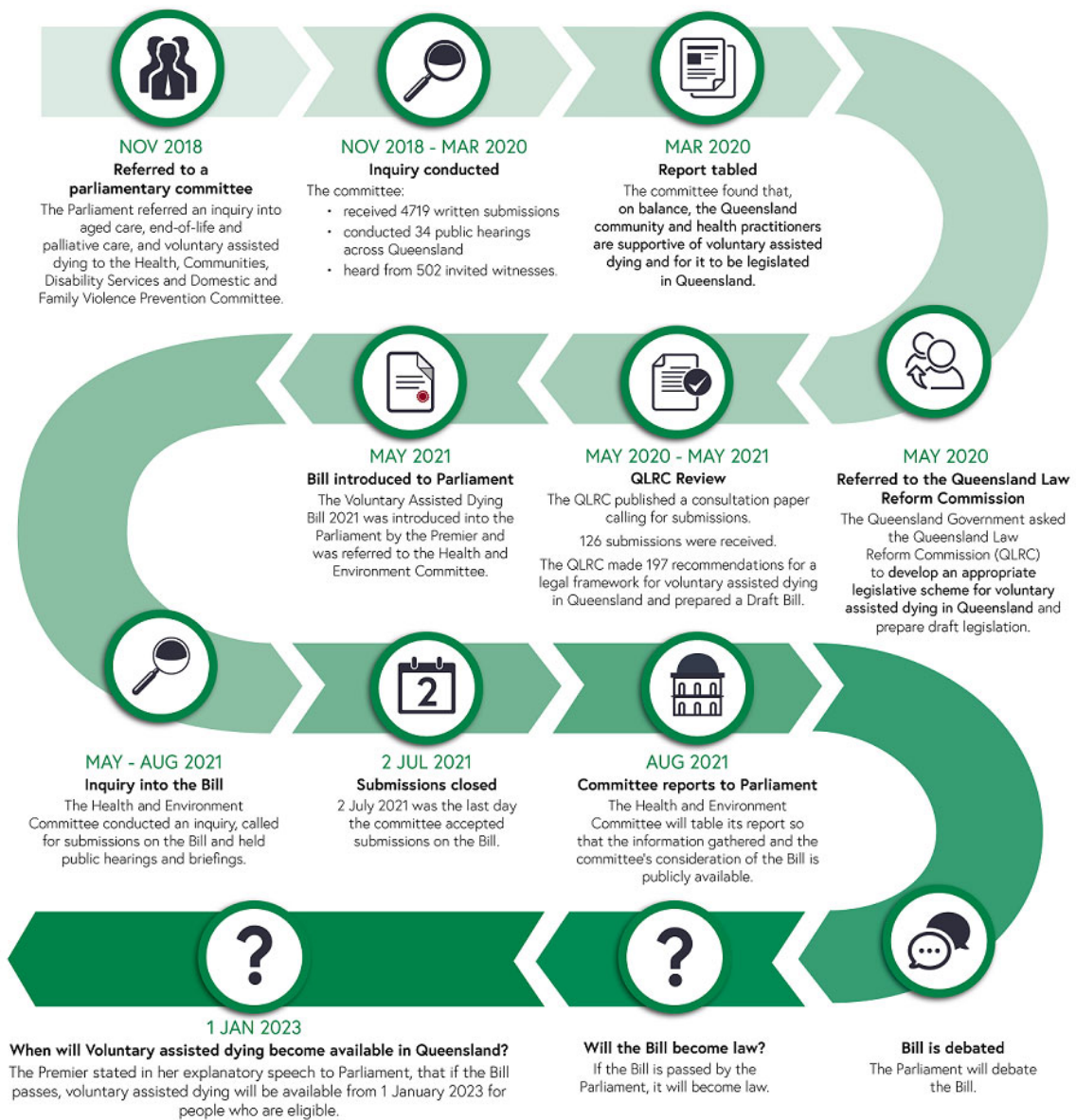
⁴⁰ QLRC Report, paragraph 1.31.

⁴¹ Professor Ben White and Professor Lindy Willmott, submission 1199 to the former Health Committee's inquiry into aged care, end-of-life and palliative care and voluntary assisted dying (11 April 2019). The draft bill is available as Appendix A to: Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020: <https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf#page=165>

⁴² Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, pp x-xii.

⁴³ Explanatory notes, p 5.

Figure 1: The Queensland Parliament's consideration of voluntary assisted dying



Source: Health and Environment Committee.

A number of submitters were supportive of the comprehensive process undertaken to develop a voluntary assisted dying scheme in Queensland. Queensland Doctors For Assisted Dying Choice (DADC) stated:

DADC strongly commends the political process that has led to the draft legislation being developed and tabled. It reflects the democratic process in action, with numerous contributions to both the initial parliamentary committee inquiry and the subsequent QLRC drafting process from Queensland citizens and institutions.⁴⁴

2.1 Community views on voluntary assisted dying

The committee's task was to examine the Bill and to consider the proposed legal framework for voluntary assisted dying in Queensland. Given that the former committee had comprehensively examined the policy debate in relation to voluntary assisted dying, this inquiry primarily focussed on the Bill.

However, the committee received several thousand submissions from people in Queensland who did not comment directly on the Bill but expressed their views in relation to the policy of voluntary assisted dying. To ensure that the views of all submitters were considered, an overview of opinions on voluntary assisted dying is set out below.

2.1.1 Support for voluntary assisted dying

Submitters expressed support for voluntary assisted dying for the following reasons:

- terminally-ill people have a right to choose when they die
- voluntary assisted dying can provide dignity for dying patients
- people would value the option of being able to access voluntary assisted dying
- palliative care cannot resolve all suffering
- the objections of some should not prohibit access to voluntary assisted dying for those who seek it
- terminally-ill people take their own lives in traumatic ways
- introducing voluntary assisted dying will not lead to more groups being eligible for it.

2.1.1.1 Terminally-ill people have a right to choose when they die

Some submitters were of the view that terminally-ill people should be able to choose the timing of their death. Lindy Collins considered this to be 'basically a human right. It is a human right of your choice to end your life as you choose when you choose'.⁴⁵

May Glaney added:

Everyone should have a choice and I am not against people who want to die whichever way they want. For me, I want to die peacefully and quickly. I do not want to linger and that is my choice, not theirs. Nobody should have a say over what I am allowed to do.⁴⁶

⁴⁴ Submission 720, p 1.

⁴⁵ Public hearing transcript, Townsville, 12 July 2021, p 32.

⁴⁶ Public hearing transcript, Townsville, 12 July 2021, p 35.

Jennifer Blake explained:

Watching my father struggle with motor neurone disease has been heartbreaking. My father is dying and there is nothing I can do to stop that. But my father is dying painfully, slowly and without dignity. My father deserves the opportunity to decide when and how he leaves the body that is failing him.⁴⁷

Denise Fernance explained her desire to have a choice over when she dies:

I have Stage IV Non Hodgkin Lymphoma and AL Amyloidosis - both terminal. It will be my choice when I feel the time is right. I do not want my family to suffer watching me die and I want to die with dignity. My life - My Choice.⁴⁸

Mark Vollmer believed his parents would have appreciated choice over when they died:

I was the hospice carer for both of my parents and the process of watching them both die from cancer was excruciating! To have been able to give them a legitimate choice would have been amazing and I would have been so grateful.⁴⁹

Lyn Hill-Webber highlighted a relative's situation:

I have an adult family member with a degenerative neurological condition. He has been unable to walk for several years now, and his quality of life is reducing significantly. He has many seizures and severe pain, and needs constant supervision. He and his wife both wish to be able to jointly decide when he has reached his limit. His parents and adult children also support his wishes, I hope this bill is passed, so he has this choice when the time comes.⁵⁰

2.1.1.2 Voluntary assisted dying can provide dignity for dying patients

Some submitters considered that being able to choose the timing of their death would mean they would be able to experience a dignified death. This was a point made by Fiona Brown, who has ovarian cancer:

I am well aware that my luck is going to run out sooner or later and when that occurs I would like the right to die with dignity.⁵¹

Another submitter made a similar point:

I am in middle life and healthy, but if one day I am in a position of suffering due to my health I wish to be able to choose to end my life with dignity and not to be forced into medically prolonging a life that has no quality for me.⁵²

One submitter explained:

I saw both my parents die in agony over several years, one of bowel cancer, the other of bone cancer in the jaw. Their deaths were agonising, degrading, and inevitable. If they had been given the option to end their lives when the pain and loss of control of body function became too much for them to bear, it would have given them a sense of control over their deaths, and they could have died with dignity.⁵³

Susan Wollstein considered:

We can fight with every ounce of our being to stay the inevitable but when there is no further hope and the person is in pain and the body is shutting down, why do we not allow them the dignity of leaving this life in peace not drugged up on medication that dims the pain but still the pain is there. I sat by my

⁴⁷ Submission 6, p 1.

⁴⁸ Submission 1111, p 1.

⁴⁹ Submission 1116, p 1.

⁵⁰ Submission 1132, p 1.

⁵¹ Submission 693, p 1.

⁵² Submission 12, p 1.

⁵³ Submission 1141, p 1.

husbands side as he went through this. It's a memory that will never leave me, or the family around us. I would hope that we have more compassion for those with no other alternative than death.⁵⁴

Linda Gardiner considered that voluntary assisted dying did not necessarily contravene God's will over the timing of people's death:

I believe God is a caring loving God who gave us the ability and right of free will. VAD is [giving] us our right to make an informed knowing choice to end of life, our suffering, our pain in a human and dignified way. It enables family to be with us and limits the possibility of dying alone as they couldn't get there or stay any longer.⁵⁵

2.1.1.3 People would value the option of being able to access voluntary assisted dying

Submitters argued that knowing they had the option of accessing voluntary assisted dying if they were terminally would be of comfort to them, a sentiment expressed by Cheryl Laizans:

My view is, that if I find myself with a terminal illness, I would most likely never take advantage of this law, BUT it would give me great peace of mind to know that option was there if I needed it.⁵⁶

Colin Hylton expressed the following view after witnessing his father's death:

To have had the option of VAD would have given him relief from the depressive process of simply waiting to die, and would have also ensured his final moments of consciousness were not spent in great pain.

I watched him die in such a manner. I do not want the same for myself and others. I want the option, the choice, to end my life with dignity at the time of my choosing, if there is no hope, if I have simply had enough of suffering.⁵⁷

One submitter explained the circumstances of their husband's death, and highlighted their husband would have valued a choice to end their life when they were terminally ill and suffering:

Michael showed great strength in making the decision he did to stop treatment and I know he was alert and astute enough that if the choice had of been his to make he would had chosen a much more dignified and peaceful end for himself and those he loved. This choice was not available, so he suffered unnecessarily as I still do left with the memories of what he went through and there was absolutely nothing I could do to help him The end result is Michael suffered and I am left with feelings of guilt and failure because I still feel there should have been something I could have done to make it easier.⁵⁸

Kathleen Ager explained:

As an Australian citizen in her seventies, I do not wish to be a burden or be dependent on others due to dementia or other mentally or physically debilitating (and humiliating) conditions, even if those are not considered terminal. I would like the option to end my life before I reach this stage.⁵⁹

2.1.1.4 Palliative care cannot resolve all suffering

While many submitters highlighted the relief that palliative care can provide, some submitters considered palliative care cannot resolve all end-of-life suffering, a view shared by Marj Lawrence:

We will always need palliative care. It helps a lot of people. But it is acknowledged that all pain cannot be controlled and pancreatic cancer is one of them. The treatment for patients is to increase the appropriate drug, which would render the patient unconscious until death supervenes. This process is not controlled.

⁵⁴ Submission 1179, p 1.

⁵⁵ Submission 17, p 1.

⁵⁶ Submission 347, p 1.

⁵⁷ Submission 25, p 2.

⁵⁸ Submission 21, p 1.

⁵⁹ Submission 1190, p 1.

The patient has no say in the matter. They can go on living for days or weeks, gasping and moaning all that time, and their family has to look on in desperation, not being able to do a thing about it.⁶⁰

Lindy Collins shared the story of her grandmother's death:

She was fully cognisant and she needed the relief of a death, a choice to die, but she was kept alive and every treatment just prolonged the agony she was in. She was fully cognisant right up to the end. She was given the option of choking to death or having an overdose of morphine. She chose the overdose of morphine. She had to make that conscious decision. With her little tracheotomy in her neck, she wrote to me and asked, 'Am I dying now?' I said, 'Gran, you have to make that decision of whether you have an overdose of morphine or you choke to death.' How much kinder could it have been? For 12 hours we sat with her and we sang to her. We were not allowed to stimulate her in any way so that it would interfere with her morphine death. We had to sit with her. We could sing to her but that is all we could do. To me that was totally inhumane. It was disgustingly inhumane.⁶¹

Gillian Callaghan shared her view based on her nursing career:

As a nurse for over 30 I have seen too many people die a painful death. People have been taken off strong pain medications when they can't swallow and given minuscule doses of morphine. Palliative care is often inadequate and drags on. People who are at the end of their life should have the right to shorten the dying process.⁶²

Alex Webling highlighted the limitations of palliative care to ease his grandmother's suffering as she died of leukaemia:

She got good palliative care because we had the resources to fund that, but that was not enough and did not take away the existential distress. Nothing could.⁶³

Another submitter stated:

I have sat by the bedside of a family member diagnosed with cancer, with widespread metastases.

The palliative care he was receiving could not be faulted. However, the feelings he shared with me showed clearly that palliative care does not have all the answers.

He said "Its not that I'm dying – its the way that I'm dying!" ie He had a colostomy to relieve his obstructed bowel – a catheter to empty his bladder – dependent on others for feeding, bathing, bowel and bladder management – pain unrelieved.⁶⁴

2.1.1.5 *The objections of some should not prohibit access to voluntary assisted dying for those who seek it*

While respecting the right of people to oppose voluntary assisted dying on religious or other grounds, some submitters argued that the opposition of some people to voluntary assisted dying should not be a reason for all people to be denied access to it. John O'Toole AM stated:

Australia is a multi-faith society with essentially secular laws, and it is therefore improper and unjust for any religion to impose its particular moral code on the citizens who obey those laws. Appeals to 'sacred traditions' are usually based on the traditional dominance of established Christianity, which must be respected as appropriate for Christians but not forced on those who do not share it.⁶⁵

⁶⁰ Public hearing transcript, Townsville, 12 July 2021, p 33.

⁶¹ Public hearing transcript, Townsville, 12 July 2021, p 31.

⁶² Submission 16, p 1.

⁶³ Submission 30, p 1.

⁶⁴ Submission 1003, p 1.

⁶⁵ Submission 835, p 1.

Penny Tovey, the wife of Peter Simpson, former secretary of the Electrical Trades Union Qld and NT branch, highlighted the suffering her husband experienced as he died from cancer and the need for this voluntary assisted dying for those who seek it:

I saw a placard at a recent rally outside Adelaide's Parliament House, ahead of them passing their own VAD law. It said 'Dying is hard enough, don't make it any harder'. That was certainly true of Peter's experience. Please keep this sentiment in mind as you consider this bill.⁶⁶

Adjunct Professor Gracelyn Smallwood also thought that a person's experience of pain and suffering should not be dictated by others:

I speak to you today about the imperatives of recalibrating our moral compass. We must show compassion for those families, friends and associates who are terminally ill so that they, through inconsistencies in state legislation, should not have to endure pain and suffering to appease the sensibilities of influential players actively engaged in this controversial debate.⁶⁷

Daniel Stewart considered:

Freedom of religion means that privately run public hospitals, whatever their religious background, need to respect the religious or non-religious beliefs of their patients. This means that whatever the religious background of the hospital, they need to allow VAD to happen in their hospitals.⁶⁸

Winifred Arthur stated:

How dare those who oppose VAD ie the minority, seek to make that choice for me and everyone else. While they fret about the slippery slope that isn't there in the legislation - and God's will that is clearly indicated when people are only kept alive by human intervention - people are dying in horrible and lonely ways.⁶⁹

A submitter stated voluntary assisted dying:

... will also not diminish anyone's religion whatsoever – those who are religious have a choice as well. It is not mandatory.⁷⁰

While acknowledging that some people of faith may object to voluntary assisted dying, one submitter who identified as a Christian submitted:

Do not deny me the destiny our creator has already chosen for me. Do not speak for God when God speaks directly to the suffering and offers hope to the dying. Be humble in your faith practice, not judgemental, overbearing, all-wielding of power. Be gentle with those whose faith or lifestyle differ from yours.⁷¹

2.1.1.6 Terminally-ill people take their own lives in traumatic ways

Some submitters discussed that terminally-ill people who do not wish to live any longer take their own lives, sometimes in distressing circumstances. This was a point highlighted by Phil Browne during his time as an advanced care paramedic, which included:

Attending horrifically violent suicides (e.g. by firearms) of Queenslanders who were terminally ill and experiencing grievous suffering. I've witnessed some of the seven frequently graphic suicides (and usually

⁶⁶ Submission 916, p 1.

⁶⁷ Public hearing transcript, Townsville, 12 July 2021, p 1.

⁶⁸ Submission 31, p 1.

⁶⁹ Submission 893, p 1.

⁷⁰ Submission 460, p 1.

⁷¹ Submission 446, p 1.

alone) by terminally ill Queenslanders each month (84 per year), as identified in the Queensland Coronial report provided to the previous Parliamentary Health committee VAD inquiry.⁷²

Chris Ennor outlined the experiences of some of his friends:

... at 75 yrs, I am at an age where a number of my friends and wider family had died experiencing Palliative Care. Of 4 cases with which I was closely associated 3 were good or just OK but the 4th was terrible where the sufferer felt that her only way out of the pain was suicide. She was successful on her 4th attempt and her husband came home from the supermarket to find she had hanged herself.⁷³

Jacqui Possingham discussed a person who:

... shot himself in the heart with a gun. He was terminally ill and the deterioration was horrendously and excruciatingly slow. His last independence was taken from him, when he could no longer get from his chair to his gopher to get the daily paper. This was the only activity left in his life.⁷⁴

Vanessa Quirk shared that she had:

... heard of 3 suicides in the last 6 months of people with terminal illnesses, 2 of whom were only in their 50's. They would have preferred Euthanasia with loved ones by their side but this was denied them by our current laws. Some suicides are very unpleasant; awful tragic experiences for the ill person and those that find them.⁷⁵

2.1.1.7 *Introducing voluntary assisted dying will not lead to more groups being eligible for it*

Some submitters rejected claims that, once introduced, voluntary assisted dying would become available to a wider group of people than included in the Bill. John O'Toole AM considered:

According to comprehensive and well-publicised studies internationally, there is little or no evidence from any of the VAD jurisdictions that to permit VAD will lead to progressive loosening and misuse of it by those of bad faith or motives. Many of the 'statistics' used to promote this 'slippery slope' argument are misusing real statistics by conflating the diverse practices in jurisdictions with different levels of permission, to make it look like a progressive and malevolent 'slide'.⁷⁶

A submitter considered:

I think the main thing about Voluntary Assisting Dying is that it is VOLUNTARY. I reject arguments that it is a slippery slope or that people will be coerced.⁷⁷

Marj Lawrence was also of the view that voluntary assisted dying eligibility would not broaden after its introduction:

Very few, if any, changes have been made to laws around the world and there are many countries that have these laws. Those that have changed them have done so because the public wanted them.⁷⁸

2.1.2 Opposition to voluntary assisted dying

Submitters expressed their opposition to voluntary assisted dying. Key concerns expressed were that voluntary assisted dying:

- fails to recognise that the timing of a person's death is God's decision
- may contradict health practitioners' religious beliefs

⁷² Submission 259, p 1.

⁷³ Submission 39, p 1.

⁷⁴ Submission 49, p 2.

⁷⁵ Submission 655, p 1.

⁷⁶ Submission 835, p 2.

⁷⁷ Submission 1108, p 1.

⁷⁸ Public hearing transcript, Townsville, 12 July 2021, p 33.

- may contradict health practitioners' ethical beliefs
- may lack sufficient safeguards to protect vulnerable people
- may eventually become available to more people than originally intended and is a 'slippery slope'
- may not be needed if good palliative care is available
- may contradict the message of anti-suicide campaigns.

2.1.2.1 The timing of a person's death is God's decision

Some submitters considered the timing of a person's death was a decision for God. Mark and Sheyl Gore stated:

All human beings are made in the image of God and it is God's prerogative to determine when a person's life ends.⁷⁹

Veronica Garnier expressed similar sentiments:

As a practicing Catholic I am extremely concerned with this bill. I feel it goes against freedom of religion when people are asked to something that is contrary to our beliefs. [It] goes against the fifth commandment of GOD Himself --- YOU SHALL NOT KILL. This was given to Moses. Disobedience to this is punishable to HELL for both the patient and health practitioner after death. Think about this please, PLEASE!⁸⁰

2.1.2.2 Voluntary assisted dying may contradict health practitioners' religious beliefs

A number of submitters considered that individual health practitioners' religious beliefs could be contravened if they were required to participate in a voluntary assisted dying scheme, as expressed by Mary Crabb:

This Bill runs roughshod over the freedom of conscience, religion and belief and respect of enjoyment of culture of those opposed to the Bill.⁸¹

Another submitter expressed concern that:

Health professionals with a conscientious objection would be forced to refer a patient for euthanasia. Their religious freedom must be protected by the bill.⁸²

Concern was expressed that requiring faith-based institutions, such as Christian aged care homes, to allow voluntary assisted dying to occur on their premises may violate the values on which they were founded. This point was raised by Dr Theo Shemansky, who considered that voluntary assisted dying:

... seeks to infringe upon a person's individual religious freedom as well as upon the collective religious freedom of an institution. This simply cannot be allowed to happen.⁸³

Nicholas Crowther stated:

Aged Care institutions that have charters opposed to euthanasia e.g. Catholic Health Australia and UnitingCare would be forced to permit the poison to be delivered to the patient or let an outside doctor come in and kill the patient.⁸⁴

⁷⁹ Submission 789, p 1.

⁸⁰ Submission 518, p 1.

⁸¹ Submission 940, p 1.

⁸² Submission 35, p 2.

⁸³ Submission 53, p 1.

⁸⁴ Submission 634, p 1.

2.1.2.3 Voluntary assisted dying may contradict health practitioners' ethical beliefs

Some submitters considered that health practitioners may object to voluntary assisted dying for ethical reasons. Gail Petherick stated:

Many doctors and Nurses don't want to assist a person to die and yet this law proposes they have to. That is unethical.⁸⁵

Madelein Venter considered that requiring a medical practitioner who has a conscientious objection to voluntary assisted dying to refer a patient to another medical practitioner is:

... morally and ethically wrong. At least grant a physician the option of abstaining from giving advise/referral if they object to it. You ask us to respect the choice that a patient wants to make to die, and similarly we should respect the choice a physician makes to step aside regarding this issue. A physician's job is to heal, not to kill.⁸⁶

Samantha Bryan considered this objection applied to institutions as well as individuals:

Many medical professionals and institutions will have ethical objections to VAD. Being obliged to refer someone elsewhere makes them complicit in what they may view as murder or assisted suicide. Medical professionals and institutions who are upholding the Declaration of Geneva should be able to follow their ethical beliefs and not be party, indirectly, to something they cannot support.⁸⁷

2.1.2.4 Voluntary assisted dying may lack sufficient safeguards to protect vulnerable people

Submitters raised concerns that the Bill may not adequately protect vulnerable patients. Majella Eva suggested 'the terminally ill will be susceptible to coercion',⁸⁸ while one submitter considered 'there is so much elder abuse already'⁸⁹

Camden McKenzie stated:

There are no mental health checks in place and no specialised training required to refer patients for euthanasia. Stronger controls need to be put in place.⁹⁰

2.1.2.5 Voluntary assisted dying may become available to more people than originally intended

Some submitters raised concerns that once voluntary assisted dying was introduced, eligibility for it would gradually expand beyond the groups it was originally intended for and become a 'slippery slope'. Valerie Wicks expressed the following concerns:

My limited research informs me that countries who have adopted euthanasia generally relax from the original intention of the law to include people suffering from depression and other non-life threatening conditions. No human government should buy into this but rather provide radically upgraded palliative care and counseling services.⁹¹

⁸⁵ Submission 545, p 1.

⁸⁶ Submission 599, p 1.

⁸⁷ Submission 42, p 1.

⁸⁸ Submission 588, p 1.

⁸⁹ Submission 907, p 1.

⁹⁰ Submission 856, p 1.

⁹¹ Submission 173, p 1; also see submission 588, p 2.

2.1.2.6 Voluntary assisted dying may not be needed if good palliative care is available

Some submitters to the inquiry were of the view that voluntary assisted dying is not needed when people have access to good palliative care. Vito and Lynette Cuzzubbo stated:

We support the many health professionals who say we should do all we can to protect Queenslanders rather than assist them in dying. Every Queenslander has a right to high quality palliative care, this then would negate the need for assisted suicide.⁹²

Carmen Thamm considered:

Well funded palliative care allows for dignity and care in death. Pain is managed and the person dies without the emotional turmoil to themselves and health care workers that is bound to occur with the decision making process prior to assisted suicide.⁹³

2.1.2.7 Voluntary assisted dying may contradict the message of anti-suicide campaigns

Some submitters argued that introducing voluntary assisted dying would undermine the impact of suicide reduction campaigns. Ellen Turnbull expressed this concern as follows:

In essence, this is an assisted suicide bill. In a time of increased fear and uncertainty, where suicides and attempted suicides continue to rise, it would be incredibly foolish and irresponsible to open up a pathway to more carnage.

After consistently hearing via the media over the past 18 months about how important it is to stay safe and save lives it is almost laughable that you now present a bill that in effect will not save lives and will in fact increase death. I'm not sure that representing or creating a culture of death is attractive or moral at all.⁹⁴

Hannah Berardi stated of the Bill:

What message does this send to those most vulnerable in society? On one hand you fund suicide hotlines providing hope, yet on the other you schedule the injection claiming it also as support. This is a terribly conflicting message for those facing decisions and thoughts of such nature.⁹⁵

⁹² Submission 283, p 1.

⁹³ Submission 360, p 1.

⁹⁴ Submission 515, p 1.

⁹⁵ Submission 606, p 1.

3 Overview of the Bill

According to the explanatory notes, the Bill proposes to establish a framework for voluntary assisted dying in Queensland that:

... sets out the eligibility criteria for accessing voluntary assisted dying, the request and assessment process that must be followed, qualification and training requirements for participating practitioners, and matters to support the operation of the scheme.⁹⁶

The Bill defines voluntary assisted dying as ‘the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration’.⁹⁷

The Bill embeds a number of safeguards to ensure voluntary assisted dying is accessed only by eligible people and to protect vulnerable people from coercion and exploitation.⁹⁸ The explanatory notes state the scheme should be accessible to people who are suffering and dying, and that the scheme should not become so complex and burdensome that it leads to adverse outcomes for people who wish to access it.⁹⁹

The Bill provides a list of principles that underpin it, including:

- human life is of fundamental importance
- every person has inherent dignity and should be treated equally and with compassion and respect
- a person’s autonomy, including autonomy in relation to end of life choices, should be respected
- every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person’s suffering and maximise the person’s quality of life
- access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland
- a person should be supported in making informed decisions about end of life choices
- a person who is vulnerable should be protected from coercion and exploitation
- a person’s freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.¹⁰⁰

Comments by submitters in relation to how these principles are achieved form part of subsequent discussions in this report. The Queensland Council of Unions expressed the view that the principles are consistent with the principles outlined in the HRA as they incorporate the ‘principle of autonomy and the importance of self-determination in decision-making about end-of-life care’ and they also recognise the need to provide protections for the more vulnerable people within the community’.¹⁰¹

⁹⁶ Explanatory notes, p 5.

⁹⁷ Voluntary Assisted Dying Bill 2021, Schedule 1.

⁹⁸ Explanatory notes, p 5.

⁹⁹ Explanatory notes, p 5.

¹⁰⁰ Voluntary Assisted Dying Bill 2021, s 5.

¹⁰¹ Submission 1148, p 4.

Similarly, the Clem Jones Group stated:

We submit that the Bill meets these principles and draws upon and improves VAD laws passed elsewhere in Australia and in jurisdictions overseas.¹⁰²

The Queensland Human Rights Commission (QHRC), Queensland Law Society and Aged and Disability Advocacy Australia (ADA Australia) proposed that these principles be extended by including an extra principle stating that each person in Queensland enjoys all relevant human rights, including those legislated in the HRA.¹⁰³

3.1 Key elements of the Bill

The committee's consideration of the Bill is broadly grouped into the following four areas:

- eligibility criteria
- voluntary assisted dying assessment and administration processes
- additional safeguards
- operational matters.

However, the Bill is part of a wider suite of health pathways and therefore the committee also considered stakeholders' views on palliative care and equity of access to voluntary assisted dying.

3.2 Eligibility criteria to access voluntary assisted dying

The Bill sets out eligibility requirements for access to voluntary assisted dying. To be eligible, a person must fulfil requirements relating to:

- a disease, illness or medical condition
- decision-making capacity
- acting voluntarily and without coercion
- age
- residency.¹⁰⁴

3.2.1 A person must have an eligible disease, illness or medical condition

The Bill provides that a person would be eligible to access voluntary assisted dying if they have been diagnosed with a disease, illness or medical condition that is:

- advanced, progressive and will cause death
- expected to cause death within 12 months
- causing suffering that the person considers to be intolerable.¹⁰⁵

In its report, the QLRC explained that whether a disease, illness or medical condition was advanced and would cause death is a clinical determination taking into account a person's individual circumstances.¹⁰⁶ It also stated that a person with a disability or mental illness who met all the eligibility criteria would not be excluded from accessing voluntary assisted dying. However, under the

¹⁰² Submission 984, p 4.

¹⁰³ See submissions 1314, 1031, 1055.

¹⁰⁴ Voluntary Assisted Dying Bill 2021, cl 10.

¹⁰⁵ Voluntary Assisted Dying Bill 2021, cl 10 (1).

¹⁰⁶ QLRC Report, paragraph 7.76.

Bill, a person would not be eligible for voluntary assisted dying solely on the basis of a disability or mental illness.¹⁰⁷

Stakeholder views

3.2.1.1 *Advanced, progressive and will cause death*

In terms of eligibility criteria, a number of stakeholders outlined their support for the Bill as drafted.¹⁰⁸ In particular, the Clem Jones Group argued that the eligibility criteria also served as safeguards in the Bill, together with additional safeguards that are discussed in section 3.4 of this report:

The eligibility criteria alone provide safeguards in prerequisites of having a terminal illness that is advanced and progressive, with death to occur within 12 months and the illness causing intolerable suffering, together with the age requirement of adulthood and decision-making capacity.¹⁰⁹

DWDV stated that ‘the eligibility criteria are similar to those that apply in Victoria. They are reasonable in view of community expectations at this time’.¹¹⁰

In answer to a question about whether Queensland Advocacy Inc (QAI) was comfortable with the eligibility criteria set out in the Bill, CEO Matilda Alexander agreed, stating:

Yes. From a human rights perspective, our main concern would be where the criteria of disability is the sole criteria for a scheme of voluntary assisted dying. That would not be in compliance with the Convention on the Rights of Persons with Disabilities. As this has those additional criteria which are not related to disability, this is a more acceptable scheme.¹¹¹

However, other stakeholders submitted that the eligibility criteria should be either widened¹¹² or narrowed.¹¹³

Philip Nitschke from Exit International favoured the widening of eligibility criteria. He was of the view that the issues being debated were a by-product of modern medicine which has allowed people to be kept ‘technically alive but with a rather decreasing quality of the life’.¹¹⁴

Conversely, some stakeholders including the Australian Medical Association Queensland suggested that the medical condition of a person seeking voluntary assisted dying should be incurable and therefore should be included in the eligibility criteria.¹¹⁵ AMA Queensland argued that ‘the word ‘incurable’ must be included, otherwise the legislation could include curable conditions’.¹¹⁶

DADC provided an example of why including incurable in eligibility criteria may present problems:

For instance, a terminally ill person may be offered an operation that was totally unacceptable for them to go along with, so that would potentially exclude that person from it even though they are exercising the ethical right they have to have autonomy and decide with their medical professionals what treatments to take. I would be personally—this is just very quick—cautious about putting that word in as an obligatory eligibility requirement just for that reason.¹¹⁷

¹⁰⁷ QLRC Report, paragraph 7.77.

¹⁰⁸ For example, see submissions 278, 984, 1003, 1050, 1065, 1087, 1146, 1148, 1189.

¹⁰⁹ Submission 984, p 5.

¹¹⁰ Submission 1056, p 2.

¹¹¹ Public hearing transcript, Brisbane, 14 July 2021, p 16.

¹¹² For example, see submissions 1004, 1027, 1086.

¹¹³ For example, see submissions 1054, 1063, 1126.

¹¹⁴ Public hearing transcript, Brisbane, 15 July 2021, p 73.

¹¹⁵ See submissions 260, 1110.

¹¹⁶ Public hearing transcript, 15 July 2021, p 36.

¹¹⁷ Public hearing transcript, 15 July 2021, p 48.

In terms of a patient's right to refuse medical treatment, Professors White and Willmott commented that the Bill does not expressly deal with how treatment refusals should be considered when interpreting the eligibility criteria, and suggested that 'it would be helpful for the Bill to explicitly state that the eligibility criteria are to be interpreted in light of the existing right to refuse medical treatment'.¹¹⁸ However, they stated that 'the Commission's report appears to endorse the proposition that existing rights to refuse treatment should be taken into account when determining the meaning of the eligibility criteria'.¹¹⁹

QLRC view

Both the explanatory notes and the QLRC Report state that the eligibility criteria clarify that voluntary assisted dying is an option only for people at the end of life who are suffering and dying.¹²⁰ The QLRC Report stated:

It is not a choice between life and death; it is an option for those who are in the process of dying to exercise some control over how and when they die. This approach strikes the right balance between the fundamental value of human life and the values of individual autonomy and reduced suffering.¹²¹

With respect to the inclusion of the word 'incurable', as outlined in its report, the QLRC did not consider it necessary to include it in the eligibility criteria because it did not materially add to the other eligibility criteria, and:

... it could cause confusion about the extent to which a person must have exhausted all available treatment options before becoming eligible to access voluntary assisted dying, even though such an interpretation is inconsistent with a person's right to refuse medical treatment that is not acceptable to them.¹²²

3.2.1.2 Expected to cause death within 12 months

Stakeholders held a wide range of views with respect to the inclusion of the timeframe of 12 months until death as an eligibility criterion. A number of stakeholders such as DADC, the Royal Australian and New Zealand College of Psychiatrists, Queensland Branch and Christians Supporting Choice for Voluntary Assisted Dying supported the 12-month timeframe until death.¹²³ DWDQ was also supportive of this aspect of the Bill stating:

A 12-month timeframe is more encompassing of the varied clinical trajectories of different diseases, illnesses, and medical conditions. It also allows the dying person more time to come to terms with their situation and make preparations in a timely way.¹²⁴

Similarly, Fay Wise stated:

I strongly commend the draft writers on making eligibility available at 12 months instead of 6 months, as is the case with other states. We all realise that unbearable suffering can occur for many people with terminal illnesses well before 6 months of life expectancy. Why make people suffer until an arbitrary time is arrived at.¹²⁵

¹¹⁸ Submission 906, p 2.

¹¹⁹ Submission 906, p 8.

¹²⁰ QLRC Report, paragraph 7.71.

¹²¹ QLRC Report, paragraph 7.71.

¹²² QLRC Report, paragraph 7.71.

¹²³ See submissions, 720 p 1, 1266, p 2, 24, p 2.

¹²⁴ Submission 278, p 3.

¹²⁵ Submission 1146, p 1.

Some stakeholders including the Queensland Council for Civil Liberties and the Australian Lawyers Alliance (ALA)¹²⁶ proposed that there should be no timeframe until death in the eligibility criteria, because including such a requirement complicates the process for the coordinating and consulting practitioner.¹²⁷ The QNMU were of the view that the inclusion of a timeframe until death not only diminishes the complexity of a prognosis but has the effect of removing a person's autonomy.¹²⁸

Similarly, the ALA contended that a person 'should not be excluded from a voluntary assisted dying scheme because their disease, illness or medical condition, which causes them intolerable suffering, is expected to cause their death in a slower timeframe'.¹²⁹

Further, QCCL expressed support for extending voluntary assisted dying to people who are experiencing unbearable pain and suffering, with no prospect of improvement on the basis that many illnesses cause terrible suffering, but are not terminal nor will cause death.¹³⁰

In contrast, other stakeholders such as the Queensland Baptists, Health Professionals Say No!, Lutheran Church of Australia (Queensland District), and Cherish Life Queensland proposed a timeframe of 6 months.¹³¹ Each of the organisations that proposed the 6 month timeframe indicated that they do not support voluntary assisted dying in principle.¹³²

Some stakeholders including Professors White and Willmott, Clem Jones Group, Voluntary Assisted Life Ending Group (VALE Group) and DWDQ took the view that while they preferred no timeframe be applied to the eligibility criteria, a 12-month timeframe was preferable to a 6-month timeframe as it would allow more time for a person seeking voluntary assisted dying.¹³³ Professor White stated:

It is hard to justify having different time limits for different illnesses. ... The Victorian experience shows that the process is very demanding for terminally ill and sick patients and takes some time. ... A 12-month period may allow patients to start this process a little earlier and reduce the likelihood that they may die or lose capacity first.¹³⁴

Professors White and Willmott warned of the consequences of political compromise and provided the example from Victoria where a last minute political compromise, which was not evidence based, led to the timeframe to death of 6 or 12 months until expected death – depending on the nature of a patient's illness.¹³⁵ They explained that this last minute addition in Victoria has 'since been uncritically adopted and replicated in other states in Australia' despite research by the professors showing 'that the Victorian VAD law fails to meet its own stated policy goals in important respects, sometimes because of these later ad hoc additions during the law-making process'.¹³⁶

QLRC view

The QLRC was of the view that a specific timeframe gives clear guidance to the community and the health profession about who is eligible.¹³⁷

¹²⁶ Submissions 1004, 1027, 1345.

¹²⁷ Submission 1027, p 8.

¹²⁸ Submission 937, p 7.

¹²⁹ Submission 1027, p 8.

¹³⁰ Submission 1004, p 2.

¹³¹ See submissions 1044, 1228, 1309, 1360, 1226.

¹³² See submissions 1044, 1226, 1228, 1309, 1360.

¹³³ See submissions 278, 906, 987, 1271.

¹³⁴ Public hearing transcript, Brisbane, 15 July 2021, p 2.

¹³⁵ Submission 906, p 5.

¹³⁶ Submission 906, p 5.

¹³⁷ QLRC Report, paragraph 7.146.

While acknowledging that in both Victoria and Western Australia the timeframe in which death is expected is 6 months, or 12 months for people with neurodegenerative conditions, the QLRC outlined the advantages of a single timeframe of 12 months:

While a timeframe of six months may be more consistent with an end of life clinical trajectory for most advanced cancers, a timeframe of 12 months also encompasses the clinical trajectories of people with other types of eligible diseases, illnesses or medical conditions, including neurodegenerative diseases such as motor neurone disease, or chronic illnesses such as chronic heart failure.¹³⁸

The QLRC considered that the timeframe of 12 months is consistent with current health care practice in Australia, particularly in relation to end-of-life and palliative care¹³⁹ and that it was undesirable to adopt different policies for different types of diseases.¹⁴⁰

3.2.1.3 Causing suffering that the person considers to be intolerable

The Bill requires a person to be diagnosed with a disease, illness or medical condition that 'is causing suffering that the person considers to be intolerable'¹⁴¹ and that the suffering must be causally linked to the disease or illness or medical condition that makes them eligible for voluntary assisted dying.¹⁴²

The QNMU attributed the growing number of people who may experience pain and suffering towards the end of life to the development of modern medical technology and the ability to prolong life for conditions that were previously terminal.¹⁴³

Dr Will Cairns stated:

I think there are very few palliative care professionals who believe we can resolve all of the issues from which people are suffering at the end of their life. We are pretty good at controlling pain but certainly not to 100 per cent. Some people have some pretty horrible things which we cannot fix. I will not go into graphic detail, but there are some dreadful scenarios that people find themselves in.

...

I think the key thing in the descriptions of the reasons that people might want voluntary assisted dying is that it is insufferable from their point of view, not from someone else's. It can also be about non-physical distress that people are experiencing at the end of their life.¹⁴⁴

Conversely, a small number of submitters¹⁴⁵ commented on the lack of objectivity in the criteria referencing 'suffering that the person considers to be intolerable'.¹⁴⁶ Ben Lawson called attention to the subjectivity of the criterion and suggested adding a degree of objectivity:

'Suffering' is subjective and hence is open to a wide degree of interpretation by different patients. The interpretation can also be affected by a patient's mental health and wellbeing and hence it is possible for a misinterpretation to occur by the patient.

As such, there needs to be a degree of objective assessment here, which could include a physician interviewing close family members or friends regarding the daily experiences of the patient that they observe.¹⁴⁷

¹³⁸ QLRC Report, paragraph 7.147.

¹³⁹ QLRC Report, paragraph 7.146.

¹⁴⁰ QLRC Report, paragraph 7.150.

¹⁴¹ Voluntary Assisted Dying Bill 2021, cl 10.

¹⁴² Explanatory notes, p 8.

¹⁴³ Submission 937, p 5.

¹⁴⁴ Public hearing transcript, Townsville, 12 July 2021, p 9.

¹⁴⁵ For example, see submissions 1228, 1285, 1058.

¹⁴⁶ Donna Purcell, submission 1285, p 3.

¹⁴⁷ Submission 1058, p 3.

The Bar Association of Queensland highlighted the absence of an objective test for mental suffering and questioned whether the drafting of the Bill reflects the policy intention underpinning the Bill.¹⁴⁸ It also suggested including an additional requirement ‘that a relevant condition cause suffering that is ‘not temporary’.¹⁴⁹

AMA Queensland were of a similar view and considered that a person’s request to access voluntary assisted dying should be enduring ‘to ensure that the person’s request is well considered and is more than a short-term reaction to their condition’.¹⁵⁰

In relation to mental suffering, the Australian Family Association raised the concern that ‘the Bill would allow a terminally ill patient to request voluntary assisted dying on the basis of “intolerable suffering” which is just mental or emotional, not strictly physical’.¹⁵¹

Similarly, the Uniting Church in Australia Queensland Synod, St Kevin’s Parish Pastoral Council and Health Professionals Say No! questioned the inclusion of mental suffering in the definition of suffering on the basis that this would allow vulnerable people suffering from a mental illness to access the scheme.¹⁵²

QLRC view

The QLRC considered that its approach recognises that suffering is a personal experience best determined by the sufferer and that it may take various forms.¹⁵³

While suffering can include physical and mental suffering, the QLRC clarified that unrelated pre-existing conditions such as loneliness do not qualify a person to access voluntary assisted dying.¹⁵⁴

In addition, the QLRC stated:

We acknowledge that a person should not be able to access voluntary assisted dying for trivial or temporary suffering, or because the person is lonely or feels they are a burden on others. The draft Bill does not provide access in such cases. The Bill must be considered in totality.¹⁵⁵

Further to considering the Bill in totality, the QLRC stated that to access voluntary assisted dying, the person must complete the requirements of the request and assessment process which demonstrates that the person’s request is enduring and this indirectly ensures that the intolerable suffering that prompts the person’s separate requests is not temporary.¹⁵⁶ The QLRC outlined that the elements of the assessment process that embed the enduring nature of a person’s request for voluntary assisted dying include:

- the requirement for the person to make three separate requests during the request and assessment process, one of which is in writing, coupled with a minimum waiting period;
- the assessment of decision-making capacity, which forms part of the coordinating assessment and the consulting assessment, includes an assessment of whether the person understands the nature and effect of their decision to access voluntary assisted dying; and to have that capacity, the person must be able to communicate their decisions about voluntary assisted dying;

¹⁴⁸ Submission 1311, p 4.

¹⁴⁹ Submission 1311, p 6.

¹⁵⁰ Submission 260, p 2.

¹⁵¹ Submission 1301, p 4.

¹⁵² See submissions 244, 568, 1228.

¹⁵³ QLRC Report, paragraph 7.195.

¹⁵⁴ QLRC Report, paragraphs 7.194; Voluntary Assisted Dying Bill 2021, cl 10 (2).

¹⁵⁵ QLRC Report, paragraph 7.196.

¹⁵⁶ QLRC Report, paragraph 7.199.

- the requirement for the coordinating practitioner and the consulting practitioner, if they are satisfied that the person is eligible, to each inform the person that they can decide not to continue the request and assessment process or not to access voluntary assisted dying at any time;
- the making of an administration decision by an eligible person; and in the case of practitioner administration, the requirement for the administering practitioner to be satisfied that, at the time of administering the substance, the person had decision-making capacity.¹⁵⁷

3.2.2 A person must have decision-making capacity

The Bill provides that a person must have decision-making capacity to be eligible to access voluntary assisted dying.¹⁵⁸ The Bill specifies that a person has decision-making capacity in relation to voluntary assisted dying when they can:

- understand the nature and effect of decisions about access to voluntary assisted dying
- freely and voluntarily make decisions about access to voluntary assisted dying
- communicate decisions about access to voluntary assisted dying in some way.¹⁵⁹

The Bill also provides guidance as to how decision-making capacity should be determined and includes a presumption that a person has decision-making capacity unless there is evidence to the contrary.¹⁶⁰

Stakeholder views

Stakeholders commented on the eligibility of persons who lack or may lose decision making capacity, the possibility of using of substitute decision makers or advance health directives, and the assessment of capacity under the Bill.

3.2.2.1 Eligibility of persons who lack or may lose decision making capacity

The Public Advocate supported the approach of the QLRC in requiring that a person must have decision-making capacity throughout the voluntary assisted dying process:

I further support the Bill's clear approach that the VAD process is not applicable to the Guardianship and Administration Act or the Powers of Attorney Act, meaning that the VAD process will not be open to people through a substitute decision-maker or other enduring arrangements.¹⁶¹

However, several stakeholders raised concerns that the Bill will not assist people suffering from dementia given the inclusion in the eligibility criteria of a requirement to have decision-making capacity.¹⁶² Dementia Australia submitted that while its position is neutral on voluntary assisted dying, it supports the right of people with dementia to have choice in their end-of-life care including voluntary assisted dying.¹⁶³ It stated:

Unlike other terminal conditions, the later stages of dementia often hinder communication and cognition. This means that people with dementia are more likely to be given unwanted life-sustaining treatments, and are often denied the choice in how and when they die.¹⁶⁴

¹⁵⁷ QLRC Report, paragraph 7.561.

¹⁵⁸ Voluntary Assisted Dying Bill 2021, cl 10 (1)(b).

¹⁵⁹ Voluntary Assisted Dying Bill 2021, cl 11 (1).

¹⁶⁰ Voluntary Assisted Dying Bill 2021, cl 11 (2).

¹⁶¹ Submission 1295, p 1.

¹⁶² See submission 281 and Professor Colleen Cartwright, public hearing transcript, Brisbane, 15 July 2021, p 9.

¹⁶³ Submission 281, p 2.

¹⁶⁴ Submission 281, p 3.

Professor Colleen Cartwright also considered that a person who loses decision making capacity should not necessarily be ineligible to access voluntary assisted dying:

While this proposed legislation is the best that has been developed so far in Australia, it does not address the inherent discrimination against people with dementia. Many people have experienced the impact of dementia on someone they loved, and they do not want to experience the ravages of the disease themselves.¹⁶⁵

3.2.2.2 *Advanced and substitute decision making*

Despite the access to voluntary assisted dying being conditional on decision-making capacity of the person at all stages of the process, a number of stakeholders suggested the use of advance health directives or substitute decision-makers under the *Powers of Attorney Act 1998* or the *Guardianship and Administration Act 2000*. QCCL, AMA Queensland and RANZCP Queensland submitted that a person who made the decision to access voluntary assisted dying services prior to their loss of capacity should be eligible to access voluntary assisted dying in circumstances where capacity has been subsequently lost.¹⁶⁶

Dr Heather McNamee on behalf of DADC explained:

... the loss of dignity and autonomy that dementia inevitably brings is one of the biggest causes of distress to people diagnosed with it. The use of a possible advance health directive with VAD built into I think would give people immense comfort. Even the AMAQ, who have not been overly supportive of the legislation until recently because I think they have seen the writing on the wall, have stated their support for the use of advance health directives for someone to say that 'in the event of my becoming completely incapacitated I wish to access VAD'.¹⁶⁷

The ANZSGM stated that it did not support other decision-makers having the ability to make decisions about voluntary assisted dying on behalf of someone who does not have capacity to do so.¹⁶⁸ The Public Advocate concurred, advising:

I further support the Bill's clear approach that the VAD process is not applicable to the Guardianship and Administration Act or the Powers of Attorney Act, meaning that the VAD process will not be open to people through a substitute decision-maker or other enduring arrangements.¹⁶⁹

While QLS recommended that the Bill should expressly invalidate a desire to access voluntary assisted dying in an advance health directive, enduring power of attorney or similar,¹⁷⁰ the QHRC advised:

The Explanatory Notes also discuss that clause 173 of the Bill makes amendments to the *Guardianship and Administration Act 2000* to provide that the Voluntary Assisted Dying Act is not a matter to which that Act applies. The Notes suggest the purpose of this amendment is to ensure that an adult is excluded from making decisions about voluntary assisted dying in an advance health directive.¹⁷¹

While not discussed in detail, this reflects the recommendation of the QLRC that a person who loses decision-making capacity should not continue to participate in the scheme.¹⁷²

¹⁶⁵ See submission 1000, p 4.

¹⁶⁶ See submissions 1004, 260, 1266.

¹⁶⁷ Public hearing transcript, Townsville, 12 July 2021, p 15.

¹⁶⁸ Submission 1320, p 2.

¹⁶⁹ Submission 1295, p 1.

¹⁷⁰ Submission 1031, p 2.

¹⁷¹ Submission 1314, p 20.

¹⁷² Submission 1314, p 20.

A number of stakeholders considered that advance decision making about voluntary assisted dying should be the subject of further research or that loss of capacity could be revisited when the law is reviewed.¹⁷³

DWDQ advised that while their position on decision making capacity is a matter for future consideration, the topic is overwhelmingly a concern for its 20,000 members and supporters and it raised at every public meeting.¹⁷⁴ Similarly, ADA Australia recommended 'that further consultation regarding the possible use of advance health directives be included upon review of the legislation, pursuant to the review provisions under clause 154(2)'.¹⁷⁵

Professor Sarah Larkin held a similar view, stating:

Personally, I am a supporter of looking at that for future legislation. I think it has to be done very carefully. For this legislation, I think how it is probably optimal to get VAD on the table. As someone who has witnessed family members dying of dementia and so on who have very clearly expressed their views while they still are competent and in the early stages, I think that is something we need to tackle as a society. It needs a lot more debate, but it is worth considering.¹⁷⁶

Dementia Australia outlined its support for family members and carers having the opportunity to be included in the decision-making process for voluntary assisted dying where the person seeking voluntary assisted dying made an initial request at a time when they had capacity and had also given formal consent for others to be involved.¹⁷⁷

3.2.2.3 *Assessment of capacity*

With respect to the assessment of capacity, the Bill includes a presumption that a person has decision-making capacity unless there is evidence to the contrary. A number of stakeholders supported the presumption of capacity and the consistency in its application across the health sector in Queensland.¹⁷⁸ The Public Advocate stated:

I support the approach in the Bill in relation to the adoption of guiding principles, the definition of capacity, the ability of those diagnosed with a disability or mental illness (should they have capacity to make such decisions), and the involvement of QCAT to review administrative decisions regarding the VAD process.¹⁷⁹

QHRC endorsed the presumption of capacity and also suggested that those who assess capacity are obliged to provide appropriate supports:

The QHRC welcomes the confirmation in clause 11 that a person is presumed to have decision making capacity, and should not be presumed not to have capacity because of a personal characteristic or disability. Further, the clause provides that a person may be capable of having decision making capacity with adequate and appropriate supports. However, the QHRC suggests that this safeguard would be further strengthened if those assessing capacity were obliged to seek out or provide such supports whenever necessary and appropriate.¹⁸⁰

¹⁷³ Dying with Dignity Queensland, public hearing transcript, 14 July 2021, p 10; submissions 937, 1055.

¹⁷⁴ Public hearing transcript, Brisbane, 14 July 2021, pp 10-11.

¹⁷⁵ Submission 1055, p 2.

¹⁷⁶ Public hearing transcript, Townsville, 12 July 2021, p 20.

¹⁷⁷ Submissions 281, p 3, 1148, p 5.

¹⁷⁸ For example, see submissions 720, 1148, 1295, 1027, 1314.

¹⁷⁹ Submission 1295, p 1.

¹⁸⁰ Submission 1314, p 20.

In addition to supporting the presumption of capacity, the QHRC, the Public Advocate, QLS, DADC and ALA supported the definition of decision-making capacity provided in the Bill.¹⁸¹ ALA explained:

The definition of ‘decision-making capacity’ in section 11 of the VAD Bill is the same definition as ‘capacity’ in the *Guardianship and Administration Act 2000* (Qld) and, given the complexities associated with determining a person’s ‘capacity’, it is appropriate that the definition is consistent with other legislation in Queensland.¹⁸²

In contrast, several submitters challenged this presumption and suggested that the presumption be removed.¹⁸³ Catholic Health Australia acknowledged that the presumption of decision-making capacity aligns with the *Mental Health Act 2016*, but questioned its applicability to voluntary assisted dying, stating:

... it fails to consider a key difference: the fact that VAD results in death. Determining a person’s capacity to request VAD should not be treated in the same way as any other assessment about capacity. Assessing a person’s capacity to end their life (and understand all the steps involved and their potential consequences) should have a higher bar than, for example, assessing their ability to enter a commercial transaction.¹⁸⁴

Similarly, the Australian Christian Lobby (ACL) submitted that given the gravity of the decision, the presumption should be removed, and called for the clause to be amended to specifically state ‘that a person with a disability or mental illness is taken to lack decision-making capacity’.¹⁸⁵

Some stakeholders expressed concern about how a person’s decision making capacity would be assessed under the scheme.¹⁸⁶ ANZSGM submitted that all people requesting voluntary assisted dying should have a capacity assessment prior to accessing the scheme:

The ANZSGM agrees people requesting VAD should have a capacity assessment prior to accessing the scheme as per *Guardianship and Administration Act 2000*. Capacity should be assessed by a specialist medical practitioner who has expertise in capacity assessment.¹⁸⁷

However, it acknowledged that capacity may need to be re-assessed again through the assessment process to ensure that any action taken is consistent with the person’s wishes.¹⁸⁸

RANZCP Queensland highlighted the challenges in performing capacity assessments in some situations and submitted that training modules for assessing capacity were insufficient.¹⁸⁹

Similar calls were made by Catholic Health Australia who submitted that where a person has a condition that could affect capacity, the practitioner should be required to obtain an independent assessment by a relevant specialist.¹⁹⁰

Professor Lindy Willmott commented that specialists are not currently required to undertake capacity assessments¹⁹¹ and DADC also advised that it is normal practice in Australia for general practitioners (GPs) to conduct capacity assessments:

¹⁸¹ See submissions 1314, 1027, 720.

¹⁸² Submission 1027, p 8.

¹⁸³ For example, see submissions, 1110, 1054, 1150.

¹⁸⁴ Submission 1150, p 9.

¹⁸⁵ Submission 1054, p 6.

¹⁸⁶ For example, see submissions 1320, 1150.

¹⁸⁷ Submission 1320, p 2.

¹⁸⁸ Submission 1320, p 3.

¹⁸⁹ Public hearing transcript, Brisbane, 15 July 2021, p 31.

¹⁹⁰ Submission 1150, p 3.

¹⁹¹ Public hearing transcript, Brisbane, 15 July 2021, p 7.

GPs have the training and the experience to assess somebody's capacity and to pick up those who do not have capacity or are immensely unwell or whose dementia has reached the level where they do not have the capacity anymore. That is an intrinsic part of being a GP and seeing hundreds of patients a week.¹⁹²

Health Consumers Queensland (HCQ) provided implementation suggestions to support people with a cognitive disability who still have decision making capacity and recommended consultation with QAI and Queenslanders with Disability Network, should the Bill pass:

These consumers need to be given information about their options at the end of life in an accessible way that works for them, to enable them to make informed decisions. This may include simplified information, extra information or detail, time to consider their options and discuss if they wish with caregivers or family.¹⁹³

QLRC view and department response

The QLRC considered that the scheme should be limited to those with decision-making capacity.¹⁹⁴ While sympathetic to the views of respondents who advocated for decisions about voluntary assisted dying to be made in advance and those who identified concerns about people with dementia, the QLRC was of the view that access to voluntary assisted dying should be available only where the person seeking access has capacity at all stages of the process.¹⁹⁵

This is one of the fundamental safeguards in the draft Bill. It recognises and protects individual autonomy. In conjunction with other safeguards, this requirement will help ensure that a person's decision is voluntary, and protect people who might be vulnerable to coercion or exploitation.¹⁹⁶

The QLRC did not consider that the voluntary assisted dying scheme it proposed, and upon which the Bill is based, could adequately provide for advance decision-making.

The QLRC confirmed that the requirement to have decision-making capacity was consistent with legislation in other Australian jurisdictions and is generally consistent with the Queensland's *Guardianship and Administration Act 2000* and associated Capacity Guidelines.¹⁹⁷

The QLRC recognised the argument that a person's autonomy may be protected by permitting a person to make an advance decision about voluntary assisted dying through which the choices they have clearly laid out are implemented.¹⁹⁸ However, it stated that this must be balanced against the need to protect the vulnerable. If an advance authority to administer were binding, a person could not change their mind and halt the process at that point.¹⁹⁹ In such circumstances, the process would not be voluntary.²⁰⁰

Additionally, the QLRC highlighted a range of difficulties associated with designing a scheme that would permit advance decision-making about voluntary assisted dying, including:

- when a person could be permitted to make an advance decision, and how this could occur – for example, is the person eligible to make an advance decision from the period after diagnosis or at the point of being found eligible for access to voluntary assisted dying?

¹⁹² Public hearing transcript, Townsville, 12 July 2021, p 16.

¹⁹³ Submission 1355, p 4, public hearing transcript, Brisbane, 14 July 2021, p 16.

¹⁹⁴ See Report No. 34, 56th Parliament – Voluntary Assisted Dying, Recommendation 6 and QLRC Report, paragraph 7.307.

¹⁹⁵ QLRC Report, paragraph 7.307.

¹⁹⁶ QLRC Report, paragraph 7.254.

¹⁹⁷ QLRC Report, paragraph 7.271. See also QLRC Report, paragraph 7.313.

¹⁹⁸ QLRC Report, paragraph 7.310.

¹⁹⁹ QLRC Report, paragraph 7.309.

²⁰⁰ QLRC Report, paragraph 7.309.

- the onus on a medical practitioner to decide when a person should be administered a voluntary assisted dying substance would place a significant burden on the practitioner
- the difficulty for a medical practitioner to apply any subjective criterion, such as a person's level of suffering
- the need for any further safeguards around advance decision-making for voluntary assisted dying, and what they should be – the QLRC provided examples such as:
 - ... limited and well-defined criteria for providing voluntary assisted dying in accordance with an advance decision, additional review and assessment requirements, time limits on the validity of advance directives, counselling for people who wish to make an advance directive, and additional training and support services for health practitioners.
- difficulties associated with the operation of the Powers of Attorney Act 1998, which limits the circumstances in which an advance health directive will be followed.²⁰¹

The QLRC advised that these broader issues should be resolved first before any advance decision-making for voluntary assisted dying is considered. It commented that these matters were the subject of a QLRC report more than a decade ago and were commented on by the former committee that considered the issue of voluntary assisted dying and they are overdue for attention.²⁰²

In terms of assessing capacity, the department's response to submissions outlined that assessing practitioners are required to meet the eligibility requirements, as well as completing approved training.²⁰³ Additionally, if the coordinating practitioner or consulting practitioner is unable to determine whether or not the person has decision-making capacity in relation to voluntary assisted dying, they must refer the person to a registered health practitioner who has appropriate skills and training to determine the matter.²⁰⁴

3.2.3 Voluntary assisted dying request must be made voluntarily and without coercion

For a person to access voluntary assisted dying, the Bill requires that at all stages of the process, the person seeking access must be acting voluntarily and without coercion.²⁰⁵

The Bill defines coercion to include 'intimidation or a threat or promise, including by an improper use of a position of trust or influence'.²⁰⁶ As with the other eligibility criteria, the assessment process includes three points at which the person must be assessed as acting voluntarily and without coercion.²⁰⁷ If the 'coordinating practitioner' (the medical practitioner who accepts a person's first voluntary assisted dying request²⁰⁸) or a 'consulting practitioner' (the medical practitioner who accepts a referral to conduct a 'consulting assessment'²⁰⁹) of the person²¹⁰ is unable to determine whether or not the person is acting voluntarily and without coercion, they must refer the person

²⁰¹ QLRC Report, paragraph 7.312.

²⁰² QLRC Report, paragraph 7.312.

²⁰³ Director-General Queensland Health correspondence dated 13 July 2021, p 7.

²⁰⁴ Director-General Queensland Health correspondence dated 13 July 2021, p 7.

²⁰⁵ Voluntary Assisted Dying Bill 2021, cl 10 (1)(c).

²⁰⁶ Voluntary Assisted Dying Bill 2021, Schedule 1.

²⁰⁷ Voluntary Assisted Dying Bill 2021, part 3.

²⁰⁸ Voluntary Assisted Dying Bill 2021, Schedule 1.

²⁰⁹ A 'consulting assessment' is performed by a consulting practitioner, and is to assess whether a person is eligible to access voluntary assisted dying; Bill, cl 30.

²¹⁰ Voluntary Assisted Dying Bill 2021, Schedule 1.

seeking access to voluntary assisted dying to another person who has the appropriate skills and training to determine the matter.²¹¹

Stakeholder views

There was universal acceptance by stakeholders that those seeking voluntary assisted dying should be acting voluntarily and without coercion. Many stakeholders considered that the Bill, when taken as a whole, would sufficiently safeguard that a person's decision to access voluntary assisted dying was made voluntarily.²¹² For example, the Australian Psychological Society advised:

The APS commends the requirement for patients to make three separate requests to access VAD and the necessary specialist judgement to help maximise the likelihood that the patient is acting voluntarily.²¹³

However, a number of stakeholders were concerned that the Bill does not ensure that the person seeking voluntary assisted dying is acting voluntarily and without coercion.²¹⁴ Dr Gerard Purcell stated 'the proposed safeguards as mentioned in the draft legislation offer no meaningful safeguards to those that do have capacity to consent or whose consent is swayed by coercion'.²¹⁵ Similarly the Australian Care Alliance highlighted the issue of elder abuse including from adult children with 'inheritance impatience' and asserted that this was a growing problem and concluded that the legislation is unsafe.²¹⁶

Dr Donna Purcell raised concern that a society where voluntary assisted dying is legal and where the request for voluntary assisted dying is treated as a respectable or a positive choice, would not be sensitive to subtle forms of coercion.²¹⁷ Her submission also discussed the difficulties for practitioners in identifying coercion:

It is pertinent to ask at this point what procedures will be undertaken by the "coordinating" and "consulting" practitioners to ensure that coercion does not happen. The "tick a box" approach stating they are acting voluntarily will surely not guarantee competence to establish this. It is highly likely that these doctors will have very little knowledge of the patient or his/her family or circle of support as they will be assessing other doctors' patients who will be largely strangers to them.²¹⁸

The APS argued that decisions are influenced by a range of factors, including the opinions of others, notably family members, carers and health professionals and as such commented on strategies to minimise coercion:

... strategies to minimise the risk of coercion, e.g. enabling people to make decisions in private, are crucial. It is worth noting here that demonstrating an understanding of the consequences of their decisions, and making those decisions freely without undue influence, are components assessed as part of decision-making capacity. This also highlights the importance of professional standards and training for medical practitioners in order to minimise the likelihood of coercion when working with individuals who may request voluntary assisted dying.²¹⁹

In his evidence to the committee, Dr Will Cairns identified how people may be coerced:

²¹¹ Voluntary Assisted Dying Bill 2021, cls 21, 32. See section 3.3 of this report for more information on the assessment process.

²¹² For example, see submissions 278, 1106, 1074.

²¹³ Submission, 1106, p 2.

²¹⁴ For example, see submissions 417, 1285, 1286, 1150, 1301.

²¹⁵ Submission 1286, p 1.

²¹⁶ Submission 417, p 24.

²¹⁷ Submission 1285, p 4.

²¹⁸ Submission 1285, pp 4-5.

²¹⁹ Submission 1106, p 2.

The question of coercion goes both ways. People might be coerced to participate in voluntary assisted dying, but then they may also be coerced to not do something they wish to do and that is legal. I think reporting requirements need to accommodate that.²²⁰

While upholding the right of people with disabilities to individual autonomy, QAI cautioned that people with disabilities are more likely to be the victims of coercion and abuse by carers. As such, QAI called attention to ‘the need to ensure sufficient safeguards, including legislative, cultural and resourcing changes, that will endure for as long as the voluntary assisted dying scheme exists’.²²¹

QHRC highlighted the importance of having ‘people doing the assessments who are able to make the right judgements and also are attuned to the risks of coercion’ and indicated that it would like to see an amendment in the Bill to strengthen that requirement.²²²

The Bill provides that where the coordinating practitioner is unable to determine whether or not the person is acting voluntarily and without coercion, the practitioner must refer the person to another person who has appropriate skills and training to determine the matter.²²³ Society of Trust and Estate Practitioners Queensland (STEP Queensland) raised concern that the Bill does not provide any guidance about who such a person might be.²²⁴

QLRC view

The QLRC included the requirement that a person wishing to access voluntary assisted dying is acting voluntarily and without coercion within the eligibility criteria, which is assessed at multiple points in the staged assessment process.²²⁵ The QLRC viewed this requirement as a fundamental safeguard.²²⁶ The QLRC also referred to other features of the Bill that safeguard against coercion and protect vulnerable individuals. These include:

- limitations on the circumstances in which a discussion about voluntary assisted dying may be initiated;
- requirements about the qualifications of medical practitioners and the assessments that must be undertaken before access to voluntary assisted dying is permitted;
- a request and assessment process that includes multiple stages and requires that all stages are thoroughly documented and reported; and
- specific provisions that persons requesting access to the scheme must be told that they may change their mind at any time.²²⁷

In addition, the Bill includes offences that relate to inducing a person to request, or revoke a request for voluntary assisted dying, and inducing self-administration of a voluntary assisted dying substance.²²⁸ Further discussion of the offences included in the Bill is located in section 3.4.4 of this report.

Department response

The department outlined the safeguards designed to prevent a patient being coerced into accessing voluntary assisted dying as ‘the scheme, taken as a whole, is there to safeguard against any coercion

²²⁰ Public hearing transcript, Townsville, 12 July 2021, p 8.

²²¹ Public hearing transcript, Brisbane, 15 July, p 13.

²²² Public hearing transcript, Brisbane, 15 July, p 26.

²²³ Voluntary Assisted Dying Bill, s 21(3).

²²⁴ Public hearing transcript, Brisbane, 15 July, p 14.

²²⁵ QLRC Report, paragraphs 7.337, 7.338.

²²⁶ QLRC Report, paragraphs 7.337, 7.338.

²²⁷ QLRC Report, paragraph 7.353.

²²⁸ Voluntary Assisted Dying Bill 2021, cls 141, 142.

or abuse'.²²⁹ In addition the department indicated that health practitioners' training would include how 'to identify and assess the risk around any coercion or abuse'.²³⁰

DJAG advised that an additional safeguard in the Bill included that decisions about capacity and coercion are subject to review by the Queensland Civil and Administrative Tribunal (QCAT).²³¹ Additionally, DJAG confirmed that if a family member was unhappy about this type of decision, a mechanism existed to have it reviewed.²³²

3.2.4 A person must be at least 18 years old

The Bill proposes that a person must be 18 years of age to access voluntary assisted dying.²³³ The QLRC stated that this limitation is consistent with voluntary assisted dying legislation in other Australian jurisdictions.²³⁴ Furthermore, the requirement is consistent with other relevant laws in Queensland in which 'a person is regarded in law as an adult and is given legal rights and responsibilities'.²³⁵

Stakeholder views

While the majority of stakeholders did not comment on the age requirement in the Bill, QCCL and ALA argued that some minors should not be excluded from accessing voluntary assisted dying should they wish to do so, and that minors should also be entitled to personal autonomy.²³⁶

QCCL called for eligibility to be extended to minors under the age of 18 years who have 'sufficient understanding and intelligence to understand fully the consequences of VAD'.²³⁷ QCCL noted the argument that care should be taken 'not to equate the capacity to consent and the capacity to withhold life-saving treatment'. However, it considered, 'such an argument fails to respect the personal autonomy of individuals who have capacity to make their own medical decisions'.²³⁸

ALA accepted that it would be appropriate to limit eligibility to VAD to persons who are at least 18 years of age, however, it stated:

... that in due course, further consideration should be given as to why children, who otherwise meet the eligibility requirements, should be excluded from a VAD scheme if they have a disease, illness or medical condition that is causing them intolerable suffering. This question should be considered even more so if one of the eligibility requirements of the VAD scheme is that the disease, illness or medical condition will cause the person's death. In this situation, the ALA considers that children who otherwise meet the eligibility requirements should be given the same end of life options as adults.²³⁹

Similarly Dr Heather McNamee of DADC stated:

I work in Headspace in Cairns with young people with mental health issues between the ages of 12 and 25 and, trust me, people under 18 are perfectly capable of understanding complex decisions and having autonomy around their own health. I realise that that is a stretch too far for most people in Australia and in Queensland, but I would suggest that there should be a provision for exceptional circumstances to

²²⁹ Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 13.

²³⁰ Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 13.

²³¹ Voluntary Assisted Dying Bill, s 102.

²³² Kim Chandler, Department of Justice and Attorney-General, public briefing transcript, Brisbane, 14 June 2021, p 13.

²³³ Voluntary Assisted Dying Bill 2021, cl 10 (1)(d).

²³⁴ QLRC Report, paragraph 7.364.

²³⁵ QLRC Report, paragraph 7.364.

²³⁶ See submissions 1004, 1027.

²³⁷ Submission 1004, p 2.

²³⁸ Submission 1004, p 2.

²³⁹ Submission 1027, p 8.

avoid 16-year-olds having protracted and painful deaths. If this is not included in the initial bill, which I suspect it will not be, I would encourage the committee to consider that at the first review.²⁴⁰

QLRC view

While the QLRC acknowledged that limiting eligibility to people aged at least 18 years has the effect of treating children differently from adults when children and adults have much in common, it was of the view that due to their youth, children also have greater vulnerabilities and consequently a greater need for protection.²⁴¹

The QLRC Report highlighted the need to explore further the application of any voluntary assisted dying scheme, with modifications, to children.²⁴² It observed:

... there are gaps in the scientific, evidence-based research available to inform the development of policy in this area. For example, there would be benefit in future consultations being undertaken with children, child health and other experts, and medical practitioners practising in the field of paediatrics, particularly in the area of end of life care and the withdrawal or withholding of life sustaining measures.²⁴³

The QLRC concluded that while the Bill provides access to voluntary assisted dying for eligible adults, the 'appropriate course is for any new legislation to be properly reviewed and evaluated before considering any extension of it'.²⁴⁴ It referred to clause 154 of the Bill, which mandates a review of the Act by the Minister after 3 years of operation including a review of the eligibility criteria.²⁴⁵

3.2.5 Residency requirement

The Bill sets out residency requirements for a person to be eligible to access voluntary assisted dying. To meet the Bill's residency requirements, a person wishing to access voluntary assisted dying must satisfy both Australian and Queensland residency requirements. The Australian requirements include that the person must be either an Australian citizen, a permanent resident, or ordinarily resident in Australia for at least 3 years immediately before making the first request.²⁴⁶ With respect to Queensland residency, the person seeking voluntary assisted dying must be ordinarily resident in Queensland for at least 12 months immediately before making the first request.²⁴⁷

However, the Bill provides for exemptions to both the Australian and Queensland residency requirements to be granted by the chief executive where a person has a substantial connection to Queensland and there are compassionate grounds for granting the exemption.²⁴⁸

Stakeholder views

Stakeholders held diverse views in relation to residency requirements. While many stakeholders who were opposed to voluntary assisted dying in principle expressed concern about the residency requirements on the basis that they were too lax, were subject to abuse,²⁴⁹ some stakeholders were

²⁴⁰ Public hearing transcript, Townsville, 12 July 2021, p 15.

²⁴¹ QLRC Report, paragraphs 7.379, 3.380.

²⁴² QLRC Report, paragraph 7.385.

²⁴³ QLRC Report, paragraph 7.385.

²⁴⁴ QLRC Report, paragraph 7.386.

²⁴⁵ QLRC Report, paragraph 7.387; Voluntary Assisted Dying Bill 2021, cl 154.

²⁴⁶ Voluntary Assisted Dying Bill 2021, cl 10(e).

²⁴⁷ Voluntary Assisted Dying Bill 2021, cl 10(f).

²⁴⁸ Voluntary Assisted Dying Bill 2021, cl 12.

²⁴⁹ For example, see submissions 1058, 1218, 568.

also opposed to the residency requirements because they would impose an unnecessary administrative burden on a person with a life-limiting illness.²⁵⁰

In contrast, a number of stakeholders supported the residency requirements.²⁵¹ DWDQ argued:

DWDQ accepts the residency criteria as per the proposed legislation and the compassion it shows to persons with difficult circumstances such as living outside Queensland but close to the Queensland border with close family or treating doctors in Queensland.²⁵²

Professors White and Willmott argued that 4 out of 6 Australian states have passed voluntary assisted dying legislation and if Queensland passes the law, voluntary assisted dying will be lawful in 5 out of 6 states, and as such, voluntary assisted dying tourism becomes less of an issue. They recommended that the Queensland residency requirement clause 10(1)(f) be abolished.²⁵³

As regards the exemptions to the residency requirements which are able to be determined by the chief executive under section 12, Professors White and Willmott suggested a further refinement to the Bill:

... given the state of health of the patient seeking an exemption, the chief executive should be required to make a determination within a prescribed period. In this regard, we would suggest that this period should be within 3 business days of receiving the application.²⁵⁴

QLRC view

The QLRC justified the residency requirements in the Bill on the basis that Queensland residents should be prioritised, given the system depends on limited resources and a finite number of qualified persons to assess eligibility and to administer medication. It stated:

... at the early stage of implementing a voluntary assisted dying scheme (when there may be few qualified practitioners), allowing persons from other countries and interstate to access the scheme could deny residents access. It could also place excessive demands on palliative care places in Queensland.²⁵⁵

However, the QLRC also acknowledged the argument that a person has a right to die at a place of their choosing and commented that 'rights are not ordinarily limited to the citizens or residents of a place'.²⁵⁶ It also referenced section 117 of the Constitution of Australia stating:

A requirement to be ordinarily resident in Queensland as a condition of eligibility for access to voluntary assisted dying may be said to give an advantage to the residents of Queensland and subject non-residents from other states to discrimination, contrary to section 117. However, any such discrimination might be justified by the need to maintain the integrity of the State's health system and to ensure the availability of voluntary assisted dying services for Queensland residents.²⁵⁷

The QLRC recognised that residency requirements 'may have harsh, and possibly unintended, consequences for individuals who have a substantial connection with Queensland and who might be thought to be deserving of access to the scheme'.²⁵⁸ It noted the possible consequences of an inflexible

²⁵⁰ For example, see submissions 906, 1345.

²⁵¹ For example, see submissions 720, 1027, 1000.

²⁵² Submission 278, p 6.

²⁵³ Submission 906, p 9.

²⁵⁴ Submission 906, p 9.

²⁵⁵ QLRC Report, paragraph 7.438.

²⁵⁶ QLRC Report, paragraph 7.441.

²⁵⁷ QLRC Report, paragraph 7.448.

²⁵⁸ QLRC Report, paragraph 7.456.

residency requirement and therefore included in the Bill a provision for the use of a discretionary power by the chief executive to grant an exemption in certain circumstances.²⁵⁹

In assessing the need for a residency requirement, the QLRC stated:

... future developments, including the introduction of voluntary assisted dying schemes in other Australian jurisdictions and the operation of the scheme in Queensland may call into question the need to have a residency requirement at all'.²⁶⁰

It recommended the inclusion of a residency requirement in any legislation be reviewed as part of a future review of the legislation's operation.²⁶¹

3.2.6 Committee comment

The committee acknowledges the diversity of views in relation to the eligibility requirements for access to voluntary assisted dying as set out in the Bill. The committee strongly supports the measured and considered requirements of the Bill which achieve a balance between accessibility and safeguards.

The committee notes that the Bill requires the Minister to review the effectiveness of the Act as soon as practicable after the end of 3 years after the commencement and that this review must include a review of the eligibility criteria.²⁶² The committee is satisfied that a mechanism is in place to review any concerns raised by stakeholders in relation to eligibility requirements.

3.3 Voluntary assisted dying assessment and substance administration processes

3.3.1 The process for accessing voluntary assisted dying

The Bill proposes that a person may access voluntary assisted dying if all of the following steps have been fulfilled:

- The person has personally²⁶³ made a first request that is clear and unambiguous, using gestures or other means of communication available to that person.
- The coordinating practitioner for the person has assessed that the person is eligible for voluntary assisted dying and the person understands the information that the coordinating practitioner is required to provide.²⁶⁴
- The consulting practitioner for the person has assessed that the person is eligible for voluntary assisted dying and the person understands the information that the consulting practitioner is required to provide.²⁶⁵
- The person has made a second request in writing, which has been signed by two eligible witnesses.²⁶⁶
- The person has personally made a final request that is clear and unambiguous.

²⁵⁹ QLRC Report, paragraph 7.459.

²⁶⁰ QLRC Report, paragraph 7.498.

²⁶¹ QLRC Report, Recommendation 7-13, p 168. See also Voluntary Assisted Dying Bill 2021, cl 154.

²⁶² Voluntary Assisted Dying Bill 2021, cl 154 (1) (2).

²⁶³ The request may not be made by another person on the person's behalf.

²⁶⁴ Voluntary Assisted Dying Bill 2021, cls 9, 23.

²⁶⁵ Voluntary Assisted Dying Bill 2021, cls 9, 34.

²⁶⁶ To be eligible as a witness, a person must be at least 18 years old and not be: a beneficiary under the person's will or otherwise stand to benefit financially or in any other material way from the person's death; the person's coordinating practitioner or consulting practitioner; or an owner or responsible for the management of any health facility at which the person is being treated or resides.

- The coordinating practitioner for the person has certified in a final review form that both:
 - the request and assessment process has been completed in accordance with the Act
 - the person has decision-making capacity in relation to voluntary assisted dying and is acting voluntarily and without coercion.
- The person has made an ‘administration decision’²⁶⁷ – a decision to self-administer (a self-administration decision)²⁶⁸ a voluntary assisted dying substance, or have a medical practitioner administer it for them (practitioner administration).²⁶⁹
- The person has appointed a ‘contact person’ – a person who is required to carry out a number of roles, including if the person wishing to access voluntary assisted dying makes a self-administration decision or a practitioner administration decision.²⁷⁰

In addition to being able to appoint a contact person, the Bill allows a person to have an ‘agent’ act on their behalf. An agent is authorised to perform a number of functions, including:

- receiving the voluntary assisted dying substance from an authorised supplier
- possessing the voluntary assisted dying substance for the purpose of supplying it to the person
- supplying voluntary assisted dying the substance to the person²⁷¹
- making requests for the person to be assessed to access voluntary assisted dying.²⁷²

The Bill provides for a waiting period of 9 days between the person’s first and final requests, unless the person is likely to die or lose decision-making capacity before the end of the waiting period.²⁷³

At the public briefing the department explained to the committee that the staged request and assessment process, involving three separate requests, ‘is there as a safeguard against any coercion or abuse’.²⁷⁴

The process to access voluntary assisted dying is illustrated in Figures 2 and 3.

²⁶⁷ Voluntary Assisted Dying Bill 2021, cl 50.

²⁶⁸ Voluntary Assisted Dying Bill 2021, cl 50(1)(a).

²⁶⁹ Voluntary Assisted Dying Bill 2021, cl 50(1)(b).

²⁷⁰ Voluntary Assisted Dying Bill 2021, Division 2.

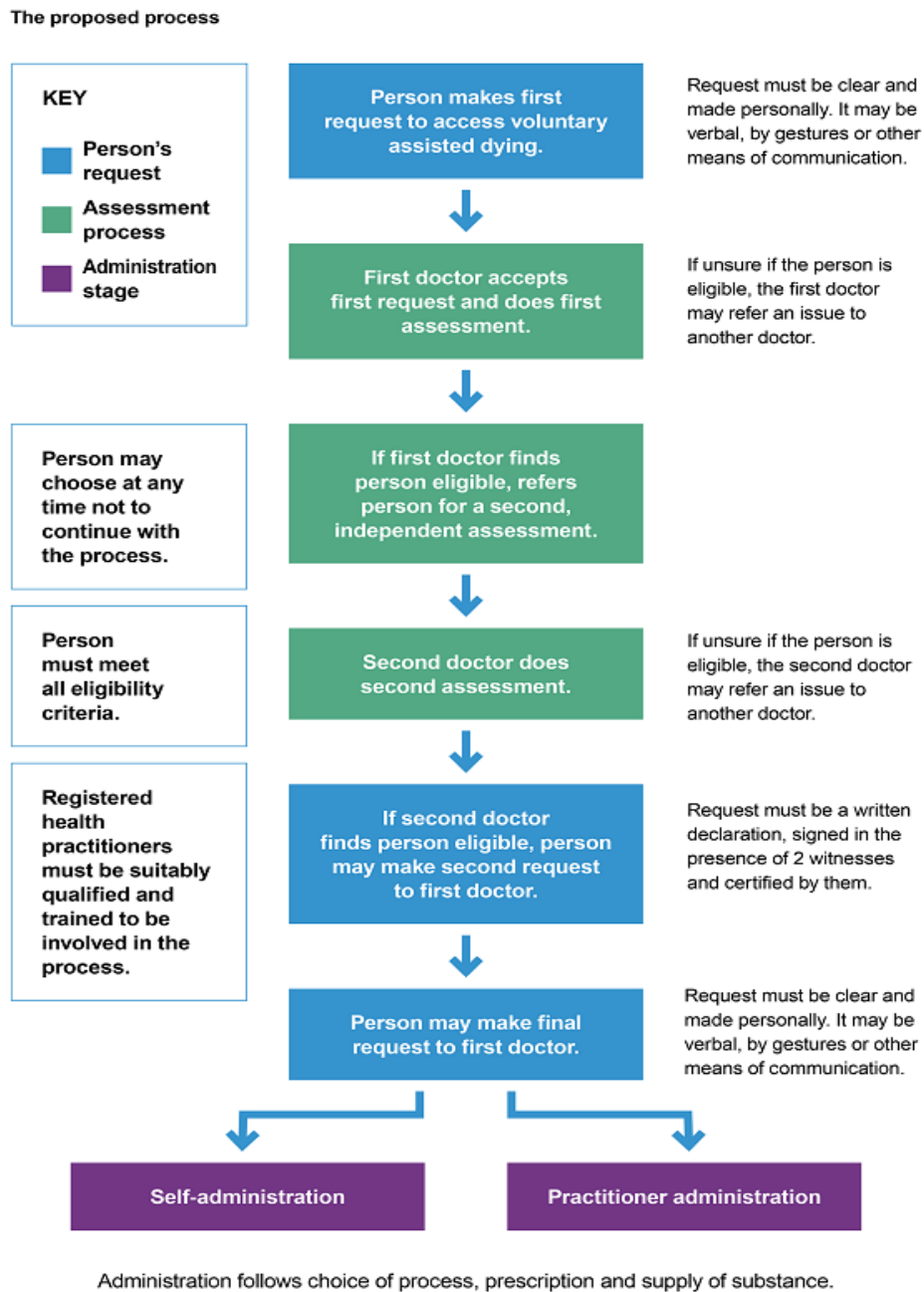
²⁷¹ Voluntary Assisted Dying Bill 2021, cl 52(6).

²⁷² Voluntary Assisted Dying Bill 2021, cls 92-97.

²⁷³ Voluntary Assisted Dying Bill 2021, cl 43.

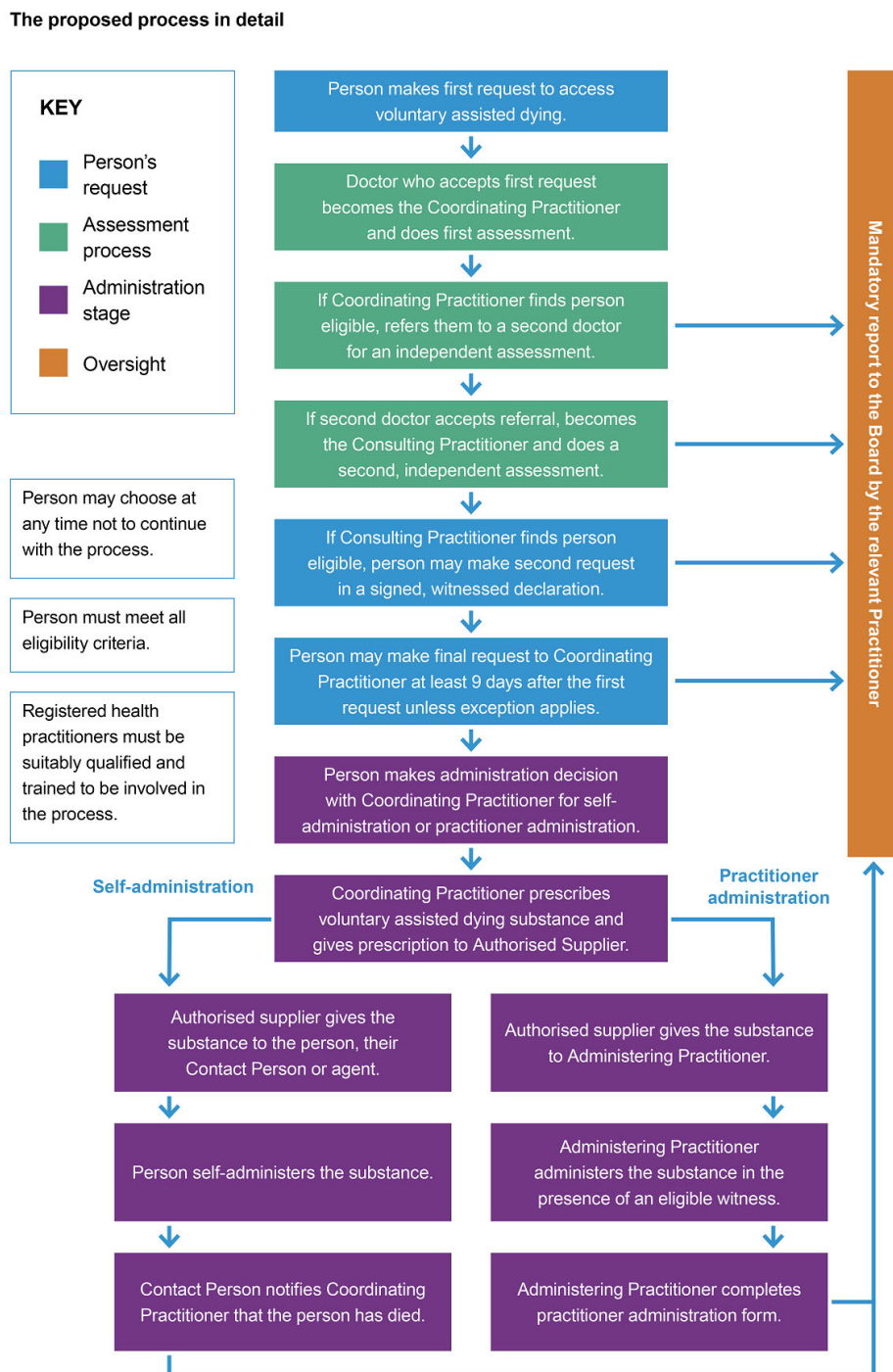
²⁷⁴ Public briefing transcript, Brisbane, 14 June 2021, p 13.

Figure 2: The proposed process for accessing voluntary assisted dying



Source: Queensland Law Reform Commission, *A legal framework for voluntary assisted dying*, Report No. 79, May 2021, p 5.

Figure 3: The proposed process for accessing voluntary assisted dying in detail



Source: Queensland Law Reform Commission, A legal framework for voluntary assisted dying, Report No. 79, May 2021, p 6.

Stakeholder views

Stakeholders expressed support for the process of accessing voluntary assisted dying.²⁷⁵ The process was considered sufficiently robust by the Clem Jones Group, who observed:

A person seeking access to VAD is required to pass through a multi-stage request and assessment process with three separate requests dealing with voluntariness and lack of coercion, with at least two medical practitioners and independent witnesses.²⁷⁶

DWDQ also commented on the process:

It fulfils a necessary independent safeguard against coercion for or against VAD. It removes the coordinating practitioner and the consulting practitioner from the second request-making process to safeguard against influence by practitioners.

Dr Cairns supported the Bill's proposed framework as it allowed flexibility of choice for the person. He stated:

People may make the request while not knowing exactly how the disease is going to progress or what issues will arise for them, so maybe the things they fear will not happen. If there is a reasonable chance that they will or circumstances change for some reason, they may not do it, but they have the option to refuse. I think that is where the issue of voluntary assisted dying, where you have to have capacity at the time, is really important so that the outcomes for people can reflect the fact that it has been about their control.²⁷⁷

In contrast, some submitters expressed concerns about the sections of the Bill relating to the process and prescribed requirements for the administration of the voluntary assisted dying substance.²⁷⁸ Recommendations from these submissions ranged from amendments to improve the proposed legislative framework for the voluntary assisted dying scheme,²⁷⁹ to opposition to any legislated voluntary assisted dying process.²⁸⁰

3.3.1.1 Communication

The Bill allows a person making the first request to access voluntary assisted dying to do so verbally or by gestures or other means of communication available to the person. Similarly the person, having made a second request, may make a further, final request for access to voluntary assisted dying verbally, or by gestures or other means of communication.

A concern was expressed that requests made by communication other than verbal communication increased the risk of misinterpretation.²⁸¹

In relation to the witnesses to the second request for voluntary assisted dying, DWDQ stated:

A barrier to Voluntary Assisted Dying access in Queensland is removed by not requiring the health practitioner to physically be present at the time of making the second request. This is important in Queensland with its geographical remoteness and decentralization. It eliminates a barrier to accessing Voluntary Assisted Dying for a person who may suffer distress or discomfort with movement or travel that would occur if the health practitioner cannot visit the person.²⁸²

²⁷⁵ See for example submissions 5, 278, 984, 1087.

²⁷⁶ Submission 984, p 4.

²⁷⁷ Public hearing transcript, Townsville, 12 July 2021, p 12.

²⁷⁸ For example, see submissions 244, 260, 417, 442, 1044, 1110.

²⁷⁹ For example, see submissions 244, 455, 738, 906, 917, 934, 1031, 1054, 1058, 1345, 1346.

²⁸⁰ For example, see submissions 634, 921.

²⁸¹ Public hearing transcript, Brisbane, 14 July 2021, p 40.

²⁸² Submission 278, p 4.

The ACL proposed that if the person makes a second request with the assistance of an interpreter, the interpreter must certify on the request that the interpreter provided a true and correct translation of any material translated.²⁸³

QLRC view

In common with the processes set out in the Victorian, WA and Tasmanian Acts, the proposed process to access the Queensland voluntary assisted dying scheme would require a person to follow a staged request and assessment process.²⁸⁴ The staged nature of the process, requiring multiple requests and multiple assessments would ensure 'the person has decision-making capacity, is acting voluntarily and without coercion'²⁸⁵ and demonstrates 'that the person's decision to request access is enduring'.²⁸⁶

The Bill proposes that the first request must be clear and unambiguous.²⁸⁷ This is important so that the doctor can distinguish the request from a more general request for information about voluntary assisted dying or about a person's end of life options'.²⁸⁸

The proposed requirement that the first request and the final request be made by the person personally, and not by any other person on their behalf²⁸⁹ would:

... assist in demonstrating, among other things, that it is the person's own decision to make the request and that the request is made voluntarily and without coercion. It also reflects the position that no one except for the person themselves can make a decision about whether they access voluntary assisted dying.²⁹⁰

Department response

In response to a question regarding a person who wished to access voluntary assisted dying but was unable to make any requests in writing due to health reasons, the department advised:

There are provisions in the wording that enable that to be overcome, understanding that some people cannot write. There is a written submission that needs to be made, and how that can be auspiced is covered in the bill.²⁹¹

The department also clarified that the 'QLRC noted that the requirements will not be overly burdensome and are not intended to be complex.'²⁹²

3.3.1.2 Specialist assessment

Some submitters raised concerns that the proposed eligibility for the voluntary assisted dying process is based upon the approval of two doctors, who do not have to be specialists, and can therefore be GPs with no specialised training in end-of life management. ACC argued:

Given the serious nature of these decisions, best practice and medical professional standards should require at least one of the approving doctors to be a Palliative Care specialist who as such has extensive

²⁸³ Submission 1054, p 8.

²⁸⁴ Explanatory notes, p 11.

²⁸⁵ Explanatory notes, p 12; QLRC Report, paragraph 8.24.

²⁸⁶ Explanatory notes, p 12; QLRC Report, paragraph 8.24.

²⁸⁷ Voluntary Assisted Dying Bill 2021, cl 14(2).

²⁸⁸ QLRC Report, paragraph 8.55.

²⁸⁹ Voluntary Assisted Dying Bill 2021, cls 14(2), 42(2).

²⁹⁰ QLRC Report, paragraph 8.56.

²⁹¹ Professor Keith McNeil, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 4.

²⁹² Queensland Health, correspondence 13 July 2021, p 11.

and lengthy training in this field. Further, there is no requirement for assessment by a mental health expert such as a psychiatrist or at very least a qualified counsellor.²⁹³

The Queensland Baptists and the ACC submissions raised concern that there is no apparent requirement in the legislation for those requesting assisted death to be assessed by a mental health expert such as a psychiatrist or psychologist, or seen by a specialist in the area of the patient's suffering.²⁹⁴ The ACL stated:

The Bill does not protect the mentally unwell and vulnerable. No-one should be able to access VAD without first having a mental health assessment by a psychologist to exclude any undiagnosed mental illness or distress.²⁹⁵

The submission from Heath Professionals Say No! argued:

It would be unrealistic and negligent to consider that all health care professionals, as simply proposed in these sections, would be adequately trained to assist with decisions around VAD or to inform patients of all their management options and outcomes. Nor would they be able to reliably assess prognosis and contributing factors leading to a request for VAD, inclusive of depression or demoralisation. This situation would require specialist doctors to ensure accurate mental health assessment, diagnostic and management options, and appropriate physical and psycho-social care has been delivered.²⁹⁶

Dr Boon from RANZCP Queensland acknowledged that 'voluntariness' can be difficult to assess in a patient requesting voluntary assisted dying, as it is 'very hard to know where influence ends and undue influence starts'.²⁹⁷ She further stated that 'people who are very ill are prone to undue influence'.²⁹⁸ Dr Boon recommended that there be 'a role for psychiatrists or an acknowledgment of the role of psychiatrists—not mandated—but it should be recognised that mental health is a core factor in end-of-life care and a request for voluntary assisted dying'.²⁹⁹ Dr Boon argued that mandating psychiatric assessment could create 'a workforce' problem, due to the lack of psychiatrists in regional and remote Queensland in particular.³⁰⁰

Dr Alexandra Murray, from the APS confirmed:

... the importance of the assessment of acting voluntarily and without coercion. This should include strategies to minimise the risk of coercion and patients being fully informed of all options available to them. This will of course involve the understanding of the ramifications of any decisions they make... psychologists are in a unique position to conduct capacity assessments due to a core skill set that uses a combination of evidence based assessments of cognition and behaviour and the ability to differentiate between certain conditions such as mental illness, dementia and delirium on decision-making.³⁰¹

The AMA Queensland submitted:

... the decision to refer the patient to a psychiatrist for mental health and/or capacity assessment should be made by the coordinating medical practitioner if they are unable to assess the person's capacity but

²⁹³ Submission 1052, p 2.

²⁹⁴ Submission 1044, p 1; submission 1052, p 2.

²⁹⁵ Submission 1054, p 4.

²⁹⁶ Submission 1228, p 1.

²⁹⁷ Public hearing transcript, Brisbane, 15 July 2021, p 31.

²⁹⁸ Public hearing transcript, Brisbane, 15 July 2021, p 31.

²⁹⁹ Public hearing transcript, Brisbane, 15 July 2021, p 31.

³⁰⁰ Public hearing transcript, Brisbane, 15 July 2021, p 34, public hearing transcript, Townsville, 12 July 2021, p 14.

³⁰¹ Public hearing transcript, Brisbane, 15 July 2021, p 67.

that the requirement to refer to a psychiatrist for mental health and/or capacity assessment should not be mandatory.³⁰²

DWDQ supported the Bill and expressed concern that, if a patient were required to seek a psychiatrist to assess their mental health or competency, it would delay the voluntary assisted dying process, because ‘people tend to not ask for VAD until the last moment’:

By the time they come to request voluntary assisted dying, seeing the first doctor, seeing the second doctor, a delay of nine days until they can progress it further—some of these people in Victoria, from the time that they have requested VAD, actually die before the process is completed. That delay may not have a huge impact on some people, but on other people it may be catastrophic.³⁰³

Dr David Kirchoffer of the Queensland Bioethics Centre, Australian Catholic University, suggested coordinating and consulting practitioners should be required to inform and consult with treating practitioners, and at a minimum either the coordinating practitioner or the consulting practitioner should be a specialist in the patient’s disease. He argued that consultation between practitioners would ‘at least bring to light any mental health issues that might impact a patient’s capacity’.³⁰⁴

Considering the qualifications of health practitioners and the requirement to have a specialist assess capacity in relation to illness, Professor Willmott stated:

I have heard concerns expressed that there should be specialists required. However, I am very comfortable about the ability of Queensland doctors to carry out the duties which are requested of them in this legislation.³⁰⁵

Dr Bav Manoharan argued:

We absolutely do back our GPs in this space. For the most part, GPs have a really good understanding of their patients and their psychosocial needs as well, on top of their medical and biological needs. It is disappointing to think that we would consider a GP unable to make capacity assessments when capacity assessments are made every day by junior doctors who are interns onwards about their consumers and patients that they look after. There will be instances where capacity assessments are more difficult. In those rare instances, it would be best on that practitioner to seek advice. It could be due to mental health conditions. In that case, there might be an avenue for a psychiatrist to be involved. However, that would be very unusual and rare. For the most part, GPs would be well placed to make those decisions.³⁰⁶

Similarly Professor Malcolm Parker stated:

I think it is also important to recognise that things are a bit out of date because general practitioners—and you are talking about general practitioners essentially being the two doctors involved and the question over that about specialist knowledge and skills—are now recognised as specialists officially by Ahpra and by the Medical Board of Australia so there is that sort of terminological lack of currency. I think also that general practitioners are the ones, by and large, who do look after patients at the end stages of life in their homes or nursing homes and particularly if they do have an elderly population they are more than capable, with support from specialist care, ... obviously a general practitioner will be working in cahoots with specialist support with the patient, but they are the ones on the ground and they are the ones who know not just about the physical aspects of the illness but the emotional and psychological and spiritual ones better than the consulting specialist in most, if not all, cases.³⁰⁷

³⁰² Submission 260, p 3.

³⁰³ Public hearing transcript, Brisbane, 14 July 2021, p 11.

³⁰⁴ Submission 455, p 5.

³⁰⁵ Public hearing transcript, Brisbane, 15 July 2021, p 7.

³⁰⁶ Public hearing transcript, Brisbane, 15 July 2021, p 40.

³⁰⁷ Public hearing transcript, Brisbane, 15 July 2021, p 50.

Clause 21 of the Bill provides that if a coordinating practitioner or consulting practitioner is unable to determine a specific matter relating to eligibility, they must refer the matter to another practitioner with the relevant skill set for determination.

3.3.1.3 *Nurse practitioners*

The Bill allows a nurse practitioner to initiate and/or discuss voluntary assisted dying with a person if, at the same time, the practitioner also informs the person about treatment and palliative options available to the person.³⁰⁸ Additionally, the Bill provides that a person is eligible to act as an administering practitioner if they are a nurse practitioner who meets the approved nurse practitioner requirements, or a registered nurse who has practised in the nursing profession for at least five years and meets the approved nurse requirements.³⁰⁹

However, the QLRC considers nurse practitioners are not eligible to act in the role of coordinating practitioner or consulting practitioner in the assessment process, and concluded that as voluntary assisted dying is a new scheme, responsibility for assessing people against the eligibility criteria should remain with medical practitioners.³¹⁰

A number of submissions were supportive of extending eligibility to a wider choice of health practitioners, including nurses, in the assessment process to facilitate better access to voluntary assisted dying, especially in rural and regional areas of Queensland.³¹¹ Dr Kristin Cornell stated:

Really, to expand on the number of core people who are able to be VAD assessors, whether they be general practitioners, nurse practitioners or consultant specialists, will actually help on both fronts, for the patient and also for the workforce.

Some submissions expressed support for nurse practitioners to be able to perform more roles in the assessment process, especially in Queensland where there is a high demand for specialists in rural and regional areas.³¹² For example, the ALA stated:

The ALA considers that where a first or second medical practitioner is unavailable, suitably qualified nurse practitioners should be permitted to participate in the VAD scheme to enable delivery of VAD services in rural and remote areas of Queensland. Given that under the VAD Bill, nurse practitioners are able to initiate discussions and suggest VAD to a person and can act as an 'administering practitioner' (along with suitably qualified registered nurses), it seems reasonable to allow appropriately qualified and trained nurse practitioners to act as a 'coordinating practitioner' under the VAD scheme.³¹³

Adjunct Professor Kylie Ward FACN, Chief Executive Officer of the Australian College of Nursing stated it 'strongly advocate for nurse practitioners, advanced practice registered nurses and clinical nurse consultants to act as a coordinating or consulting practitioner and assess eligibility requirements'.³¹⁴

QNMU submitted that 'once the medical practitioner has assessed the person as meeting the eligibility requirements, we believe they can then refer the person to either another medical practitioner or a nurse practitioner'.³¹⁵

³⁰⁸ Voluntary Assisted Dying Bill 2021, cl 7.

³⁰⁹ Voluntary Assisted Dying Bill 2021, cl 83.

³¹⁰ QLRC Report, paragraphs 13.119 – 13.120.

³¹¹ For example, see submissions 455, 937, 1031.

³¹² For example, see submissions 937, 1031, 1271.

³¹³ Submission 1027, p 10.

³¹⁴ Public hearing transcript, Brisbane, 15 July 2021, p 54.

³¹⁵ Submission 937, p 7.

Australian College of Nurse Practitioners (ACNP) submitted, 'enabling Nurse Practitioners to accept the first request would reduce the burden on patients and families in having to locate or travel to a medical practitioner to begin the process'.³¹⁶

The submission from DADC also supported the Bill's approach allowing for nurses in certain stages of the process, 'especially in a dispersed state such as Queensland where nurse practitioners at times will be required to fulfil the role of administering practitioner'.³¹⁷

In contrast, AMA Queensland submitted that 'suitably qualified nurse practitioners should not be eligible to either assess a patient's eligibility or be provided authority to supply and administer the voluntary assisted dying substance'.³¹⁸

QLRC views

Nurse practitioners were not included as eligible practitioners for coordination or consultation assessments because, despite their clinical expertise and experience, the QLRC considered that 'responsibility for assessing whether a person meets the eligibility criteria should remain with medical practitioners' given voluntary assisted dying is a new scheme.³¹⁹

Nurse practitioners were considered eligible to be an administering practitioner because they are 'highly qualified, skilled and experienced', already undertake advanced practice roles and 'are authorised to autonomously manage complete episodes of care for people with a variety of health needs, in a range of healthcare settings'.³²⁰ The QLRC Report stated that authorising them to act as an administering practitioner 'may facilitate access to voluntary assisted dying, particularly for those Queenslanders residing in rural and remote areas where there are fewer medical practitioners'.³²¹

According to the QLRC Report, nurses who are eligible to be administering practitioners have been included as eligible because of their care for patients at the end of life and experience and expertise in effective communication, and respectful and compassionate care, in addition to expertise in physical care. The QLRC identified these skills as being transferable to the provision of care for those people accessing voluntary assisted dying.³²²

3.3.1.4 Designated period

The Bill proposes a designated, or waiting, period of 9 days between the person's first and final requests must be met, unless the person is likely to die or lose decision-making capacity in that time.³²³

DWDQ and DADC expressed support for the proposed 9-day waiting period.³²⁴

In addition, DWDQ and QLS expressed support for subsection 43(2) enabling the final request to be made before the end of the 9 day prescribed period if the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying.³²⁵ The QLS stated the flexibility of this provisions contributed to 'a compassionate and balanced measure for people wishing to access the

³¹⁶ Submission 1353, p 1.

³¹⁷ Submission 720, p 2.

³¹⁸ Submission 260, p 10.

³¹⁹ QLRC Report, paragraph 13.120.

³²⁰ QLRC Report, paragraph 13.148.

³²¹ QLRC Report, paragraph 13.149.

³²² QLRC Report, paragraph 13.150.

³²³ Explanatory notes, p 12.

³²⁴ Submissions 278, 720.

³²⁵ Submissions 278, 1031.

VAD scheme, while ensuring that access to the scheme is limited to those with decision-making capacity'.³²⁶

Some stakeholders recommended the waiting period be extended,³²⁷ to 'allow sufficient time for appropriate assessments, and subsequent palliative or psychosocial interventions to be put in place, to ensure the request to hasten death is not sustained'.³²⁸ Reverend Andrew Gunton of Uniting Church of Australia recommended extending the designated period of 9 days as a minimum amount of time a person can access voluntary assisted dying to at least 14 days. This would fit with the safeguard that the request be 'an enduring request and not some last-minute fancy'.³²⁹

Dr Gerard Purcell opposed the provision arguing that it goes to 'lengths to create a process and claim that this is an appropriate safeguard only to offer a clause by which anyone can avoid the aforementioned minimum period of assessment'.³³⁰

The ACL recommended that 'subclause 43(2) should be removed from the Bill. If a person is likely to die or lose decision-making capacity before the end of 9 days after the person's first request, the person is not in need of assistance to die sooner'.³³¹

QLRC views

In regard to the proposed waiting period, the QLRC was of the view that the inclusion of a waiting period 'is appropriate as a means of ensuring that a person's decision is not rushed and that a person has a period of time to reflect on their choices'.³³² The QLRC viewed the designated period of 9 days as representing 'an appropriate balance between the need to ensure a decision is well considered and to avoid prolonging a person's suffering'. However, the QLRC considered it would be unreasonable to require a person to wait 9 days if they were likely to die or lose decision-making capacity in that period as it may preclude them from accessing voluntary assisted dying and lead to further suffering.³³³

3.3.1.5 Witnesses to second request

DADC and DWDQ supported clause 38 of the Bill that prevents the coordinating and consulting practitioners being witnesses to the second request for voluntary assisted dying by the person.³³⁴ According to the DADC, 'this will ensure and be seen to ensure that, while it would be unlikely, undue influence by practitioners on the person's decision-making cannot occur'.³³⁵

While acknowledging that the voluntary assisted dying scheme should not prove to be too 'administratively difficult' such that it hinders access, the QLS recommended that consideration be given to whether:

... the coordinating practitioner should also be present at and witness the second request (in addition to the two eligible witnesses), or another appropriately qualified medical or nurse practitioner (where, for example, the coordinating practitioner is unable to attend the making of the second request).³³⁶

³²⁶ Submission 1031, p 7.

³²⁷ For example, see submissions 1054, 1058, 1226, 1311.

³²⁸ Submission 1226, p 1.

³²⁹ Public hearing transcript, Brisbane, 14 July 2021, p 28.

³³⁰ Submission 1286, p 2.

³³¹ Submission 1054, p 9.

³³² QLRC Report, paragraph 8.475.

³³³ QLRC Report, paragraphs 8.478-8.479.

³³⁴ Submissions 278, 720.

³³⁵ Submission 720, p 4.

³³⁶ Submission 1031, p 6.

The ACL argued that the Bill does not preclude the same person from both witnessing the administration of a voluntary assisted dying substance by an administering practitioner and certifying the signing of a person's second request as a witness. The ACL submitted: 'to ensure greater checks in the process, the Bill should be amended to require that the same person cannot carry out both roles'.³³⁷

To the provisions relating to witnesses to the voluntary assisted dying process, QHRC observed:

The requirement in clause 38 of the Bill, that the second request to access voluntary assisted dying is signed in the presence of two witnesses is identified as an important safeguard in the Explanatory Statement. However, the necessity and eligibility of witnesses, either as a safeguard, or as a potential limitation on rights (such as the right to consent to medical treatment under s 17 of the HRA) is not discussed in the Statement of Compatibility.³³⁸

QHRC submitted that a potentially less restrictive option, 'would be to require that at least one of the witnesses is completely independent in the sense of not being a family member, carer, or would have an ongoing relationship with the individual's family or affairs after death'.³³⁹ Returning to the statement of compatibility accompanying the Bill, QHRC suggested that 'further justification is required to explain why the Bill should not require that at least one of the witnesses is completely independent from the person seeking voluntary assisted dying'.³⁴⁰

The Australian Centre for Health Law Research noted a technical drafting point in this clause:

We note that a person is excluded from being a witness to the second request if they are an owner or manager of a 'health facility'. ... The term 'health facility' did not appear to be defined in the Bill, and we raise the question of whether this term is broad enough to extend to all possible facilities where the patient is treated or resides.³⁴¹

QLRC view

The QLRC emphasised that the person's making of the request voluntarily and without coercion, and their understanding of the nature and effect of the request 'should be explicitly addressed in the second request because it is critical that the person makes their request under these conditions, and therefore important that they are recorded in writing'.³⁴²

3.3.2 Administration of a voluntary assisted dying substance

The Bill sets out the proposed process for the administration of a voluntary assisted dying substance, which is illustrated in Figure 4.³⁴³

³³⁷ Submission 1054, p 9.

³³⁸ Submission 1314, p 16.

³³⁹ Submission 1314, p 16.

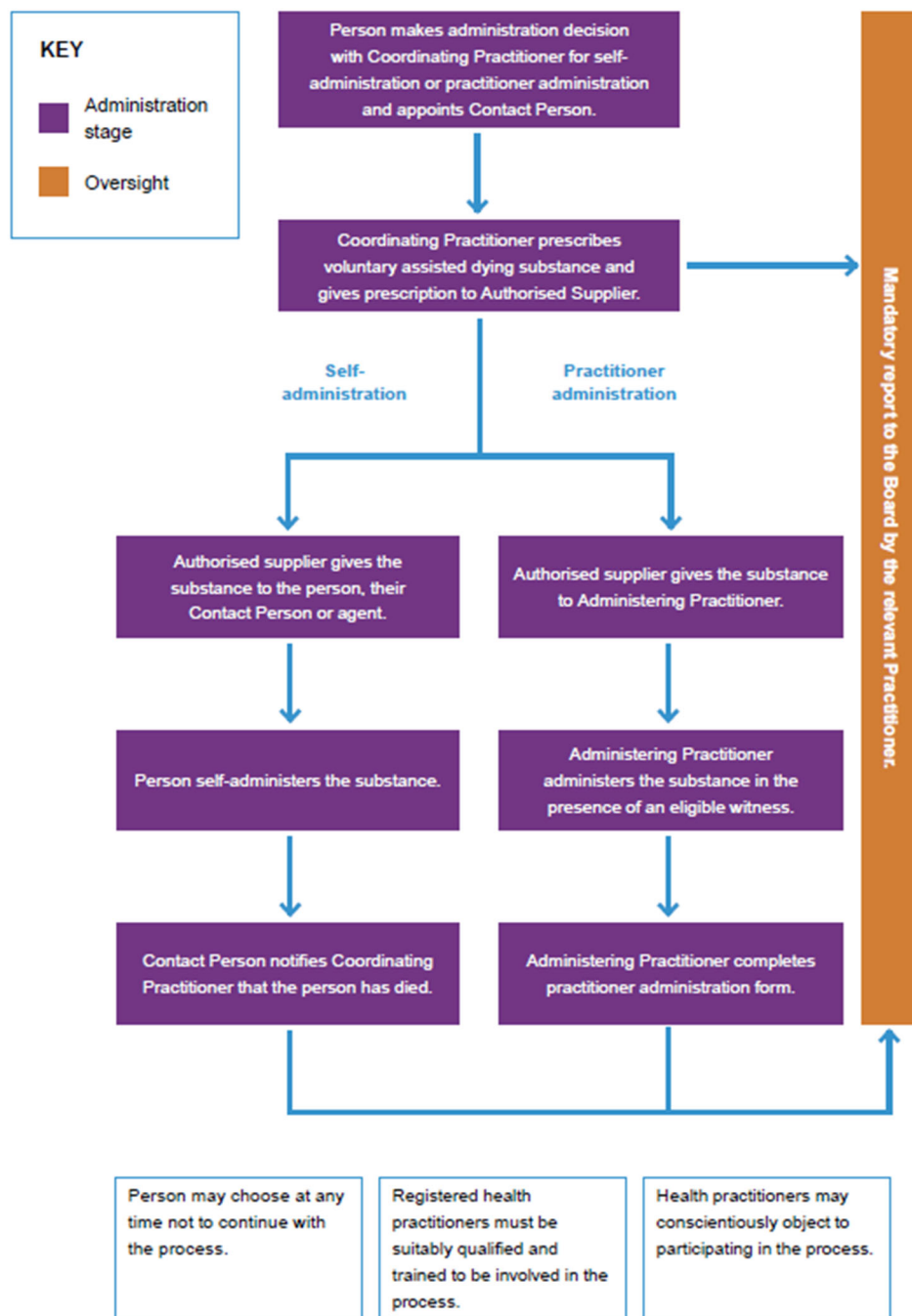
³⁴⁰ Submission 1314, p 17.

³⁴¹ Submission 906, p 9.

³⁴² QLRC Report, paragraph 8.298.

³⁴³ Voluntary Assisted Dying Bill 2021, part 4, div 1.

Figure 4: Proposed process for the administration of a voluntary assisted dying substance



Source: Queensland Law Reform Commission, *A legal framework for voluntary assisted dying*, Report No. 79, May 2021, p 279.

3.3.2.1 Administration decision

The Bill provides that once a person has made a final request and their coordinating practitioner has completed the final review form, the person may choose to continue the process and make an administration decision.³⁴⁴ In consultation with, and on the advice of, their coordinating practitioner, the person may decide to take a voluntary assisted dying substance themselves (self-administration) or decide that a voluntary assisted dying substance is to be administered to them by an administering

³⁴⁴ Voluntary Assisted Dying Bill 2021, cls 49-50.

practitioner (a practitioner administration decision).³⁴⁵ The person may revoke the administration decision at any time.³⁴⁶

Stakeholder views

Emeritus Professor Colleen Cartwright was supportive of the proposed framework in the Bill that allows a person to self-administer or have a practitioner there to administer the voluntary assisted dying substance.³⁴⁷ DADC also expressed support for the Bill's approach to the administration of the voluntary assisted dying substance (section 50), and providing for self-administration or practitioner administration, with the former being the default position. DADC believed there was 'appropriate flexibility' in relation to patient concerns.³⁴⁸ DADC further stated, 'the section is worded to both provide choice to the patient but also to maintain the role of the doctor as information provider and supporter'.³⁴⁹

Department response

Details around the nature, and the administration, of the substance are 'yet to be determined' but will be provided 'through a centralised pharmacy process'.³⁵⁰ The department explained the substance is yet to be defined but will be of medical quality and appropriate for the function that it is designed for.³⁵¹

The department informed the committee that 'the substance needs to be kept in accordance with the storage requirements, which will be that it is in a locked box and not easily accessible by other people'.³⁵² As to the method by which the substance will be administered to the person, the department advised:

Only the people accessing voluntary assisted dying and the practitioners who are involved will be given that specific information. The route of administration will depend on whether the person accesses practitioner administration or self-administration. Some people who access practitioner administration because they will be unable to self-administer would be likely to have it intravenously, but, as Professor McNeil said, that will be worked out during implementation.³⁵³

3.3.2.2 Self-administration

As prescribed in the Bill, once a person has made a self-administration decision and appointed a contact person, the following authorisations would apply:

- The coordinating practitioner would be authorised to prescribe a voluntary assisted dying substance for the person that is sufficient to cause death.
- The authorised supplier who is given the prescription would be authorised to possess, prepare and supply the substance to the person or person's contact person or agent.
- The person would be authorised to receive, possess, prepare and self-administer the substance.
- The agent of the person would be authorised to receive, possess and supply the substance to the person.

³⁴⁵ Voluntary Assisted Dying Bill 2021, cl 50.

³⁴⁶ Voluntary Assisted Dying Bill 2021, cl 51.

³⁴⁷ Submission 1000, p 1.

³⁴⁸ Submission 720, p 3.

³⁴⁹ Submission 720, p 3.

³⁵⁰ Professor McNeil, Queensland Health, public briefing transcript, Brisbane, 14 June 2021, p 9.

³⁵¹ Public briefing transcript, Brisbane, 14 June 2021, p 9.

³⁵² Public briefing transcript, Brisbane, 14 June 2021, p 9.

³⁵³ Public briefing transcript, Brisbane, 14 June 2021, p 9.

- Another person, requested by the person to prepare the substance for the person, would be authorised to possess, prepare and supply the substance to the person.
- The contact person for the person would be authorised to receive, possess, supply the substance to the person, and give the substance or any unused or remaining substance to an authorised disposer.³⁵⁴

According to the explanatory notes, consistent with other jurisdictions, there would be no requirement for the coordinating practitioner or another health practitioner to be present when the person self-administers.³⁵⁵

Stakeholder views

A number of submitters were supportive that the Bill creates a default in favour of self-administration. DWDQ stated:

DWDQ commends the proposed legislation for having self-administration as the default method and for allowing flexibility for practitioner administration availability based on the person's concerns about, ability to, and suitability for self-administration. DWDQ finds personal choice in self administration or practitioner administration consistent with the overall legislation being voluntary and enabling of choice.³⁵⁶

Professors White and Willmott maintained:

Clause 50 of the Bill creates a default in favour of self-administration. We prefer that people be given a free choice as to method and this is one of the very few issues where we return to the position expressed in the White and Willmott Model. We believe giving a person the choice of administration options better promotes the principle of 'autonomy, including autonomy in relation to end of life choices' which is one of the principles that underpins the QLRC Bill (clause 5(c)).³⁵⁷

In contrast, AMA Queensland argued:

... self-administering the voluntary assisted substance should not be the default option. The decision whether to self-administer the voluntary assisted dying substance or practitioner administered should be for the patient to decide based on the advice provided by the coordinating practitioner.³⁵⁸

Similarly, QLS was not supportive of default self-administration and considered, 'the most appropriate method should be determined in the context of the individual, their family, support persons and healthcare practitioners.'³⁵⁹ The ACA expressed concern around the currency of the self-administration decision:

Under the Bill there is no check of decision-making capacity when self-administration occurs – which may be months after it was prescribed. If the person was tricked or bullied into ingesting it, who would know?³⁶⁰

The Pharmaceutical Society of Australia (PSA) commented on the use of the term 'authorised supplier' in clause 52, and strongly recommended that 'the use of the term authorised supplier is reconsidered and amended to be clear and explicit that this must be a pharmacist'.³⁶¹

³⁵⁴ Voluntary Assisted Dying Bill 2021, cls 52, 59(6), 61.

³⁵⁵ Explanatory notes, p 13.

³⁵⁶ Submission 278, p 5.

³⁵⁷ Submission 906, pp 9-10.

³⁵⁸ Submission 260, p 2.

³⁵⁹ Submission 1031, p 8.

³⁶⁰ Submission 417, p 3.

³⁶¹ Submission 1346, p 2.

QLRC view

The QLRC expressed the view that self-administration should be the default method of administration as ‘the act of self-administering the voluntary assisted dying substance is itself the final indication that the person is acting voluntarily’.³⁶² Further, the QLRC considered that self-administration would maximise the person’s autonomy and control over the timing and circumstances of their death.³⁶³

3.3.2.3 Risks associated with self-administration

Some stakeholders expressed concern that a person undertaking self-administration could be vulnerable if the substance does not work.³⁶⁴ Lutheran Services argued that ‘the bill is wholly silent on the question of medication not working’.³⁶⁵ Reverend Dr Adam McIntosh of Uniting Care Queensland suggested there be a witness requirement in the proposed legislation for self-administration, stating: ‘that would be a simple amendment, to at least have a person there. That does not solve all the issues, but I think it would be an additional safeguard’.³⁶⁶

Professors Colleen Cartwright and Wendy Bonython were also supportive of amendment to the self-administration option, so that ‘a presumptive option for patients to choose to have their healthcare practitioner, the nurse practitioner or whoever it is who is managing that final stage, to be there with them’.³⁶⁷ Professor Bonython further explained; ‘I do not think it should be assumed that, “You’ve chosen the self-administration option. You’re on your own.” I think it very much needs to be a choice made by the patient’.³⁶⁸

QLRC view

According to the QLRC, the administration decision requirements proposed in the Bill would allow the person ‘to discuss their wishes and concerns with the coordinating practitioner and make an informed choice about the method of administration best suited to them’.³⁶⁹ The QLRC considered a person having the ability to choose the method of administration of the voluntary assisted dying substance would maximise ‘the person’s autonomy, while also ensuring that the method of administration is clinically appropriate for the person’.³⁷⁰

3.3.2.4 Practitioner administration

The Bill provides that a person may make a practitioner administration decision only if the coordinating practitioner for the person advises them that self-administration of a voluntary assisted dying substance is inappropriate, taking into account:

- the ability of the person to self-administer the substance
- the person’s concerns about self-administering the substance
- the method of administering the substance that is suitable for the person.³⁷¹

³⁶² QLRC Report, paragraph 10.58.

³⁶³ QLRC Report, paragraph 10.58.

³⁶⁴ Submissions 1285, 244, 1345.

³⁶⁵ Public hearing transcript, Brisbane, 14 July 2021, p 29.

³⁶⁶ Public hearing transcript, Brisbane, 14 July 2021, p 28.

³⁶⁷ Professor Cartwright, public hearing transcript, Brisbane, 14 July 2021, p 12.

³⁶⁸ Professor Bonython, public hearing transcript, Brisbane, 14 July 2021, p 12.

³⁶⁹ QLRC Report, paragraph 10.62.

³⁷⁰ QLRC Report, paragraph 10.62.

³⁷¹ Voluntary Assisted Dying Bill 2021, cl 50.

The Bill allows the coordinating practitioner to become the administering practitioner who would administer the substance, unless the role of administering practitioner is transferred to another practitioner.³⁷²

The Bill proposes that, once a person has made a practitioner administration decision and appointed a contact person, the following authorisations would apply:

- the coordinating practitioner would be authorised to prescribe a voluntary assisted dying substance for the person that is sufficient to cause death
- the authorised supplier who is given the prescription would be authorised to possess, prepare and supply the substance to the administering practitioner for the person
- the administering practitioner would be authorised to receive, possess and prepare the substance
- the administering practitioner would be authorised to administer the substance to the person in the presence of an eligible witness if the administering practitioner is satisfied at the time of administration that:
 - the person has decision-making capacity in relation to voluntary assisted dying
 - the person is acting voluntarily and without coercion.³⁷³

The Bill proposes that, after administering the substance, the administering practitioner would be required to certify the following:

- the person made a practitioner administration decision
- the person did not revoke the decision
- the administering practitioner was satisfied the person had decision-making capacity and was acting voluntarily and without coercion.³⁷⁴

The eligible witness would also be required to certify that the person appeared to be acting voluntarily and without coercion, and that the administering practitioner for the person administered the substance to the person in the presence of the witness.³⁷⁵

Stakeholder views

The QLS recommended, 'that [clause] 50 provide[s] that a person can make a practitioner administration decision even where the coordinating practitioner has not advised the person that self-administration is inappropriate'.³⁷⁶ Professors White and Willmott argued that the term 'inappropriate' in clause 50 of the Bill, be defined in the legislation at clause 50(2)(c) to better illustrate 'inappropriateness'.³⁷⁷

QLRC view

In relation to the Bill's omission of a requirement for the coordinating practitioner or another health practitioner to be present for self-administration, the QLRC recognised 'many people may choose to

³⁷² Explanatory notes, p 14.

³⁷³ Voluntary Assisted Dying Bill 2021, cl 53.

³⁷⁴ Voluntary Assisted Dying Bill 2021, cl 55.

³⁷⁵ Voluntary Assisted Dying Bill 2021, cl 54.

³⁷⁶ Submission 1031, p 9.

³⁷⁷ Submission 906, p 10.

have their coordinating practitioner or another health practitioner present' but 'some may wish for independence and privacy'.³⁷⁸ Additionally, the QLRC cautioned:

... a requirement for the coordinating practitioner or another health practitioner to be present for self-administration may cause difficulties in rural, regional and remote areas where the medical workforce is limited. Such a requirement raises a significant obstacle to access for voluntary assisted dying in many parts of Queensland.³⁷⁹

The QLRC was of the view that, subject to additional safeguards to ensure voluntariness, 'practitioner administration should not be limited to circumstances where the person is physically incapable of self-administering or digesting the voluntary assisted dying substance'.³⁸⁰ Rather, the QLRC explained that 'permitting practitioner administration in broader circumstances gives the person more discretion to choose the method of administration best suited to them and is one way of ensuring the person is provided with high quality care'.³⁸¹

3.3.3 Committee comment

The committee supports the well-considered assessment and substance administration processes in the Bill.

The committee notes the variety of views on the various aspects of the voluntary assisted dying processes, however, considers that the processes set out in the Bill return autonomy to those living with a life-limiting illness and provide a balanced approach between the scheme's access and its safeguards.

3.4 Additional safeguards

In addition to the safeguards provided by the requirement to meet the eligibility criteria, the requirement for the person to make three requests, the assessment and administration processes, and minimum qualifications, experience and training requirements for practitioners, the Bill includes further safeguards to support the proposed voluntary assisted dying scheme. These further safeguards are discussed below.

3.4.1 Initiating a discussion about voluntary assisted dying

The Bill allows a medical practitioner or nurse practitioner to initiate a discussion about voluntary assisted dying, if at the same time the practitioner also informs the person about options available and likely outcomes of treatment and palliative care.³⁸²

A health care worker,³⁸³ however, is prohibited from suggesting voluntary assisted dying or initiating a discussion about voluntary assisted dying with a person in the course of providing a health or personal care service to them.³⁸⁴ If a person asks for information about voluntary assisted dying, a health care worker may provide such information.³⁸⁵

³⁷⁸ QLRC Report, paragraph 10.199.

³⁷⁹ QLRC Report, paragraph 10.200.

³⁸⁰ QLRC Report, paragraph 10.59.

³⁸¹ QLRC Report, paragraph 10.59.

³⁸² Voluntary Assisted Dying Bill 2021, cl 7(2).

³⁸³ Health care worker in this clause means a registered health practitioner (defined in proposed Schedule 1 as 'a person registered under the Health Practitioner Regulation National Law (Queensland) to practise a health profession, other than as a student), or another person who provides a health service or personal care service; see Voluntary Assisted Dying Bill 2021, cl 7(4).

³⁸⁴ Voluntary Assisted Dying Bill 2021, cl 7(1).

³⁸⁵ Voluntary Assisted Dying Bill 2021, cl 7(3).

The explanatory notes and the QLRC Report note that a breach of the requirements may be dealt with under the Health Practitioner Regulation National Law (Queensland) (if committed by a registered health practitioner) or as a complaint investigated by the Health Ombudsman under the *Health Ombudsman Act 2013* (if committed by another individual who provides a health service).³⁸⁶

Stakeholder views

A number of stakeholders supported the qualified prohibition on initiating discussion as proposed in the Bill.³⁸⁷ They argued that allowing a medical practitioner or a nurse practitioner to initiate a discussion about voluntary assisted dying, on the proviso they discuss the other available treatment options, would ensure a person has access to the necessary information to make a fully informed choice.³⁸⁸ The Clem Jones Group submitted:

We believe this strikes a correct and workable balance for optimal medical care and the right to information by a patient, allowing them to make informed choices.³⁸⁹

DWDQ supported the qualified prohibition, and in reference to the Victorian legislation, considered that the prohibition on initiating discussions about voluntary assisted dying had proven discriminatory, stating:

Such a prohibition is also discriminatory in that it disproportionately disadvantages marginalized groups and disadvantaged groups. Examples are those who do not have internet access, those who do not have a good grasp of English language, those in ethnic groups where this topic is not discussed and those older people who have difficulty using technology. Many of these groups rely on and trust their doctors and nurses to provide them with reliable health information.³⁹⁰

Similarly, DADC considered a complete prohibition on initiating discussion about voluntary assisted dying as in Victoria unworkable, stating:

The initiation of the discussion about VAD in the Victorian bill is completely unworkable and would really be against the principles of modern medical practice, where all decisions should be shared between the doctor and the patient. If you cannot inform a patient of all of the options then you are not doing your job properly. Were Queensland to amend their bill in line with Victoria, then the most vulnerable groups—such as those with limited English, low literacy or limited education— are the people who will not be able to access VAD, as they will not have the background knowledge.³⁹¹

The ALA strongly agreed with the Queensland approach, and thought the Victorian model was problematic because:

It does not allow practitioners to have open and fulsome discussions with patients about all of their options, which is something that they do in every other aspect of health care. We think having a provision that prevents those discussions is inconsistent with the current legal principles that we have in Queensland and it is also inconsistent with the ethical principles that we have.³⁹²

Some stakeholders argued that there should be a prohibition on initiating discussions about voluntary assisted dying as is legislated in Victoria.³⁹³ RACP recognised that the provision supports equitable access to information, but highlighted its ‘potential for coercion and misuse of power’.³⁹⁴ RACP

³⁸⁶ QLRC Report, paragraph 6.148; explanatory notes, p 71.

³⁸⁷ For example, see submissions 984, 278, 1055.

³⁸⁸ For example, see submissions 984, 278, 1055.

³⁸⁹ Submission 1055, p 5.

³⁹⁰ Submission 278, p 4.

³⁹¹ Public hearing transcript, Townsville, 12 July 2021, p 14.

³⁹² Public hearing transcript, Brisbane, 15 July 2021, p 19.

³⁹³ For example, see submissions 1309, 1054, 244, 1004, 1218.

³⁹⁴ Submission 1042, p 7.

proposed that ‘safeguards against coercion within the Bill must closely oversee and monitor those cases where a medical practitioner initiates a discussion of or suggests VAD’.³⁹⁵

QCCL advised that it was important that the person seeking voluntary assisted dying should initiate the discussion, given the imbalance of power between medical practitioners and the person seeking voluntary assisted dying.³⁹⁶ Similarly, ANZSGM stated that ‘if medical practitioners are able to suggest VAD, it opens the door to subtle coercion by well-meaning practitioners not fully aware of palliative care options’.³⁹⁷

Conversely, with respect to the qualified prohibition in the Bill, Professor Colleen Cartwright considered the provision discriminatory and that it did not support patient autonomy or informed consent.³⁹⁸ She provided the following example:

In many situations, e.g., in residential aged care facilities, “a medical practitioner or nurse practitioner” might not be available to speak to the resident, but this section indicates that no-one else, even a Registered Nurse or Care Manager, can provide such information, unless the resident asks for it directly. Many residents might want the information but not know how to ask for it. I think this section is discriminatory!³⁹⁹

Andrew Calabro and Daniel Calabro submitted that making informed decisions involved ‘receiving information about different options available for a life-limiting illness, such as palliative care and voluntary assisted dying’.⁴⁰⁰ They concluded:

... a person who is diagnosed with a life-limiting illness and only informed about palliative care cannot be said to have made a fully informed decision. In such circumstances, a person would be denied a right of autonomy to choose voluntary assisted dying.⁴⁰¹

Some stakeholders expressed the view that the prohibition was too complex as it affects different health care workers in different ways and may lead to confusion.⁴⁰² Professors White and Willmott argued:

The concern is that this confusion may lead to health professionals taking a conservative approach of not raising VAD (although they are permitted to do so) even if they think a patient may wish to consider it, for fear of being in breach of a legislative prohibition.⁴⁰³

Professor Willmott also referred to a project which interviewed 32 doctors who had been involved in voluntary assisted dying in the first year of operation in Victoria and which recorded their experiences with the legislation in supporting patients to access voluntary assisted dying.⁴⁰⁴ The findings of the research included:

... that the doctors did not perceive there were issues around safety. They were not concerned that non-eligible people were able to access voluntary assisted dying. Rather, they had concerns about the ability of eligible patients to access VAD and to get through the process.

...

³⁹⁵ Submission 1042, p 7.

³⁹⁶ Public hearing transcript, Brisbane, 15 July 2021, p 22.

³⁹⁷ Public hearing transcript, Brisbane, 15 July 2021, p 30.

³⁹⁸ Submission 1000, p 3.

³⁹⁹ Submission 1000, p 3.

⁴⁰⁰ Submission 1345, p 3.

⁴⁰¹ Submission 1345, p 3.

⁴⁰² For example, see submissions 906, 1000.

⁴⁰³ Submission 906, p 12.

⁴⁰⁴ Public hearing transcript, Brisbane, 15 July 2021, p 3.

The first was the section 8 prohibition in the Victorian legislation against health professionals being able to initiate a conversation about voluntary assisted dying. The doctors felt this inhibited the ability of patients to make an informed choice about end-of-life options. It disadvantaged people whose first language was not English and people potentially with low health literacy.⁴⁰⁵

Professor Willmott stated that while the Bill does not propose a blanket prohibition on initiating discussions, she was concerned that there are any restrictions in raising voluntary assisted dying.⁴⁰⁶

ACN highlighted practical challenges associated with the prohibition for health care workers advising under clause 7 (1) of the Bill:

Oftentimes, the way patients raise issues about their end-of-life care means that it is often the nurse who is with them who provides that support. We need to understand and appreciate the complexity around this. There needs to be education for nurses around how they have those conversations, about points of referral and understanding the law.

...

And nurses' understanding of what that means so that they are not fearful of engaging in conversations which might be supportive for patients.⁴⁰⁷

With respect to nurse practitioners initiating a conversation about voluntary assisted dying as outlined in clause 7(2) of the Bill, the ACNP raised the concern that this would pose risks for nurse practitioners:

If we were considered to be the instigator of a conversation, does that actually make us more at risk and things along those lines—not necessarily in terms of the client but their family? We always have to consider that. The client will most likely not be still present, but the family could be there and they could have reservations about the whole process and have a different agenda. We need to know that all nurses in that process are considered. Everything I do is informed consent. If it is not informed consent, it is not coercion. It never has been coercion, but it could be seen as that by the way this is written. I did not see clear wording that allowed informed consent to be okay.⁴⁰⁸

In response to a question taken on notice about the implications for its members of the prohibition on initiating discussions about voluntary assisted dying, the QNMU advised:

As indicated in the [QLRC] report, any breach may be deemed unprofessional conduct under the national law (for a health practitioner regulated under the national law) or subject to scrutiny by the Office of the Health Ombudsman (OHO) Queensland for unregulated health care workers. The OHO has existing processes for receipt of any complaints regarding both regulated and unregulated health care workers.⁴⁰⁹

Additionally the QNMU advised:

... that regulated health practitioners should 'already have a high sensitivity to the issue of unprofessional practice and while the VAD legislation introduces the risk of unprofessional practice in relation to the prohibition on initiating discussions about VAD, all clinicians should already be aware of practicing in a manner that reduces the risk of such situations.⁴¹⁰

The QNMU acknowledged the risk of miscommunication in any health care interaction between health care workers, those they care for, and their significant others. It stated that the risk can be mitigated by having regard to:

- legislative clarity and comprehensive training and support

⁴⁰⁵ Public hearing transcript, Brisbane, 15 July 2021, p 3.

⁴⁰⁶ Public hearing transcript, Brisbane, 15 July 2021, p 3.

⁴⁰⁷ Public hearing transcript, Brisbane, 15 July 2021, p 57.

⁴⁰⁸ Public hearing transcript, Brisbane, 15 July 2021, pp 57-58.

⁴⁰⁹ Queensland Nurses and Midwives' Union, correspondence dated 22 July 2021, p 2.

⁴¹⁰ Queensland Nurses and Midwives' Union, correspondence dated 22 July 2021, p 2.

- effective training and support for health care workers and information for those who may access VAD will help to reduce the risk of miscommunication or misinterpretation of the voluntary assisted dying process
- public communication and education around the voluntary assisted dying legislation and process
- comprehensive organisational policies to support health care workers and those wishing to access the voluntary assisted dying scheme (including those organisations claiming institutional conscientious objection)
- support from regulatory authorities such as the Office of the Health Ombudsman (OHO) and the Australian Health Practitioner Regulation Agency (Ahpra) and relevant boards, eg professional standards, codes of ethics and conduct and decision-making tools that reflect the voluntary assisted dying issues that may arise in clinical practice
- lessons learned from other states.⁴¹¹

ALA suggested the inclusion of penalties in the Bill for registered health practitioners who contravene the prohibition on initiating discussions.⁴¹²

QLRC view

In its examination of this topic, the QLRC Report considered a number of issues including:

- respect for autonomy⁴¹³
- the need to protect vulnerable people against improper influence and coercion⁴¹⁴
- the position of trust and influence of health practitioners in their relationships with patients⁴¹⁵
- the possibility that the provision of information about voluntary assisted dying might be interpreted as a recommendation⁴¹⁶
- patients' differing levels of literacy and understanding about health matters and options⁴¹⁷
- difficulties a patient may have in initiating a conversation about end of life options or communicating their wishes⁴¹⁸
- the right of patients to be provided with relevant, sufficient, and clear information about options to enable them to make informed choices⁴¹⁹
- a practitioner's duty of care to the patient in providing all relevant information to allow the patient to give informed consent⁴²⁰

⁴¹¹ Queensland Nurses and Midwives' Union, correspondence dated 22 July 2021, pp 2-3.

⁴¹² Submission 1027, p 6.

⁴¹³ QLRC Report, paragraph 6.120.

⁴¹⁴ QLRC Report, paragraphs 6.33, 6.74.

⁴¹⁵ QLRC Report, paragraphs 6.75-6.76; 6.70-6.71; 6.76.

⁴¹⁶ QLRC Report, paragraph 6.97.

⁴¹⁷ QLRC Report, paragraphs 6.23, 6.25; 6.84-6.85.

⁴¹⁸ QLRC Report, paragraph 6.86.

⁴¹⁹ QLRC Report, paragraph 6.64.

⁴²⁰ QLRC Report, paragraph 6.82.

- the need for practitioners to be clinically skilled or sufficiently qualified to properly raise and discuss end of life treatment options and outcomes.⁴²¹

While it recognised the importance of concerns with practitioners initiating discussions about voluntary assisted dying, the QLRC Report stated that the concerns:

... do not, however, justify a total prohibition on all health practitioners initiating discussions about voluntary assisted dying. Instead, they justify a qualified prohibition, which does not apply if, at the same time, the person is provided with information about their treatment and palliative care options. This is consistent with professional standards and codes of ethics regarding informed consent and respect for patient choice. Those requirements include that patients should be provided with all the necessary information to make informed decisions about their condition, prognosis, preferences and all alternative treatment options.⁴²²

The QLRC Report accorded with the approach in other jurisdictions that a prohibition should not apply if information about voluntary assisted dying is provided to a person at the person's request.⁴²³

3.4.2 Prescribing, supplying and disposing of voluntary assisted dying substance

Prescription, supply and disposal of a voluntary assisted dying substance are specified in the Bill⁴²⁴ to ensure its safe management throughout the process and to ensure the roles and responsibilities of persons involved in the process are clear.⁴²⁵ The Bill provides for requirements for labelling and storage,⁴²⁶ and additional requirements for prescription, supply and disposal,⁴²⁷ of a voluntary assisted dying substance to be prescribed by regulation.

QLRC view

In considering the need to regulate the voluntary assisted dying substance, the QLRC Report determined that in self-administration situations where a registered health practitioner does not maintain control of the voluntary assisted dying substance, provisions were required to ensure the safe management of the voluntary assisted dying substance throughout the process.⁴²⁸

The QLRC considered that to support a person to self-administer without requiring a practitioner to be present, and to ensure the voluntary assisted dying substance is managed safely, the Bill should provide for the appointment of a contact person.⁴²⁹

The contact person would fulfil a number of roles, including receiving the voluntary assisted dying substance, supplying it to the person, and giving any unused or remaining substance to an authorised disposer following the person's death or the self-administration decision being revoked.⁴³⁰ Where a self-administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies, whether as a result of self-administering the substance or some other cause.⁴³¹

⁴²¹ QLRC Report, paragraph 6.124.

⁴²² QLRC Report, paragraph 6.117.

⁴²³ QLRC Report, paragraph 6.113.

⁴²⁴ Voluntary Assisted Dying Bill, cls 65-79.

⁴²⁵ Explanatory notes, p 29.

⁴²⁶ Voluntary Assisted Dying Bill, cls 71, 74.

⁴²⁷ Voluntary Assisted Dying Bill, cls 67, 73, 79.

⁴²⁸ QLRC Report, paragraphs 11.11-11.15.

⁴²⁹ QLRC Report, paragraph 11.21.

⁴³⁰ QLRC Report, p 323.

⁴³¹ QLRC Report, p 323.

The Bill provides that where a person has revoked a self-administration decision or has subsequently died, the contact person must as soon as practicable and within 14 days return the voluntary assisted dying substance to the authorised disposer.⁴³²

Where a practitioner administration decision has been made and not revoked, the contact person must inform the coordinating practitioner if the person dies from a cause other than practitioner administration of the substance.⁴³³ Additionally the contact person would also be a point of contact for the Voluntary Assisted Dying Review Board (Board) in its recording and monitoring of voluntary assisted dying.⁴³⁴

Stakeholder views

Some submitters expressed concern about the management of the voluntary assisted dying substance.⁴³⁵ In relation to the dispensing of the substance, the PSA recommended that the term authorised supplier be changed to ensure that a person supplying the substance must be a pharmacist.⁴³⁶ Also in relation to supplying the substance, Andrew Calabro and Daniel Calabro called for clarification as to how an authorised supplier could confirm the authenticity of a prescription.⁴³⁷

In terms of storage of the voluntary assisted dying substance, Andrew Calabro and Daniel Calabro posed a number of questions in relation to the requirement that the substance be stored in a locked box.⁴³⁸ Health Professionals Say No! raised concerns about the safe management of a voluntary assisted dying substance in residential aged care facilities (RACFs) stating:

... there are also clear accreditation standards around medication and patient safety, medication management and the delivery of palliative care. There is also legislation around medication storage and prescribing for RACFs which make it difficult for meds to be stored without an existing administration order for administration order for an indefinite period.⁴³⁹

Dr Donna Purcell commented that it seemed unnecessarily long to allow 14 days for a contact person to return any unused voluntary assisted dying substance. She stated: 'This is a safety issue. The longer it is left, the more easily it can be misplaced or even interfered with'.⁴⁴⁰

Department response

The department provided further detail on who can collect a voluntary assisted dying substance and how it should be stored before its use:

If the person makes a practitioner administration decision, only the administering practitioner can be given the substance directly by the statewide pharmacy service and it is kept in their possession until the person actually goes through with administration. If they have made a self-administration decision, the substance can be given to either the person's nominated contact person or an agent or the person themselves. That is to deal with some of those regional and remote access issues and the fact that if the person is terminally ill they may not be able to travel to the statewide pharmacy service to collect the substance themselves. That is to enable family members to assist in that regard. As Professor McNeil said,

⁴³² Voluntary Assisted Dying Bill, cl 63.

⁴³³ QLRC Report, p 323.

⁴³⁴ QLRC Report, p 323.

⁴³⁵ For example see submissions 1346, 1345, 1285, 1228.

⁴³⁶ Submission 1346, p 2.

⁴³⁷ Submission 1345, p 5.

⁴³⁸ Submission 1345, p 5.

⁴³⁹ Submission 1228, p 8.

⁴⁴⁰ Submission 1285, pp 6-7.

the substance needs to be kept in accordance with the storage requirements, which will be that it is in a locked box and not easily accessible by other people.⁴⁴¹

The department confirmed that additional requirements relating to the regulation of the voluntary assisted dying substance, including prescriptive matters such as labelling and disposal, will be prescribed in a Voluntary Assisted Dying Regulation.⁴⁴²

The department explained that as part of implementing the scheme, a statewide Pharmacy Service will be established. It advised the service will closely support the person, their loved ones and practitioners to ensure the substance is managed appropriately and everyone involved in the process is aware of their roles and responsibilities.⁴⁴³

3.4.3 Voluntary Assisted Dying Review Board

The Bill establishes the Board⁴⁴⁴ as an independent statutory board 'to support the safe, practical and transparent operation of the voluntary assisted dying scheme'.⁴⁴⁵ The Bill provides that the Board's functions are to:

- monitor the operation of the Act
- review the compliance in relation to each completed request for voluntary assisted dying
- refer issues identified by the Board to relevant entities
- keep records of requests for, and provision of, voluntary assisted dying
- analyse information and research matters related to the operation of the Act
- advise the Minister or chief executive about the operation of the Act, the Board's functions, or improvement of processes and safeguards of voluntary assisted dying
- promote compliance including by providing information on the operation of the Act to registered health practitioners and the community
- promote continuous improvement in the operation of the Act
- engage with the community and other entities in relation to voluntary assisted dying
- perform any other function given to the Board under the Act.⁴⁴⁶

The Bill requires that the Board act independently and in the public interest and that it is not subject to direction by anyone, including the Minister, about how it performs its functions.⁴⁴⁷ The Board's powers are to 'do anything necessary or convenient' to perform its functions, including collecting, using and disclosing information for the purpose of performing its functions.⁴⁴⁸

The Board will not have an approval, dispute resolution or enforcement role in order to 'maintain its impartiality and avoid unnecessary and costly duplication of functions'.⁴⁴⁹ It will however be responsible for identifying and referring such matters to relevant entities, such as Ahpra and the

⁴⁴¹ Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 9.

⁴⁴² Queensland Health correspondence, 13 July 2021, p 31.

⁴⁴³ Queensland Health correspondence, 13 July 2021, p 32.

⁴⁴⁴ Voluntary Assisted Dying Bill 2021, part 8.

⁴⁴⁵ QLRC Report, p 571.

⁴⁴⁶ Voluntary Assisted Dying Bill 2021, cl 117. Note: a request for voluntary assisted dying is 'completed' if the person has died, or the request has been discontinued (see cl 117(2)).

⁴⁴⁷ Voluntary Assisted Dying Bill 2021, cl 119(1).

⁴⁴⁸ Voluntary Assisted Dying Bill 2021, cl 118.

⁴⁴⁹ QLRC Report, paragraph 18.224.

national health practitioner boards, the Health Ombudsman, and police, as appropriate.⁴⁵⁰ This approach is consistent with other jurisdictions, and with other death review bodies in Queensland.⁴⁵¹

Board membership, criteria for appointment, conditions of appointment, and requirements for Board proceedings, reporting, and other matters related to the operation of the Board are prescribed by the Bill.⁴⁵²

Additionally, the Bill requires that the Board must give an annual report to the Minister within 3 months of the end of each financial year. Annual reports, or a report about the Board's functions provided on the request of the Minister or chief executive, must be tabled by the Minister in the Legislative Assembly within 14 sitting days of receipt.⁴⁵³

QLRC view

An independent oversight body was considered by the QLRC to be essential to achieving appropriate safeguards and monitoring compliance, particularly as the scheme may apply in both the public and private health systems and involve a wide range of individuals and institutions.⁴⁵⁴ The QLRC Report stated:

Voluntary assisted dying evokes strong views. It is also a new and relatively untested area of law in Australia. If introduced, the legislation will confer new rights and responsibilities. It will authorise actions that would otherwise be unlawful. It will impact on, and need to operate within, other existing frameworks that govern end of life care in Queensland. An oversight mechanism is necessary to monitor the operation of the legislation, identify systemic issues and build a knowledge base about voluntary assisted dying in Queensland.⁴⁵⁵

Stakeholder views

Submitters supported the establishment of an independent expert Board as an important safeguard under the scheme.⁴⁵⁶ The AMA Queensland argued:

AMA Queensland agrees that there should be an oversight body to act as an extra safeguard against coercion, similar to that established in Victoria with a mix of legal, medical practitioners, academics and consumer representatives.⁴⁵⁷

While submitters were supportive of the establishment of the Board, some proposed amendments to its composition or functions. The Queensland Council of Unions (QCU) recommended:

... that consideration is given to including a community advocate representative to ensure inclusion of community representation within the board functions particularly as they relate to its functions under Clause 117(1)(e), (f), (h) and (i).⁴⁵⁸

AMA Queensland proposed that 'the oversight body should have additional functions such as community engagement and promoting compliance and continuous improvement of the VAD

⁴⁵⁰ QLRC Report, paragraph 18.224.

⁴⁵¹ QLRC Report, paragraph 18.224.

⁴⁵² Voluntary Assisted Dying Bill 2021, cls 120-139.

⁴⁵³ Voluntary Assisted Dying Bill 2021, cls 134-135.

⁴⁵⁴ QLRC Report, p 578, paragraph 18.52.

⁴⁵⁵ QLRC Report, paragraphs 18.49-18.50.

⁴⁵⁶ Submission 937, p 10.

⁴⁵⁷ Submission 260, p 14.

⁴⁵⁸ Submission 1148, p 6.

system.⁴⁵⁹ The QHRC proposed that the Board have a statutory function to independently monitor the quality and funding of palliative care.⁴⁶⁰

Several submitters commented on the reporting requirements of the Board. PCQ argued the need for more frequent reporting and recommended that the:

... Board be required by law to report to the Parliament every six months (as well as produce an annual report) and that this be an ongoing reporting requirement.⁴⁶¹

Go Gentle Australia proposed that the Board collect and report on the circumstances driving people's voluntary assisted dying choice:

We urge that Queensland's Review Board include, as part of its remit, information about the circumstances driving people's VAD choice. A strong template for this exists in Oregon, where patients who access VAD are asked to complete a questionnaire asking them to rate their end of life concerns...⁴⁶²

Dr David Kirchhoffer argued the need for evidence of eligibility to be submitted to the Board.⁴⁶³ Dr Kirchhoffer added:

The provision of such evidence should be a requirement because this will both enhance the ability of the bill to protect vulnerable people, and improve the quality of information and therefore the quality of the free choice made by people accessing VAD. There is little point in having a review board and a series of steps in the process of accessing VAD if there is no objective way of ascertaining whether the claim that a person is eligible for VAD is legitimate. In the current bill, the purpose of the review board is limited to determining whether all the steps in the process have been followed.⁴⁶⁴

Department response

The department explained that the QLRC considered that eligibility assessments are a matter for the person's assessing medical practitioners and that the Board should not have an approval function.⁴⁶⁵ The department stated:

The QLRC noted that it is not intended that the Board will review documentation during the request and assessment process (paragraph 18.233). Rather, this will assist the Board in its monitoring and compliance role. The QLRC considered that the scheme contains other safeguards, including for an assessing practitioner to refer certain matters to another qualified person for determination, and that an application for review may also be made in particular circumstances to QCAT (paragraph 18.234).⁴⁶⁶

In response to the issues raised by submitters on reporting requirements, the department confirmed the Board's annual report must include information for the financial year about:

- the number of completed requests for voluntary assisted dying the Board has reviewed;
- the number of referrals, if any, the Board has made to other entities;
- recommendations of the Board relevant to the performance of its functions, including, for example, recommendations about systemic matters in voluntary assisted dying or the improvement of voluntary assisted dying; and

⁴⁵⁹ Submission 260, p 15.

⁴⁶⁰ Public hearing transcript, Brisbane, 14 July 2021, p 23.

⁴⁶¹ Submission 1158, p 11.

⁴⁶² Submission 1189, p 17.

⁴⁶³ Public hearing transcript, Brisbane, 16 July 2021, p 9.

⁴⁶⁴ Submission 455, p 5.

⁴⁶⁵ Queensland Health correspondence, dated 14 July 2021, p 7.

⁴⁶⁶ Queensland Health correspondence, dated 14 July 2021, p 8.

- a summary in de-identified form of the information required to be recorded and kept.⁴⁶⁷

The department also stated that the Bill:

... provides that the Board may at any time, and must on request, give the Minister or the chief executive of Queensland Health a report about the Board's functions (clause 135). A copy of a report given to the Minister must be tabled by the Minister in the Legislative Assembly within 14 sitting days after receiving it.⁴⁶⁸

3.4.4 Offences

The Bill creates specific offences which, according to the QLRC Report 'are needed to secure key safeguards'⁴⁶⁹ in the proposed voluntary assisted dying scheme. The new offences would not affect the operation of the *Criminal Code Act 1899* (Criminal Code) – for actions taken in a way not permitted by the Bill.⁴⁷⁰ The offences included in the Bill are outlined below.

3.4.4.1 Unauthorised administration of the substance

Unless authorised as an administering practitioner in accordance with proposed section 53(6), for a person to administer a voluntary assisted dying substance to another person would be a crime under section 140 of the Bill, with a maximum penalty of 14 years imprisonment.

The Bill provides that an offence is not committed if the person administers a medicine to another person under the *Medicines and Poisons Act 2019* (Medicines and Poisons Act).⁴⁷¹ The QLRC Report confirmed that specific regulation of a voluntary assisted dying substance will be required given that it is intended to cause a person's death, which does not align with the Medicines and Poisons framework's regulation of medicines used for therapeutic purposes.⁴⁷²

QLRC view

The QLRC recognised that voluntary assisted dying would be unlawful under the Criminal Code (Qld) except as authorised in particular circumstances under the provisions of the Bill⁴⁷³ and that unauthorised administration of a voluntary assisted dying substance 'covers a range of potential conduct' such as:

- an inadvertent breach, such as where a family member or carer provides some assistance to the person in self-administering the substance
- situations where a person administers a substance but is not qualified to do so, either knowingly or inadvertently
- egregious breaches where a person knowingly or recklessly acts outside the scheme, for example, where the administering practitioner knows the person has not made or has withdrawn their request or does not have the required decision-making capacity.⁴⁷⁴

⁴⁶⁷ Queensland Health correspondence, dated 14 July 2021, p 26.

⁴⁶⁸ Queensland Health correspondence, dated 14 July 2021, p 26.

⁴⁶⁹ QLRC Report, paragraph 17.69.

⁴⁷⁰ Explanatory notes, p 30; QLRC Report, p 534.

⁴⁷¹ Voluntary Assisted Dying Bill 2021, cl 140(2).

⁴⁷² QLRC Report p 326, paragraph 11.20; see also *Medicines and Poisons Act 2019*, ss 11(2) (definition of 'medicine'), 12(2) (definition of 'poison').

⁴⁷³ QLRC Report, paragraph 17.87.

⁴⁷⁴ QLRC Report, paragraph 17.88.

The QLRC Report stated:

Given the range of possible circumstances in which conduct might fall outside the limits of what is authorised by the scheme, we consider it desirable for the draft legislation to include a separate and specific offence, with a lower maximum penalty. This would provide additional flexibility in the appropriate exercise of prosecutorial discretion on whether to prosecute and, if so, for which offence.⁴⁷⁵

The QLRC considered that a maximum penalty of 14 years imprisonment for the offence to be appropriate as it ‘distinguishes the offence from the Criminal Code offences, while retaining a high maximum penalty indicative of the seriousness of the conduct’.⁴⁷⁶ The QLRC Report also set out the Commission’s expectations in relation to offences:

The Commission expects that the most serious cases involving unauthorised administration would be dealt with under the Criminal Code, where a higher sentence up to life imprisonment may be imposed.⁴⁷⁷

3.4.4.2 *Inducement by dishonesty or coercion*

The Bill makes it an offence for a person to, dishonestly or by coercion:⁴⁷⁸

- induce a person to make, or revoke, a request for access to voluntary assisted dying⁴⁷⁹
- induce a person to self-administer a voluntary assisted dying substance.⁴⁸⁰

The Bill classifies an offence under this clause as a misdemeanour and provides for a maximum penalty of 7 years’ imprisonment.

Stakeholder views

While many stakeholders were supportive of the safeguards in the Bill including the offence provisions,⁴⁸¹ some stakeholders raised concerns about provisions which state that it is an offence for a person to dishonestly or by coercion induce another person to revoke a request for voluntary assisted dying. A number of faith-based organisations called for the clause to be amended to specifically remove the reference to revoking a request.⁴⁸² The ACL argued:

It should not be a criminal offence to encourage someone to live and there is no real risk of a person dishonestly inducing another person to revoke a request for voluntary assisted dying; indeed it is difficult to conceive of circumstances in which this could occur. It is certainly not a risk that warrants a maximum criminal penalty of 7 years.⁴⁸³

ACL also argued that ‘there is no moral equivalence to talking somebody into taking their life as talking somebody into keeping their life’.⁴⁸⁴

⁴⁷⁵ QLRC Report, paragraph 17.90.

⁴⁷⁶ QLRC Report, paragraph 17.97.

⁴⁷⁷ QLRC Report, paragraph 17.98.

⁴⁷⁸ Voluntary Assisted Dying Bill 2021, cl 140.

⁴⁷⁹ Voluntary Assisted Dying Bill 2021, cl 141.

⁴⁸⁰ Voluntary Assisted Dying Bill 2021, cl 142.

⁴⁸¹ DWDQ, public hearing transcript, Brisbane, 14 July 2021, p 7, Go Gentle, also see submissions 1189, 984, 1003, 1087, 1148.

⁴⁸² Lutheran Church, public hearing transcript, Brisbane 14 July 2021, also see submissions 1052, 1044, 244.

⁴⁸³ Submission 1054, p 12.

⁴⁸⁴ Public hearing transcript, Brisbane, 14 July 2021, p 42.

Similarly, the ACC challenged the inclusion of the provision stating:

There is however, a very significant difference between making such a request, and revoking a request, and these two actions should be treated differently under the legislation.⁴⁸⁵

Uniting Church in Australia, Queensland Synod was concerned that clause 141 of the Bill:

... will have the consequences of making it an offence for spiritual advisors, such as a Minister of religion or chaplain, and psychological advisors, such as counsellors and therapists, to provide advice opposing voluntary assisted dying. There is no other explanation for the inclusion of 'or revoke a request for' in the Final Report to justify its inclusion and no other legislation in Australia includes such a reference.⁴⁸⁶

In addition, the Lutheran Church in Australia was of the opinion that clause 141 was the most 'objectionable provision of the Bill'.⁴⁸⁷

The concern that religious ministers, qualified counsellors or family members could be subject to criminal liability in counselling an individual engaging with the voluntary assisted dying scheme was challenged by several stakeholders. The Clem Jones group expressed the view:

... that if somebody in honest and good faith is seeking advice about whether they should take up the VAD option or not and that person gives them advice, no, they shouldn't for these reasons, that will not be an offence ...⁴⁸⁸

Similarly, Professors White and Willmott stated:

... the wording of s 141 requires dishonesty or coercion, and [it is] our view that this would not be breached by a person having an open discussion about options at the end of life.

We have considered this issue further and our view remains that the circumstances flagged by Mr Molhoek would not be captured within s 141, because:

- a) To be captured by s 141, the person must have dishonestly, or by coercion, induced another person to revoke a request for VAD. This requires something more than simply having a discussion that involves VAD.
- b) 'Induce' and 'dishonesty' are not defined in the VAD Bill and have their ordinary meanings.⁴⁸⁹ However, coercion is defined in the dictionary of the VAD Bill and includes 'intimidation or a threat or promise, including by an improper use of a position of trust or influence'. Our view is that a genuine conversation about options at end of life or support provided to a family in a time of crisis, as contemplated by Mr Molhoek, would not be considered to be 'dishonestly' or 'by coercion' inducing a person to revoke a request to access VAD because: the person is not attempting to persuade the person to take a particular course of action (i.e. leading them to access or to not access VAD); there is no intimidation, threat or promise; and there is no dishonesty.
- c) A hypothetical situation we do believe could be captured by s 141 is where a church pastor, during a discussion with a person who has made a first request for VAD, states that if they do not revoke their request they will be excommunicated from the church. This is because such a discussion involves a threat by a person in a position of trust and influence to take a particular course of action. This kind of situation is clearly distinguishable from the circumstances flagged by Mr Molhoek.
- d) One of the key principles reflected in s 5(c) of the VAD Bill is respect for an individual's autonomy at end of life. The hypothetical situation described at 9.d is contrary to this principle, and we believe

⁴⁸⁵ Submission 1052, p 2.

⁴⁸⁶ Submission 244, p 31.

⁴⁸⁷ Public hearing transcript, Brisbane, 14 July 2021, p 30.

⁴⁸⁸ Public hearing transcript, Brisbane, 16 July, 2021, p 23.

⁴⁸⁹ The Report at page 578 refers to the *Macquarie Dictionary* definition of induce, which is 'to lead or move by persuasion or influence, as to some action, state of mind, etc'.

it is appropriate for these kinds of situations to be captured by the criminal offence provisions in the VAD Bill.⁴⁹⁰

With respect to the maximum penalty of 7 years imprisonment for breaching clause 141, Professors White and Willmott advised that they considered it was an appropriate maximum penalty because:

- a. The VAD Bill recognises in s 5(a) that ‘human life is of fundamental importance’, and in s 5(c) that ‘a person’s autonomy, including autonomy in relation to end of life choices, should be respected’.
- b. In its Report, the QLRC emphasised that the proposed maximum penalty of 7 years for both offences of inducing a person to access, and not to access, VAD ‘reflects the seriousness of the conduct in undermining the autonomy and voluntary choice of the person’.
- c. The conduct giving rise to the offence is the same whether it applies to a circumstance where a person is inducing someone to access, or to not access VAD: in both cases the person’s autonomy and voluntary choice is equally undermined. The law takes very seriously dishonestly inducing or coercively inducing people to change their mind about this significant decision. Therefore, we believe the QLRC’s position is an appropriate one.
- d. However, we recognise that the consequences of a person being induced to access VAD are very significant and that harm (i.e. death) may be caused to a person who is induced to access VAD. Different harm (i.e. continued intolerable suffering) may result for a person who is induced not to access VAD. We believe that these differences in consequences would be appropriately addressed in sentencing. We refer to s 141 of the Penalties and Sentences Act 1992 (Qld), which requires the Court in sentencing an offender to have regard to:
 - i. the nature of the offence and how serious the offence was, including any physical, mental or emotional harm done to a victim;
 - ii. damage, injury or loss caused by the offender;
 - iii. the presence of any aggravating or mitigating factor concerning the offender;
 - iv. any other relevant circumstance.
- e. We expect that these factors would generally result in a substantially higher sentence being imposed in cases involving an inducement to access VAD rather than cases involving an inducement not to access VAD.
- f. We also note for completeness that we believe it would be possible for a court to impose a sentence of a fine instead of any period of imprisonment, and this sentencing option may be utilised in cases involving inducements to not access VAD.⁴⁹¹

Go Gentle Australia suggested that consideration be given to building financial penalties into the Bill ‘for institutions, or individuals, who block, harass, or attempt to coerce people from their legal choice to access VAD’.⁴⁹²

QLRC view

The QLRC Report explains that the aim of this provision is to ensure the ‘best legal safeguards’ to address the risk of coercion are included in the Bill and is in addition to other provisions in the Bill aimed at safeguarding that any request for, and access to, assisted dying is voluntary.⁴⁹³ The QLRC Report states that specifying the offence as a misdemeanour with a maximum penalty of 7 years’

⁴⁹⁰ Professors White and Willmott, correspondence dated 21 July 2021, pp 2-3.

⁴⁹¹ Professors White and Willmott, correspondence dated 21 July 2021, pp 3-4.

⁴⁹² Submission 1189, p 16.

⁴⁹³ QLRC Report, paragraph 17.70-17.71.

imprisonment ‘reflects the seriousness of the conduct in undermining the autonomy and voluntary choice of the person’.⁴⁹⁴

Department response to stakeholder concerns

In response to concerns that the Bill would capture family members, friends or spiritual advisors for discussions which may lead to inducing a person to revoke a request for voluntary assisted dying, the department stated:

The Bill therefore makes it an offence for a person, dishonestly or by coercion, to induce another person to make or revoke a request for access to voluntary assisted dying (clause 141). Coercion is defined for the Bill to include intimidation or a threat or promise, including by an improper use of a position of trust or influence... This offence only applies where the person has induced the person to revoke their request dishonestly or by coercion, and would not capture discussions between a terminally ill person and their family, friends or spiritual advisors, unless they used dishonesty or coercion to induce the person to revoke their request for voluntary assisted dying.⁴⁹⁵

3.4.4.3 Providing false or misleading information

The Bill provides for offences relating to the provision of information and falsifying documents under clauses 143, 144 and 145. The Bill makes it an offence for a person to give information to the Board that the person knows to be false or misleading.⁴⁹⁶ The offence provision does not apply if, when giving information in a document, the person tells the Board how the document is false or misleading, and gives the correct information to the Board, if the person has or can reasonably obtain the correct information.⁴⁹⁷

The Bill also makes it an offence to make a statement in a form or other document required to be made under the legislation that the person knows to be false or misleading,⁴⁹⁸ and to falsify a form or other document required to be made under the legislation.⁴⁹⁹

An offence under each of these clauses is specified as a misdemeanour, with a maximum penalty of 5 years imprisonment.

QLRC view

The QLRC Report explains that the offences in clauses 143 – 145 of the Bill would relate to, for example, a false certification by a witness in an approved form, or the alteration or falsification of a document or form, such as producing a ‘fake’ prescription for a voluntary assisted dying substance, or producing a false assessment record form where there has been no request for voluntary assisted dying.⁵⁰⁰ The QLRC recognised that providing false information about a person’s request, eligibility or other matter would undermine the oversight and safe operation of the scheme⁵⁰¹ and stated that the proposed penalty for these offences reflected the seriousness of the conduct.⁵⁰²

3.4.4.4 Non-disclosure of personal information

Clause 146 of the Bill provides that it is an offence for a person to record or disclose personal information obtained in the course of, or because of, the exercise of a function or power under the

⁴⁹⁴ QLRC Report, paragraph 17.73.

⁴⁹⁵ Queensland Health, correspondence dated 14 July 2021, p 29.

⁴⁹⁶ Voluntary Assisted Dying Bill 2021, cl 143.

⁴⁹⁷ Voluntary Assisted Dying Bill 2021, cl 143(3).

⁴⁹⁸ Voluntary Assisted Dying Bill 2021, cl 144.

⁴⁹⁹ Voluntary Assisted Dying Bill 2021, cl 145.

⁵⁰⁰ QLRC Report, paragraph 17.77.

⁵⁰¹ QLRC Report, paragraph 17.74.

⁵⁰² QLRC Report, paragraph 17.78.

legislation,⁵⁰³ unless the record is made, or the personal information is disclosed for at least one of the following reasons:

- for a purpose under the legislation
- with the consent of the person to whom the personal information relates
- to comply with a lawful process requiring the production of documents to, or in giving evidence before a court or tribunal
- as authorised or required by law.⁵⁰⁴

The Bill provides for a maximum penalty of 100 penalty units (\$13,785)⁵⁰⁵ for failure to comply with the provision.⁵⁰⁶

Stakeholder views

A form submission raised a concern that the government will be unable to keep track of the number of people who access voluntary assisted dying as it construed that clause 146 makes it an offence to obtain information about anyone who accesses assisted suicide.⁵⁰⁷ However, clause 146(3) provides that clause 146(2) does not apply if the record is made or if the personal information is disclosed, for a purpose under the Act.⁵⁰⁸

QLRC view

As outlined in the QLRC Report, those involved in the administration of voluntary assisted dying legislation would acquire personal information while performing their functions. This information may often be of a sensitive nature and the protection of privacy requires that such information be protected from unauthorised disclosure. The QLRC confirmed that existing legislation and obligations to respect patient privacy under professional codes would provide some protection, but considered that ‘to provide clarity and ensure consistency’ the Bill should prohibit disclosure of personal information obtained in the administration of the legislation. The QLRC stated, ‘the establishment of a new legislative scheme creates new roles and new forms of personal information. It is desirable for non-disclosure of that information to be addressed in the same legislation’.⁵⁰⁹

Department response

In response to concerns regarding the recording or disclosing personal information, the department advised:

The Human Rights Act 2019 provides that individuals have the right to protection of their privacy. Government agencies are required to comply with the privacy principles in the Information Privacy Act 2009 when collecting and handling personal information. The privacy principles provide that agencies are not permitted to disclose personal information to another person unless an exception applies, for example, if an individual consents to the disclosure or the disclosure is authorised or required by law.

Consistent with the QLRC recommendation (Recommendation 17-6), the Bill prohibits disclosure of personal information obtained in the administration of the Act (clause 146).

⁵⁰³ Voluntary Assisted Dying Bill 2021, cls 146(1), 146(2).

⁵⁰⁴ Voluntary Assisted Dying Bill 2021, cl 146(3).

⁵⁰⁵ The value of a penalty unit is \$137.85. See the Penalties and Sentences (Penalty Unit Value) Amendment Regulation 2021; the Penalties and Sentences Regulation 2015, s 3; and the *Penalties and Sentences Act 1992*, s 5A.

⁵⁰⁶ Voluntary Assisted Dying Bill 2021, cl 146(2).

⁵⁰⁷ Form submission I, p 1.

⁵⁰⁸ Voluntary Assisted Dying Bill 2021, cl 146(3).

⁵⁰⁹ QLRC Report, paragraphs 17.102-17.104.

The Bill provides that a person must not make a record of or disclose personal information about an individual that the person obtains in the course of, or because of, the exercise of a function or power under the Act other than:

- for a purpose under the Act;
- with the consent of the person to whom the information relates;
- in compliance with a lawful process requiring production of documents to, or giving evidence before, a court or tribunal; or
- as authorised or required by law.⁵¹⁰

3.4.4.5 Failure to give voluntary assisted dying substance to authorised disposer

The contact person for a person who has made a decision to self-administer a voluntary assisted dying substance is responsible for returning a voluntary assisted dying substance to an authorised disposer. The Bill creates two offences for failure to do so:

- Clause 63(2) of the Bill requires that the contact person must, as soon as practicable, and in any event within 14 days after the day on which a self-administration decision is revoked, give the voluntary assisted dying substance to an authorised disposer. Failure to comply would be an offence with a maximum penalty of 100 penalty units (\$13,785).
- Clause 63(4) requires that the contact person must, as soon as practicable and in any event within 14 days after a person who has made a self-administration decision dies, give any unused or remaining substance to an authorised disposer. Failure to comply would be an offence with a maximum penalty of 100 penalty units (\$13,785).

QLRC view

The QLRC advised that while the possibility of criminal liability for breach of this obligation may be a disincentive for people to accept, or continue in, the role of a contact person, and may limit a person's access to the scheme, 'this has been balanced with the need to ensure the voluntary assisted dying substance is safely managed'.⁵¹¹

3.4.4.6 Other penalties

The Bill contains a number of other provisions which impose penalties for non-compliance. These provisions require forms to be completed and provided to the Board with respect to records of:

- the first assessment,⁵¹² a medical practitioner's acceptance or refusal of referral,⁵¹³ and the outcome of the consulting assessment⁵¹⁴
- a second request,⁵¹⁵ a final request,⁵¹⁶ and the final review⁵¹⁷

⁵¹⁰ Queensland Health, correspondence dated 14 July 2021, p 29.

⁵¹¹ Explanatory notes, p 33.

⁵¹² Voluntary Assisted Dying Bill 2021, cl 24.

⁵¹³ Voluntary Assisted Dying Bill 2021, cl 28.

⁵¹⁴ Voluntary Assisted Dying Bill 2021, cl 35.

⁵¹⁵ Voluntary Assisted Dying Bill 2021, cl 41.

⁵¹⁶ Voluntary Assisted Dying Bill 2021, cl 45.

⁵¹⁷ Voluntary Assisted Dying Bill 2021, cl 46.

- transfer of the coordinating practitioner’s role to the consulting practitioner,⁵¹⁸ or transfer of the administering practitioner’s role to a new practitioner⁵¹⁹
- an administration decision being revoked⁵²⁰
- an administration decision and the prescription of a voluntary assisted dying substance⁵²¹
- appointment of a contact person⁵²²
- supply of a voluntary assisted dying substance by an authorised supplier⁵²³
- administration of a voluntary assisted dying substance⁵²⁴
- disposal of a voluntary assisted dying substance by an authorised disposer,⁵²⁵ or by an administering practitioner⁵²⁶
- notification of death⁵²⁷
- a final decision of a review by QCAT of a reviewable decision.⁵²⁸

The Bill specifies that the maximum penalty for each of these offences is 100 penalty units (\$13,785).

QLRC view

The QLRC outlined that another important safeguard is the requirement for requests, assessments and other stages of the process to be documented, and for that documentation to be given to the oversight body. The QLRC considered that providing for specific offences with a lower penalty level in the Bill would ‘serve as a visible disincentive and ensure there is an appropriate mechanism to deal with noncompliance’.⁵²⁹ Consequently the Bill makes it an offence to fail to give a copy of a document or form to the Board as required under the legislation. The maximum penalty of 100 penalty units (\$13,785) is generally consistent with the legislation in other jurisdictions.⁵³⁰

3.4.5 Committee comment

The committee supports the wide-ranging safeguards embedded throughout the scheme including specific offences provisions. The committee notes stakeholder support for the additional safeguards. The committee is satisfied that the offence requires dishonesty or coercion, and therefore the Bill establishes key safeguards while capturing unlawful conduct.

⁵¹⁸ Voluntary Assisted Dying Bill 2021, cl 47.

⁵¹⁹ Voluntary Assisted Dying Bill 2021, cl 56.

⁵²⁰ Voluntary Assisted Dying Bill 2021, cl 51.

⁵²¹ Voluntary Assisted Dying Bill 2021, cl 68.

⁵²² Voluntary Assisted Dying Bill 2021, cl 59.

⁵²³ Voluntary Assisted Dying Bill 2021, cl 72.

⁵²⁴ Voluntary Assisted Dying Bill 2021, cl 55.

⁵²⁵ Voluntary Assisted Dying Bill 2021, cl 76.

⁵²⁶ Voluntary Assisted Dying Bill 2021, cl 78.

⁵²⁷ Voluntary Assisted Dying Bill 2021, cl 80.

⁵²⁸ Voluntary Assisted Dying Bill 2021, cl 114.

⁵²⁹ QLRC Report, paragraphs 17.74-17.75.

⁵³⁰ QLRC Report, paragraph 17.76.

3.5 Operational matters

3.5.1 Protections from liability

The Bill provides protections from criminal liability for people who act or make an omission, in good faith, to assist a person to access voluntary assisted dying, or who are present when a person self-administers or is administered a voluntary assisted dying substance.⁵³¹

Additionally, no civil or criminal liability attaches to a person for an act done or omission made under the proposed Act in good faith and without negligence.⁵³² Persons this may cover include health practitioners, the agent or contact person for the person accessing voluntary assisted dying, or a witness.⁵³³

The Bill also provides protection from civil or criminal liability for a ‘protected person’ – a health practitioner, student⁵³⁴ and ambulance officer- if, in good faith, they do not administer life sustaining treatment to a person who has not requested life sustaining treatment. The protected person must also believe that the person is dying after self-administering or being administered a voluntary assisted dying substance in accordance with the Bill.⁵³⁵

To remove any doubt, a person who does an act or makes an omission that is covered by the above protections does not commit an offence against sections 300, 302, 303, 305 and 310 (murder and manslaughter), 306 (attempt to murder), 307 (accessory after the fact to murder), 309 (conspiring to murder) or 311 (aiding suicide) of the Criminal Code (Qld).⁵³⁶

If someone alleges that the above protections do not prevent liability from attaching to a person, the Bill provides that the person making the allegation bears the onus of proving that the protected person did not do the act or make the omission in good faith in the circumstances covered by the protection.⁵³⁷

The Bill provides that a person is not liable – civilly, criminally or under an administrative process – if the person acts honestly in giving information to the Board.⁵³⁸ Board members, and persons engaged to help in the performance of the Board’s functions, would not be civilly liable for an act done, or omission made, honestly and without negligence.⁵³⁹

No consequences for non-compliance with the conscientious objection provisions have been included in the Bill. However, this does not prevent a person from making a mandatory notification or voluntary notification about another person under the Health Practitioner Regulation National Law (Queensland), or making a health service complaint or referral of an issue to the Health Ombudsman.⁵⁴⁰

⁵³¹ Voluntary Assisted Dying Bill 2021, s 147(1).

⁵³² Voluntary Assisted Dying Bill 2021, s 148(1).

⁵³³ Explanatory notes, p 33.

⁵³⁴ Under the Health Practitioner Regulation National Law (Queensland).

⁵³⁵ Voluntary Assisted Dying Bill 2021, s 149.

⁵³⁶ Voluntary Assisted Dying Bill 2021, ss 147(2), 148(2); explanatory notes, pp 130-131; Mrs Robertson, public briefing transcript, Brisbane, 14 June 2021, p 3.

⁵³⁷ Voluntary Assisted Dying Bill 2021, ss 147(3), 148(3).

⁵³⁸ Voluntary Assisted Dying Bill 2021, ss 138, 139.

⁵³⁹ Voluntary Assisted Dying Bill 2021, s 153.

⁵⁴⁰ Voluntary Assisted Dying Bill 2021, s 150; explanatory notes, p 34.

QLRC view

Protections from liability were included in the legislation proposed by the QLRC ‘to provide clarity and certainty for those who may act under, or interact with, the legislation’.⁵⁴¹

The QLRC Report advised that protections for people assisting with access to voluntary assisted dying or who are present for the administration of the substance will ensure the person assisting or attending will not be guilty of a criminal offence, including the offence of ‘aiding suicide’ under the Criminal Code (Qld), and will provide reassurance that loved ones or others may be with the person.⁵⁴²

Similarly, the QLRC sought protections (either for an act done or omission made in good faith and without negligence) for those acting under the Bill to ‘provide comfort to health practitioners and other persons who participate in the process’, and to allay the potential concerns of health practitioners and ambulance officers for being ‘civilly liable for failing to provide aid or assistance in an emergency’.⁵⁴³

The QLRC Report stated that relying on the role of the existing health practitioner disciplinary framework, including the potential for disciplinary proceedings for concerns about the conduct of health practitioners, was to ensure ‘strong oversight of the scheme’.⁵⁴⁴

Stakeholder views

Stakeholders expressed support for the protections from liability contained in the Bill.⁵⁴⁵ Additionally, Ahpra expressed support for clause 150, which provides that the protections from liability does not affect disciplinary proceedings.

Medical Insurance group Australia (MIGA) argued that the protections from liability should extend to disciplinary or administrative sanctions, findings and/or other action, and breaches of professional ethics, standards, principles of conduct or etiquette, where an act or omission is performed in accordance with the Bill and in good faith:

MIGA is concerned that the proposed protections for practitioners in Part 10 of the VAD bill are too narrow, particularly for adverse disciplinary findings and actions. Unlike other Australian VAD regimes the VAD bill protections apply only to criminal and civil liability.

There are likely to be ‘grey areas’ and scope for legitimate difference amongst the profession. In those circumstances protections against adverse disciplinary findings and actions are needed to ensure that reasonable, good faith actions and legitimate differences do not lead to disciplinary processes.⁵⁴⁶

The QCCL argued that in relation to Part 10 of the Bill, which outlines the protection provided to persons assisting access to voluntary assisted dying, a person who wishes to take advantage of the statutory immunity should be required to report their actions to the Board:

If the supervisory board assesses that the person has complied with the requirements of the legislation, then he or she would be immune from prosecution in the absence of evidence of dishonesty.

This is consistent with the position in the Netherlands, where the supervisory board reviews each death ... It improves transparency and oversight, and allows the regime to be accurately evaluated. This requirement would also enhance the public’s confidence in the scheme by demonstrating that the persons involved in administering the scheme are operating as they should.⁵⁴⁷

⁵⁴¹ QLRC Report, paragraph 17.150.

⁵⁴² QLRC Report, paragraph 17.166.

⁵⁴³ QLRC Report, paragraphs 17.153, 17.171.

⁵⁴⁴ Explanatory notes, p 34.

⁵⁴⁵ For example, see submissions 937, 1240.

⁵⁴⁶ Submission 1007, p 2.

⁵⁴⁷ Submission 1004, p 4.

Department response

In relation to concerns raised by MIGA in relation to the extension of protections from liability, the department clarified:

The QLRC considered that protections from liability should not extend to disciplinary proceedings as there is an existing health practitioner disciplinary framework that should be left to operate on its own terms (paragraph 17.157).

The QLRC noted that while in some instances a practitioner's conduct might not give rise to criminal or civil liability it may still raise concerns about matters of practice or lead to the identification of systemic issues that can be addressed by changes to professional standards, education or training (Paragraph 17.159).⁵⁴⁸

3.5.2 Conscientious objection

3.5.2.1 Participation by individuals and conscientious objection

The explanatory notes outline that a conscientious objection is 'a refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner's personal beliefs, values or moral concerns'.⁵⁴⁹

The Bill provides for registered health practitioners who have a conscientious objection to voluntary assisted dying to have the right to refuse to participate in the process by refusing to do any of the following:

- (a) provide information to another person about voluntary assisted dying;
- (b) participate in the request and assessment process;
- (c) participate in an administration decision;
- (d) prescribe, supply or administer a voluntary assisted dying substance;
- (e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.⁵⁵⁰

The Bill seeks to recognise a registered health practitioners' right to freedom of conscience and belief and the rights of an individual to autonomy in end of life choices and to be supported in making informed decision about those choices. Therefore, if a health practitioner exercised a conscientious objection, the Bill requires the practitioner to:

- (a) inform the person that other health practitioners, health service providers or services may be able to assist the person; and
- (b) give the person—
 - (i) information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or
 - (ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.⁵⁵¹

⁵⁴⁸ Queensland Health, correspondence dated 14 July 2021, pp 30-31.

⁵⁴⁹ Explanatory notes, p 17.

⁵⁵⁰ Voluntary Assisted Dying Bill 2021, s 84; explanatory notes, p 17.

⁵⁵¹ Voluntary Assisted Dying Bill 2021, s 84; explanatory notes, p 17.

Stakeholder views

Submitters supported the provisions to allow conscientious objection by individuals and argued that the personal beliefs and values of medical and health practitioners should be recognised in the scheme.⁵⁵² The QNMU survey found:

... 9 out of 10 respondents (89%) said they agree or strongly agree that health practitioners who have a conscientious objection to voluntary assisted dying have the right to choose not to participate.⁵⁵³

Faith-based organisations and submitters opposed the requirement that practitioners exercising a conscientious objection must provide information and details about a health practitioner, health service provider or service who is likely to be able to assist the person.⁵⁵⁴ Reverend Dr Andrew Chase argued:

When one's basic commitment to health care rests on the principle that first of all we try to heal and if we cannot do that we try to provide care for the person, the referral for euthanasia is not something that I feel one can do in good conscience. To do so would be to formally cooperate in an act that one believes to be essentially unethical.⁵⁵⁵

The ACC argued that subclause 84(2) should be removed from the Bill, as requiring an individual to be complicit in contravening their deeply held beliefs and values could potentially create serious emotional and mental conflict within the person.⁵⁵⁶

Professor Colleen Cartwright, Chair of the Human Research Ethics Committee, Southern Cross University informed the committee:

My research found that many health care providers and entities who have strong religious or ethical objections to VAD would consider even allowing someone to provide such information, or allowing a resident to consult with a coordinating practitioner or be provided with VAD in their facility – or to transfer the person to another location where they can access such things - to be equivalent to “aiding and abetting” someone to perform an activity which the provider or entity considers morally unacceptable.⁵⁵⁷

Some submitters argued that the requirement for a medical practitioner who refuses to participate in voluntary assisted dying to inform the person of another practitioner who provides this service or information about the care navigator service (clause 84(2)(b)) misunderstands the idea of a conscientious objection.⁵⁵⁸

A person who conscientiously objects does so because they have reached a judgment of conscience that the practice in question is morally wrong. This judgment does not mean that they believe only that this is morally wrong for themselves, but that it is morally wrong for everyone. To provide information to someone about how they can do something morally wrong would make the provider complicit in the act of wrongdoing, and so providing such information would itself be morally wrong.⁵⁵⁹

Submitters argued that clause 84 of the Bill could cause a conflict for some health professionals and may impact upon employment choices for some health professionals.⁵⁶⁰ The ANZSPM supported the

⁵⁵² For example, see submissions 937, 1027, 1031, 1055, 1218, 1266; Professor Alan Sandford, public hearing transcript, Rockhampton, 13 July 2021, p 7.

⁵⁵³ Submission 937, p 8.

⁵⁵⁴ For example, see submissions 568, 1288, 1309; public hearing transcript, Brisbane, 14 July 2021, p 34.

⁵⁵⁵ Public hearing transcript, Rockhampton, 13 July 2021, p 17.

⁵⁵⁶ Submission 1052, p 2; also see submission 1226, 1229, 1301.

⁵⁵⁷ Submission 1000, p 2.

⁵⁵⁸ Submission 455; also see submissions 1286, 1288, 1309.

⁵⁵⁹ Submission 455, p 5.

⁵⁶⁰ For example, see submission 1285, 1301.

provisions to allow institutions and individuals to exercise these expressed positions, but raised concerns that staff will find it difficult to conscientiously object and not impact their work colleagues.⁵⁶¹ Ms Webb observed:

Yes, within the bill people can conscientiously object, but it is not that simple. The impost upon a nurse or any health professional in a team who has a conscientious objection to what is occurring in a unit they are working on makes their life very difficult, because the thing that binds a healthcare team together is that common goal... conscientious objection for a healthcare professional is not done in a bubble. It is not done in isolation.⁵⁶²

Similarly, ANZSPM argued:

ANZSPM draws the Inquiry's attention to the fact that, in jurisdictions where VAD has been implemented, some staff on specialist palliative care units have been unable to exercise their individual right to conscientious objection because of an overriding institutional position. Employee rights on transition to the new arrangements should be carefully considered. Guidelines should be provided to services that either oblige or encourage VAD services to consult with their employees, with a view to conferring rights to conscientious objection and/or compensation if departure from the organisation is the only feasible option for them.⁵⁶³

Associate Professor Wendy Bonython argued that the training requirements for health practitioners to participate in the voluntary assisted dying scheme⁵⁶⁴ are a mechanism for practitioners to conscientiously object and self-select out of providing voluntary assisted dying services by not undertaking the requisite training:

The fact that the model includes a requirement for mandatory training means that people can opt in or choose not to. That is a better way of managing that gateway into provision of the service or not, both from the perspective of patients and from the perspective of practitioners.⁵⁶⁵

Notwithstanding the ability of practitioners to conscientiously object to participation in the voluntary assisted dying scheme, the RACP argued that physicians should not be forced to refer, but neither should they hinder patients from accessing such services:

Although physicians should not be forced to act outside their values and beliefs, they also should not disengage from patients holding different values and beliefs without ensuring that arrangements for ongoing care are in place.⁵⁶⁶

Dr Will Cairns stated that there is a fine line between being facilitating and being obstructive and that medical professionals work across the spectrum and often react in ways that reflect their own beliefs versus the patient's beliefs.⁵⁶⁷ Dr Phillip Parente argued:

The way I see it is that a referral does not mean you are agreeing to it. A referral is enabling access. That does not actually mean that you subscribe to the legislation. Just because you refer does not mean you agree to what is going on. It is enabling access. We live in a country that is non-secular. Patients should expect the right to access health care. That is what the mandatory referral process does. I really would say to my colleagues and institutions that referral does not actually mean that they are participating in voluntary assisted dying. It is enabling a patient to see another health professional to enable access. A lot

⁵⁶¹ Submission 1244, p 4.

⁵⁶² Public hearing transcript, Rockhampton, 13 July 2021, p 27.

⁵⁶³ Submission 1244, p 3.

⁵⁶⁴ See section 3.5.3 of this report.

⁵⁶⁵ Public hearing transcript, Brisbane, 15 July 2021, p 9.

⁵⁶⁶ Submission 1042, p 3.

⁵⁶⁷ Public hearing transcript, Townsville, 12 July 2021, p 11.

of referrals relate to medicine that we may not necessarily agree to, but it enables them to see another doctor—like a second opinion and so forth.⁵⁶⁸

Similarly, Dr Kristin Cornell commented:

At the end of the day, they are doctors and they have a duty of care. We need to bring it back a little bit to the patient and their rights. If it is a legislated law and something that they can access, they deserve to be able to access it... it is not just about us the doctors. We can be a bit precious. If it becomes a law then the patient has rights.⁵⁶⁹

In answer to a question at the public hearing, the AMA Queensland confirmed that 74 per cent of respondents to an AMA Queensland survey of 1250 of its members said that they would support referring a patient to a voluntary assisted dying practitioner, if they conscientiously object.⁵⁷⁰

Ahpra outlined that a decision by a registered practitioner in response to a person requesting access to voluntary assisted dying and/or to assist in the ending of another person's life may raise questions about the practitioner's professional ethics and conduct. However, as all professions regulated in the National Scheme have a Code of Conduct, for example, the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*, 'registered medical practitioners are aware of their right not to provide treatment for which they conscientiously object, but also not using this objection to impede access to treatments that are legal'.⁵⁷¹ Ms Heather Edwards, State Manager of Ahpra, stated:

While individual practitioners have their own personal beliefs and values, there are certain professional values and standards on which all practitioners are expected to practise. Practitioners must be honest, ethical and trustworthy. Importantly, all codes of conduct condemn discrimination. It is these codes and standards that national boards use to evaluate practitioners' conduct. The standards also play an important role for the public as they can help the public understand what behaviour they can expect from a registered practitioner and whether their care meets professional standards.⁵⁷²

The QLRC considered that by allowing health practitioners to make a conscientious objection, but requiring practitioners who do so to provide information about a health practitioner, service provider or navigation service who is likely to be able to provide the requested assistance, the Bill attempts to ensure 'the exercise of a right to refuse to participate should not hinder or deprive a person of their right to access a process that is lawful'.⁵⁷³ Dr Eliana Close argued:

It is appropriate that registered health practitioners are permitted to conscientiously object to participate in voluntary assisted dying, due to the deeply-held divergent views on the subject. However, given registered health practitioners' special status in the healthcare system as key gatekeepers of access to medical care, it is important that this right to conscientiously object does not impede patients' access to lawful medical services. This gatekeeping function is particularly salient in rural and regional areas where individuals often do not have meaningful choices of healthcare providers.⁵⁷⁴

Some submitters considered that the Bill provided 'a fair compromise between allowing for individual conscientious objection, but also for efficient accessibility, without obstruction, to voluntary assisted dying as a lawful health service'.⁵⁷⁵ The ALA stated:

⁵⁶⁸ Public hearing transcript, Brisbane 15 July 2021, p 27.

⁵⁶⁹ Public hearing transcript, Brisbane 15 July 2021, p 27.

⁵⁷⁰ Public hearing transcript, Brisbane 15 July 2021, p 38.

⁵⁷¹ Submission 1240, p 3.

⁵⁷² Public hearing transcript, Brisbane 16 July 2021, p 2.

⁵⁷³ QLRC Report, paragraph 14.81.

⁵⁷⁴ Submission 1304, pp 3-4.

⁵⁷⁵ Submission 720, p 3.

... ALA also strongly supports the current requirements in the VAD Bill for medical practitioners to immediately advise a person of their conscientious objection. The ALA also supports the requirement for medical practitioners who refuse to act as a coordinating practitioner following a person's first request, to provide the person with information as set out in section 16(4) of the VAD Bill, provided that there is a VAD care navigator service available for practitioners to refer to.⁵⁷⁶

Similarly, the Clem Jones Group argued:

Clauses 84 and 85 is balanced with a requirement to inform a person that others can assist as well as providing information of those who can assist or details of the official assisted dying care navigator service. This formulation represents the middle ground in balancing rights as it does not require a referral. We believe this is a fair and workable balance.⁵⁷⁷

Concerns were raised that the individual conscientious objection could lead to the denial of access to the voluntary assisted dying scheme. Dr Heather McNamee asserted:

Conscientious objection is well covered in the proposed bill... We need to have that in a society where we have differing views; however, in the Victorian experience there has been obstruction to access to VAD by doctors who did not support the patient's request. I know of one case where there was a seven-day delay in the doctor even telling the patient they did not agree with VAD, let alone referring them to someone else. I would suggest that if a doctor does not agree with VAD and receives a request from a patient they should be required to immediately tell the patient their views and that within 24 hours the details of a care navigation service should be provided to the patient.⁵⁷⁸

To avoid any potential delays, DADC proposed that the Bill be amended to:

... qualify the wording of s84(2)(a) to require practitioners to immediately inform requesting patients that they object to facilitating VAD. Furthermore, we encourage legislators to qualify the wording of s84(2)(b) to require that objecting practitioners must provide the information about service providers, services, and/or the VAD navigator service, without undue delay, eg within 24 hours of the patient's request.⁵⁷⁹

Thomas O'Grady argued that:

In my reading of the bill it would seem that there is no penalty for a medical practitioner whom objects to providing voluntary assisted dying and subsequently refuses to refer patients to a practitioner or service that may be able to assist them. Therefore I request that a penalty be added to the bill for medical practitioners that refuses to [refer] patients to services that may be able to assist them.⁵⁸⁰

3.5.2.2 *Participation by entities*

The Bill provides that an entity⁵⁸¹ is not obliged to provide or participate in the voluntary assisted dying process, but sets out requirements that an entity must meet if a resident or non-resident receiving services at a facility of that entity wishes to access the proposed voluntary assisted dying scheme.⁵⁸² The distinction between residents and non-residents reflects the different entities that will be subject to this Bill. For individuals who reside in one of these entities, they may enjoy security of tenure under statutory regulation or contract.⁵⁸³

⁵⁷⁶ Submission 1027, p 11.

⁵⁷⁷ Submission 984, p 8.

⁵⁷⁸ Public hearing transcript, Townsville, 12 July 2021, p 14.

⁵⁷⁹ Submission 720, p 3.

⁵⁸⁰ Submission 72, p 1.

⁵⁸¹ An entity is a non-natural person, typically a corporation or a body given legal status, and includes residential aged care services, public hospitals, private hospitals and hospices (explanatory notes, p 19).

⁵⁸² Explanatory notes, p 20.

⁵⁸³ QLRC Report, p 457.

Table 1 outlines the requirements of an entity for each stage of the voluntary assisted dying process if the entity conscientiously objects and does not provide information, or provide access to the request, assessment, or administration process at the facility.

Table 1: Requirements of entities at selected stages of the voluntary assisted dying process

Phase of process	Requirement of entity
Access to information	<ul style="list-style-type: none"> • must not hinder the person's access at the facility to information about voluntary assisted dying • must allow reasonable access by a registered health practitioner or a staff member of an official voluntary assisted dying care navigator service to provide the requested information to the person⁵⁸⁴
First requests and final requests	<ul style="list-style-type: none"> • must allow reasonable access by a registered health practitioner who is qualified and willing to receive a first or subsequent request under the legislation • if such a practitioner is not available to attend at the facility, then the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place at which the request may be made⁵⁸⁵
Second requests	<ul style="list-style-type: none"> • must allow reasonable access to the person at the facility by the coordinating practitioner and the two people who are eligible to witness the signing of a second request • if such a coordinating practitioner is not available to attend, then the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place at which the second request may be made to the coordinating practitioner or another medical practitioner who is eligible and willing to act as a coordinating practitioner⁵⁸⁶
First assessments Consulting assessments Administration decision	<ul style="list-style-type: none"> • if the person is a permanent resident of the facility, the entity must allow reasonable access to the person by a relevant practitioner (for the assessment) or coordinating practitioner (for consultation and advice on making the administration decision); or if a relevant practitioner/coordinating practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment/consultation on administration may be carried out by the relevant practitioner/coordinating practitioner or another medical practitioner who is eligible and willing to act in either capacity • if the person is not a permanent resident of the facility, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment/consultation on the administration decision may be carried out by a relevant practitioner/coordinating practitioner, or if, in the opinion of the deciding practitioner, transfer of the person would not be reasonable in the circumstances,⁵⁸⁷ the entity must follow the provision for a permanent resident regarding attendance of a practitioner⁵⁸⁸
Administration of voluntary assisted dying substance	<ul style="list-style-type: none"> • if the person is a permanent resident of the facility, the entity must allow reasonable access to the facility by the administering practitioner to undertake practitioner administration, together with any person whose presence is required to witness the practitioner administration, or for self-administration, not hinder access by the person to the voluntary assisted dying substance • if the person is not a permanent resident of the facility, the relevant entity must take reasonable steps to facilitate the person's transfer to a place outside the facility for the purpose of administration, or in circumstances where transfer for the purpose of administration would not be reasonable, the entity must follow the provision for a permanent resident

Source: Health and Environment Committee, based on ss 90 & 92-98, Voluntary Assisted Dying Bill 2021.

⁵⁸⁴ Voluntary Assisted Dying Bill 2021, s 90(2).

⁵⁸⁵ Voluntary Assisted Dying Bill 2021, s 92.

⁵⁸⁶ Voluntary Assisted Dying Bill 2021, s 93.

Additionally, the Bill provides that if an entity does not provide access to voluntary assisted dying, it must inform the public, including current or future users of the facility, that it does not provide services associated with access to voluntary assisted dying (such as access to the request and assessment process, access to the administration of a voluntary assisted dying substance, or both) at the facility. Entities must do this in a way that is likely to be brought to the attention of consumers or potential consumers of its services at the facility, such as placing the information on its website, in brochures and on signage at the facility.⁵⁸⁹

Stakeholder views

Go Gentle Australia questioned the validity of an entity to hold a conscientious objection:

Conscience is a person's moral sense of right and wrong. Only natural persons have conscience. While institutions are "persons" in law, they are merely corporate persons, not natural persons. They do not therefore have a natural mind that processes thoughts and feelings to inform the decisions and actions of a single real person. Rather, institutions have a set of ideological rules (which are not "conscience"). An institution's ideological rules, where they require a certain action or demand abstinence from certain actions by everyone, extinguish the actual, real consciences of natural persons who work in, or are clients of the institution.⁵⁹⁰

Similarly, the Human Rights Commissioner confirmed that conscientious objection is limited to individuals, however, argued that a balance must be found in relation to limiting rights:

The right to object on conscientious grounds is limited to individuals, not to institutions. That is the first point. In terms of the balance that is struck on the right to protect freedom of religion, for example, I think the balance that is struck in the bill is the least restrictive way of limiting that right whilst also achieving the objective of respecting the autonomy of people to make that end-of-life choice.⁵⁹¹

The QLS stated:

A decision by an entity to refuse access to VAD, or to transfer a patient to and from a facility that does allow access to VAD, may limit the rights of individuals enshrined under the HRA. Entities do not have rights under the HRA, although individuals who work in such entities will enjoy this protection.⁵⁹²

Additionally, the QLS stated that the issue of whether an entity should be allowed to refuse access to voluntary assisted dying within its facility on the basis of a conscientious objection is complex, but considered that the Bill had achieved a balance:

At the heart of the issue of institutional objection is how best to weigh the individual's right to access VAD against an institution's desire not to permit VAD within its facility. Academics have highlighted that legislation is the optimal regulatory response to institutional objections.

It is QLS' view that the Bill strikes the right balance between the ability of an entity to reject VAD if it considers the practice to be in conflict with its established doctrine or tenets, and the right of an individual

⁵⁸⁷ In making a decision regarding the transfer, the deciding practitioner must have regard to whether the transfer would be likely to cause serious harm to the person (eg serious pain); whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying (eg the transfer would likely result in a loss of decision-making capacity of the person); whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying; whether the place to which the person is proposed to be transferred is available to receive the person; whether the person would incur financial loss or costs because of the transfer (s 94(4)).

⁵⁸⁸ Voluntary Assisted Dying Bill 2021, ss 94, 95, 96.

⁵⁸⁹ Voluntary Assisted Dying Bill 2021, s 98.

⁵⁹⁰ Submission 1189, p 7.

⁵⁹¹ Public hearing transcript, Brisbane, 14 July 2021, p 24.

⁵⁹² Submission 1031, p 11.

to access healthcare in accordance with established common law principles, including autonomy, equality, self-determination, and reducing suffering.⁵⁹³

Faith-based organisations, communities and submitters expressed opposition to the participation in the scheme by faith-based entities.⁵⁹⁴ The ACC argued that Division 2 should be amended to exclude entities that are faith-based hospitals, hospices or organisations providing residential aged care, as providing voluntary assisted dying, and enabling any step in the voluntary assisted dying process, is precluded by the ethos of such entities. The ACC stated:

To require an institution or organisation to violate the very core values and beliefs upon which it was built and has successfully and effectively operated in the delivery of invaluable health services, in many cases for decades, is a serious breach of fundamental freedoms, and an imposition that we consider unacceptable.⁵⁹⁵

Lutheran Services argued rather than co-opting or compelling faith-based aged-care providers to support the voluntary dying scheme on their premises, the state has significant resources and should provide voluntary assisted dying services.⁵⁹⁶

Concerns were raised that the Bill, in supporting the rights of those who wished to access the voluntary assisted dying scheme, would diminish the rights of both residents and staff in faith-based care facilities who do not support voluntary assisted dying. The Reverend Stewart Piper, Director of Queensland Baptist Services, argued:

Primarily, it seems to me, this conversation has been around choice of those who feel that they would like to take advantage of processes to end their life, but that has to be balanced with those who choose to stay in institutions where they would not agree or approve or the staff would be traumatised because that happened on the grounds of that facility.⁵⁹⁷

Similarly, Lutheran Services stated:

... this will go contrary to their choices about the home in which they live. We understand that the Law Reform Commission and, by default, the government are of the view that the person who is seeking voluntary assisted dying has rights. I think it has been very light on the question of the choices that other residents in that home might wish to exercise.⁵⁹⁸

Some submitters also highlighted that faith based organisations and workplaces have a duty of care to their staff and that under the Bill, would be unable to exercise this duty of care effectively.⁵⁹⁹ The Right Reverend Dr Joseph, a Bishop of the Anglican Church of North Queensland, also highlighted the potential impact of the scheme on staffing aged-care facilities and therefore upon residents:

The problem you are going to have is that, if most of the staff there conscientiously object, you will have to bring a series of staff into that place to do the VAD. At the very least, I would have thought, if that is going to be the solution, it ought to be done in a way which has the least impact on the other residents and the least impact on their sense of security, safety and being in a place which they believe was one where that was not going to occur.⁶⁰⁰

⁵⁹³ Submission 1031, p 10.

⁵⁹⁴ For example, see submissions 455, 1054, 1165, 1285.

⁵⁹⁵ Submission 1052, p 3.

⁵⁹⁶ Mr Nick Ryan, public hearing transcript, Brisbane, 14 July 2021, p 29.

⁵⁹⁷ Public hearing transcript, Brisbane, 14 July 2021, p 35.

⁵⁹⁸ Mr Nick Ryan, public hearing transcript, Brisbane, 14 July 2021, p 29.

⁵⁹⁹ Submission 455, p 1.

⁶⁰⁰ Public hearing transcript, Townsville, 12 July 2021, pp 25-26; also see public hearing transcript 14 July 2021, p 52.

In contrast, Go Gentle Australia argued:

The whole point of VAD law is to hand some measure of power back to terminally ill people. People who, up until now, have been largely disempowered within the medical system when it comes to end-of-life choices. To enshrine institutional conscientious objection into VAD law is to effectively remove that power from some dying individuals and hand it back to institutions.⁶⁰¹

Similarly, VALE Group argued:

... to even contemplate they would need to move to another facility or have the focus removed from their plight, based on an “entity’s faith-based objection” whilst receiving funding (government and private sector) is hard to digest. Many, many supporters of VAD feel that this is totally unacceptable.⁶⁰²

Dying With Dignity NSW argued:

It is a problem that religious institutions which object to VAD have such a major role in hospital and hospice care. We believe that such institutions should facilitate the visit of health practitioners from outside the institution to enter and carry out VAD assessments. We also believe that such institutions should allow VAD to be administered on site if that is in the best interests of the patient, that is, if moving the patient somewhere else would add to their suffering. This is the compassionate way.⁶⁰³

Therese McLean stated:

Patients do not have a voice... The willingness for any institution to say, ‘Trust me,’ is beyond my belief. I do not want to be shopped around to a range of practitioners to prove that I am dying. God has chosen that I am coming early, and I am quite happy with that choice. I am not afraid to die. I am only afraid that institutional objection will have a greater power in the state of Queensland than the power of the people.⁶⁰⁴

Some submitters argued that the Bill had found a balance between both institutional and individual interests however, ultimately they believed that the rights of the individual must not be diminished at the expense of institutional rights. Professors White and Willmott argued that:

... it is important to find a middle path to accommodate both institutional and individual interests where possible, but if both cannot be accommodated in a particular case, then the interests of the individual who is seeking VAD should be prioritised as it is the individual who is potentially terminally ill and enduring intolerable suffering. We consider that the Bill strikes the appropriate balance on this issue.⁶⁰⁵

The QCU stated:

This aspect of the Bill is particularly important to protect the rights of residents from being infringed on by the views of a religious or other organisation being able to effectively veto access to voluntary assisted dying because of their own organisational policies or views.⁶⁰⁶

3.5.2.3 Administration of voluntary dying substance

Clause 97 of the Bill provides that an entity that does not wish to provide access to voluntary assisted dying in its facility should not be required to do so and that a person wishing to self-administer or receive administration of a voluntary assisted dying substance should transfer from the facility for the purpose of administration, unless transfer is unreasonable.⁶⁰⁷

⁶⁰¹ Submission 1189, p 12.

⁶⁰² Submission 1271, p 4.

⁶⁰³ Submission 891, p 1.

⁶⁰⁴ Public hearing transcript, Brisbane, 16 July 2021, p 27.

⁶⁰⁵ Submission 906, p 13.

⁶⁰⁶ Submission 1148, p 5.

⁶⁰⁷ Voluntary Assisted Dying Bill 2021, cl 97.

Stakeholder views

Some stakeholders supported the ability to transfer residents to another facility or location due to an institutional conscientious objection. Dr Chris Perry from AMA Queensland proposed:

We acknowledge that most people accessing VAD wish to die in their own home or the home of close family members. Surely, transport out of an objecting institution's premises to another site, a home, a beach or a respectful quiet room in a public hospital is a better choice than pursuing religious and other organisations out of the hospital and aged-care space. We believe that some healthcare facilities may have a distinctive mission or ethos that should allow it to refuse to provide particular services due to an institutional conscientious objection.⁶⁰⁸

However, a number of submitters raised concern in relation to the transfer of individuals from an aged-care facility which holds an institutional objection to facilitating a voluntary dying request to another location or aged-care facility.

Stakeholders considered that the removal of people from their homes when they were near to death was not compassionate. Dr Heather McNamee argued:

For the residents of these institutions, that is their home. If you are in an aged-care facility, that is your home. That is where your furniture is. That is where you live. That is where all of your clothes are. That is where all of your possessions are. You should not be forced to leave your home in your dying days or weeks. Access to these institutions by other professionals who support VAD must be allowed. It is not realistic to transfer someone in their dying days or weeks. In fact, it is completely inhumane.⁶⁰⁹

Similarly, Dr Jenny Brown stated:

I also think it is entirely inappropriate to be moving people around who are terminally ill and at end of life. I had a person myself just last week who had end-stage Parkinson's disease with a PEG and could not swallow and there was discussion about going back to another hospital. We spoke to the family and with him and he said he wanted to stay where he was and he died quietly there. It is really important that these things are managed in a low-key, but comfortable way for people. Ambulances and trolleys and then, worst of all, people dying in the ambulance is just hopeless really.⁶¹⁰

Stakeholders raised concerns in relation to clause 97 arguing that the lack of alternative non-faith based services in regional Queensland would exclude access to the scheme for many.⁶¹¹ Submitters argued that in many regional centres there was often only one aged care facility, which was likely to be operated by a faith-based organisation.⁶¹² The logistical difficulty in transferring patients, particularly in rural and remote regions of Queensland where there is a limited availability of alternative care locations, was also highlighted:

Incredibly messy, incredibly difficult and probably impossible, to be honest. If you look at any medical ward in a hospital, people are queuing for aged-care beds, and they do not often get a choice of where they are going to go. When the first available beds come free, they are put into that institution. I am not sure where we think these beds are going to even be, that there is going to be some magical empty aged-care facility specifically for VAD, considering the limited number of hospice beds there are in Queensland let alone bringing a whole new institution. I think really in the aged-care setting that is practically impossible.⁶¹³

⁶⁰⁸ Public hearing transcript, Brisbane, 15 July 2021, p 37.

⁶⁰⁹ Public hearing transcript, Townsville, 12 July 2021, p 14; also see submission 1189.

⁶¹⁰ Public hearing transcript, Brisbane, 15 July 2021, p 51.

⁶¹¹ Dr McNamee, public hearing transcript, Townsville, 12 July 2021, p 14; Mr McDougall, public hearing transcript, Brisbane, 14 July 2021, p 24.

⁶¹² Public hearing transcript, Brisbane, 14 July 2021, p 22.

⁶¹³ Dr McNamee, public hearing transcript, Townsville, 12 July 2021, p 15.

Go Gentle Australia argued that clause 97 will institutionalise discrimination for those individuals who will not have an alternative facility to be transferred to:

However, it is a reality that some (dying) people won't have realistic access to a nonreligious institution at the end of life; while others may be too ill to consider transfer to another facility in the face of blanket institutional refusal. These people will, in effect, be denied access to a legal service to which they are entitled (VAD) by an enshrined right to institutional conscientious objection. Enshrining institutional conscientious objection into VAD law will have the effect of creating two classes of Queensland citizens – those who have options to be transferred (and, therefore, options to access VAD), and those who do not.⁶¹⁴

The Reverend Andrew Gunton, Moderator of the Uniting Church in Australia, Queensland Synod proposed that for entities that do not wish to provide voluntary assisted dying, and where it is reasonable for a permanent resident to be transferred, then the entity should not be obligated to allow self-administration or practitioner administration of the voluntary assisted dying substance. However, the Reverend Gunton stated:

In cases where it is deemed not reasonable to transfer a person because of health, then we would support a compassionate position to obligate the entity to allow administration or practitioner administration in that facility.⁶¹⁵

3.5.2.4 Access to information about non-availability of voluntary assisted dying

The Bill allows that where a person receiving a health service, residential aged care or a person care service from a relevant entity at a facility asks the entity for information about voluntary assisted dying, and the entity does not provide the requested information at the facility, the entity (and any other entity that owns or occupies the facility) must:

- not hinder the person's access at the facility to information about voluntary assisted dying; and
- allow reasonable access by a registered health practitioner or a staff member of an official voluntary assisted dying care navigator service to provide the requested information to the person.⁶¹⁶

Stakeholder views

Submitters raised concerns in relation to the definition of 'reasonable steps' to facilitate the voluntary assisted dying care process in a facility that does not wish to provide voluntary assisted dying care services. VALE Group argued:

"Reasonable steps" could be open to a lack of real effort to actually facilitate the process. Perhaps some further safeguards which benefit those seeking to use the VAD service are required.⁶¹⁷

Similarly, Professors White and Willmott argued:

Clause 90 – Access to information about VAD Under this clause, there is only a passive duty on institutions to allow access to information if requested by a person. We suggest there should be a positive obligation on an entity to provide information upon a person's request akin to the obligation imposed on a health professional who refuses a patient's first request by clause 16(4)(b).⁶¹⁸

ADA Australia raised concerns in relation to the non-availability of voluntary assisted dying in a facility. ADA Australia argued as currently drafted, clause 98 may result in the production of published

⁶¹⁴ Submission 1189, p 6.

⁶¹⁵ Public hearing transcript, Brisbane, 14 July 2021, p 28. Also see Rebecca Burdick Davies, Catholic Health Australia, public hearing transcript, Brisbane, 16 July 2021, p 19.

⁶¹⁶ Explanatory notes, p 20.

⁶¹⁷ Submission 1271, p 4.

⁶¹⁸ Submission 906, p 13.

information that is interpreted by a resident at such a facility to mean that they cannot, or should not, raise a request regarding voluntary assisted dying services. ADA Australia proposed:

A new subsection (4) should be inserted after clause 98(3) to ensure that any information published clearly states that although a relevant entity does not provide services associated with voluntary assisted dying, it is otherwise required to take reasonable steps to provide or facilitate access for those persons who wish to discuss an application for voluntary assisted dying services.⁶¹⁹

The Clem Jones Group argued:

In summary, the rights of conscientious objection are extensive, however these rights cannot be a barrier to providing information that would enable access to VAD... Once again we believe the right balance has been achieved in the interests of equity and access.⁶²⁰

QLRC view

For entities choosing not to participate in the voluntary assisted dying process, the QLRC Report proposed legislating the processes by which these entities balanced their right not to provide the service with the rights of persons seeking access to the proposed voluntary assisted dying scheme, so as not to 'leave processes uncertain, governed only by non-enforceable policies'.⁶²¹ To reconcile the competing rights of both groups, the Bill includes a process 'by which certain rights and interests are assumed and reasonably accommodated'.⁶²² The QLRC chose legislation over policy because 'it will inform individuals and entities of the basic ground rules by which their respective rights and interests are reconciled and the process which applies'.⁶²³

The provisions requiring entities not to hinder a person's access to information and advice about voluntary assisted dying were developed because the QLRC believed that 'it is difficult to justify denying an individual access to information and advice about voluntary assisted dying on the grounds of an entity's conscientious objection'.⁶²⁴ Similarly, the QLRC stated that for first and subsequent requests, 'it is hard to see why a patient or resident who is dying should be put to the trouble of being transferred outside of a facility to make a "first request" to a practitioner who is qualified and willing to receive it', hence access should be allowed unless the relevant practitioner is not available to attend to receive the request at the facility.⁶²⁵

The same applies to eligibility assessments. Assessments may result in ineligibility, a decision not to proceed to administration, or the person may die before administration is possible. Therefore, according to the QLRC, 'access for the purpose of receiving a "first request" or for assessment should not be confused with access for the purpose of administration'.⁶²⁶

The QLRC noted that an insistence by the entity which operates such a facility that the individual go elsewhere to access advice and assistance would require that individual to leave their home and to attempt to find a new home when they may be in an extremely vulnerable state. Depending on the circumstances, insisting that the person go elsewhere in the final stages of the person's life may be inconsistent with the person's legal right of residence at the entity's facility.⁶²⁷

⁶¹⁹ Submission 1055, p 3.

⁶²⁰ Submission 984, p 8.

⁶²¹ Explanatory notes, p 19.

⁶²² QLRC Report, paragraph 15.282.

⁶²³ QLRC Report, paragraph 15.226.

⁶²⁴ Explanatory notes, p 20.

⁶²⁵ QLRC Report, paragraph 15.235.

⁶²⁶ QLRC Report, paragraph 15.241.

⁶²⁷ QLRC Report, p 457.

The provisions regarding transfer of a person for an assessment, or consultation and advice on an administration decision, were developed in recognition that ‘transfer of care comes at a human and financial cost’.⁶²⁸

For the administration of the voluntary assisted dying substance, the QLRC considered that the position reached for eligibility assessments should not equally apply to administration of such a substance because ‘while an eligibility assessment does not in any real or immediate sense cause the person’s death, administration of the substance does, and that this difference may justify greater weight being accorded to the entity’s objection at the administration stage’.⁶²⁹

Therefore, unless a person enjoys security of tenure by virtue of the *Aged Care Act 1997* (Cth) or on some other basis, an entity that does not wish to provide access to voluntary assisted dying in its facility should not be required to do so, and a person wishing to self-administer or receive administration of a voluntary assisted dying substance should transfer from the facility for the purpose of administration, unless a transfer is unreasonable.⁶³⁰

The QLRC considered an entity should be required to inform the public of its opposition to providing access to voluntary assisted dying to ‘avoid a person finding out after their admission, or taking up residence’.⁶³¹

The QLRC considered that a failure to comply with any of the provisions regarding conscientious objection should be subject to professional and legal consequences, such as a referral of a matter for investigation and possible disciplinary proceedings rather than ‘any specific penalty for failure to comply with the requirements associated with the conscientious objection provisions’.⁶³² The QLRC stated that this approach is ‘consistent with the approach taken elsewhere in the draft Bill, and with the *Termination of Pregnancy Act 2018*’.⁶³³

Department response

The department highlighted the challenges raised by the issue of conscientious objection by entities in the voluntary assisted dying process:

The QLRC considered non-participation by entities to be one of the most complex issues it was required to consider. It concluded, however, that the complexity of the issue is not a reason to avoid regulation of processes for entities, otherwise processes will be uncertain. The bill sets out requirements for nonparticipating entities at each stage of the voluntary assisted dying process to ensure that a person’s access to the scheme is not hindered.⁶³⁴

Additionally, the department highlighted that the HRA applies differently to individuals and entities with respect to exercising a conscientious objection:

As a starting point, the Human Rights Act has certain rights that apply to individuals rather than to entities. Under the bill, an individual can conscientiously object—so [can] the individuals within that organisation. The right under the Human Rights Act does not apply to an entity. As Professor McNeil said, if an institution objects as a policy or religious matter, there are other detailed provisions around how that will play out within their institution. That is a balance between the rights of everyone involved.⁶³⁵

⁶²⁸ QLRC Report, paragraph, p 496.

⁶²⁹ Explanatory notes, p 23.

⁶³⁰ Explanatory notes, p 23.

⁶³¹ QLRC Report, paragraph 15.278.

⁶³² QLRC Report, paragraph 14.207.

⁶³³ QLRC Report, paragraph 14.207.

⁶³⁴ Professor Keith McNeil, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 2.

⁶³⁵ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 14.

The Bill proposes that entities that have a conscientious objection against voluntary assisted dying would be required to clearly communicate their objection in a number of ways, such as on their website, in brochures and on signage at the facility.⁶³⁶ The department clarified how entities would be advised of these requirements:

We will have a detailed implementation plan around that. Part of that implementation plan will be wide stakeholder engagement. We will embrace that issue during stakeholder engagement because of the complexities and differences at an institutional level but also at the individual facility level. That will be part of the implementation process. If the legislation is passed then we will be able to put the details around how that will happen.⁶³⁷

3.5.2.5 *Speech Pathologists*

The Bill provides that a speech pathologist who has a conscientious objection to voluntary assisted dying has a right to refuse to participate in any stage of the process. Speech pathologists are provided for in the Bill because, although not registered health practitioners, they may play a role in facilitating communication between a health practitioner and a person seeking access to voluntary assisted dying.⁶³⁸

Where an employer or any other person has requested speech pathology services in relation to voluntary assisted dying and the speech pathologist refuses to participate, they must:

- inform the employer or other person of their conscientious objection
- inform the employer or other person of another speech pathologist or speech pathology service who, in the speech pathologist's belief, is likely to be able to assist in providing the speech pathology services requested
- not intentionally impede the person's access to speech pathology services in relation to voluntary assisted dying.⁶³⁹

Additionally, if a speech pathologist is employed or otherwise engaged by a health service provider and knows, or ought reasonably to know, the health service provider provides, or is likely to provide, services relating to voluntary assisted dying, the speech pathologist must:

- inform the health service provider of their conscientious objection to voluntary assisted dying
- discuss with the health service provider how they can practise in accordance with their beliefs without placing a burden on their colleagues or compromising a person's access to voluntary assisted dying under this Act.⁶⁴⁰

The explanatory notes state:

The QLRC report provides that the different requirements for speech pathologists reflect the fact that medical practitioners are subject to a code of conduct which requires them to disclose their conscientious objection to patients and, if relevant, colleagues, and to not deny a patient access to the relevant service, which speech pathologists are not.⁶⁴¹

⁶³⁶ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 8.

⁶³⁷ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 8.

⁶³⁸ Explanatory notes, p 18.

⁶³⁹ Voluntary Assisted Dying Bill 2021, cl 85(2).

⁶⁴⁰ Voluntary Assisted Dying Bill 2021, cls 85(3), 85(4).

⁶⁴¹ Explanatory notes, p 19.

Stakeholder views

Stakeholders supported the provisions of the Bill which allow a speech pathologist who has a conscientious objection to voluntary assisted dying the right to refuse to participate in any stage of the process.⁶⁴²

Speech Pathology Australia (SPA) highlighted their concerns in relation to the meaning of ‘speech pathologist’ as defined in the Bill. SPA advised that a Certified Practising Speech Pathologist (CPSP) can obtain accreditation as a member or non-member of Speech Pathology Australia, when the following requirements are met:

1. Appropriate qualification from an accredited university course;
2. Specified recency of practice; and
3. Continuing professional development requirements

Speech Pathology Australia’s regulatory functions protect the public by ensuring speech pathologists with CPSP status provide safe, effective and evidence-based services. Annual random auditing occurs as per NASRHP [National Alliance of Self Regulating Health Professions] standards.⁶⁴³

The Bill defines speech pathologist to mean a person who is eligible for practising membership of The Speech Pathology Association of Australia Limited. SPA proposed the Bill be amended so that speech pathologist means a person who holds the credential CPSP under the professional self-regulation framework of The Speech Pathology Association of Australia Limited.⁶⁴⁴

3.5.3 Practitioners’ qualifications and experience

The Bill provides that health practitioners must meet minimum qualification, experience and training requirements to perform particular roles within the proposed voluntary assisted dying scheme. Practitioners who do not meet the minimum qualification and training requirements under the Bill are not eligible to act in these roles.⁶⁴⁵

To act as a coordinating or consulting practitioner a medical practitioner is eligible if the practitioner satisfies one of the following criteria:

- they hold specialist registration and have practised for at least one year as the holder of that registration
- they hold general registration and have practised for at least 5 years as the holder of that registration
- they hold specialist registration and have practised for at least 5 years as the holder of general registration
- they are an overseas-trained specialist who holds limited registration or provisional registration.⁶⁴⁶

In addition, the medical practitioner must meet any additional medical practitioner requirements approved for this purpose by the chief executive.⁶⁴⁷

⁶⁴² For example, see submissions 278, 1027, 1055.

⁶⁴³ Speech Pathology Australia, correspondence dated 22 July 2021, p 2.

⁶⁴⁴ Speech Pathology Australia, correspondence dated 22 July 2021, p 1.

⁶⁴⁵ Explanatory notes, p 15.

⁶⁴⁶ Voluntary Assisted Dying Bill 2021, cl 82(1)(a).

⁶⁴⁷ Voluntary Assisted Dying Bill 2021, cl 82(1)(b); QLRC Report, paragraph 13.113.

The Bill provides that the coordinating practitioner and consulting practitioner must have completed approved training before undertaking a person's eligibility assessments.⁶⁴⁸ The chief executive must approve training for this purpose and publish the approval on the department's website.⁶⁴⁹

The Bill provides that the approved training may provide for the following matters:

- the operation of the Act in relation to medical practitioners, nurse practitioners and nurses, including the functions of coordinating practitioners, consulting practitioners and administering practitioners
- assessing whether or not a person meets the eligibility criteria
- identifying and assessing risk factors for abuse or coercion
- other matters relating to the operation of the Act.⁶⁵⁰

However, a medical practitioner who meets the above criteria is not eligible if they are a family member of the person requesting access to voluntary assisted dying, or they may benefit financially or in any other material way from the person's death (other than by receiving reasonable fees for the provision of services).⁶⁵¹

QLRC view

Coordinating practitioner or consulting practitioner

Minimum requirements for practitioners were included in the legislation because the QLRC considered that 'inexperienced practitioners should not be eligible for the role of coordinating practitioner or consulting practitioner'.⁶⁵² Furthermore, the QLRC stated 'the requirement for two independent assessments of the person's eligibility is a key safeguard. Practitioners who act in these roles must have appropriate skills and expertise to undertake these assessments'.⁶⁵³

In identifying the minimum eligibility requirements to act as a coordinating or consulting practitioner, the QLRC considered minimum eligibility requirements in other jurisdictions, the large geographical area and decentralised population the scheme must accommodate, and the health workforce in Queensland. The QLRC wanted to ensure that practitioners who undertake eligibility assessments have appropriate skills and qualifications, and that these requirements are not a barrier to access voluntary assisted dying.⁶⁵⁴ The QLRC considers that the practitioners who meet these minimum qualification requirements will typically have spent many years in practice, gaining experience in end of life care.⁶⁵⁵

Accessibility for people in rural, regional and remote areas was a key consideration for the QLRC. The QLRC did not recommend the Victorian approach of requiring the coordinating practitioner or consulting practitioner to be a specialist with at least 5 years' experience, or for either to be a specialist in the person's disease, illness or medical condition, as they saw this as a barrier to access, especially in rural, regional and remote areas.⁶⁵⁶

⁶⁴⁸ Voluntary Assisted Dying Bill 2021, cl 20, cl 31.

⁶⁴⁹ Voluntary Assisted Dying Bill 2021, cl 165.

⁶⁵⁰ Queensland Health, correspondence 13 July 2021, p 16.

⁶⁵¹ Voluntary Assisted Dying Bill 2021, cl 82; explanatory notes, p 15.

⁶⁵² QLRC Report, paragraph 13.108.

⁶⁵³ QLRC Report, paragraph 13.109.

⁶⁵⁴ QLRC Report, paragraph 13.110.

⁶⁵⁵ QLRC Report, p 381.

⁶⁵⁶ QLRC Report, paragraph 13.114.

Although not an eligibility requirement, the Bill requires a coordinating practitioner or consulting practitioner to refer a matter to another practitioner for determination if they are unable to determine a specific matter related to eligibility. The QLRC Report considered:

... this balances the need for practitioners to meet specified eligibility requirements, including minimum qualification and experience requirements, and the need for access to the scheme, including in remote parts of Queensland far away from where most specialists in certain fields are based.⁶⁵⁷

The QLRC Report also stated that overseas-trained specialists with limited or provisional registration are included in the scheme to capture suitably qualified specialists, including in areas of need, to improve accessibility in rural, regional and remote areas, noting that to hold limited or provisional registration, an overseas-trained specialist must be enrolled in a specialist pathway.⁶⁵⁸

Administering practitioners

The QLRC similarly considered that, given the nature of voluntary assisted dying, only suitably qualified and trained practitioners with the skills and experience required should carry out the role of administering practitioner.⁶⁵⁹ While it is generally anticipated the person's coordinating practitioner will become the administering practitioner, the consulting practitioner has the option of transferring the role to another eligible health practitioner.⁶⁶⁰

Finally, not allowing health practitioners to assess or administer the voluntary assisted dying substance to a family member is a requirement that is consistent with existing professional obligations and ensures there is no conflict of interest between the practitioner and the person requesting access to voluntary assisted dying.⁶⁶¹

Stakeholder views

A number of submitters endorsed the Bill's approach to qualification, experience and training requirements for health practitioners to participate in the voluntary assisted dying scheme. It was argued that given both the size and dispersed population of Queensland, the Bill's approach will maximise access to, and provision of, voluntary assisted dying.⁶⁶² DADC argued:

- The omission of a requirement that any of the involved practitioners must be a specialist in the disease the patient is suffering from is consistent with the needs of a dispersed state, with the acknowledged skills and qualifications of the doctors and nurses as described, and with the fact that specialist information will already be available from the patient's history and be available via further consultation, if required.
- The provision for overseas trained specialists to act as the coordinating or consulting practitioner reflects the reality of the Queensland medical workforce and its disposition, and is endorsed by DADC.⁶⁶³

DWDQ highlighted barriers to access of the voluntary assisted dying scheme when consultation with a specialist in a specific disease is required:

DWDQ commends the proposed legislation for not requiring the coordinating practitioner or consulting practitioner to be a specialist in a specific disease. In Victoria, this has led to unacceptable and distressing

⁶⁵⁷ QLRC Report, paragraph 13.115.

⁶⁵⁸ QLRC Report, paragraph 13.116; explanatory notes, p 5.

⁶⁵⁹ QLRC Report, paragraph 13.145.

⁶⁶⁰ QLRC Report, paragraph 13.143.

⁶⁶¹ QLRC Report, paragraph 13.206.

⁶⁶² For example, see submissions 720, 1031.

⁶⁶³ Submission 720, p 2.

delays to the person in finding a specialist willing to be involved. This would be a barrier to access the scheme in regional and remote areas of Queensland.⁶⁶⁴

Professors White and Willmott argued the eligibility of practitioners to undertake roles in the voluntary assisted dying system 'should not be onerous and discourage otherwise eligible practitioners from becoming involved'.⁶⁶⁵

Discussing the Victorian voluntary assisted dying experience, Dr Kristin Cornell outlined:

I have done the training myself now. GPs often wait to be asked by a patient until they do the training. We have been trying to advocate, through my involvement in Western Australia, for GPs to train before they are asked because that phase of the program can take weeks.⁶⁶⁶

Some submitters raised their concerns in relation to practitioner qualification, experience and training requirements to participate in the voluntary assisted dying scheme. Dr David van Gend questioned the required level of professional experience and in particular was concerned that junior doctors could act as coordinating or consulting practitioners in a complex field of medicine.⁶⁶⁷

ANZSPM argued that non-specialist palliative care practitioners usually have limited palliative care education and the online education for voluntary assisted dying scheme is six-hours long and focused on medico-legal matters rather than the process of voluntary assisted dying.⁶⁶⁸ ANZSPM proposed that persons delivering voluntary assisted dying will require a high level of competency in communicating with patients beyond current training, to include a knowledge of:

- Health system pathways and the role of other professional groups in counselling for and delivering VAD, including when working with vulnerable populations
- Exploring the reasons for a VAD request with patients who may be depressive and/or dealing with difficult family circumstances, live in isolation, or have multiple comorbidities
- Practising clinical neutrality
- Detecting signs of coercion and reduced capacity.⁶⁶⁹

Dr Kym Boon from the RANZCP Queensland highlighted the value of professional experience:

Medicine [is] not a tick-the-box process. The best learning is years of experience, which is what we and old age psychiatrists have in these kinds of assessments. Assessing capacity for these VAD decisions can be a lot more nuanced than is able to be applied in a tick-the-box 30-minute online assessment.⁶⁷⁰

However, Professor Willmott argued that the scheme does require experience:

A junior doctor will not be able to undertake eligibility assessments. They will [not] have experience for some years. ...doctors must do training before they will be able to do eligibility assessments. They will know precisely what is expected of them under the legislation, including in relation to eligibility assessments. The bill also requires them to refer to a specialist if they believe they are not certain as to whether a person satisfies the eligibility requirements.⁶⁷¹

In relation to the practitioner training to perform particular roles within the proposed voluntary assisted dying scheme, the RACP argued that this be adequately funded to support practitioners to

⁶⁶⁴ Submission 278, p 5.

⁶⁶⁵ Submission 906, p 15.

⁶⁶⁶ Public hearing transcript, Brisbane, 15 July 2021, p 23.

⁶⁶⁷ Public hearing transcript, Brisbane, 14 July 2021, p 42.

⁶⁶⁸ Submission 1244, p 4.

⁶⁶⁹ Submission 1244, p 4.

⁶⁷⁰ Public hearing transcript, Brisbane, 15 July 2021, p 31.

⁶⁷¹ Public hearing transcript, Brisbane, 15 July 2021, p 7.

develop a genuine and enduring relationship with the person. The RACP considered that this would avoid reliance on potentially simplistic assessments or reviews and is an important safeguard in the voluntary assisted dying scheme.⁶⁷²

Department response

In response to concerns regarding practitioner experience, the department advised:

The QLRC considered that practitioners who meet these minimum qualification requirements will typically have spent many years in practice, gaining experience in end of life care.

The QLRC noted that requiring practitioners who conduct eligibility assessments to be a specialist with at least five years' experience, or for the practitioner to be a specialist in a specific disease, illness or medical condition would be a barrier to a person's access to the scheme, particularly in rural, regional and remote areas.⁶⁷³

In relation to health practitioners training for the voluntary assisted dying process, the department outlined that training would:

... take the practitioners through all the steps and the stages of the process, depending on whether they are the coordinating practitioner, the consulting practitioner, the pharmacist or the nurse practitioner. Each one of those will have a very specific training package about the steps and what they are required to do. Obviously it has to be quite detailed because the bill is detailed around their roles in that regard. Then at the end of that process they will have met one of their eligibility requirements to be that practitioner under the act.⁶⁷⁴

Additionally, mandatory training under the legislation will specifically deal with capacity assessment and flags for coercion:

Both Victoria and Western Australia have a similar provision in their act, the minimum requirements for the coordinating practitioner or consulting practitioner. In addition, they have to go through a training process. QUT has developed the training package for both Western Australia and Victoria. It is an online training process that they have to go through that will look at how to determine capacity issues, how to determine eligibility issues and also whether a person is being coerced or undertaking the process voluntarily. It has been a well-worn path through those other two states.⁶⁷⁵

3.5.4 Review of eligibility decision by the Queensland Civil and Administration Tribunal

The Bill provides for review by the QCAT of the following decisions about a person's eligibility for voluntary assisted dying:

- a decision of a coordinating practitioner, in a first assessment of a person requesting access to voluntary assisted dying, relating to whether the person meets the residency requirements, has decision-making capacity in relation to voluntary assisted dying, or is acting voluntarily and without coercion
- a decision of a consulting practitioner, in a consulting assessment of a person, relating to whether the person meets the residency requirements, has decision-making capacity in relation to voluntary assisted dying, or is acting voluntarily and without coercion
- a decision of a coordinating practitioner in a final review of a person, in relation to whether the person has decision-making capacity in relation to voluntary assisted dying, or whether the person is acting voluntarily and without coercion.⁶⁷⁶

⁶⁷² Submission 1042, p 5.

⁶⁷³ Queensland Health, correspondence dated 13 July 2021, p 14.

⁶⁷⁴ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 11.

⁶⁷⁵ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 11.

⁶⁷⁶ Voluntary Assisted Dying Bill 2021, cl 99.

The Bill proposes that an application for a review of a decision must be made within 5 business days after the ‘relevant day’ for the reviewable decision.⁶⁷⁷ For reviewable decisions at each of the relevant stages in the voluntary assisted process, the ‘relevant day’ is the day the person was notified of the decision (by being given an assessment record form, consulting assessment record form or final review form) or the day the eligible person making the application becomes aware of the reviewable decision.⁶⁷⁸

The Bill defines a person who would be eligible to make an application for review to QCAT as one of the following:

- a person who is the subject of the decision
- an agent of a person who is the subject of the decision
- any other person who has a sufficient and genuine interest in the rights and interests of a person who is the subject of the decision in relation to voluntary assisted dying.⁶⁷⁹

QLRC view

Whilst the QLRC recommended that QCAT should be given jurisdiction to review the eligibility of a person to access voluntary assisted dying,⁶⁸⁰ the QLRC considered it ‘is not desirable to leave every decision of an assessing practitioner open to review by the tribunal’.⁶⁸¹ The QLRC was of the view that to do so would add a layer of complexity to the process, cause uncertainty and delay and had the potential to cause significant undue distress.⁶⁸²

The QLRC considered that the ‘eligibility criteria about the person’s disease, illness or medical condition are matters of clinical judgment that are best determined by a medical practitioner, rather than an administrative body’.⁶⁸³ In this regard, the QLRC advised that ‘the requirement for a requesting person to be assessed as eligible by two qualified practitioners is a central safeguard’, with provision for referral to another health practitioner for determination if the assessing practitioner is uncertain.⁶⁸⁴

In relation to the residency requirements for eligibility proposed in the Bill, the QLRC observed that some aspects of those criteria ‘involve judgment in the particular circumstances ... and may involve different interpretations’.⁶⁸⁵ Accordingly, the QLRC concluded that ‘therefore it is appropriate for decisions about the “ordinarily resident” criterion to be reviewable by the tribunal’.⁶⁸⁶

Noting that the decision-making capacity of a requesting person is a ‘key feature and major safeguard’, the QLRC considered:

It is therefore important that, in exceptional circumstances, genuine disagreement with a practitioner’s assessment of this issue can be addressed through an independent review mechanism. QCAT already has jurisdiction under the guardianship legislation to make declarations about an adult’s capacity for particular matters. It has a body of evidence upon which to draw in this context ...⁶⁸⁷

⁶⁷⁷ Voluntary Assisted Dying Bill 2021, cl 103(1).

⁶⁷⁸ Voluntary Assisted Dying Bill 2021, cl 103(2).

⁶⁷⁹ Voluntary Assisted Dying Bill 2021, cl 100.

⁶⁸⁰ QLRC Report, Recommendation 16-1.

⁶⁸¹ QLRC Report, paragraph 16.79.

⁶⁸² QLRC Report, paragraph 16.79.

⁶⁸³ QLRC Report, paragraph 16.84.

⁶⁸⁴ QLRC Report, paragraph 16.86.

⁶⁸⁵ QLRC Report, paragraph 16.84.

⁶⁸⁶ QLRC Report, paragraph 16.84.

⁶⁸⁷ QLRC Report, paragraph 16.88.

Similarly, given that the ‘criterion that the requesting person is acting voluntarily and without coercion is a major safeguard’, the QLRC was of the view that ‘the assessing practitioner’s decision in this respect should be reviewable by the tribunal’.⁶⁸⁸ Further, the QLRC stated:

Assessment of this matter requires consideration of a range of factors, some of which might be subtle or, depending on the circumstances, unknown to the practitioner. There could be situations where there is a genuine concern about the influence of another person on the voluntariness of the requesting person’s choice; for example, a family member, carer or medical practitioner (including an assessing practitioner).⁶⁸⁹

Stakeholder views

The ability to seek a review of a finding by a medical practitioner regarding a person’s capacity before QCAT was supported by a number of submitters.⁶⁹⁰ QLS confirmed:

QLS supports the review mechanism included in Pt 7 of the Bill, and considers that the Queensland Civil and Administrative Tribunal (QCAT) is best suited to provide the review mechanism because its procedures are sufficiently flexible to accommodate the nature of applications that may be made in relation to the VAD scheme.⁶⁹¹

Submitters argued that QCAT should be given additional resources to ensure the effective operation and the timely determination of applications under the Bill. QLS argued:

The enactment of the Bill is likely to increase the number of complex cases lodged with QCAT, with serious implications for the Tribunal's ongoing workload. It is imperative that QCAT deal with applications in relation to the VAD legislation in a timely manner that is cognisant of the purpose of the VAD scheme: to give persons who are suffering and dying, and who meet the eligibility criteria, the option of requesting medical assistance to end their lives. Our members raise concerns about the current resourcing and capacity of the Tribunal, which will only increase when the Bill is enacted.⁶⁹²

QCCL sought amendment to subclause 103(1) of the Bill which requires that the application for review be made within 5 business days after the relevant day:

The Council submits that the default time limit of 28 days under ss 33(3) and (4) of the QCAT Act should instead apply. Alternatively, and at the very least, a longer period of ten business days should apply. This would enable a party to properly decide whether he or she would like to bring a review application, which is a decision that requires delicate consideration.⁶⁹³

The Public Advocate argued the need for the definition of ‘interested person’ as defined in the *Guardianship and Administration Act 2000*:

The suggestion that the categories of interested parties include both the individual themselves or another person who QCAT determines is an ‘interested person’ is supported in principle. However, consideration should be given to adopting the definition of ‘interested person’ in the *Guardianship and Administration Act*, which is defined as a person who has a ‘sufficient and continuing interest in the other person’ the subject of the application. This definition would provide flexibility for QCAT to determine the suitability of other people making the application, while also having precedents to guide these determinations.⁶⁹⁴

⁶⁸⁸ QLRC Report, paragraph 16.89.

⁶⁸⁹ QLRC Report, paragraph 16.89.

⁶⁹⁰ For example, see submissions 260, 1055, 1295.

⁶⁹¹ Submission 1031, p 12.

⁶⁹² Submission 1031, p 12.

⁶⁹³ Submission 1004, p 4.

⁶⁹⁴ Submission 1295, p 7.

Similarly, ADA Australia stated:

ADA broadly supports the drafting of Part 7 of the Bill. We suggest inserting a definition of ‘agent’ in relation to clause 100, to clarify if the term includes a person with a power of attorney or other legally appointed representative. We recommend that the definition should expressly include a solicitor or advocate appointed by the person who is the subject of the decision.⁶⁹⁵

Department response

In response to the QCCL comments on the timeframes for an application for review, the department advised:

... although the default time limit for an application for review under the QCAT Act is 28 days, the tribunal has a general power to extend or shorten this time. However, the QLRC considered that a significantly shorter time limit should apply in the context of voluntary assisted dying as it was not preferable to rely on the exercise of power by the tribunal in every case to shorten the time (paragraph 16.121). The QLRC noted that a shorter time limit would also provide greater certainty without the possibility of an application for review being made late in the voluntary assisted dying process and is consistent with the compassionate and practical aim of the Bill (paragraph 16.122). The Bill does not prevent the tribunal from exercising its power to extend or shorten the time limit of five business days if the decision will not cause prejudice or detriment to a party.⁶⁹⁶

As to who may apply for review, to ensure that the review mechanism does not become ‘a means of unjustified interference or delay’, the QLRC advised that ‘the range of potential applicants should be kept small’.⁶⁹⁷ Recognising that the requesting person is dying and suffering, the QLRC considered the provision of an agent to apply on the person’s behalf to be a ‘practical necessity’.⁶⁹⁸

In response to clarification of the definition of an interested or eligible person, the Bill proposes that an eligible person includes ‘any other person who has a sufficient and genuine interest in the rights and interests of a person who is the subject of the decision in relation to voluntary assisted dying’.⁶⁹⁹ The QLRC considered that this category ‘should reflect a particular proximity or connection between the applicant and the requesting person in relation to the subject matter’, and that that approach would be ‘consistent with the general approach to standing for review of administrative decisions’.⁷⁰⁰

3.5.4.1 A complaints pathway

It was proposed that while the Bill includes review and appeal mechanisms to QCAT in relation to decisions about a person’s eligibility for voluntary assisted dying, there are no mechanisms or independent process for complaints to be made which lie outside of these parameters.⁷⁰¹

Go Gentle Australia argued that while there are provisions in the Bill that allow for appeals in relation to residency, decision-making capacity, and voluntariness, there is no pathway or mechanism for people to flag issues with blocked access.⁷⁰² Go Gentle Australia proposed:

We strongly urge that Queensland become the first Australian state to create a pathway for complaint that is both clear and direct, should an applicant, or the family of an applicant, feel they have been impeded or discouraged from pursuing the VAD pathway. Ideally, this would sit within the Voluntary Assisted Dying Review Board, who will have the capacity to hear complaints; warn doctors about

⁶⁹⁵ Submission 1055, pp 3-4.

⁶⁹⁶ Queensland Health, correspondence 13 July 2021, p 27.

⁶⁹⁷ QLRC Report, paragraphs 16.105-16.106.

⁶⁹⁸ QLRC Report, paragraph 16.109.

⁶⁹⁹ Voluntary Assisted Dying Bill 2021, cl 100.

⁷⁰⁰ QLRC Report, paragraph 16.113.

⁷⁰¹ Australian and New Zealand Society of Palliative Medicine, submission 1244, p 6.

⁷⁰² Submission 1189, p 14.

inappropriate behaviour when it occurs (for example, failing to respond to a first request within the mandated 2-day period); if necessary, refer them to the appropriate professional body for sanction; and include as part of their annual reporting requirements.⁷⁰³

Mr Andrew Brown, Health Ombudsman, outlined that Queensland does have a health service complaint system to deal with complaints against registered health practitioners:

In the case of registered practitioners, it is my view that the bill makes it clear that the national law will apply and, by virtue of that, the OHO [Office of the Health Ombudsman] will be able to receive complaints and notifications about registered practitioners involved in the scheme. Both the OHO and Ahpra will have jurisdiction to deal with complaints and notifications in this space.⁷⁰⁴

Mr Brown clarified that a breach of the proposed Act by a registered practitioner could form the basis of a complaint or a notification of professional misconduct. This would be prosecution through QCAT and referral to Ahpra as a matter of professional performance.⁷⁰⁵

Mr Brown also advised that under the *Health Ombudsman Act 2013*, the OHO has the power to deal with a health service complaint, however, the Health Ombudsman does not have jurisdiction over unregistered persons or organisations. Mr Brown stated:

If it is the government's intention that the OHO be able to receive complaints about unregistered persons and organisations who have roles under the scheme, I do not consider the current bill makes that necessarily clear enough.⁷⁰⁶

The need for regulatory clarity on this aspect of the Bill was identified by the Health Ombudsman to ensure the smooth operation of the scheme and prevent possible legal challenges in the future.⁷⁰⁷

3.5.5 Voluntary assisted dying is not suicide

The Bill proposes that a person who dies as a result of the self-administration or administration of a substance in accordance with the Bill does not die by suicide, but is taken to have died from the disease, illness or medical condition that made them eligible to access voluntary assisted dying.⁷⁰⁸

The QLRC proposed that a person who dies as a result of the self-administration or administration of a substance in accordance with the Bill does not die by suicide because:

- the death of a person through voluntary assisted dying raises questions as to its impact on access to life insurance or the receipt of a death benefit from a superannuation fund⁷⁰⁹
- the Western Australian, Tasmanian, South Australian (SA) and New Zealand (NZ) voluntary assisted dying acts provide that a death in accordance with those schemes is not a suicide⁷¹⁰
- of the stigma attached to the term suicide⁷¹¹

⁷⁰³ Submission 1189, p 14.

⁷⁰⁴ Public hearing transcript, Brisbane, 16 July 2021, p 1.

⁷⁰⁵ Public hearing transcript, Brisbane, 16 July 2021, p 4.

⁷⁰⁶ Public hearing transcript, Brisbane, 16 July 2021, p 2.

⁷⁰⁷ Public hearing transcript, Brisbane, 16 July 2021, p 3.

⁷⁰⁸ Voluntary Assisted Dying Bill 2021, cl 8.

⁷⁰⁹ QLRC Report, paragraph 12.97.

⁷¹⁰ *Voluntary Assisted Dying Act 2019* (WA) s 12, *End of Life Choice Act 2019* (NZ) s 35, *Voluntary Assisted Dying Act 2021* (Tas) s 140, *Voluntary Assisted Dying Act 2021* (SA), s 6. Also see QLRC Report, paragraphs 1.50-1.55, 12.93.

⁷¹¹ QLRC Report, paragraph 12.94.

- to do so may reduce the Bill's probability of breaching the *Criminal Code Act 1995* (Cth) (Criminal Code (Cth))'s prohibition on the use of 'carriage services'⁷¹² to publish or distribute material that counsels or incites committing or attempting to commit suicide.

Stakeholder views

Submitters supported the designation that voluntary assisted dying is not suicide.⁷¹³ The Clem Jones Group argued:

We believe VAD is not suicide... we believe that suicide is a choice between life and death usually by a person in an irrational state of mind despite having reasons to live. Voluntary assisted dying is a choice made by a competent person whose life is already drawing to a close who simply wishes to avoid further suffering.⁷¹⁴

DADC endorsed the Bill's distinction between dying from voluntary assisted dying and dying by suicide noting that:

This distinction is clear, from both a common sense point of view and a medical perspective. The medical and allied health professions are strongly committed to preventing suicides that are motivated by mental illness. Death as a result of VAD that complies with the eligibility and other criteria as set out in the Bill, is not something that there is any medical or social justification for preventing.⁷¹⁵

Some submitters were critical of this aspect of the Bill.⁷¹⁶ The ACL argued that clause 8 should be removed from the Bill so 'that if a person dies as a result of the provision of assisted dying, the laws should acknowledge the truth of what it has allowed to take place'.⁷¹⁷

In contrast, the Clem Jones Group argued that the provision at clause 8 strengthens arguments that the Queensland Bill does not conflict with Commonwealth law, noting that the 'express provision that VAD is not suicide goes toward avoiding any conflict between state and federal laws where health practitioners may be using electronic means to deliver services under the VAD laws'.⁷¹⁸

Department response

The department stated that one of the reasons the Bill proposes that a person who dies by voluntary assisted dying will be taken to have died from the condition that made them eligible for voluntary assisted dying was to maintain the person's eligibility to receive insurance payments:

For the purposes of a contract, deed or other instrument entered into in the state or governed by the law of the state, they are not considered to have died as a result of VAD or by suicide but they are considered to have died from the disease, illness or medical condition from which that person suffered. That was to address the issue of insurance contracts. Clearly insurance contracts are a contractual relationship between a person and a corporation, but that was the QLRC's position and other states have that position as well.⁷¹⁹

⁷¹² Section 7 of the *Telecommunications Act 1997* (Cth) defines a carriage service as 'a service for carrying communications by means of guided and/or unguided electromagnetic energy'. As clarified on p 37 of the explanatory notes, this means 'a telephone, videoconference, email or other forms of electronic communication.'

⁷¹³ See submissions 278, 984, 1027, 1189, 1271, 1304.

⁷¹⁴ Submission 984, p 7.

⁷¹⁵ Submission 720, p 2.

⁷¹⁶ For example see submissions 1228, 1285, 1309; Public hearing transcript, Rockhampton, 13 July 2021, p 29.

⁷¹⁷ Submission 1054, p 5.

⁷¹⁸ Submission 984, p 6.

⁷¹⁹ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 12.

3.5.6 Notification and certification of death

The Bill requires the coordinating practitioner and administering practitioner to each notify the Board of a person's death in the approved form, and each practitioner must notify the Board within 2 business days of becoming aware of the person's death.⁷²⁰

The Bill also requires a medical practitioner who is required to give a cause of death certificate for the person and who reasonably believes or knows that the person self-administered or was administered a voluntary assisted dying substance in accordance with the Bill, must, within 2 business days of becoming aware that the person has died, notify the Board of the person's death. This requirement does not apply if the medical practitioner is the coordinating practitioner or administering practitioner.⁷²¹

The Bill proposes to amend the *Coroners Act 2003* to provide that a death which occurs as a result of administration of a voluntary assisted dying substance in accordance with the requirements of the Bill is not to be a reportable death.⁷²²

Stakeholder views

Both DADC and VALE Group confirmed their support for clause 81 as the Bill supports the distinction between dying as a result of voluntary assisted dying and dying by suicide.⁷²³ The Clem Jones Group stated:

We support the inclusion at Clauses 8 and 81 of a provision stating that a person whose death is the result of them having accessed and used voluntary assisted dying in line with the proposed law, must have their cause of death recorded and registered (eg: on a cause of death certificate and death certificate) only as being their underlying terminal illness or neurodegenerative condition.⁷²⁴

Some submitters did not support the requirement that the relevant medical practitioner must state in the cause of death certificate that the cause of death was the disease, illness or medical condition from which the person suffered, and must not include any reference to voluntary assisted dying.⁷²⁵ Queensland Baptists argued that not recording a voluntary assisted dying death as suicide was a gross misrepresentation:

It is astounding that Section 81 (3) a and b mandate that the cause of death of a person whose life was ended as a result of VAD be recorded as resulting from an underlying disease and not the truth that it was though the administration of a life ending substance. This is not being honest about the cause of death and is a gross misrepresentation. If there was nothing morally wrong with VAD then why record the cause of death untruthfully?⁷²⁶

Mr Ben Lawson submitted:

Whilst there is no denying (it is hoped) that the disease, illness or medical condition has been the primary likely eventual cause of death, a record of the patient accessing VAD needs to be made. To not do so practically allows a falsehood to be established at law. The death certificate requirement should be that the primary cause of death was the disease or illness, and that the secondary cause was the administration of the VAD substance.⁷²⁷

⁷²⁰ Voluntary Assisted Dying Bill 2021, cl 81.

⁷²¹ QLRC Report, Recommendation 12-3.

⁷²² Explanatory notes, p 36.

⁷²³ Submissions 720, 1271.

⁷²⁴ Submission 984, p 6.

⁷²⁵ For example, see submissions 417, 1054, 1058, 1218.

⁷²⁶ Submission 1044, p 1.

⁷²⁷ Submission 1058, p 3.

RACP and the ANZSGM submitted that a person's death certificate should include both the underlying cause of death and that the person took a voluntary assisted dying substance.⁷²⁸

In relation to the requirement that the coordinating practitioner and administering practitioner each notify the Board of a person's death within 2 businesses days of becoming aware of the person's death, the QNMU highlighted that the time parameters within the Bill raised concerns that non-compliance with these recordkeeping and reporting requirements may be unavoidable in particular circumstances such as dying on country:

This may not be achievable due to geographical challenges. Placing regulatory timeframes on aspects of the voluntary assisted dying process, may not suit all specific circumstances concerning someone's death.⁷²⁹

Department response

In response to these concerns the department clarified:

The QLRC stated that this approach would ensure the privacy of the individual and their family, while also ensuring consistency with the approach in Victoria and Western Australia and for data collection by the Australian Bureau of Statistics. Deaths from voluntary assisted dying will be recorded through notification to the Board (paragraph 12.45).⁷³⁰

3.5.7 Impact of the *Criminal Code Act 1995 (Cth)*

Queensland's size or a patient's poor health may make it difficult for patients and health practitioners to discuss voluntary assisted dying in person. While health matters are often discussed using telehealth, using this communication method to discuss voluntary assisted dying may breach the Commonwealth *Criminal Code Act 1995 (Cth)* (Criminal Code (Cth)), which prohibits the use of a carriage service⁷³¹ to publish or distribute material that counsels or incites committing or attempting to commit suicide.⁷³² This legislation may impede patients' and health practitioners' ability to discuss voluntary assisted dying.

The meaning of 'suicide' under the Criminal Code (Cth) is a key consideration in assessing whether discussing voluntary assisted dying via a carriage service may breach the Criminal Code (Cth).⁷³³

If a death caused by the self-administration of a voluntary assisted dying substance does not meet the definition of 'suicide' under the Criminal Code (Cth), no breach of the carriage service offences can occur.

However, if such a death does meet the definition of 'suicide' under the Criminal Code (Cth), the carriage service offences in the Criminal Code (Cth) may be breached if patients and health practitioners discuss voluntary assisted dying via a carriage service.

The QLRC stated that it is unsettled whether voluntary assisted dying, authorised by a state law, constitutes 'suicide' within the meaning of the Criminal Code (Cth) carriage service offences.⁷³⁴ While it has been stated that voluntary assisted dying laws 'create a new form of dying ... legally

⁷²⁸ Submissions 1042, 1320.

⁷²⁹ Submission 937, p 9.

⁷³⁰ Queensland Health, correspondence dated 13 July 2021, p 32.

⁷³¹ Page 37 of the explanatory notes define a 'carriage service' as 'a telephone, videoconference, email or other forms of electronic communication'.

⁷³² Explanatory notes, p 37.

⁷³³ The QLRC notes 'suicide' is not defined in the Criminal Code (Cth) for the purposes of the carriage service offences. Source: QLRC Report, paragraph 20.29.

⁷³⁴ QLRC Report, paragraph 20.26.

distinguishable from suicide',⁷³⁵ it has also been expressed that voluntary assisted dying would likely meet the definition of suicide for the purpose of the Criminal Code (Cth).⁷³⁶

To seek to remedy this problem, the Bill states that a death as a result of self-administration or administration of a voluntary assisted dying substance is not a suicide. However, the QLRC stated that 'issues of statutory interpretation are not resolved by the fact that a state law permits voluntary assisted dying or even declares that it does not constitute "suicide"'.⁷³⁷

In order to resolve this uncertainty, the Premier wrote to the Prime Minister to request the Australian Government amend the Criminal Code (Cth) 'so it does not impede the operation and availability of Queensland's proposed voluntary assisted dying scheme'.⁷³⁸

On 24 June 2021, it was reported that the Australian Government had stated it had no plans to amend the Criminal Code (Cth).⁷³⁹

Stakeholder views

Stakeholders commented on the challenges of providing voluntary assisted dying services to people living in a state as large as Queensland.⁷⁴⁰ Jacqueline King, Assistant General Secretary of the QCU stated:

I have lived in both Victoria and Queensland and, as most people in Queensland would be aware, we are a much more vast state with more remote, rural and regional areas perhaps than any other state. In that context this is, from our perspective, about being consistent with human rights and ensuring that every single person in Queensland who wishes to and meets the eligibility criteria should be able to access voluntary assisted dying if they choose to.⁷⁴¹

Given Queensland's size, decentralised nature and the lack of availability of health practitioners in parts of the state, submitters such as DWDV highlighted the need for voluntary assisted dying consultations to occur via telehealth:

Issues of cost, time, and convenience make this essential, especially for people in remote areas. Telehealth also permits (say) two medical attendants, and family, to be effectively present during consultations.⁷⁴²

Similarly, Penny Tovey stated:

Experiences of the Victorian law highlight the strain that is put on doctors having to travel to remote areas to conduct in-person assessments. We know we will face the same challenges in Queensland - so please, let's fix this now.

The ban on accessing VAD via Telehealth consultation is a significant hurdle for regional, rural and remote Indigenous communities to overcome, and an unnecessary barrier that means some dying people may not be able to access the choice they so sorely need.⁷⁴³

⁷³⁵ QLRC Report, paragraph 20.6.

⁷³⁶ QLRC Report, paragraph 20.8.

⁷³⁷ QLRC Report, paragraph 20.27.

⁷³⁸ Queensland Parliament, Record of Proceedings, 25 May 2021, p 1515.

⁷³⁹ Lydia Lynch, 'Ban stands for euthanasia phone tips', *Australian*, 24 June 2021.

⁷⁴⁰ See for example: Wendy Francis, and Northern Territory Director, Australian Christian Lobby, public hearing transcript, Brisbane, 14 July 2021, p 40; Tricia Matthias, public briefing transcript, Brisbane, 14 June 2021, p 6; submission 1031, p 9.

⁷⁴¹ Public hearing transcript, Brisbane, 15 July 2021, p 64.

⁷⁴² Submission 1056, p 2.

⁷⁴³ Submission 916, p 1.

Dr Eliana Close considered that quality healthcare can occur using telehealth services, and that using telehealth can improve equity of access to voluntary assisted dying, especially where health practitioners are in limited supply:

... evidence from Canada suggests high-quality assessments can take place via telehealth, improving equity of access.⁷⁴⁴ This is beneficial if an individual has difficulty locating a VAD provider. There are currently only 65 medical practitioners throughout regional and rural Victoria who are trained and registered to be able to provide VAD assessments. Some people wishing to access VAD have reported difficulty in locating a medical practitioner willing to assist.⁷⁴⁵ Telehealth would also be advantageous when the patient is too unwell to travel.⁷⁴⁴

There was a range of views expressed on what limitations the Criminal Code (Cth) would place on discussions about voluntary assisted dying occurring via a carriage service. Submitters including Go Gentle Australia, Dr Eliana Close, the QCU and Dr Kristin Cornell stressed that if people living in regional, rural and remote areas are unable to discuss voluntary assisted dying with a health practitioner using a carriage service, these people would find accessing voluntary assisted dying very challenging.⁷⁴⁵ Dr Will Cairns considered:

I think the issue of communication is really important in our very large state. First of all, the Commonwealth law does seem to cause obstacles for using the technology which has become the norm, and particularly in mask-wearing COVID time, but also for people in remote areas to be assured that, if we do have legislation that allows voluntary assisted dying, people, wherever they live in the state, can access it without having to travel vast distances to complete assessments.

...

We have a friend who has a motor neurone disease-like illness, and him having to travel a few hundred kilometres or even 50 kilometres for an assessment would be beyond his ability.⁷⁴⁶

Leigh Bell stated:

Queenslanders in regional, rural and remote areas must have equity of access to choices as outlined in this Bill. It is essential that Drs are able to communicate with each other and their patients via electronic means. All other medical records (test results, drs letters, etc) are shared electronically currently. With end stage heart failure, it is increasingly difficult for me to leave the house. If I wished to discuss my prognosis and palliative care arrangements, including for example sharing updated advanced health care directives and DNR (do not resuscitate) orders with multiple centres (treating hospital, palliative care facility, local gp etc), I would rely on electronic means (scanned copies). It is essential that VAD, if legal, is allowed to be part of these conversations and emails - in fact I don't think it will be workable to exclude it.⁷⁴⁷

Penny Tovey considered the Criminal Code (Cth) would impact access to voluntary assisted dying for Aboriginal and Torres Strait Islander people:

At the moment, this bill's prohibition of conducting any of the VAD eligibility assessments by phone - or anything other than in person - will pose a significant barrier to regional, rural and remote Indigenous communities.

Peter championed Indigenous rights and despised discrimination, but sadly I fear that is what the current ban on the use of Telehealth translates as; that people living in remote places will face additional barriers to accessing VAD, for no reason other than their postcode.⁷⁴⁸

⁷⁴⁴ Submission 1304, p 71. Footnotes in quote not replicated.

⁷⁴⁵ For example, see submissions 1189, 1304, 1148; public hearing transcript, Brisbane, 15 July 2021, p 25.

⁷⁴⁶ Public briefing transcript, Townsville, 12 July 2021, pp 8-9.

⁷⁴⁷ Submission 814, p 1.

⁷⁴⁸ Submission 916, p 1.

DWDV included legal opinion from Barristers Robert Richter QC and William Stark on the impact of the Criminal Code (Cth) on the *Voluntary Assisted Dying Act 2017* (Vic).⁷⁴⁹ It stated a conviction under the Criminal Code (Cth) of a medical practitioner who is engaging in a discussion about voluntary assisted dying would be extremely difficult to achieve because:

- a. A medical practitioner who is engaging in a discussion about VAD will not have the intent required to be guilty of an offence under the Commonwealth Code;
- b. The relevant sections of the federal Criminal Code relating to use of telecommunications are not breached by persons complying with the relevant state legislation.
- ...
- c. A discussion by a medical practitioner with a patient about the eligibility criteria set out in the VAD Act, without any discussion about the process, neatly avoids any potential conflict with the Commonwealth Criminal Code provisions.⁷⁵⁰

In contrast, Dr Eliana Close submitted⁷⁵¹ that voluntary assisted dying ‘would likely meet the definition of “suicide” under Australian law and hence fall under the Commonwealth Criminal Code’.⁷⁵²

Submitters including the AMA Queensland, the RANZCP Queensland, Professor Lindy Willmott and Dr Jenny Brown considered the Criminal Code (Cth) should be amended to remove any doubt that voluntary assisted dying can be discussed using a carriage service.⁷⁵³ Professors White and Willmott submitted:

We repeat our earlier calls for the Commonwealth Government to amend the Commonwealth Criminal Code prohibition relating to ‘suicide’ and a carriage service... We recognise this is not a matter that the state of Queensland can resolve as this is Commonwealth law but urge continued advocacy from the state government during the implementation period.⁷⁵⁴

There was stakeholder support for the QLRC Report recommendation⁷⁵⁵ that, pending the amendment of the Criminal Code (Cth), the Commonwealth Director of Public Prosecutions be asked to consider issuing prosecutorial charging guidelines indicating that the relevant offences in the Criminal Code (Cth) will not be prosecuted where a doctor or other person acts in accordance with the procedure outlined in state or territory voluntary assisted dying laws.⁷⁵⁶ Dr Heather McNamee outlined the desirability of such guidelines being issued:

We have to be able to use telehealth for this and we have to be able to do that confidently, without being concerned that we are going to be prosecuted under Commonwealth law. I am not common amongst my profession: I believe that my oath to do the best by my patients is more important than laws I may not agree with. Most of my colleagues would not subscribe to that. They are absolutely terrified of any sort of prosecution or legal redress, so the fact that the QLRC suggested that the Commonwealth DPP brings

⁷⁴⁹ Submission 1056, pp 5-9.

⁷⁵⁰ Submission 1056, p 5.

⁷⁵¹ Submission 1304, p 63. The attached paper is: K Del Villar, E Close, R Hews, L Willmott, & B White (2020), ‘Voluntary assisted dying and the legality of using a telephone or internet service: The impact of Commonwealth ‘Carriage Service’ offences’, *Monash University Law Review*.

⁷⁵² Submission 1304, p 63.

⁷⁵³ Submission 260, p 2; public hearing transcript, Brisbane, 15 July 2021, p 37; submission 1266, p 2; public hearing transcript, Brisbane, 15 July 2021, p 3; public hearing transcript, Brisbane, 15 July 2021, p 49.

⁷⁵⁴ Submission 906, p 15.

⁷⁵⁵ QLRC Report, Recommendation 20-2.

⁷⁵⁶ See for example: Public hearing transcript, Brisbane, 16 July 2021, p 24; submission 270, p 3; public hearing transcript, Brisbane, 15 July 2021, p 49.

in prosecutorial guidelines whilst they address the Criminal Code on the use of carriage services is really to be highly commended and needs to be addressed with urgency before implementation.⁷⁵⁷

Stakeholders opposed to voluntary assisted dying were of the view that there was no need for the Criminal Code (Cth) to be amended, or for the Commonwealth Director of Public Prosecutions (DPP) to be asked to consider issuing prosecutorial charging guidelines, because they considered voluntary assisted dying discussions should only take place in person.⁷⁵⁸ Health Professionals Say No! argued:

... TeleHealth application of VAD legislation should not be permitted. The difficulty in assessing body language, carer/family interaction with the patient and to assess the patient's environment, safety or vulnerability, or conduct a physical examination, are all impacted though remote technology and lend themselves to inaccurate assessments.⁷⁵⁹

Department response

The department acknowledged the potential impact the carriage service offences may have on the operation of a voluntary assisted scheme, noting it 'is definitely an implementation issue if the law is not changed'.⁷⁶⁰

In response to concerns that the offences of using a carriage service to discuss suicide that are in the Criminal Code (Cth) may impede access to voluntary assisted dying for people in some parts of Queensland, the department highlighted how other states had attempted to overcome this issue:

Western Australia and Victoria have financial schemes that enable practitioners to attend to patients and the reverse—patients who are able to attend to a practitioner. Given Queensland's unique geography and decentralisation, it will obviously be a challenge for us.⁷⁶¹

Responding to a question about the operation of the Bill if the carriage service offences remain in the Criminal Code (Cth), DJAG highlighted the role the Commonwealth DPP would play in any decision to prosecute a person for any breach of the Criminal Code (Cth):

... just like all prosecution decisions, a Commonwealth decision to prosecute is the exercise of what we call prosecutorial discretion. That would be a matter for the Commonwealth DPP. How they exercise their discretion in particular situations would be a matter for them. We of course at a state level cannot bind that in any shape or form.⁷⁶²

The department also considered that the carriage service offences may not prevent all discussion of voluntary assisted dying taking place:

There are degrees of information that will breach the Commonwealth legislation. General information may be okay, but actually telling a person how to administer a voluntary assisted dying substance may not be okay in that context. It is looking at the continuum of behaviour that has to happen and how it is delivered.⁷⁶³

...

As you think about the continuum of things, the passage of an electronic prescription is done over a carriage service so you could include that or not. There is a lot that we will have to go through to unpick exactly what the detailed implications are from a legal perspective about what that means. For instance,

⁷⁵⁷ Public hearing transcript, Townsville, 12 July 2021, p 14.

⁷⁵⁸ See submissions 1309, 1229.

⁷⁵⁹ Submission 1228, p 4.

⁷⁶⁰ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 6.

⁷⁶¹ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 6.

⁷⁶² Leanne Robertson, Department of Justice and Attorney-General, public briefing transcript, Brisbane, 14 June 2021, p 11.

⁷⁶³ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 6.

does the electronic transmission of a form regarding voluntary assisted dying fall under that legal coverage?⁷⁶⁴

3.5.8 Statewide Pharmacy Service

The QLRC Report recommended the establishment of a statewide pharmacy service to facilitate the supply of the voluntary assisted dying substance across Queensland and to provide a central source of information about the substance for people accessing voluntary assisted dying, and for their loved ones and medical practitioners.⁷⁶⁵ The QLRC considered the service could be established and run out of a tertiary hospital pharmacy.⁷⁶⁶

The QLRC Report recommended the statewide pharmacy service should supply the voluntary assisted dying substance, but not be responsible for its disposal. The QLRC Report considered that the department should determine how a voluntary assisted dying substance is disposed of, with consideration given to accessibility of voluntary assisted dying by people in rural and remote areas.⁷⁶⁷

The QLRC advised that under Queensland's current medicines and poisons framework, pharmacists may dispense Schedule 4 and Schedule 8 medicines provided they comply with specific quality standards and conditions. The QLRC Report stated that from approximately the third quarter of 2021 the *Medicines and Poisons Act 2019* (Qld) (Medicines and Poisons Act) would provide a new regime for the regulation of substances, including the prescription, supply, administration, storing and disposal of Schedule 4 and Schedule 8 medicines.

In addition, the QLRC proposed regulating the voluntary assisted dying substance separately from the Medicines and Poisons Act, and instead requiring the Bill to set out specific obligations, including for supply and disposal of the voluntary assisted dying substance.

The Bill defines 'authorised supplier' as a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive under section 158 of the Bill.⁷⁶⁸ The Bill also defines an 'authorised disposer' as a registered health practitioner, or persons in a class of registered health practitioners, authorised by the chief executive under section 159 of the Bill.⁷⁶⁹

The QLRC Report highlighted that Western Australia and Victoria had each adopted a statewide pharmacy service, and noted the role they play in informing and educating patients and medical practitioners accessing voluntary assisted dying.⁷⁷⁰ The QLRC Report also noted stakeholder support for such a service.⁷⁷¹

Department view

The department outlined the practicalities of the proposed operation of the statewide pharmacy service in regards to its supply and control of the prescribed substance:

... the person's particular condition would determine the route of administration that is appropriate for the particular person. That will be dealt with in clinical guidelines and the statewide pharmacy service will work closely with the practitioner to determine the appropriate substance on a case-by-case basis.⁷⁷²

⁷⁶⁴ Tricia Matthias, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 6.

⁷⁶⁵ QLRC Report, paragraph 21.101.

⁷⁶⁶ QLRC Report, paragraph 21.102.

⁷⁶⁷ QLRC Report, paragraph 21.104.

⁷⁶⁸ Voluntary Assisted Dying Bill 2021, Schedule 1; s 158 of the Bill is titled 'Authorised suppliers'.

⁷⁶⁹ Voluntary Assisted Dying Bill 2021, Schedule 1; s 159 of the Bill is titled 'Authorised disposers'.

⁷⁷⁰ QLRC Report, paragraph 21.91-21.93.

⁷⁷¹ QLRC Report, paragraph 21.99-21.100.

⁷⁷² Public briefing transcript, Brisbane, 14 June 2021, p 10.

The scheme includes a range of provisions around managing the substance to ensure there is a chain of responsibility for the substance at all times. Once it has been supplied by the statewide pharmacy service, if it is practitioner administration and it is in the practitioner's possession, if the person revoked their administration decision or they died before they were able to access it then the practitioner would return the substance to the statewide pharmacy service for disposal. There is also a provision for that practitioner to dispose of the substance themselves, and that is to address those rural and regional access issues.

For self-administration, once it is in the person's possession, again, if they either revoke their decision, decide not to go ahead with it or die before they self-administer the substance, then there are provisions requiring their contact person to return the substance to the statewide pharmacy service. That needs to be done as soon as possible and within 14 days to make sure that it is not just left lying around the person's house. It needs to be returned for disposal within that 14 days, and there is a penalty on the contact person for not complying with that.⁷⁷³

3.5.9 Committee comment

The committee is satisfied that the Bill has achieved a balance between competing views to construct a legislative framework which is workable.

The committee considers that the Bill strikes a balance between a practitioner's right not to participate on the grounds of a conscientious objection and the right of a person to access voluntary assisted dying and to be informed about it and other lawful end-of-life options.

The committee notes the range of views on the conscientious objection and participation in the scheme by entities. The committee fully supports providing end-of-life choices to people with a life limiting illness, no matter where they reside.

Given the geographic size of Queensland and the dispersed nature of the Queensland population, telehealth services are critical for the delivery of health services to regional and remote communities. The committee is concerned that without amendments to the Commonwealth Criminal Code, to allow practitioners to discuss voluntary assisted dying through telehealth, access for people in rural and remote areas of Queensland may be impacted.

The committee notes that the Premier wrote to the Prime Minister on 25 May 2021 requesting the Commonwealth Government take urgent action to amend Commonwealth legislation.

Given the current uncertain legal position of the operation of a voluntary assisted dying scheme in Queensland as a result of Commonwealth 'Carriage Service' offences and in order to provide certainty for doctors that their conduct is lawful under any Queensland voluntary assisted dying scheme, the committee recommends that the Commonwealth Government amend the Criminal Code (Cth) by inserting a definition declaring that "suicide" does not include voluntary assisted dying when carried out lawfully pursuant to a law of a state or territory'.

Recommendation 2

The committee recommends that the Commonwealth Government amend the *Criminal Code Act 1995* (Cth) by inserting a definition declaring that 'suicide' does not include voluntary assisted dying carried out lawfully pursuant to a law of a state or territory.

The committee notes that a request to amend Commonwealth 'Carriage Service' offences has been made previously by the Queensland Government. In order to provide immediate reassurance for doctors that their conduct is lawful the committee recommends the Commonwealth Director of Public Prosecutions issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the *Criminal Code Act 1995* (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state voluntary assisted dying laws.

⁷⁷³ Public briefing transcript, Brisbane, 14 June 2021, p 13.

Recommendation 3

The committee recommends that as a matter of urgency the Commonwealth Director of Public Prosecutions issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the *Criminal Code Act 1995* (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in state or territory voluntary assisted dying laws.

3.6 Palliative Care

In addition to the requirement to inform a person considering voluntary assisted dying about palliative care,⁷⁷⁴ the Bill includes the principle:

... every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life.⁷⁷⁵

The QLRC argued that 'any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care',⁷⁷⁶ stating:

The resources required to ensure that any legislated scheme for voluntary assisted dying operates safely and compassionately should not be at the expense of palliative care services.⁷⁷⁷

Stakeholder views

Many submitters strongly supported the availability of high quality palliative care services in Queensland.⁷⁷⁸ The Public Advocate stated:

As a community we must commit to the availability of high-quality palliative care for all Queenslanders. In a first-world country we should all be entitled to 'die a good death' and this cannot occur unless people can easily access the specialist pain relief and sedation provided by palliative care that is necessary to support this outcome.⁷⁷⁹

Certain submitters argued that despite the Bill's principles, high-quality palliative care for all Queenslanders was not always available.⁷⁸⁰ Submitters argued the need for equitable availability of palliative care and support for end-of-life decision-making. Cancer Council Queensland stated:

Consideration of assisted dying should occur in the broader context of improving end-of-life care. High quality end-of-life care should be available for all Australians regardless of any choices a person may make about assisted dying. This includes equitable availability of palliative care and support for end-of-life decision-making.⁷⁸¹

Some stakeholders commented upon the historical underfunding of palliative care and the resulting discrimination of access in current service provision. ACA argued:

... palliative care is underfunded and unevenly available in Queensland; also many doctors are inadequately trained in palliative care; people may die whose suffering – whether physical, psychological or existential - could have been relieved to their satisfaction with gold standard palliative care...⁷⁸²

⁷⁷⁴ Voluntary Assisted Dying Bill 2021, cl 7, 22(c).

⁷⁷⁵ Voluntary Assisted Dying Bill 2021, cl 5(d).

⁷⁷⁶ QLRC Report, paragraph 1.15.

⁷⁷⁷ QLRC Report, paragraph 3.24.

⁷⁷⁸ For example see submissions 278, 417, 1042, 1266.

⁷⁷⁹ Submission 1295, pp 1-2.

⁷⁸⁰ Submissions 455, 1150, 1244; Mr Stephen Richards, public hearing transcript, Rockhampton, 13 July 2021, p 1.

⁷⁸¹ Submission 725, p 2.

⁷⁸² Submission 417, p 3.

Both the RACP and ANZSPM considered that the issue of underfunding for palliative care was a national issue. Their submissions were in accordance, stating:

... it is imperative that all state and territory governments, including the Queensland Government, endorse palliative care and end-of-life care as a key priority for the National Cabinet. Appropriate palliative care services must be prioritised and funded across all age groups and settings, including an expanded presence in the community.⁷⁸³

The ACL argued that an ageing Australian population will require greater availability of quality palliative care services and that the current service is not meeting the needs of the elderly and dying in Queensland and will not meet these needs into the future.⁷⁸⁴

The call for a significant increase in funding for palliative care services in Queensland was supported by numerous submitters.⁷⁸⁵ The need for increased palliative care resources to be provided in rural, regional and remote areas of Queensland was also noted by submitters, regardless of their stance on voluntary assisted dying.⁷⁸⁶ The Clem Jones Group argued:

We believe that the State Government needs to address any inequality in access to palliative care in the regions of Queensland as well as metropolitan areas. Hospices, in particular, are largely concentrated in South East Queensland and ought to be more available in regional Queensland.⁷⁸⁷

Ms Beverly Young, a former palliative care nurse of 12 years provided a practical perspective on palliative care funding and how it intersects with the debate around voluntary assisted dying legislation, arguing:

The other significant reason some deny the need for voluntary assisted dying legislation is the mistaken belief that increased palliative care funding will deliver better palliative care and negate the need for such legislation. Might I say here that the proposed increased funding for palliative care is a significant and positive step in addressing some of the identifiable needs, especially for people in regional and remote areas.⁷⁸⁸

Amongst the concerns over the funding of palliative care, a number of submitters raised the issue of whether resourcing of the proposed voluntary assisted dying scheme would occur at the expense of palliative care.⁷⁸⁹ QLS stated:

The introduction of the Bill should not detract from the Queensland Government's responsibility to ensure high-quality palliative care is available, not only for those who are deciding whether to access the voluntary assisted dying (VAD) scheme, but also for those who are ineligible to access VAD. Accordingly, QLS reiterates the QLRC's recommendation that the Queensland Government must ensure the VAD scheme complements, not detracts from, the provision of high-quality and accessible palliative care.⁷⁹⁰

A number of submitters highlighted that 'the evidence shows that in jurisdictions where VAD law has come into effect other end-of-life services, for instance, our palliative care services, actually get better. There is more talk about it, more money into it and more awareness.'⁷⁹¹

⁷⁸³ Submissions 1244, 1042.

⁷⁸⁴ Submission 1054, p 13.

⁷⁸⁵ For example, see submissions 48, 455, 527, 618, 646, 753, 1052, 1054, 1064, 1110, 1150, 1202, 1209, 1216, 1221, 1294, 1237, 1301, 1306, 1309, 1344.

⁷⁸⁶ For example, see submissions 19, 419, 439, 568, 605, 725, 937, 984, 1015, 1030, 1054, 1057, 1290, 1314, 1344; public hearing transcript, Rockhampton, 13 July 2021, p 3.

⁷⁸⁷ Submission 984, p 10.

⁷⁸⁸ Public hearing transcript, Brisbane, 16 July 2021, pp 26-27.

⁷⁸⁹ For example, see submissions 937, 1158, 1242, 1314.

⁷⁹⁰ Submission 1031, p 2.

⁷⁹¹ Dr Finnigan, public hearing transcript, Brisbane, 15 July 2021, p 52.

Andrew Denton of Go Gentle Australia advised the committee that funding for palliative care increased on average by \$140 million in states where voluntary assisted dying had been legislated.⁷⁹² He concluded, that ‘the very existence of a debate about VAD brings palliative care into enormous focus right across the parliament, which is to its benefit’.⁷⁹³

Similarly Professor Lindy Willmott also commented on the correlation between palliative care funding and the introduction of voluntary assisted dying legislation, stating:

Some years ago Palliative Care Australia commissioned a report from Aspex Consulting which looked at correlations between palliative care funding and countries which had introduced voluntary assisted dying. There was a correlation of certainly as good palliative care funding or increases in palliative care funding in equivalent, for example, European jurisdictions which did not have euthanasia. Palliative care seems to go hand in hand with voluntary assisted dying. It should not be a competition.⁷⁹⁴

Similarly the Public Advocate submitted:

VAD should never be viewed as an alternative to high-quality palliative care. Quality palliative care and VAD should exist as options in a larger end-of-life package of supports for Queenslanders. The choice of a good death supported with properly resourced, accessible, high-quality palliative care should be just as available to every Queenslanders as the government is proposing VAD should be.⁷⁹⁵

Fay Tomlin described the need to respect an individual’s choice to palliative care or voluntary assisted dying:

I want to be very clear that palliative care sits on one side and voluntary assisted dying is a whole separate issue. This is around respecting a person’s choice to be autonomous: to be provided with compassion, understanding, good health information and good information about dying and to be provided that information in a way that allows the person to understand what their choices are and what their options are for care.⁷⁹⁶

Department response

The department stated that in 2021, Queensland hospital and health services would spend approximately \$149 million on palliative care service provision and approximately \$12.9 million to fund 8 non-government organisations to provide palliative care in the community.⁷⁹⁷ In clarification, the department advised:

Palliative care services are delivered in a range of settings including public and private hospitals, hospices, residential aged care facilities and private residences (home-based care). Hospital and Health Services (HHSs) are responsible for prioritising, planning and delivering health services to meet the needs of their local communities within their allocated budgets. While the Department of Health administers an overarching allocation to each HHS, it is the HHSs, as the providers of the care, who make operational decisions about its own budget. This approach delivers maximum flexibility to respond to local needs and priorities.⁷⁹⁸

In addition, the department highlighted upcoming increases in palliative care funding starting in the 2021-22 financial year:

... the government has announced that it will invest a further \$171 million in palliative care funding in the five years starting next financial year. In the 2021-22 financial year it is estimated that the Queensland

⁷⁹² Public hearing transcript, Brisbane, 14 July 2021, p 4.

⁷⁹³ Public hearing transcript, Brisbane, 14 July 2021, p 4.

⁷⁹⁴ Public hearing transcript, Brisbane, 15 July 2021, p 7.

⁷⁹⁵ Submission 1295, p 2.

⁷⁹⁶ Public hearing transcript, Rockhampton, 13 July 2021, p 31.

⁷⁹⁷ David Harmer, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 5.

⁷⁹⁸ Queensland Health, correspondence dated 13 July 2021, p 3.

government will spend approximately \$176 million in total on palliative care, and that investment will grow to \$247 million by the 2025-26 financial year.⁷⁹⁹

The department advised that the introduction of a voluntary assisted dying scheme would not detract from the provision of palliative care across Queensland, as the voluntary assisted dying scheme:

... is not an alternative to; it should be complementary to palliative care services, and that is made clear in the discussions. That is important. We do have issues across Queensland with equity of access and we are striving in the department to address that. A key pillar of our reform process is to address equity in all of its dimensions and wherever that may become an issue, palliative services being one.⁸⁰⁰

When commenting on Queensland's size and its decentralised nature, the department considered a hub-and-spoke model of service delivery could be implemented:

... we have a lot more metropolitan centres outside of Brisbane where there is access where there could be a hub-and-spoke model.⁸⁰¹

To address issues in relation to palliative care services, the department highlighted the development of the Palliative and End of-Life Care Strategy:

The Strategy will guide local service delivery to ensure all Queenslanders can access high quality palliative care and achieve their goals for care at the end of life. Undertaking this strategic planning work, to inform the development of the Strategy and workforce plan, is an essential part of making sure that the new funding is allocated to areas of greatest need... The commitment to a new Strategy and palliative care reform builds on ongoing investment in the Queensland palliative care system.⁸⁰²

Finding of the former committee in relation to palliative care

The former committee recognised that:

... palliative care needs to be adequately resourced and supported irrespective of whether voluntary assisted dying legislation is introduced or not and, if it is introduced, it is imperative that people have the full range of options available to them so that they can make an informed choice.⁸⁰³

It acknowledged the complexity involved in the delivery of palliative care by both state and federal governments. As the department explained:

Under the National Health Reform Agreement, the states and territories are the system managers of the public hospital system, whilst the Australian Government has full funding and program responsibility for aged care and lead responsibility for general practitioner (GP) and primary care. Therefore, in relation to palliative care services in Queensland:

- “The Australian Government has responsibility for funding palliative care through general practice and Residential Aged Care Facilities (RACFs).
- The Australian Government and Queensland Government jointly fund palliative care through public hospital funding, with the Queensland Government being responsible for the delivery of specialist public palliative care services, including community palliative care, inpatient and outpatient services, and providing support to primary health care providers.”

⁷⁹⁹ David Harmer, Department of Health, public briefing transcript, Brisbane, 14 June 2021, p 5.

⁸⁰⁰ Professor Keith McNeil, Department of Health, public briefing transcript, Brisbane, 14 June 2021, pp 4-5.

⁸⁰¹ Public briefing transcript, Brisbane, 14 June 2021, p 6.

⁸⁰² Queensland Health, correspondence dated 13 July 2021, p 2.

⁸⁰³ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 34, 56th Parliament – Voluntary Assisted Dying, 31 March 2020, p 109.

This results in a complex funding, policy and delivery framework for palliative care. As acknowledged by Queensland Health, ‘the challenge for both governments is to deliver person-centred models of care that overcome the policy and funding barriers and result in good patient outcomes’.⁸⁰⁴

The former committee appreciated the difficulties some Queenslanders can face accessing palliative care, particularly in rural, remote and Indigenous communities. It recommended that both the Australian and Queensland Governments take actions to address these issues including increasing palliative care funding.⁸⁰⁵

The Queensland Government response to the former committee’s report into aged care, end-of-life and palliative care outlined a roadmap for delivery of systemic reform and strategic investment to increase the quality of, and access to, integrated palliative care that is person-centred and driven by local needs, noting:

This response to the end-of-life and palliative care recommendations sets out a roadmap that acknowledges current constraints yet allows for controlled investment to support gradual and targeted growth to deliver:

- A viable and sustainable palliative care system and workforce that is comparable to other Australian jurisdictions;
- An increase in the volume and quality of services;
- Person-centred and flexible palliative care that delivers services focused on the local community and individual needs; and
- Innovative services that use technologies to promote equity of access to palliative care for all Queenslanders.
- System improvement focussed on patient outcomes to build accountability for investment and enable improved system oversight and governance.⁸⁰⁶

3.6.1 Committee comment

The committee endorses the principle outlined in the Bill that every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person’s suffering and maximise the person’s quality of life.

While the committee appreciates the difficulties some Queenslanders can face accessing palliative care, particularly in rural, remote and Indigenous communities, it notes the work by the department in developing its Palliative and End of-Life Care Strategy and the extra funding dedicated to palliative care which will support gradual and targeted growth in the area. Ultimately, a good death supported by properly resourced, accessible, high-quality palliative care should be available to every Queenslanders.

3.7 Equity of access to voluntary assisted dying

The Bill includes the principal that ‘access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland’.⁸⁰⁷

⁸⁰⁴ Queensland Health, Queensland Health Palliative Care Services Review – Key Findings, March 2019, p 8 in Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care, 24 March 2020, p 258.

⁸⁰⁵ Queensland Health, Queensland Health Palliative Care Services Review – Key Findings, March 2019, p 8 in Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee: Report No. 33, 56th Parliament – Aged care, end-of-life and palliative care, 24 March 2020, pp xix-xxiii.

⁸⁰⁶ Queensland Government Response, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No. 33: Aged care, end-of-life and palliative care, p 4.

⁸⁰⁷ Voluntary Assisted Dying Bill 2021, s 5(e).

The QLRC Report states that any voluntary assisted dying legislation must be:

... appropriate for Queensland's geography, the spread of its population in regional and remote areas, and its public and private health systems. It must also account for availability and accessibility of suitably qualified and eligible health practitioners to participate in the request and assessment and administration processes of the legislation.⁸⁰⁸

The QLRC Report highlighted the importance of 'the availability of services and information to persons whose first language is not English, including Aboriginal and Torres Strait Islander peoples living in remote areas of Queensland'⁸⁰⁹ and stated:

The principle of equality of access warrants legislation that supports the provision of services without discrimination based on where people live in Queensland. The scheme should be accessible to individuals of diverse cultures throughout the State.⁸¹⁰

As discussed above, the potential barriers to using telehealth to discuss voluntary assisted dying are a potential impediment to people living in regional, rural and remote Queensland.⁸¹¹ When introducing the Bill to Parliament the Hon Anastacia Palaszczuk MP, Premier and Minister for Trade, acknowledged the impact not being able to use a carriage service to discuss voluntary assisted dying may have on access to voluntary assisted dying for people in rural and remote areas.⁸¹²

Given the challenges to access, the QLRC recommended that a care navigator service for Queensland be established stating, 'without a well-resourced care navigator service, any voluntary assisted dying scheme in Queensland is unlikely to work as envisaged'.⁸¹³

As such, the Bill provides that the chief executive may approve a service to be an official voluntary assisted dying care navigator service for the Act.⁸¹⁴ The explanatory notes state that 'the service is to provide support, assistance and information to people relating to voluntary assisted dying'.⁸¹⁵

Roles for the care navigator service, as suggested by the QLRC include:

- providing medical practitioners, those wishing to access voluntary assisted dying and the community in general, with wide-ranging information about the process and what is involved;
- giving support and information tailored to the person seeking it;
- providing education to health services and health practitioners;
- helping a person seeking to access voluntary assisted dying to connect with appropriate participating medical practitioners and health services.⁸¹⁶ This is essential if a person's own practitioner is not willing to participate;
- helping a person identify appropriate referral pathways;
- providing holistic advice and follow-up on end of life care services, including palliative care and treatment; and
- helping persons access financial support through the Regional Access Support Scheme.⁸¹⁶

⁸⁰⁸ QLRC Report, paragraph 4.73.

⁸⁰⁹ QLRC Report, paragraph 4.74.

⁸¹⁰ QLRC Report, paragraph 4.75.

⁸¹¹ QLRC Report, paragraphs 2.50-2.51.

⁸¹² Queensland Parliament, Record of Proceedings, 25 May 2021, p 1510.

⁸¹³ QLRC Report, paragraph 21.69.

⁸¹⁴ Voluntary Assisted Dying Bill 2021, cl 156.

⁸¹⁵ Explanatory notes, p 41.

⁸¹⁶ QLRC Report, paragraph 21.71.

Stakeholder views

Stakeholders commented on factors that might limit access to voluntary assisted dying focused on:

- workforce size, location and qualifications
- telehealth
- the need for the scheme to be equitable and cater for the needs of people living with a disability, people from culturally and linguistically backgrounds and Aboriginal and Torres Strait Islander peoples.

Stakeholders argued that for access to voluntary assisted dying to be equitable, it is crucial to have appropriately-trained staff in many locations across Queensland.⁸¹⁷

Submitters considered nursing staff should play a greater role in the voluntary assisted dying scheme than the Bill proposes, to improve access for people in regional, rural and remote Queensland.⁸¹⁸ Dr Heather McNamee, Queensland State Convenor Group of DADC stated:

We cannot restrict health professionals involved in this to doctors. As you all know, there is a chronic shortage of doctors in rural areas, and our nursing colleagues carry a lot of the responsibility that in other countries would be carried by doctors. To limit it to nurse practitioners would be equally restricting because there are a minimum of nurse practitioners present again in remote areas, so it is very important that the legislation also says that registered nurses can take part in this process.⁸¹⁹

The QNMU considered that nurse practitioners could perform the role of a consulting practitioner, as did ALA,⁸²⁰ with the QNMU stating that nurse practitioners are involved in Canada's Medical Assistance in Dying scheme.⁸²¹ The QNMU considered:

Given Queensland covers a large land mass, extending the consulting role to include nurse practitioners would increase accessibility to the scheme for those who live in rural and remote areas.⁸²²

Catherine Smith, a Board Member of the ACNP, proposed that nurse practitioners should be considered to perform the consulting practitioner role, due to:

... possible inequality in access to care, which is a key consideration in all health legislation. Several populations of patients will be quite challenged without nurse practitioner inclusion. These include but are not limited to the homeless population, rural and remote areas, aged-care facilities and patients who do not have a regular GP as their primary healthcare practitioner. Without nurse practitioners involved, some of these groups of patients will be very reliant on state healthcare services.⁸²³

The ACNP also considered nurse practitioners could play a broader role than outlined in the Bill:

Enabling Nurse Practitioners as co-ordinating and consulting practitioner would ensure that many people in remote and rural areas, who may rarely see a medical practitioner, will be able to make a first request, and proceed with the process. Further to this suggestion, there could be a requirement that a Nurse

⁸¹⁷ Public hearing transcript, Brisbane, 16 July 2021, pp 26-27.

⁸¹⁸ For example, see: Ms Faye Tomlinson, public hearing transcript, Rockhampton, 13 July 2021, p 31; Ms Sarah Vallance, State Committee Member, Australian Lawyers Alliance, public hearing transcript, Brisbane, 15 July 2021, p 19; submission 720.

⁸¹⁹ Public hearing transcript, Townsville, 12 July 2021, p 14.

⁸²⁰ Submission 1027, p 10.

⁸²¹ Submission 937, pp 8-9; public hearing transcript, Brisbane, 15 July 2021, p 60.

⁸²² Submission 937, p 9.

⁸²³ Public hearing transcript, Brisbane, 15 July 2021, p 55.

Practitioner only act in one of the consulting or co-ordinating roles, and a medical practitioner in the other.⁸²⁴

Dr Parente highlighted the potential for medical staff who are accredited to provide voluntary assisted dying consultations to become overwhelmed by the demand for their services, which underlined the need for a broad range of staff being able to be involved in the voluntary assisted dying process:

It has been shown that having just a small core of people who are VAD assessors is not going to work. They would also get what is called work stress and become overburdened. Really, to expand on the number of core people who are able to be VAD assessors, whether they be general practitioners, nurse practitioners or consultant specialists, will actually help on both fronts, for the patient and also for the workforce.⁸²⁵

This was a view echoed by Dr Kris Cornell:

I think that is such a strong point. We have people who are burning out in Victoria really quickly because the burden of who can do this training as a specialist is huge, and we do not want to lose people because they are overburdened with this care.⁸²⁶

Some stakeholders considered that people with a disability who were considering accessing voluntary assisted dying should be provided with accessible information, as outlined by QAI:

Ensuring all information regarding voluntary assisted dying, as well as associated disability support services and palliative care information is available to people with a diverse range of communication needs and available in a range of accessible formats and languages.⁸²⁷

It was highlighted in submissions that any voluntary assisted dying scheme should cater to the needs of Aboriginal and Torres Strait Islander Peoples and people from culturally and linguistically diverse backgrounds.⁸²⁸ HCQ stated:

Whether or not they are, as we have heard, living in regional, rural and remote Queensland, whether or not they are First Nations consumers, consumers with a cognitive disability and/or impaired decision-making or those from a culturally and linguistically diverse background, the information and support must be tailored and accessible to them.⁸²⁹

Adjunct Professor Gracelyn Smallwood provided a cultural perspective voluntary assisted dying, stating:

As you all know, my religion and culture have been around for 60,000 years. Our people have a very strict lore. Voluntary assisted dying was dealt with very culturally appropriately. There was no fuss. There were people not saying no or yes, because we had a team of elders and traditional healers and what we call ngangkaris who always dealt with that.⁸³⁰

Similarly, ADA Australia advised:

In addition to the development of policies and guidance materials, training for medical and nurse practitioners must be developed in consultation and with contribution from Aboriginal and Torres Strait Islander Peoples, as well as representatives from culturally and linguistically diverse communities. This is critical to ensure that guidance materials and training programs will equip the recipient with the cultural

⁸²⁴ Submission 1353, p 2.

⁸²⁵ Public hearing transcript, Brisbane, 15 July 2021, pp 24-25.

⁸²⁶ Public hearing transcript, Brisbane, 15 July 2021, p 25.

⁸²⁷ Submission 1242, p 9.

⁸²⁸ For example, see submission 1242, p 9.

⁸²⁹ Public hearing transcript, Brisbane, 14 July 2021, p 12.

⁸³⁰ Public hearing transcript, Townsville, 12 July 2021, p 2.

awareness which they will require to assess whether initiating a discussion about VAD is appropriate, and delivered appropriately, in the context of an individual.⁸³¹

Department response

At the committee's public briefing, the department was asked about equity of access to voluntary assisted dying, given Queensland's size and dispersed population. It stated:

The bill itself is clear on making voluntary assisted dying available for the whole of the Queensland community, and we have to be very mindful of that in terms of how we go about implementing processes that enable that to happen. We have made reference to one of those, which is the carriage services which are going to be important in one way, shape or form moving forward. Largely, the answer to the question is on the implementation side of things as opposed to the bill specifying in detail how we would go about it from an operational sense.⁸³²

In relation to the challenges posed by Commonwealth carriage laws, the department noted the development of the statewide care navigator service:

In other states they have looked at how to increase that equity of access. Western Australia and Victoria have financial schemes that enable practitioners to attend to patients and the reverse—patients who are able to attend to a practitioner. Given Queensland's unique geography and decentralisation, it will obviously be a challenge for us. That being said, we have a lot more metropolitan centres outside of Brisbane where there is access where there could be a hub-and-spoke model. In the bill itself there is the concept of the statewide care navigator service and a statewide pharmacy. They will enable access from a statewide perspective and we will need to look at how that model is developed.⁸³³

Regarding access to voluntary assisted dying for Aboriginal and Torres Strait Islander Peoples, the department stated:

I also acknowledge the traditional owners of our lands across Queensland and let the committee know that, throughout the proceedings that we will go through in terms of discussions and any enactment or implementation, the issue of equity of access in Queensland with our diverse geography and our devolved population will always be front of mind for us. That is never more so an issue than with our First Nations people.⁸³⁴

3.7.1 Committee comment

The committee endorses the principle outlined in the Bill that access to voluntary assisted dying and other end-of-life choices should be available regardless of where a person lives in Queensland and to the whole Queensland community.

The committee encourages the Minister to ensure that there is Aboriginal and Torres Strait Islander representation during the implementation process of the voluntary assisted dying scheme in Queensland.

⁸³¹ Submission 1055, p 2.

⁸³² Professor Keith McNeil, Department of Health, public briefing transcript, Brisbane, 14 June 2021, pp 5-6.

⁸³³ Public briefing transcript, Brisbane, 14 June 2021, p 6.

⁸³⁴ Public briefing transcript, Brisbane, 14 June 2021, p 1.

4 Compliance with the *Legislative Standards Act 1992*

4.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals
- the institution of Parliament.

The committee has examined the application of the fundamental legislative principles to the Bill. The committee brings the following to the attention of the Legislative Assembly.

4.1.1 Rights and liberties of individuals – right to privacy regarding personal information – information sharing and disclosure⁸³⁵

The clauses of the Bill relating to recording steps in a person’s medical record, providing information to the Board, and disclosure of interests by members of the Board raise issues of fundamental legislative principle relating to the rights and liberties of individuals,⁸³⁶ particularly regarding an individual’s right to privacy with respect to their personal information.

4.1.1.1 *Recording steps in a person’s medical record*

The Bill requires medical practitioners and coordinating practitioners to record particular information relating to the voluntary assisted dying process in the person’s medical record. According to the explanatory notes, ‘this is appropriate given the need to ensure the various steps in the voluntary assisted dying process are appropriately documented’.⁸³⁷

The explanatory notes also highlight the safeguard provided for this information through the introduction of an offence provision in clause 146:

An offence provision is included in clause 146 (Personal information not to be recorded or disclosed) requiring a person who obtains personal information in the course of, or because of, the exercise of a function or power under the Act not to make a record of the personal information or disclose the personal information to a person, unless the record is made, or the personal information is disclosed, for a purpose under the Act, with the consent of the person to whom the personal information relates, in compliance with a lawful process requiring production of documents to or giving evidence before a court or tribunal, or as authorised or required by law. This ensures that any personal information obtained by a practitioner when exercising a function under the Act will not be misused. A maximum penalty of 100 penalty units applies.⁸³⁸

4.1.1.2 *Providing information to the Board*

The Bill introduces a number of provisions that require practitioners to record information relating to steps in the voluntary assisted dying process in the approved form and to send a copy of the form to the Board.

The explanatory notes set out why the Board requires the information:

The QLRC [Queensland Law Reform Commission] recommended that an oversight Board be established with functions including monitoring the operation of the Act, reviewing compliance with the Act by relevant individuals involved in a request for voluntary assisted dying, referring any issues identified to

⁸³⁵ *Legislative Standards Act 1992*, s 4(2)(a).

⁸³⁶ See *Legislative Standards Act 1992*, s 4(2)(a).

⁸³⁷ Explanatory notes, p 55.

⁸³⁸ Explanatory notes, p 55. The monetary value of a penalty unit is \$137.85 so a maximum penalty of 100 penalty units would equate to a maximum penalty of \$13,785.

particular entities, recording and keeping information about requests for and provision of voluntary assisted dying, and analysing information given to the Board (Recommendation 18-1). The Board requires information on each completed request for voluntary assisted dying in order to carry out these functions effectively.⁸³⁹

The explanatory notes then provide the following justification:

The record-keeping and reporting provisions are therefore considered justified as they are essential to ensuring the effective operation of the scheme, effective oversight by the Board and appropriate record-keeping by practitioners. Requiring practitioners to record key steps in the voluntary assisted dying process and providing the information to the Board is an important safeguard to ensure all relevant steps in the process are complied with and to enable the Board to retrospectively review compliance with the Act by all individuals involved in the process.⁸⁴⁰

Clause 146 also applies to personal information provided to the Board, providing a safeguard for how an individual's personal information is used and disclosed by making it an offence to record or disclose certain personal information.

4.1.1.3 Disclosure of interests

A member of the Board is required to disclose direct or indirect interests that could conflict with the proper performance of the member's duties in a matter being considered by the Board, or about to be considered, at a meeting. Requiring a member to disclose information to the Board could be seen as breaching their right to privacy.

The explanatory notes provide background as to why the disclosure requirement was included in the Bill:

The QLRC considered that the inclusion of a disclosure requirement was appropriate to ensure a clear obligation of disclosure and clear procedures when a disclosure is made, and that provisions to the same effect are in other Queensland legislation, including the Coroners Act s 91X and *Family and Child Commission Act 2014* (Qld) s 29ZJ ...⁸⁴¹

The explanatory notes offer the following justification for the requirement:

This is justified to ensure that Board members disclose any interest that could conflict with the proper performance of their duties. This will ensure the effective functioning of the Board in monitoring the voluntary assisted dying scheme.⁸⁴²

Again, clause 146 offers a safeguard by making it offence for a person to make a record of, or disclose, personal information obtained through the exercise of a function or power under the Bill.

Committee comment

Given the purpose of the provisions is either to facilitate a person's request to access voluntary assisted dying or to ensure the process is sound, the committee is satisfied that the breach of a person's privacy relating to their personal information is justified in the circumstances.

4.1.2 Rights and liberties of individuals – right to freedom of conscience and belief and right to freedom of expression⁸⁴³

4.1.2.1 Conscientious objection by health practitioners and speech pathologists

By requiring registered health practitioners and speech pathologists who have a conscientious objection to voluntary assisted dying to nevertheless provide certain information to individuals who

⁸³⁹ Explanatory notes, p 56.

⁸⁴⁰ Explanatory notes, p 56.

⁸⁴¹ Explanatory notes, p 58.

⁸⁴² Explanatory notes, p 58.

⁸⁴³ *Legislative Standards Act 1992*, s 4(2)(a).

want to access the scheme may impact on their right to freedom of conscience or belief and their right to freedom of expression (ie their right to say nothing or the right not to say certain things).

The explanatory notes provide the following justification for these provisions:

The QLRC were of the view that the right to make such a conscientious objection should be subject to other principles and other individual rights, including a person's autonomy in end of life choices and the right to be supported in making informed decisions about those choices and considered that the right of an individual, including a health practitioner, to conscientiously object to participating in voluntary assisted dying should be subject to reasonable provisions that respect the rights of other individuals ... Any potential breach of fundamental legislative principles is justified on this basis.⁸⁴⁴

The QLRC Report provides further detail in relation to this issue, stating:

The right of a health practitioner to conscientiously object to participating in voluntary assisted dying is subject to the qualification that the objection should not impede access to care and treatment that is lawful, including voluntary assisted dying.

... The exercise of a right to refuse to participate should not hinder or deprive a person of their right to access a process that is lawful.⁸⁴⁵

The statement of compatibility addresses this issue from a human rights perspective, concluding that:

On one side of the scales, cll 16(4), 84(2) and 85(2) of the Bill require some health practitioners to go against fundamental beliefs they hold about what is right and what is wrong. However, the impacts on their freedom of thought, conscience, belief and religion as well as their freedom of expression are mitigated in a number of ways. First, the Bill contains an extensive right of conscientious objection which allows health practitioners the freedom not to participate in most aspects of voluntary assisted dying. The only aspect they cannot opt out of is the requirement to provide information that would enable access to voluntary assisted dying by another health practitioner.

On the other side of the scales, patients have human rights too, including rights to autonomy, dignity and access to health services without discrimination. They 'should not bear the burden of managing the consequences of physicians' religious objections'.

Ultimately, as the QLRC found, cll 16(4), 84(2) and 85(2) of the Bill represent 'the appropriate balance between a practitioner's right to refuse to do certain things on the grounds of a conscientious objection and the right of a person to access voluntary assisted dying and be informed about it and other lawful end of life options.'⁸⁴⁶

4.1.2.2 Health worker not to initiate discussion about voluntary assisted dying

Preventing a health care worker from discussing voluntary assisted dying with a person they are caring for could impact on the rights and liberties of the worker by restricting their freedom of expression with respect to imparting information and ideas.

Clause 7(2) provides an exception for a medical practitioner or nurse practitioner, which permits the practitioner to inform the person about voluntary assisted dying, if at the same time, the practitioner informs the person about treatment options available to the person and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

Further, a health care worker is not prevented from providing information about voluntary assisted dying where a person requests it.⁸⁴⁷

⁸⁴⁴ Explanatory notes, p 51.

⁸⁴⁵ QLRC Report, paragraphs 14.80-14.81.

⁸⁴⁶ Statement of compatibility, p 22.

⁸⁴⁷ Voluntary Assisted Dying Bill 2021, cl 7(3).

The explanatory notes refer to the QLRC report and note matters including:

- a prohibition on a health practitioner initiating a discussion about voluntary assisted dying could be regarded by some as an extra safeguard against a person being unduly influenced but could also be seen by others as preventing health practitioners from performing their professional duty of telling patients about their end of life options
- the QLRC preferred the current model of allowing a practitioner to inform the person about voluntary assisted dying while at the same time informing the person about other palliative and treatment options and providing information on request, rather than a complete prohibition
- a breach of the prohibition is not an offence under the Act but may be dealt with as unprofessional conduct under the National Health Practitioner Regulation Law or as a health service complaint under the Health Ombudsman Act.⁸⁴⁸

The explanatory notes also provide the following justification:

The qualified prohibition on initiating a discussion about voluntary assisted dying appropriately balances the right of the person to make an informed decision about accessing voluntary assisted dying and the practitioner's ability to do their professional duty with the need to safeguard against undue influence and coercion. Any potential breach of FLPs is justified on this basis.⁸⁴⁹

Committee comment

The committee considers given the justification provided in the explanatory notes and the reasoning provided in the QLRC Report, that on balance, any impact on the rights and liberties of individuals to freedom of conscience and belief and right to freedom of expression, is justified.

4.1.3 Rights and liberties of individuals – proportionality and relevance of penalties (crimes and misdemeanours)⁸⁵⁰

The Bill includes a number of new 'high level' offences in part 9 of the Bill, each designated as a crime or misdemeanour and attracting a maximum penalty involving a term of imprisonment.⁸⁵¹

The creation of new offences and penalties affects the rights and liberties of individuals. Penalties should be consistent and proportionate to the offence.

The Office of the Queensland Parliamentary Counsel (OQPC) elaborated:

In the context of supporting fundamental legislative principles, the desirable attitude should be to maximise the reasonableness, appropriateness and proportionality of the legislative provisions devised to give effect to policy.

... Legislation should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other.⁸⁵²

Non-compliance with the Bill's requirements is relevant when considering matters regarding the professional conduct or performance of a registered health practitioner or a health service provider, including regarding:

- a notification under the Health Practitioner Regulation National Law (Queensland) or
- a complaint under the *Health Ombudsman Act 2013*, or

⁸⁴⁸ Explanatory notes, p 54.

⁸⁴⁹ Explanatory notes, p 55.

⁸⁵⁰ *Legislative Standards Act 1992*, s 4(2)(a).

⁸⁵¹ Voluntary Assisted Dying Bill 2021, cls 140-145.

⁸⁵² OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 120.

- a referred matter under the Health Practitioner Regulation National Law (Queensland).⁸⁵³

4.1.3.1 *Unauthorised administration of voluntary assisted dying substance*⁸⁵⁴

The explanatory notes observe that the QLRC considered whether the maximum penalty for this offence should be life imprisonment, as is the case in Victoria and Western Australia, and concluded that the offence should be distinguished from offences in the Criminal Code that cover the same conduct.⁸⁵⁵ Further, the QLRC stated unauthorised administration of a substance under the scheme would cover a range of potential conduct, with examples including:

- inadvertent breaches, such as where a family member or carer provides some assistance to the person in self-administering the substance
- a person, either knowingly or inadvertently, administering a substance when they are not qualified to do so
- a person knowingly or recklessly acting outside the scheme, for example, where the administering practitioner knows the person has not made or has withdrawn their request or does not have the required decision-making capacity.⁸⁵⁶

The QLRC was of the view that, given the range of possible circumstances in which conduct might fall outside the limits of the scheme, it was desirable to include a separate and specific offence, with a lower maximum penalty.⁸⁵⁷ The QLRC noted that while most serious cases involving unauthorised administration would be dealt with under the Criminal Code (for murder, manslaughter, aiding suicide and the like, and particularly in circumstances where a higher sentence up to life imprisonment may be imposed), the Bill should include additional flexibility for the exercise of prosecutorial discretion whether to prosecute and, if so, for what offence.⁸⁵⁸

The explanatory notes state that the offence is justified:

... as it is a critical safeguard for the scheme, ensuring that administration of a voluntary assisted dying substance occurs only in accordance with an authorisation under the Act. It is fundamental to the scheme that a person must only administer a voluntary assisted dying substance to a person if they are authorised under the Act and all relevant requirements have been complied with.⁸⁵⁹

In relation to the penalty of a maximum 14 years imprisonment, the explanatory notes state:

The QLRC report considered that a maximum penalty of 14 years is appropriate, as it distinguishes the offence from relevant Criminal Code offences, which carry a maximum penalty of life imprisonment, while retaining a high maximum penalty indicative of the seriousness of the conduct ...

Any potential breach of [fundamental legislative principles] is considered justified on this basis.⁸⁶⁰

⁸⁵³ Voluntary Assisted Dying Bill 2021, cl 152.

⁸⁵⁴ Voluntary Assisted Dying Bill 2021, cl 140.

⁸⁵⁵ Explanatory notes, p 30, referencing paragraphs 17.92-17.93 of the QLRC Report.

⁸⁵⁶ QLRC Report, paragraph 17.88.

⁸⁵⁷ QLRC Report, paragraph 17.90.

⁸⁵⁸ QLRC Report, paragraph 17.90.

⁸⁵⁹ Explanatory notes, p 60.

⁸⁶⁰ Explanatory notes, p 60.

4.1.3.2 *Inducing a person to request or revoke a request for voluntary assisted dying and inducing self-administration of voluntary assisted dying substance*⁸⁶¹

In relation to these offences, and the maximum penalties of 7 years imprisonment, the explanatory notes state:

The QLRC report considered that voluntariness is an important feature of the scheme and that the draft Bill should include safeguards to address the risk of potential coercion or exploitation ...

The QLRC report considered that the maximum penalty reflects the seriousness of the conduct in undermining the autonomy and voluntary choice of the person ... Any potential breach of FLPs is considered justified on this basis.⁸⁶²

4.1.3.3 *Giving the Board false or misleading information, making false or misleading statement, falsifying documents*⁸⁶³

The explanatory notes observe that the QLRC recommended the inclusion of offences such as those in clauses 143, 144 and 144 as an important safeguard of the scheme to require requests, assessments and other stages of the process to be documented, and for that documentation to be given to the oversight body. Failing to give the required information, falsifying a document, or otherwise providing false information would undermine the oversight and safe operation of the scheme. The QLRC considered the inclusion of specific offences would serve as a visible disincentive and ensure there is an appropriate mechanism to deal with noncompliance, or take noncompliance into account in disciplinary proceedings, without the needing to prove intent to defraud under the Criminal Code.⁸⁶⁴

As to the maximum penalty of 5 years' jail for each offence:

The QLRC report considered the penalty reflects the seriousness of the conduct in undermining the veracity of the process and the safe operation of the scheme, and noted that the level of imprisonment is consistent with the Victorian Act ...

Any potential breach of FLPs is considered justified on this basis.⁸⁶⁵

Committee comment

The committee considers given the conclusion of the QLRC that the offences are needed to secure key safeguards, that the inclusion of these offences in the Bill is warranted.⁸⁶⁶ It also considers that the penalties are reasonable, proportionate, relevant to the conduct being proscribed and therefore any potential breach of fundamental legislative principle is justified.

⁸⁶¹ Voluntary Assisted Dying Bill 2021, cls 141-142.

⁸⁶² Explanatory notes, p 61.

⁸⁶³ Voluntary Assisted Dying Bill 2021, cls 143-145.

⁸⁶⁴ Explanatory notes, p 61, referencing paragraphs 17.74-17.75 of the QLRC report.

⁸⁶⁵ Explanatory notes, p 62.

⁸⁶⁶ QLRC report, paragraph 17.69.

4.1.4 Rights and liberties of individuals – proportionality and relevance of penalties⁸⁶⁷ (maximum penalty of 100 penalty units⁸⁶⁸)

The Bill includes a number of other offences, each with a maximum penalty of 100 penalty units.⁸⁶⁹ These offences include non-compliance with:

- various provisions requiring the completion and submission to the Board of specified documents
- a general confidentiality provision (clause 146)
- a requirement to give unused voluntary assisted dying substance to an authorised disposer (clause 63).

4.1.4.1 Completion and submission to the Board of documents

The Bill provides that it is an offence not to complete a record of particular steps of the voluntary assisted dying process and provide a copy of the relevant form to the Board within two business days.

4.1.4.2 Confidentiality provision

Clause 146 is a general confidentiality provision. It makes it an offence for a person, who obtains personal information in the course of, or because of, the exercise of a function or power under the Act, to make a record of the information or to disclose it to a person.

There is no offence committed where the record or disclosure is made either:

- for a purpose under the Act
- with the consent of the person to whom the personal information relates
- in compliance with a lawful process requiring production of documents to or giving evidence before a court or tribunal, or
- as otherwise authorised or required by law.

The explanatory notes observe that the offences regarding recording and reporting requirements are justified:

... given the importance of ensuring appropriate record-keeping by practitioners involved in the voluntary assisted dying process to ensure the process was completed in accordance with the Act, and to ensure the Board has access to all appropriate documentation in order to carry out its functions, including reviewing each completed request for voluntary assisted dying and whether or not relevant individuals acted in compliance with the legislation.⁸⁷⁰

In relation to the confidentiality offence in clause 146, the explanatory notes state:

The QLRC report noted that persons involved in the administration of the Act will acquire personal information while performing their functions, which may be of a sensitive nature, and that the protection of privacy requires such information to be protected from unauthorised disclosure ... The QLRC recommended the draft Bill should prohibit disclosure of personal information obtained in the administration of the legislation, noting that the establishment of a new legislative scheme creates new roles and new forms of personal information, and that it is desirable for non-disclosure of that information to be addressed in the same legislation (Recommendation 17-6) ...

⁸⁶⁷ *Legislative Standards Act 1992*, s 4(2)(a).

⁸⁶⁸ Voluntary Assisted Dying Bill 2021, cls 24, 28, 35, 41, 45, 46, 47, 51, 55, 56, 59, 63, 68, 72, 76, 78, 80, 114, 146.

⁸⁶⁹ This amounts to a maximum penalty of \$13,785.

⁸⁷⁰ Explanatory notes, p 62. See also QLRC recommendation 17-2.

Any potential breach of FLPs is considered justified on this basis.⁸⁷¹

This provision, including the level of penalty, is very similar to provisions in a number of Acts.⁸⁷²

4.1.4.3 Contact person to give voluntary assisted dying substance to authorised disposer

Clause 63 requires a contact person to give the voluntary assisted dying substance to an authorised disposer as soon as practicable, and in any event within 14 days of the person revoking their self-administration decision, or of the person's death.

Non-compliance with this requirement carries a maximum penalty of 100 penalty units. Regarding clause 63, the explanatory notes state:

The QLRC recommended the inclusion of an offence for failure by the contact person to give the substance, or any unused or remaining substance, to an authorised disposer (Recommendation 17-4). The QLRC considered this a safeguard in ensuring that access to and provision of a voluntary assisted dying substance is appropriately restricted ...

This penalty is considered justified given the importance of ensuring the safe return of the substance, or any unused or remaining substance to the authorised disposer for disposal. This is a key component of the contact person's role where a self-administration decision has been made, and the contact person is made aware of their obligations when they are appointed. The contact person must be given information by the Board about the requirement to give the substance to an authorised disposer and support services available to them to assist in fulfilling this requirement (clause 60).

Any potential breach of FLPs is considered justified on this basis.⁸⁷³

Committee comment

The committee agrees with the conclusion of the QLRC that specific offences 'are needed to secure key safeguards'.⁸⁷⁴ The committee is satisfied the maximum penalties of 100 penalty units are proportionate and therefore any breach of fundamental legislative principle is justified.

4.1.5 Rights and liberties of individuals – general rights and liberties – ordinary activities should not be unduly restricted⁸⁷⁵

The reasonableness and fairness of treatment of individuals is relevant in deciding whether legislation has sufficient regard to the rights and liberties of individuals.⁸⁷⁶

In order to be appointed or remain a Board member, eligibility criteria must be met. The eligibility criteria to become or remain a Board member may be seen to restrict individuals from becoming a Board member if they are deemed to be ineligible under these criteria.

The explanatory notes advise that the provision is consistent with other Queensland legislation and provide the following justification:

The provision is considered justified given the need to ensure that persons appointed as members of the Board are suitable and reflect the high standards expected of members, noting the importance of the role of the Board in overseeing and monitoring the scheme. These factors are relevant to determining whether it is appropriate for a person to be appointed as a member of the Board.⁸⁷⁷

⁸⁷¹ Explanatory notes, p 63.

⁸⁷² See, for example, s 228 of the *Disability Services Act 2006* and s 272 of the *Health Ombudsman Act 2013*.

⁸⁷³ Explanatory notes, p 63.

⁸⁷⁴ QLRC report, para 17.69.

⁸⁷⁵ *Legislative Standards Act 1992*, s 4(2)(a).

⁸⁷⁶ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 133.

⁸⁷⁷ Explanatory notes, p 59.

Committee comment

The committee is satisfied that excluding a person who does not meet the eligibility criteria to be a member of the board is justified and has sufficient regard to the rights and liberties of individuals, given that there are certain standards and behaviours expected of these members.

4.1.6 Rights and liberties of individuals – general rights and liberties – administrative power⁸⁷⁸

Whether legislation has sufficient regard to rights and liberties of individuals depends on whether, for example, the legislation makes rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review.⁸⁷⁹

Depending on the seriousness of a decision and its consequences, it is generally inappropriate to provide for administrative decision-making in legislation without providing for a review process. If individual rights and liberties are in jeopardy, a merits-based review is the most appropriate type of review.⁸⁸⁰

4.1.6.1 Chief executive's power to grant an individual an exemption to the Australian or Queensland residency requirements

The explanatory notes provide:

This power is considered justified on the basis that it provides the chief executive with the ability to apply the residency requirement flexibly where necessary to avoid adverse outcomes, ensuring that individuals who can prove a substantial connection to Queensland are not excluded from accessing voluntary assisted dying. The limits on this power are clearly defined, with the criteria for considering an exemption set out in the Bill.⁸⁸¹

As stated in the explanatory notes, the ability of the chief executive to grant an individual an exemption to the Australian or Queensland residency requirements is discretionary:

... the QLRC favoured the conferral of a discretionary power to exempt a person from the residency requirement if the decision-maker is satisfied the person has a substantial connection to Queensland and an exemption is justified on compassionate grounds ... The QLRC considered the nature of the power would be best conferred on an official such as the Director-General of Queensland Health or the Director-General's delegate, rather than a review body such as the Board or QCAT⁸⁸²

This means that, whilst the administrative power to grant an exemption may be sufficiently defined, there is no mention in the explanatory notes of a review mechanism. If there is no review available, this may impact on some individuals' ability to access the scheme (for example, if the chief executive refuses to grant them an exemption).

On the other hand, the ability to apply for an exemption to the Australian or Queensland residency requirements in the first place is designed to allow those with a substantial connection to Queensland to have the ability to access the scheme even if they do not meet the technical eligibility requirements.

The statement of compatibility provides some further context:

The citizenship and residency requirements help to ensure that people with an enduring connection to Australia and Queensland – who have a higher claim on the finite resources of the State – have priority in accessing voluntary assisted dying.⁸⁸³

...

⁸⁷⁸ *Legislative Standards Act 1992*, s 4(3)(a).

⁸⁷⁹ *Legislative Standards Act 1992*, s 4(3)(a).

⁸⁸⁰ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 18.

⁸⁸¹ Explanatory notes, p 40.

⁸⁸² Explanatory notes, p 40.

⁸⁸³ Statement of compatibility, p 18.

By including a mechanism for exemptions by the chief executive under cl 12, the citizenship and residency requirements... strike a fair balance between the right to equality and non-discrimination, on the one hand, and the need to prioritise access to voluntary assisted dying by Australian and Queensland residents, on the other hand.⁸⁸⁴

4.1.6.2 Chief executive's power to grant an exemption to interpreters who do not meet the accreditation requirements

The explanatory notes state:

The QLRC report considered that there may be exceptional circumstances where an accredited interpreter is not available, and that providing the chief executive with this exemption power will provide flexibility to accredit a person who speaks emerging or low demand languages for which National Accreditation Authority for Translators (NAATI) certification is not yet available ...

Any potential breach of FLPs is considered justified on this basis, to ensure that interpreters are appropriately accredited wherever possible and that the unavailability of accredited interpreters in a particular case does not preclude the person from accessing voluntary assisted dying where there are exceptional circumstances.⁸⁸⁵

Similarly, while this administrative power may be sufficiently defined, the explanatory notes do not advise whether a decision by the chief executive to refuse to grant an exemption is subject to review.

The purpose of the eligibility requirements is to ensure that interpreters are appropriately qualified and not closely connected with the person requesting access to voluntary assisted dying. The ability to grant an exemption is designed to allow for some flexibility where accredited interpreters are not available and to prevent situations where an individual is precluded from accessing voluntary assisted dying on that basis. This may be particularly relevant to areas of rural and remote areas of Queensland, or for people who speak emerging or low demand languages, where availability of accredited interpreters may not always be available.⁸⁸⁶

Committee comment

The committee notes that while the administrative power provided for these exemptions is not subject to review, the exemptions are designed to allow for some flexibility and provide for access to the scheme in certain circumstances. The committee considers the dependence on administrative power is sufficiently defined and any potential breach of fundamental legislative principle is justified.

4.1.7 Rights and liberties of individuals – natural justice

Whether legislation has sufficient regard to rights and liberties of individuals depends on whether, for example, the legislation is consistent with principles of natural justice.⁸⁸⁷

These principles have been developed by the common law and include the following:

- Nothing should be done to a person that will deprive them of a right, interest, or legitimate expectation of a benefit without the person being given an adequate opportunity to present their case to the decision-maker.
- The decision maker must be unbiased.
- Procedural fairness should be afforded to the person, including fair procedures that are appropriate and adapted to the circumstances of the particular case.⁸⁸⁸

⁸⁸⁴ Statement of compatibility, p 19.

⁸⁸⁵ Explanatory notes, p 42.

⁸⁸⁶ QLRC report, p 622.

⁸⁸⁷ *Legislative Standards Act 1992*, s 4(3)(b).

⁸⁸⁸ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 25.

The Bill provides that the office of a member of the Board becomes vacant if the Minister ends the member's appointment, where the Minister is satisfied that the member is incapable of satisfactorily performing the member's functions.⁸⁸⁹

The office of a member also becomes vacant if the person becomes ineligible by:

- being an insolvent under administration under section 9 of the *Corporations Act 2011* (Cth)
- being convicted of an indictable offence
- being a member of the Legislative Assembly.⁸⁹⁰

There are no review mechanisms provided for in the Bill, in relation to the decision of the Minister or for a member of the Board to present their case when they become ineligible, which could be seen to contain a lack of procedural fairness.

In relation to a member of the Board being incapable of satisfactorily performing their functions, the Bill provides a number of indicators of what would constitute satisfactory performance. Clause 117 sets out the functions of the Board in broad terms and clause 119 requires the Board to act independently and in the public interest. Further, clause 125 provides that for matters not provided for in the Act, a member holds office on the terms and conditions decided by the Minister.

The explanatory notes provide the following justification in relation to a Minister terminating the member's appointment, 'this is considered appropriate given the need to safeguard the integrity of the scheme by ensuring members of the Board are performing their functions effectively'.⁸⁹¹

And, further:

Adequate safeguards are included in the provision, with the Minister only being able to exercise the power to terminate a member's appointment where satisfied that the member is incapable of satisfactorily performing their functions. Members of the Board will be fully aware of their responsibilities, with the functions of the Board clearly set out in clause 117 of the Bill (Functions).⁸⁹²

While the Minister is required to provide a signed notice under clause 127(2), there is no stated requirement to provide reasons for the decision, or a process for the member to set forth their case or a process to review this decision.

In relation to a member becoming ineligible, the explanatory notes provide:

There is a need to ensure members of the Board are held to a high standard given their monitoring and oversight role in the scheme. Under clause 119, the Board is required to act independently and in the public interest in performing its functions. Accordingly, it is appropriate for the office of a member to be vacated if they become ineligible under clause 124(3) based on the criteria outlined above, and for the member not to have the ability to respond. The circumstances in which a member becomes ineligible is clearly defined in clause 124(3), and members will be aware of these requirements.⁸⁹³

The explanatory notes fail to address the lack of opportunity for a member to present their case, be provided with reasons for a decision or to have a review undertaken.

⁸⁸⁹ Voluntary Assisted Dying Bill 2021, cl (1)(b).

⁸⁹⁰ Voluntary Assisted Dying Bill 2021, cl 127(a)(iii).

⁸⁹¹ Explanatory notes, p 47.

⁸⁹² Explanatory notes, p 47.

⁸⁹³ Explanatory notes, p 47.

Committee comment

Given the need to safeguard the integrity of the scheme by ensuring members of the Board are performing their functions effectively, the committee considers there is sufficient justification for any lack of natural justice afforded to members of the Board.

4.1.8 Rights and liberties of individuals – power to enter premises⁸⁹⁴

Whether legislation has sufficient regard to the rights and liberties of the individual depends on whether, for example, it confers power to enter premises and search for or seize documents or other property, only with a warrant issued by a judge or other judicial officer.⁸⁹⁵

An additional concern is the range of additional powers that can become exercisable after entry without a warrant or consent.⁸⁹⁶ Under the Medicines and Poisons Act, once a power of entry is exercised, many other powers flow, including search and seizure powers and provisions for possible forfeiture of property to the State.

Power to enter premises, and search for or seize documents or other property, should generally be permitted only with the occupier's consent or under a warrant issued by a judge or other judicial officer. The OQPC advise:

Fundamental legislative principles are particularly important when powers of inspectors and similar officials are prescribed in legislation because these powers are very likely to interfere directly with the rights and liberties of individuals.⁸⁹⁷

And further:

Residential premises should not be entered except with consent or under a warrant or in the most exceptional circumstances.⁸⁹⁸

Clause 151 of the Bill provides that the functions of an inspector under section 130 of the *Medicines and Poisons Act* include investigating and enforcing compliance with the provisions in the Bill.⁸⁹⁹ Further, for that purpose, an inspector can exercise certain powers conferred by that Act (the 'applied provisions'⁹⁰⁰).⁹⁰¹

For example, an inspector may be required to enter a place to ensure a voluntary assisted dying substance is being stored in accordance with the voluntary assisted dying legislation.⁹⁰²

The explanatory notes for the current Bill make brief reference to the analysis of the relevant issues of fundamental legislative principle in the explanatory notes for the Medicines and Poisons Bill 2019 (the 2019 Bill), noting that those explanatory notes in summary provided that:

⁸⁹⁴ *Legislative Standards Act 1992*, s 4(3)(e).

⁸⁹⁵ *Legislative Standards Act 1992*, s 4(3)(e).

⁸⁹⁶ Alert Digest 2004/5, p 31, paras 30-36; Alert Digest 2004/1, pp 7-8, paras 49-54; Alert Digest 2003/11, pp 20-21, paras 14-19; Alert Digest 2003/9, p 4, para 23 and p 31, paras 21-24; Alert Digest 2003/7, pp 34-35, paras 24-27; cited in OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 45.

⁸⁹⁷ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 45.

⁸⁹⁸ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 46.

⁸⁹⁹ Voluntary Assisted Dying Bill 2021, cl 151.

⁹⁰⁰ Under cl 151(3), these include the following provisions of the Medicines and Poisons Act, s 140(1)(a), (b) and (c) and (3) to (6); chapter 5, part 3, division 2; and chapter 5, part 3, division 4 and part 4.

⁹⁰¹ The relevant provisions of the Medicines and Poisons Act have not yet commenced as automatic commencement under the *Acts Interpretation Act 1954* was postponed to 27 September 2021.

⁹⁰² Explanatory notes, p 48.

- generally, the inspectors' powers were consistent with the principles set out in OQPC's FLP Notebook and were considered necessary to support the effective and transparent exercise of inspectors' powers for monitoring, compliance and enforcement of the Medicines and Poisons Act;
- a range of safeguards were included in the provisions.⁹⁰³

In summary, the effect of clause 151 is to import into the Bill powers of entry, and a wide range of consequential powers, including powers of search and seizure and potential forfeiture of property, not all of which powers are dependent on consent or warrant.

In relation to these provisions in the 2019 Bill, the relevant committee noted:⁹⁰⁴

The explanatory notes see the various powers as supporting an inspector's ability to undertake monitoring and compliance activities. They give this justification for the power to make a help requirement:

This power is justified as it enables the inspector to carry out their duties. Appropriate safeguards have been included, as the inspector must give the person an offence warning for the help requirement ... and a person may have a reasonable excuse for not complying. It is a reasonable excuse not to comply with a help requirement if complying might tend to incriminate the individual or expose them to a penalty. However, the reasonable excuse does not apply if a document or information that is the subject of the help requirement is required to be held or kept by the person under the Act.⁹⁰⁵

The explanatory notes give this justification for the power to seize evidence or property:

These powers are necessary to ensure enforcement of the scheme noting that these types of powers improve public health and safety by, for example, halting dangerous processes, securing dangerous substances, or ensuring evidence is not lost so that prosecutions may be undertaken. For example, if a retailer was selling a sports supplement containing a regulated substance that is harmful to human health, and the inspector was not able to seize the product, the retailer could continue to sell the product, exposing the public to health risks, or death, caused by the substance.⁹⁰⁶

The committee in its report also commented on the threshold of a 'reasonable suspicion' of an inspector in sections 161 and 162 of the Medicines and Poisons Act, quoting the explanatory notes:

It is considered that the threshold of a 'reasonable suspicion' under the Bill is justified because it may be critical for public health and safety to seize evidence of an offence against the Act.

... Although the reasonable belief threshold requires a basis in fact, a threshold of reasonable suspicion allows an inspector to suspect the thing is evidence on the grounds that are reasonable in the circumstances and that would also seem reasonable to others. This would enable an inspector to form a reasonable suspicion based on a range of factors.⁹⁰⁷

In reporting on the 2019 Bill, that committee said overall:

The justifications in the explanatory notes for [these powers] ... can be summed up as regarding the powers as necessary for inspectors to be able to 'effectively undertake enforcement of the scheme'.

...

⁹⁰³ Explanatory notes, p 48.

⁹⁰⁴ State Development, Natural Resources and Agricultural Industry Development Committee, *Medicines and Poisons Bill 2019*, Report No. 32, 56th Parliament July 2019, p 52.

⁹⁰⁵ Medicine and Poisons Bill 2019, explanatory notes, p 42.

⁹⁰⁶ Medicine and Poisons Bill 2019, explanatory notes, p 42.

⁹⁰⁷ Medicine and Poisons Bill 2019, explanatory notes, p 43. See State Development, Natural Resources and Agricultural Industry Development Committee, *Medicines and Poisons Bill 2019*, Report No. 32, 56th Parliament July 2019, p 53.

The Bill provides for powers of entry, and a wide range of consequential powers, including powers of search and seizure and potential forfeiture of property, which are not subject to consent or warrant.

The committee is concerned in regard to the reduced threshold of a 'reasonable suspicion'.

However, the committee considers these powers (and the breach of fundamental legislative through the infringements on the rights and liberties of individuals that are involved) are justified in the effectively undertake enforcement of the scheme.⁹⁰⁸

Committee comment

The Bill provides for powers of entry, and a wide range of consequential powers, including powers of search and seizure and potential forfeiture of property, which are not subject to consent or warrant.

However, the committee considers these powers (and the breach of fundamental legislative through the infringements on the rights and liberties of individuals that are involved) are justified to effectively undertake enforcement of the scheme.

4.1.9 Rights and liberties of individuals – immunity from proceedings⁹⁰⁹

Whether legislation has sufficient regard to rights and liberties of individuals depends on whether, for example, the legislation does not confer immunity from proceeding or prosecution without adequate justification.⁹¹⁰

One of the fundamental principles of law is that everyone is equal before the law, and each person should therefore be fully liable for their acts or omissions. Notwithstanding that, the conferral of immunity is appropriate in certain situations:⁹¹¹

A person who commits a wrong when acting without authority should not be granted immunity. Generally a provision attempting to protect an entity from liability should not extend to liability for dishonesty or negligence. The entity should remain liable for damage caused by the dishonesty or negligence of itself, its officers and employees. The preferred provision provides immunity for action done honestly and without negligence ... and if liability is removed it is usually shifted to the State.⁹¹²

A number of the Bill's provisions contain protections from criminal and civil liability. The immunity conferred by these clauses depends on the presence of good faith (and, for clause 148, an absence of negligence).⁹¹³

Each of these clauses expressly declares that a person who does an act or makes an omission mentioned in the clause does not commit an offence against sections 300, 302, 303, 305, 306, 307, 309, 310 or 311 of the Criminal Code. These sections of the Criminal Code relate to offences of murder, manslaughter, and aiding suicide.

The clauses provide that if a question arises in a proceeding as to whether the Bill prevents liability attaching to a person, the party alleging that the Bill does not prevent liability attaching to the person bears the onus of proving the person did not do the act or make the omission in good faith (and for clause 148, without negligence) in the circumstances set out in the provisions.

⁹⁰⁸ State Development, Natural Resources and Agricultural Industry Development Committee, *Medicines and Poisons Bill 2019*, Report No. 32, 56th Parliament July 2019, p 53.

⁹⁰⁹ *Legislative Standards Act 1992*, s 4(3)(h).

⁹¹⁰ *Legislative Standards Act 1992*, s 4(3)(h).

⁹¹¹ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 64; Scrutiny of Legislation Committee, *Alert Digest 1 of 1998*, p 5, para 1.25.

⁹¹² OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 64.

⁹¹³ Voluntary Assisted Dying Bill 2021, cl 147-149.

The explanatory notes state by way of background, the purpose of, and rationale behind, these provisions:

These protections from liability reflect the recommendations of the QLRC (Recommendations 17-7 - 17-10, 18-2). The QLRC report considered that protections from liability should be included in the legislation to provide clarity and certainty for those who may act under, or interact with, the legislation, and should ensure adequate protection in appropriate circumstances, while recognising that there should continue to be consequences for inappropriate conduct outside the limits of the scheme ... The QLRC noted that the operation of, and access to, the scheme will depend on the involvement of a range of persons, including medical and other health practitioners, and that participants should be confident they will not be exposed to criminal sanctions or civil liability if they act appropriately under the legislation ...

The QLRC considered that the protection from civil and criminal liability should extend to any person who acts in good faith and without negligence under the legislation, including the contact person or an agent of the person authorised by the legislation to perform certain actions, or a witness ... The QLRC noted that this protection will provide comfort to health practitioners and other persons who participate in the process ...⁹¹⁴

As set out in the explanatory notes, the protections provided are limited to actions (or omissions) which are in accordance with the scheme established by the proposed Act:

The protections from liability put beyond doubt that if someone is acting in accordance with the scheme, they do not commit an offence. If a person acts other than as authorised under the scheme, for example, to unlawfully administer a voluntary assisted dying substance to a person, they will be subject to the offence provisions of the Bill.

Protection from liability is only provided to persons performing functions under the Bill and people who believe on reasonable grounds that the person is accessing voluntary assisted dying in accordance with the Act. The immunity is appropriately limited in scope, as it does not attach to acts done or omissions made that are reckless, unreasonable or excessive (and for clause 148, where there is negligence).⁹¹⁵

Committee comment

Given the limited scope of the immunity and that it does not attach to acts done or omissions made that are reckless, unreasonable or excessive and for clause 148 where there is negligence, the committee considers the grants of immunity are justified by the policy intents of the scheme.

4.1.10 Rights and liberties of individuals – immunity from proceedings⁹¹⁶

Other immunity provisions in the Bill, with a focus different from those clauses considered immediately above, include clauses 139 and 153.

The Bill allows the Board to consult with, and request information from, other entities to help in performing its functions.⁹¹⁷

Clause 139 provides that a person acting honestly who gives information to the Board under clause 138 is not liable civilly, criminally or under an administrative process for giving the information. Further, such a person:

- cannot be held to have breached any code of professional etiquette or ethics, or departed from accepted standards of professional conduct, merely because they gave the information to the Board

⁹¹⁴ Explanatory notes, p 49.

⁹¹⁵ Explanatory notes, pp 49-50.

⁹¹⁶ *Legislative Standards Act 1992*, s 4(3)(h).

⁹¹⁷ Voluntary Assisted Dying Bill 2021, cl 138.

- in any proceeding for defamation, will have a defence of absolute privilege for publishing the information
- if otherwise required to maintain confidentiality about the information (under the Act, oath or rule of law or practice), does not contravene the Act, oath or rule of law or practice by giving the information, and is not liable to disciplinary action for giving the information.

Clause 153 provides protection from civil liability for the members of the Board, and persons engaged to assist the Board in the performance of the Board's functions, for an act done, or omission made, honestly and without negligence. Where this provision prevents liability attaching to a person, liability instead attaches to the state.⁹¹⁸

In relation to clause 139, the explanatory notes state briefly, 'this protection from liability is considered justified as the protection is conferred on individuals acting in accordance with the Act'.⁹¹⁹

As observed in the explanatory notes, there are similar provisions in other Queensland legislation.⁹²⁰

Where a person is not acting honestly in giving information to the Board, the protection from liability conferred by clause 139 is not available.

In relation to clause 153, the explanatory notes state:

The QLRC report states that this [clause] will help support the effective operation of the oversight body ...

The conferral of immunity on these persons is justified noting the former Scrutiny of Legislation Committee's recognition that conferral of immunity is appropriate in certain situations, such as to persons carrying out statutory functions. Any potential breach of FLPs is justified on this basis.⁹²¹

Immunity clauses along the lines of clause 153 are quite common in legislation. They generally serve to allow public servants, officials, statutory officers and the like to make decisions and exercise powers and functions without being unduly concerned that they may be held personally liable for acts done or omissions made in the course of carrying out their duties or functions under legislation, providing that those actions or omissions are made honestly and without negligence or malice.

In clause 153, the shifting of liability to the state for actions or omissions of a member of the Board or a person engaged to assist in the performance of the Board's functions means aggrieved persons are able to make a claim against the state for loss or damage suffered as a result of actions taken by officials under the Act.

A similar clause was included in the Hospital Foundations Bill 2018 and the Personalised Transport Ombudsman 2019 Bill. In each instance, the committee reporting on the Bill was satisfied that any breach of fundamental legislative principle was justified. In considering a similar clause in the Queensland Veterans' Council Bill 2021, the Community Support and Services Committee concluded that a virtually identical clause had sufficient regard to the rights and liberties of individuals.⁹²²

⁹¹⁸ Voluntary Assisted Dying Bill 2021, cl 153(2).

⁹¹⁹ Explanatory notes, p 57.

⁹²⁰ See for example, HRA, s 99; the *Hospital and Health Boards Act 2011*, s 89; the *Family and Child Commission Act 2014*, s 29T; and the *Coroners Act 2003*, s 91ZF.

⁹²¹ Explanatory notes, p 50.

⁹²² Community Support and Services Committee, *Queensland Veterans' Council Bill 2021*, Report No. 6, 57th Parliament, June 2021, p 36.

Committee comment

In terms of the immunity conferred by clause 139, given it is conferred only on individuals acting in accordance with the Act, the committee is satisfied the breach of fundamental legislative principle is justified.

As the liability is shifted to the state, the committee is satisfied the breach of fundamental legislative principle involved in the immunity conferred by clause 153 is justified.

4.1.11 Institution of Parliament – delegation of legislative power⁹²³

The use of regulations, rather than Acts of Parliament, to deal with these matters raises the fundamental legislative principle of the appropriateness of a delegation of legislative power.

Whether a Bill has sufficient regard to the institution of parliament depends on whether the Bill, for example, allows the delegation of legislative power only in appropriate cases and to appropriate persons.⁹²⁴

For Parliament to confer on someone other than Parliament the power to legislate as the delegate of Parliament, without a mechanism being in place to monitor the use of the power, raises obvious issues about the safe and satisfactory nature of the delegation.⁹²⁵

Generally, the greater the level of political interference with individual rights and liberties, or the institution of parliament, the greater the likelihood that the power should be prescribed in an Act of Parliament and not delegated below parliament.

Clause 167 contains a general regulation-making power, providing that the Governor in Council may make regulations under the Act. It also provides that a regulation may prescribe a matter that must be included in an approved form under the Act.⁹²⁶

The explanatory notes provide the following justification:

The QLRC recommended that the draft Bill provide that the Governor in Council may make regulations under the Act (Recommendation 19-3). This is appropriate for aspects of the scheme that are technical and detailed in nature, including specific requirements relating to management of the voluntary assisted dying substance.⁹²⁷

There is also provision for regulations to set out requirements relating to the functions of the Board. Clause 117(1)(d) provides that the Board is to record and keep information prescribed by regulation about requests for, and provision of, voluntary assisted dying.

The explanatory notes state:

The QLRC report considered that it would be appropriate for regulations to specify particular information to be collected, noting that mandating specific information in the draft Bill might have unintended practical implications for the Board and participating health practitioners, and by extension, the persons requesting access to voluntary assisted dying ... The QLRC report noted that providing for the Board to record and keep information prescribed by regulation would give scope for further consideration during

⁹²³ *Legislative Standards Act 1992*, s 4(4)(a).

⁹²⁴ *Legislative Standards Act 1992*, s 4(4)(a).

⁹²⁵ OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 154.

⁹²⁶ The Bill includes many references to 'approved forms'. For example, cl 45 states that the coordinating medical practitioner must complete a record of receiving the final request in the approved form and provide a copy to the Board. Clause 76 requires an authorised disposer who disposes of a voluntary assisted dying substance or unused or remaining substance to complete a record of the disposal in the approved form and give a copy to the Board.

⁹²⁷ Explanatory notes, p 65.

implementation of the legislation of the information that should be prescribed and greater flexibility to make subsequent changes ...⁹²⁸

Clause 55 provides that if an administering practitioner for a person administers a voluntary assisted dying substance to them, they must certify a number of matters in writing. The clause provides that additional matters to be certified in writing may be prescribed by regulation.

The explanatory notes set out the following justification, 'this provides Queensland Health with the flexibility to require the administering practitioner to certify matters additional to those set out in the clause, adding an additional safeguard to the process'.⁹²⁹

A number of other clauses provide that specific matters relating to management of the voluntary assisted dying substance may be prescribed under regulation, including requirements for:

- prescribing a voluntary assisted dying substance (clause 67)
- labelling a voluntary assisted dying substance container (clause 71)
- supplying a voluntary assisted dying substance (clause 73)
- storage of a voluntary assisted dying substance (clause 74)
- disposal of a voluntary assisted dying substance (clause 79).

The explanatory notes do not address each of these latter instances individually, but rather provide the following general statement to justify the use of regulations:

These provisions are considered to have sufficient regard to the institution of Parliament because:

- the matters to be prescribed are consistent with the policy objectives and purpose of the authorising law;
- the matters to be prescribed are technical and clinical in nature;
- this approach will allow the Government to respond promptly and flexibly if changes are needed to the framework in future, ensuring the scheme can be managed appropriately. Some flexibility for Queensland Health to be able to update requirements relating to technical, clinical matters, such as labelling of a container the voluntary assisted dying substance is kept in, is considered appropriate; and
- any changes to regulations will be tabled in the Legislative Assembly and subject to parliamentary scrutiny and disallowance.⁹³⁰

Committee comment

The committee is satisfied the circumstances in which the Bill allows the delegation of legislative power is appropriate and considers that these clauses of the Bill have sufficient regard for the institution of Parliament.

4.1.12 Institution of Parliament – scrutiny of the Legislative Assembly⁹³¹

The Bill contains references to Schedule 4 and Schedule 8 substances,⁹³² which are defined in the dictionary at schedule 1 by reference to schedules in the 'Poisons Standard'. In turn, the dictionary in schedule 1 defines the Poisons Standard as meaning the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cth).

⁹²⁸ Explanatory notes, p 66.

⁹²⁹ Explanatory notes, p 66.

⁹³⁰ Explanatory notes, p 66.

⁹³¹ *Legislative Standards Act 1992*, s 4(4)(b).

⁹³² Voluntary Assisted Dying Bill 2021, cls 65, 70, 160.

In this respect, the Bill is incorporating reference to an external document, the content of which can change from time to time and is set by an external entity, and over which the Queensland Parliament has no authority.

The significance of dealing with such matters other than by subordinate legislation is that, since the relevant document is not 'subordinate legislation', it is not subject to the tabling and disallowance provisions in the *Statutory Instruments Act 1992*.

Where there is incorporated into the legislative framework of the State, an extrinsic document that is not reproduced in full in subordinate legislation, and where changes to that document can be made without the content of those changes coming to the attention of the Legislative Assembly, it may be argued that the document (and the process by which it is incorporated into the legislative framework) has insufficient regard to the institution of Parliament.

In considering whether it is appropriate for matters to be dealt with by an instrument that was not subordinate legislation, and therefore not subject to parliamentary scrutiny, committees have considered factors including the importance of the subject dealt with, the commercial or technical nature of the subject matter, and the practicality or otherwise of including those matters entirely in legislation.⁹³³

The explanatory notes, in relation to the use of the Poisons Standard, state:

It is necessary to refer to the Poisons Standard in defining the substances used under the scheme. The Poisons Standard is a Commonwealth legislative instrument that classifies medicines and poisons into 'schedules' of substances from 'Schedule 2' through to 'Schedule 10'. A substance is categorised into a schedule based on the level of regulatory control required to deal with the public health and safety risks of the substance. As a legislative instrument, the Poisons Standard is published on the Federal Register of Legislation (<https://www.legislation.gov.au/>). The Poisons Standard is regularly reviewed, and updated approximately three times a year following extensive committee meetings and decision-making processes regarding classification, which are outlined in more detail below.

The purpose of the Poisons Standard is to provide a means by which nationally uniform scheduling of substances can occur, which can be applied in the legislation of all Australian jurisdictions, usually by referral in each jurisdiction's medicines and poisons legislation.⁹³⁴

And, further:

The QLRC recommended that voluntary assisted dying substance should be defined to mean a Schedule 4 or Schedule 8 substance, or a combination of those substances, as defined in the Poisons Standard, approved by the chief executive for use under the Act for the purpose of causing a person's death (Recommendation 11-1). The QLRC considered that the particular substances used for voluntary assisted dying should not be limited or prescribed by the Bill ... This is consistent with the approach taken in other jurisdictions and is also in keeping with the recommendation of the Parliamentary Committee (Committee report, Recommendation 11). It is therefore considered justified to refer to an external document in defining voluntary assisted dying substance, as it is not appropriate to specify the particular substances to be used.⁹³⁵

Committee comment

The committee agrees with the QLRC that the particular substances used for voluntary assisted dying should not be limited or prescribed by the Bill. As such the committee is satisfied that the references to the Poisons Standard in the Bill are justified, and that in this respect the Bill has sufficient regard to the institution of Parliament.

⁹³³ See the OQPC, *Fundamental Legislative Principles: the OQPC Notebook*, pp 155-156, and Scrutiny of Legislation Committee, *Alert Digest 1999/04*, p.10, paras 1.65-1.67.

⁹³⁴ Explanatory notes, p 64.

⁹³⁵ Explanatory notes, p 64.

4.2 Explanatory notes

Part 4 of the LSA requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

Explanatory notes were tabled with the introduction of the Bill.

The notes are fairly detailed and contain the information required by Part 4 and a sufficient level of background information and commentary to facilitate understanding of the Bill's aims and origins. However, the explanatory notes would have been more useful in the context of fundamental legislative principles if they had included:

- A proper treatment of issues arising from the power of entry of inspectors, especially noting the extensive ancillary powers involved. The explanatory notes, in merely making a cross reference to the consideration of these issues in the explanatory notes to the 2019 bill, fail to consider the issues in the context of the present Bill; in particular, there is no attention paid to the need to place the justification of the breaches of rights and liberties involved in the context of the current Bill and its purposes.
- Specific justification for breaches of fundamental legislative principles. On many occasions, there is an over-reliance on simply repeating or referencing comments made by the QLRC and then proceeding, without more, to conclude that any breach of fundamental legislative principle is justified on that basis.

In addition, the explanatory notes characterise the regulation-making powers in the Bill as matters raising issues regarding section 4(4)(c) of the LSA – whether legislation authorises the amendment of an Act only by another Act (Henry VIII clauses).⁹³⁶ The better view is that these matters involve a consideration of section 4(4)(a) of the LSA – appropriateness of a delegation of legislative power.

The explanatory notes consider the rights of entities (ie those (not individuals) who provide a health service, residential aged care or a personal service) in the context of fundamental legislative principles – this treatment does not recognise that fundamental legislative principles require that legislation has sufficient regard to the rights and liberties of *individuals*.

⁹³⁶ See explanatory notes, pp 65-66.

5 Compliance with the *Human Rights Act 2019*

The portfolio committee responsible for examining a Bill must consider and report to the Legislative Assembly about whether the Bill is not compatible with human rights, and consider and report to the Legislative Assembly about the statement of compatibility tabled for the Bill.⁹³⁷

A Bill is compatible with human rights if the Bill:

- does not limit a human right, or
- limits a human right only to the extent that is reasonable and demonstrably justifiable in accordance with section 13 of the HRA.⁹³⁸

The HRA protects fundamental human rights drawn from international human rights law.⁹³⁹ Section 13 of the HRA provides that a human right may be subject under law only to reasonable limits that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom.

The committee has examined the Bill for human rights compatibility. The committee brings the following to the attention of the Legislative Assembly.

The voluntary assisted dying scheme proposed in the Bill is not designed to bestow on Queenslanders a right to die in the way they choose. It is limited to authorising certain health professionals to receive, assess and act on requests to provide lethal medication to patients who are terminally ill and meet other strict criteria including that relate to decision-making capacity. It is a scheme that is intentionally designed to limit access to assisted dying to those who are diagnosed with an illness or disease that will lead to their death within 12 months and to preserve the primary duty of health practitioners to provide professional medical advice in the best interests of their patients.

These key features of the Bill have been considered when examining the rights involved in individual clauses to avoid any human rights compatibility being skewed or inappropriately assumed to correspond to similar but distinct voluntary assisted dying schemes in overseas jurisdictions.

5.1 Human rights compatibility

5.1.1 The right to life and the right not to be arbitrarily deprived of life

Under existing Queensland law, it is a criminal offence to aid another person to commit suicide.⁹⁴⁰ Clause 8 and Part 10 of the Bill modify this law by creating an exception for voluntary assisted dying which is carried out in accordance with the framework of the Bill.

The statement of compatibility with human rights explains that clause 8 and part 10 of the Bill engage the right not to be arbitrarily deprived of life protected under section 16 of the HRA.

5.1.1.1 *Nature of the human right*

Section 16 of the HRA protects the right to life and the right not to be arbitrarily deprived of life. The inclusion of the word 'arbitrary' is important: it means that not every action that results in death will be a breach of this provision. This right is based on Article 6(1) of the International Covenant on Civil

⁹³⁷ *Human Rights Act 2019*, s 39.

⁹³⁸ *Human Rights Act 2019*, s 8.

⁹³⁹ The human rights protected by the HRA are set out in ss 15 to 37 of the Act. A right or freedom not included in the Act that arises or is recognised under another law must not be taken to be abrogated or limited only because the right or freedom is not included in this Act or is only partly included; HRA, s 12.

⁹⁴⁰ *Criminal Code Act 1899*, s 311.

and Political Rights.⁹⁴¹ As noted by the QHRC, this right imposes both positive and negative duties on public entities.⁹⁴²

At international law, the right to life has non-derogable status which means that it cannot be suspended, even in emergency situations. Under the HRA, the right to life can be limited in accordance with section 13 (ie where it is reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom). However, as the QHRC notes, because of the nature of this right and because it cannot be limited under international law, it is difficult to see circumstances where this right would be limited in Queensland.⁹⁴³

At international law, the right to life has also been described as a ‘supreme human right’, without which ‘all other rights would be devoid of meaning’.⁹⁴⁴ However, the word ‘arbitrary’ plays an important role in understanding the practical application and scope of this right.⁹⁴⁵ For example, it is the reference to the arbitrary deprivation of life that has provided scope for the UN Human Rights Committee to suggest that laws allowing for voluntary assisted dying are not necessarily incompatible with states’ obligation to protect the right to life.⁹⁴⁶ As Manfred Novak concluded:

If a national legislature limits criminal responsibility here after carefully weighing all the affected rights and takes adequate precautions against potential abuse, this is within the scope of the legislature’s discretion in carrying out its duty to ensure the right...the State’s obligation to ensure does not go so far as to require that life and health be protected against the express wishes of those affected.⁹⁴⁷

Australian common law also recognises the right of a competent adult to refuse medical treatment even where that refusal will lead to death, and provided the refusal is informed and voluntarily made, medical practitioners acting in accordance with this refusal will avoid liability.⁹⁴⁸

In the NZ case of *Seales v Attorney-General*, Justice Collins described the right to life as a most basic human right, but noted that it is not absolute and does not oblige the state to ‘require all human life be preserved in all circumstances’.⁹⁴⁹ This decision built on the findings made in *Auckland Area Health Board v Attorney-General*⁹⁵⁰ where Justice Thomas observed that the right to life co-exists with the

⁹⁴¹ United Nations General Assembly, *International Covenant on Civil and Political Rights*, Adopted and opened for signature, 16 December 1966, entry into force 23 March 1976, Article 6(1).

⁹⁴² QHRC, ‘Fact Sheet on Right to Life’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-life>.

⁹⁴³ QHRC, ‘Fact Sheet on Right to Life’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-life>.

⁹⁴⁴ Manfred Nowak, ‘UN Covenant on Civil and Political Rights: CCPR Commentary’, *NP Engel*, 2nd rev. ed, 2005, p 121.

⁹⁴⁵ George Zdenkowski, ‘Human Rights and Euthanasia’, *Occasional Paper of the Human Rights and Equal Opportunity Commission* (1996), p 11, <https://www.humanrights.gov.au/our-work/rights-and-freedoms/projects/human-rights-and-euthanasia>.

⁹⁴⁶ See UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations Of The Human Rights Committee – Netherlands, Human Rights Committee, 72 sess, UN Doc CCPR/CO/72/NET, 27 August 2001.

⁹⁴⁷ Manfred Nowak, ‘UN Covenant on Civil and Political Rights: CCPR Commentary’, *NP Engel*, 2nd rev. ed, 2005, p 155; *Hunter and the New England Area Health Authority v A* (2009) 74 NSWLR 88, [40]; *Brightwater Care Group v Rossiter* (2009) WASC 229, [32].

⁹⁴⁸ Parliament of Australia, ‘Euthanasia - the Australian Law in an International Context’, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/RP9697/97rp3.

⁹⁴⁹ [2015] NZHC 828, [89]-[99].

⁹⁵⁰ Human Rights Commission of New Zealand, Submission to Health Select Committee, *Investigation into end of life matters*, 26 January 2016.

values of human dignity and privacy, and therefore can be consistent with legal rules that permit withdrawal or refusal of medical treatment.

Under the Queensland HRA the right to life contained in section 16 does not specifically refer to concepts of personal autonomy, self-determination and dignity however these concepts feature in the preamble to the HRA which refers to the 'inherent dignity and worth of all human beings'. This makes the Queensland 'version' of the right to life slightly different in character to that contained within other human rights regimes (such as the Canadian human rights framework) but at the same time underscores the relevance of judicial observations from other jurisdictions about the relationship between the right to life, dignity and autonomy. As discussed further below, this becomes important when thinking about the extent to which the right to life as protected under section 16 of the HRA can co-exist with a voluntary assisted dying scheme.

In order to fall within the legitimate space between actively protecting the right to life and not requiring that life and health be protected against the express wishes of those affected, the UN Human Rights Committee has emphasised that laws relating to the withdrawal of medical treatment and voluntary assisted dying must provide effective procedural safeguards against abuse.⁹⁵¹ A similar position has been adopted by the European Court of Human Rights, observing that the right to life protected in Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms does not preclude member states from legalising voluntary assisted dying, provided adequate safeguards are put in place and adhered to.⁹⁵² This was confirmed in the case of *Hass v Switzerland* where the European Court of Human Rights found that in order for a legislative scheme that authorises assisted dying to comply with Article 2 (right to life) it must include a 'procedure capable of ensuring that a decision to end one's life does indeed correspond to the free will of the individual concerned'.⁹⁵³

In the case of *Lambert and Others v France*, the European Court of Human Rights considered the lawfulness of a decision to withdraw artificial nutrition and hydration with respect to a victim of a serious road-traffic accident who had suffered permanent brain damage. The Court held that the decision to withdraw treatment did not abrogate the right to life protected in Article 2 of the European Convention,⁹⁵⁴ particularly when regard was had to Article 8 the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses.⁹⁵⁵ Emphasis was placed on the paramount importance of the patient's wishes in the decision-making process, however those wishes are expressed.⁹⁵⁶

https://www.hrc.co.nz/files/6614/5464/6095/Submission_to_the_Health_Select_Committee_in_Relation_to_its_Investigation_into_end_of_life_matters.pdf.

⁹⁵¹ See eg UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations Of The Human Rights Committee – Netherlands, Human Rights Committee, 72nd sess, UN Doc CCPR/CO/72/NET, 27 August 2001, para 5(a). UN Human Rights Committee, General Comment No. 36: Article 6 (Right to Life), 124th sess, UN Doc CCPR/C/GC/36, 3 September 2019, 1 [2].

⁹⁵² *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [39].

⁹⁵³ *Haas v Switzerland* (European Court of Human Rights, Chamber, Application No 31322/07, 20 January 2011) [58].

⁹⁵⁴ *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [121] and [124].

⁹⁵⁵ *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [142].

⁹⁵⁶ *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [147].

The European cases have not, however, gone so far as to suggest that the right to life extends to a ‘right to die’ or a right to enlist the aid of another to bring about death.⁹⁵⁷ Instead, the focus in those jurisdictions that are governed by human rights protections similar to the HRA has been on preserving the right to self-determination and private life, and the right to exercise personal autonomy in end of life decisions. This has created space for consideration of legislative schemes that authorise voluntary assisted dying, provided such schemes contain robust procedural safeguards to ensure voluntary and informed decision making at each relevant stage of the process.

This relationship between the right to life and the notion of personal autonomy has also characterised judicial findings in other jurisdictions with human rights guarantees with respect to voluntary assisted dying legislation. For example, in *Carter v Canada* the Supreme Court of Canada unanimously held:

[T]he case law suggests that the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly... This said, we do not agree that the existential formulation of the right to life requires an absolute prohibition on assistance in dying, or that individuals cannot ‘waive’ their right to life. This would create a ‘duty to live’, rather than a ‘right to life’, and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment.⁹⁵⁸

The Supreme Court of Canada also held that voluntary assisted dying may promote the right to life, because a ‘prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable’.⁹⁵⁹

These observations were referred to by the Victorian Scrutiny of Acts and Regulations Committee (SARC) when considering the rights compatibility of the Voluntary Assisted Dying Bill 2017 (Vic).⁹⁶⁰ The SARC observed that a deprivation of life by assisted dying may be ‘arbitrary’ if the person’s consent to voluntary assisted dying is the result of outside pressure, irrationality or depression.⁹⁶¹ The SARC also referred to the US decision of *Lee v Oregon*,⁹⁶² where the Court emphasised the need for legislative schemes relating to voluntary assisted dying to include features such as:

- adequate opportunity for reflection to avoid acting on requests that ‘represent a plea for help by a distraught person in physical and emotional pain’
- independently chosen consulting physician to confirm that a person is capable and acting voluntarily
- independent assessments by qualified health practitioners as to whether a condition is causing impaired judgment, if a patient is depressed, or suffering from a psychiatric or psychological disorder
- restrictions on the use of lethal medication to ensure supervision by an appropriate physician.⁹⁶³

The SARC found that, unlike the law being considered by the Court in *Lee v Oregon*, the proposed Victorian legislation contained provisions that corresponded directly to these key features and safeguards. These features are also present in the Bill (as discussed in further detail below).

⁹⁵⁷ See *Pretty v United Kingdom* (2002) 35 EHRR 1, 37 [64]; *R (Purdy) v DPP* [2009] UKHL 45; [2009] 3 WLR 403, 416 [36], 424 [60].

⁹⁵⁸ *Carter v Canada* [2015] 1 SCR 331, [62]-[63].

⁹⁵⁹ *Carter v Canada* [2015] 1 SCR 331, [57]-[58].

⁹⁶⁰ Parliament of Victoria, Scrutiny of Acts and Regulations Committee, *Alert Digest No 14 of 2017*, pp 28-32.

⁹⁶¹ Parliament of Victoria, Scrutiny of Acts and Regulations Committee, *Alert Digest No 14 of 2017*, p 29.

⁹⁶² *Lee v Oregon*, 891 F Supp 1429 (1995).

⁹⁶³ *Lee v Oregon*, 891 F Supp 1429 (1995), 1435-7.

5.1.1.2 Nature of the purpose of the limitation

By setting up a detailed regulatory framework to assist a person to die, this Bill directly engages the right to life protected by section 16 of the HRA. As the statement of compatibility notes, by creating an exception to the existing rule against aiding suicide, the Bill may ‘also create a risk of involuntary loss of life.’⁹⁶⁴ This risk demands a careful consideration of both the nature and purpose of the limitation of the right to life posed by this Bill, and the safeguards contained within the Bill that aim to minimise this risk.

As noted above, the right to life has been interpreted in overseas jurisdictions to be compatible with legislative regimes that provide individuals with a range of legal pathways to either refuse treatment or seek the assistance of others to end their life, provided robust safeguards are included.

This means that it is possible that clause 8 and part 10 of the Bill engage but do not limit the right protected in section 16 of the HRA. In other words, while the Bill creates an exception to the criminal law on aiding suicide, it does not constitute an arbitrary deprivation of life.

As the statement of compatibility notes⁹⁶⁵ the concept of ‘arbitrariness’ has a particular meaning in human rights law. At one end of the spectrum, an action or power will be arbitrary if it is unlawful or outside the scope of the law.⁹⁶⁶ However, ‘arbitrary’ also extends to include lawful but unjust or reasonable actions or powers or those that are out of proportionate to the legitimate aim or purpose being sought.⁹⁶⁷

The Bill clearly does not seek to authorise the unlawful killing of another person, and so is not ‘arbitrary’ in that sense. However, as noted above, consideration must also be given to the question of whether the design of the Bill (including eligibility criteria), constitutes a proportionate means of achieving a legitimate, rights enhancing purpose.

The purpose of the limitation on the right to life contained in clause 8 and part 10 of the Bill is articulated in the Bill itself. Clause 3 describes the main purposes of the proposed legislation as including:

- to give persons who are suffering and dying, and who meet eligibility criteria, the option of requesting medical assistance to end their lives
- to establish a lawful process for eligible persons to exercise that option
- to establish safeguards to ensure voluntary assisted dying is accessed only by persons who have been assessed to be eligible; and protect vulnerable persons from coercion and exploitation.

The Bill also contains key principles (in clause 5) which include:

- human life is of fundamental importance
- every person has inherent dignity and should be treated equally and with compassion and respect
- a person who is vulnerable should be protected from coercion and exploitation, and
- a person’s freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

When taken together with other key features of the Bill, it becomes clear that clause 8 and part 10 have a legitimate purpose: these clauses are designed to promote the dignity and autonomy of eligible

⁹⁶⁴ Statement of compatibility, p 5.

⁹⁶⁵ Statement of compatibility, p 6.

⁹⁶⁶ PJB v Melbourne Health (2011) 39 VR 373, 395.

⁹⁶⁷ PJB v Melbourne Health (2011) 39 VR 373, 395.

individuals who are experiencing intolerable suffering by providing a legal pathway for them to request medical assistance to end their lives in circumstances where their death has been confirmed as imminent by health professionals. This purpose is consistent with the criteria set out in section 13 of the HRA relating to a free and democratic society based on dignity, equality and freedom.

5.1.1.3 The relationship between the limitation and its purpose

There is a direct and rational relationship between the impact of clause 8 and part 10 on the right to life, and the purpose of those clauses. The detailed legal processes and criteria required to be fulfilled before a person can access voluntary assisted dying under the Bill are designed to promote the dual right-enhancing purposes of (1) providing those facing intolerable suffering and terminal illness with a legal pathway to request assisted dying and (2) protecting vulnerable people from the risks of coercion and exploitation. These processes and criteria are discussed further below.

In addition, as noted above, this Bill is not designed to grant Queenslanders a right to die in the way they choose. It is a scheme that is limited to authorising certain health professionals to receive, assess and act on requests to provide lethal medication to patients who are terminally ill and meet other strict criteria including that related to decision-making capacity. It is designed to limit access to assisted dying to those who are diagnosed with an illness or disease that will lead to their death within 12 months and to preserve the primary duty of health practitioners to provide professional medical advice in the best interests of their patients. It is also specifically designed to co-exist with improvements in the quality of palliative care and other end-of-life decision making schemes including those relating to the withdrawal of treatment and refusal of treatment, documented in detail in the QLRC's Report.⁹⁶⁸

5.1.1.4 Whether there are less restrictive and reasonably available ways to achieve the purpose

As noted above, while it is clear that clause 8 and part 10 of the Bill engage the right to life as protected in HRA section 16, it is not clear that these provisions arbitrarily limit the right to life. If the formulation of the nature of the right to life provided by the Canadian Supreme Court in *Carter v Canada* is accepted, and voluntary assisted dying laws are capable of being designed in a way that is compatible with the protected right, the focus shifts away from the question of limitation and towards the question of whether the safeguards and eligibility criteria contained in this Bill are reasonable ways to achieve the Bill's overall legitimate purpose.

The safeguards in the Bill have been subject to detailed consideration and consultation by the QLRC and are summarised in the Statement of Compatibility⁹⁶⁹ as including:

- protections to ensure that a person's decision to access assisted dying is truly voluntary and made with capacity (clauses 3(c), 19, 30, 33, 33)
- strict eligibility criteria (clauses 10-13)
- a multi-stage request and assessment process involving two medical practitioners undertaking separate independent assessments (clauses 19, 14, 37, 42)
- oversight by the Board (part 8)
- review of certain decisions by the QCAT (part 7).

These features of the Bill address the concerns identified by the US Court in *Lee v Oregon*,⁹⁷⁰ align with the observations of the Canadian Court in *Carter v Canada*,⁹⁷¹ the European Court of Human Rights in

⁹⁶⁸ QLRC Report, pp 199-200.

⁹⁶⁹ Statement of compatibility, p 7.

⁹⁷⁰ *Lee v Oregon*, 891 F Supp 1429 (1995).

⁹⁷¹ *Carter v Canada* [2015] 1 SCR 331.

Haas v Switzerland,⁹⁷² the UK House of Lords in Pretty v United Kingdom⁹⁷³ and the New Zealand Court in Seales v Attorney General.⁹⁷⁴ They are also consistent with the key features of similar legislation enacted in Victoria and subject to rights scrutiny by the Victorian SARC.

This suggests that while there may be different ways to design exceptions to the current prohibition on assisted suicide, the safeguards contained in this Bill fall within the legitimate space between actively protecting the right to life and not requiring that life be protected against the express wishes of those who may be suffering terminal illness. The specific safeguards and eligibility criteria contained in this Bill are considered in further detail below.

5.1.1.5 The balance between the importance of the purpose of the limitation and the importance of preserving the human right

As the statement of compatibility notes⁹⁷⁵ and the Australian Human Rights Commission has observed,⁹⁷⁶ the task of ‘balancing’ the right to life with the right to a dignified and lawfully assisted death is ultimately one that must be undertaken by democratically elected members of Parliament.

There is no doubt that the protection and promotion of the right to life is a foundational value within the Queensland community. Its importance cannot be overstated. However, the material contained in the statement of compatibility, supported by the extensive investigations and consultations undertaken by the QLRC and past parliamentary committees, also suggests that the Queensland community highly values the right of competent individuals to make end-of-life choices when faced with intolerable suffering or terminal illness. This includes withdrawing or refusing medical treatment, and in some cases, seeking assisted dying.

International jurisprudence on the nature of the right to life in human rights frameworks similar to the HRA suggests that it may not be necessary to see these two strongly-held values (the right to life and the right to a dignified death) in competition with each other. Instead, it may be possible to understand voluntary assisted dying schemes as being compatible with the right to life, provided strict safeguards are included. If this approach is accepted in Queensland, the focus must then shift to an evaluation of the proportionality and reasonableness of the safeguards and eligibility criteria contained in the Bill. This approach is preferred to artificially ‘weighing’ the right to life against (which is explicitly protected by section 16 of the HRA) concepts of dignity and self-determination (which are implied as foundational values having regard to the structure and purpose of the HRA).

Committee Comment

The safeguards contained in the Bill that protect the right to life, do not also require that life be protected against the express wishes of those who may be suffering terminal illness. The committee therefore considers that any limit on the right to life and the right not to be arbitrarily deprived of life in Bill is reasonable and justifiable.

5.1.2 The right to freedom of expression

Clause 7 of the Bill prohibits a health care worker who provides health services or professional care services to a person from initiating a discussion with that person about voluntary assisted dying or suggest voluntary assisted dying to the person, subject to certain exceptions.⁹⁷⁷ The Bill provides that

⁹⁷² Haas v Switzerland (European Court of Human Rights, Chamber, Application No 31322/07, 20 January 2011).

⁹⁷³ Pretty v United Kingdom (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002).

⁹⁷⁴ Seales v Attorney General [2015] NZHC 828.

⁹⁷⁵ Statement of compatibility, p 2.

⁹⁷⁶ Australian Human Rights Commission, *Euthanasia, human rights and the law*, May 2016, p 34.

⁹⁷⁷ Explanatory notes, p 24.

a health professional who does not comply with this provision will be regarded as engaging in ‘unprofessional conduct’ under the Health Practitioner Regulation National Law (for registered health practitioners) or made the subject to a complaint investigated by the Health Ombudsman (for another individual who provides a health service). However, the Bill also provides that a medical practitioner or nurse practitioner may initiate a discussion about voluntary assisted dying if, at the same, the practitioner also informs the person about:

- the treatment options available to the person and the likely outcomes of that treatment; and
- the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

This clause sits alongside other provisions that regulate the information that can be shared about voluntary assisted dying (for example, clauses 16(3), 22, 33 and 164).

The Statement of compatibility provides that clause 7 (and related clauses) ‘interfere with whether and how a person may express their opinions and ideas’ and as result, limit the right to freedom of expression protected by HRA s21. The nature of this right is discussed below.

5.1.2.1 *Nature of the human right*

Section 21 of the HRA protects the right to ‘hold an opinion without interference’⁹⁷⁸ and to ‘freedom of expression’⁹⁷⁹ which includes the freedom to engage with information and ideas of all kinds (including verbal and non-verbal communication). This right is based on Article 19 of the International Covenant on Civil and Political Rights (ICCPR) and is connected to cultural rights (sections 27 and 28) and freedom of thought, conscience and religion (section 20).⁹⁸⁰ Under international law, the right to freely engage with information and ideas can be restricted if necessary to protect the rights of others or to protect public order, public health, public morality or national security.⁹⁸¹ The Parliamentary Joint Committee on Human Rights (PJCHR) has explained that in order for a restriction of this right to be justifiable and valid, it must be rationally connected and proportionate to legitimate objective.⁹⁸²

As the Victorian SARC observed in its Alert Digest report on the Victorian Voluntary Assisted Dying Bill 2017, these rights have a relationship with the implied freedom of political communication that derives from the principles of representative and responsible government contained in the Australian Constitution.⁹⁸³ However, the implied freedom does not relate to communication on all issues of public importance – it only applies to communications which would ‘illuminate the choice for electors

⁹⁷⁸ *Human Rights Act 2019*, s 21(1).

⁹⁷⁹ *Human Rights Act 2019*, s 21(2).

⁹⁸⁰ QHRC, ‘Fact Sheet on Freedom of Expression’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/freedom-of-expression>.

⁹⁸¹ International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, Articles 19(3) and 21. See, for example, *Leyla Sahin v Turkey*, European Court of Human Rights (Grand Chamber) Application No. 44774/98 (2005); *Al-Adsani v United Kingdom*, European Court of Human Rights (Grand Chamber) Application No. 35763/97 (2001) [53] - [55]; *Manoussakis and Others v Greece*, European Court of Human Rights, Application No. 18748/91 (1996) [36] - [53]. See also the reasoning applied by the High Court of Australia with respect to the proportionality test in *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.

⁹⁸² See eg Parliament of Australia, PJCHR, *Report No 1 of 2020*, 5 February 2020, https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Scrutiny_reports/2020/Report_1_of_2020.

⁹⁸³ See Parliament of Victoria, Scrutiny of Acts and Regulations Committee, *Alert Digest No 14 of 2017*, p 25. See also *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.

at federal elections or in amending the Constitution' or which throw light on the administration of federal government.⁹⁸⁴

5.1.2.2 Nature of the purpose of the limitation

Clause 7 and related provisions limit the right to freedom of expression by prohibiting a health practitioner from speaking to any patient about voluntary assisted dying except at the patient's request. This provision was included in the Bill as:

... an important safeguard to ensure that someone in a therapeutic relationship with the person who is likely to be influential and trusted by the person, but may not be clinically skilled or sufficiently qualified to adequately discuss end of life options, does not initiate a discussion about voluntary assisted dying.⁹⁸⁵

However, clause 7(2) provides that the limitation does not apply to medical practitioners or nurse practitioners who initiate a discussion about voluntary assisted dying if, at the same, the practitioner also informs the person about available treatment options and their likely outcomes, including palliative care options.⁹⁸⁶

The permission of discussions between doctors and nurse practitioners and patients about voluntary assisted dying in the context of broader professional advice about treatment options and palliative care is not included in the Victorian legislation or the recently-enacted South Australian law.⁹⁸⁷

5.1.2.3 The relationship between the limitation and its purpose

The limitation on the right to freedom of expression posed by clause 7 is directly related to the rights-enhancing purpose of the Bill, namely, to ensure the proposed voluntary assisted dying scheme is accompanied by strict safeguards to protect vulnerable people from coercion and abuse. The clause has been included in the Bill in line with the recommendation of the QLRC which undertook extensive investigations into the similar laws in other jurisdictions and consultation widely with the Queensland community and subject area experts. As a result of this process, it was considered necessary to regulate the types of communications that can occur between individuals (including vulnerable individuals) and their health professionals about voluntary assisted dying.

Some scholars who have critiqued the Victorian *Voluntary Assisted Dying Act 2017* have argued that a prohibition on health practitioner-initiated discussions on voluntary assisted dying 'creates a tension between core professional, ethical and legal obligations contained in relevant codes of conduct for health practitioners.'⁹⁸⁸

They argue:

... [i]n order to make voluntary and informed end-of-life decision, including the decision not to undertake voluntary assisted dying, patients should have all the relevant options presented to them by their health practitioner. This obligation arises in recognition of the superior medical knowledge health practitioners

⁹⁸⁴ Parliament of Victoria, Scrutiny of Acts and Regulations Committee, *Alert Digest No 14 of 2017*, p 26; *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520, 571.

⁹⁸⁵ QLRC Report, paragraphs 6.124-6.125.

⁹⁸⁶ Voluntary Assisted Dying Bill 2021, cl 7(2); QLRC Report, paragraph Recommendation 6-3; Explanatory notes, p 25.

⁹⁸⁷ See *Voluntary Assisted Dying Act 2017* (Vic) s 8; *Voluntary Assisted Dying Act 2021* (SA) s 11.

⁹⁸⁸ Bryanna More, Courtney Hempton, Evie Kendal, 'Victoria's Voluntary Assisted Dying Act: navigating the s 8 gag clause' *Ethics and Law MJA*, 212(2), 3 February 2020, pp 67-68 at 67. See also Medical Board of Australia 'Good medical practice: code of conduct for doctors in Australia', *Canberra Medical Board of Australia*, 2014, s 3.2.

typically possess relative to their patients, and the social duty they have as trusted sources of health information.⁹⁸⁹

In recognition of the importance of preserving the rights of doctors and nurse practitioners to freely express their views about voluntary assisted dying as part of their professional health advice, the Queensland Bill permits doctors and nurse practitioners to share information provided it is done so in the context of a discussion about treatment options, the likely outcomes of that treatment; and palliative care.⁹⁹⁰

The QLRC Report states that the exception only applies to medical practitioners and nurse practitioners (and not other health professionals) to address concerns about allied health practitioners and professional care service providers initiating such discussions.⁹⁹¹ The QLRC justified the limited scope of this exception on the basis that although some other registered health practitioners (such as experienced registered nurses) might be well equipped to discuss end of life options in general terms, they may not be able to provide advice about various treatment outcomes. On this basis, the prohibition on initiating a discussion should therefore apply only to medical practitioners and nurse practitioners.⁹⁹² The Bill provides that the prohibition does not apply if information about voluntary assisted dying is provided to a person at the person's request. This also reflects the QLRC recommendation.⁹⁹³

5.1.2.4 Whether there are less restrictive and reasonably available ways to achieve the purpose

Other alternatives that may meet the dual goals of ensuring patients can access professional advice about voluntary assisted dying whilst providing protections against coercion include the extending the qualification contained in clause 7(2) to all health professionals. This alternative would permit a wide range of health professionals to initiate discussions about voluntary assisted dying with patients. The QLRC was concerned that this could expose vulnerable patients to potential misinformation or direct or indirect coercion from health practitioners who may not be well placed to ensure discussions about voluntary assisted dying are accompanied by professional advice about treatment options and outcomes, and palliative care.

As noted above, clause 7(2) of the Bill provides a less rights restrictive approach to regulating communications about voluntary assisted dying than that contained in the Victorian *Voluntary Assisted Dying Act 2017* or the South Australian *Voluntary Assisted Dying Act 2021*.

5.1.2.5 The balance between the importance of the purpose of the limitation and the importance of preserving the human right

Clause 7 (and related clauses) strike the right balance between ensuring patients can access professional advice about voluntary assisted dying whilst providing protections against coercion. By regulating the communications between health professionals and patients, these provisions underscore the need for individuals to proactively and independently make decisions about whether or not to initiate the process of requesting assisted dying under the scheme proposed in the Bill. However, in recognition of the need to ensure registered medical practitioner and nurse practitioners can discharge the full range of their professional duties to their patients, the Bill also permits these practitioners to share information about voluntary assisted dying with patients as part of their broader

⁹⁸⁹ Bryanna More, Courtney Hempton, Evie Kendal, 'Victoria's Voluntary Assisted Dying Act: navigating the s 8 gag clause' *Ethics and Law MJA*, 212(2), 3 February 2020, pp 67-68 at 67. See also Medical Board of Australia 'Good medical practice: code of conduct for doctors in Australia', *Canberra Medical Board of Australia*, 2014, s 3.2.

⁹⁹⁰ QLRC Report, Recommendation 6-3; Explanatory notes, p 25.

⁹⁹¹ QLRC Report, paragraph 6.140.

⁹⁹² QLRC Report, paragraph 6.139.

⁹⁹³ QLRC Report, Recommendation 6-2.

medical advice. These clauses permit a freer exchange of information and communication than that prescribed in Victoria and fit within the scope of permissible limitations of rights described in section 13 of the HRA.

Committee comment

The committee considers that while the Bill limits the communications of health professionals and patients, it does so in order to provide protections against coercion. Therefore any limitation on the right to freedom of expression in clause 7 of the Bill is reasonable and justifiable.

5.1.3 The right of recognition and equality before the law, right to privacy and reputation, right of the child, right to health services – consideration in relation to eligibility criteria

The statement of compatibility explains that clauses 10-13 of the Bill (and related clauses) engage the right of recognition and equality before the law protected by section 15 of the HRA in so far as the eligibility criteria exclude people who are suffering an intolerable condition but do not have a prognosis of death within 12 months⁹⁹⁴ and limits access to voluntary assisted dying on the basis of age⁹⁹⁵ and residential status.⁹⁹⁶ Other rights engaged by these clauses include the right to privacy protected by section 25 of the HRA, the rights of the child protected by section 26(1) of the HRA and the right to access health services protected by section 37(1) of the HRA. The nature of these rights is described below.

5.1.3.1 Right of recognition and equality before the law

Section 15 of the HRA protects the right of '[r]ecognition and equality before the law'. This right includes the right to enjoy human rights without discrimination, with equal protection of the law and equal and effective protection against discrimination.⁹⁹⁷ The right to equal and effective protection against discrimination is particularly relevant to the eligibility criteria in clauses 10-13 which seeks to limit access to lawful assisted dying on the basis of their age (only for persons 18 years or older), residential status (only for citizens or long term residents) and the nature of their illness or disease (must be likely to cause death within 12 months).

Subsection 15(5) of the HRA explicitly recognises that where measures are taken 'for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination', such measures 'do not constitute discrimination'. This provision reflects the concept of 'special measures'⁹⁹⁸ which exists under anti-discrimination legislation at the state⁹⁹⁹ and federal level.¹⁰⁰⁰ These 'special measure' provisions ensure that, where a proposed law seeks to advance the interests

⁹⁹⁴ See statement of compatibility, pp 8-9 which refers to the example of *Trunchon v Attorney General (Canada)* 2019 QCCS 3792, [17]-[35].

⁹⁹⁵ See statement of compatibility, pp 12-14.

⁹⁹⁶ See statement of compatibility, pp 16-18.

⁹⁹⁷ *Human Rights Act 2019*, s 15(1)-(5).

⁹⁹⁸ In its fact sheet on the rights protected in the HRA, the QHRC has confirmed that s 15(5) allows for 'special measures' and suggests an example of a special measure could be 'programs addressing the disadvantage experienced by many Aboriginal and Torres Strait Islander Queenslanders'. See <https://www.qhrc.qld.gov.au/your-rights/human-rights-law>.

⁹⁹⁹ *Anti-Discrimination Act 1991*, ss 104-105.

¹⁰⁰⁰ See e.g. *Racial Discrimination Act 1975 (Cth)*, s 8(1).

of a particular group, including children or persons with disabilities, it will not constitute unlawful discrimination.¹⁰⁰¹

The rights protected by section 15 of the HRA are based on Articles 2, 16 and 26 of the ICCPR. These provisions recognise that not all treatment that differs among individuals or groups on the basis of race or any of the attributes protected in the Articles will amount to prohibited discrimination. As the United Nations (UN) Human Rights Committee has observed, ‘not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant’.¹⁰⁰²

Section 15(5) aligns with the right to equality and freedom from discrimination protected under the federal *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth). When interpreting the scope of this right at the federal level, the PJCHR has explained that:

The right to equality and non-discrimination does not mean identical treatment in every instance. The principle of substantive equality sometimes requires positive action on the basis of a protected status to reflect relevant differences between different groups. This differential treatment can be justified if it is based on objective and reasonable criteria and seeks to achieve a legitimate goal.¹⁰⁰³

The QHRC has pointed to the provisions of the *Anti-Discrimination Act 1991* as a useful framework for understanding what might amount to discriminatory treatment and therefore breach the right to equality contained in HRA section 15¹⁰⁰⁴ under the *Anti-Discrimination Act 1991*, and is unlawful when based on age or disability. Each of these attributes may be relevant to the way clauses 10-13 operate in practice.

Residential location or socio-economic status is not a protected attribute under the *Anti-Discrimination Act 1991*, however ‘social origin’ and ‘other status’ is protected under Article 26 of the ICCPR. As the Commonwealth Attorney General’s website explains:

The UN Human Rights Committee has not attempted to define this term, but has decided it on a case-by-case basis. Among others, the following statuses have been held to qualify as prohibited grounds: age, nationality, marital status, disability, place of residence within a country and sexual orientation.¹⁰⁰⁵

This suggests that the scope of the right to equality contained in section 15 of the HRA may extend to residential status.

The cases of *Lambert and Pretty*¹⁰⁰⁶ highlight the need to consider the rights of people with disability when considering the rights compatibility of voluntary assisted dying schemes. It is also noted that the

¹⁰⁰¹ The Australian Human Rights Commission has described ‘special measures’ as follows: “The concept of special measures is generally understood to apply to positive measures taken to redress historical disadvantage and confer benefits on a particular racial group, so that they may enjoy their rights equally with other groups; special measures are designed to ensure the equality of outcomes for disadvantaged groups” at [4], <https://humanrights.gov.au/our-work/guidelines-understanding-special-measures-racial-discrimination-act-1975-cth-2011>.

¹⁰⁰² United Nations Committee on the Elimination of Racial Discrimination, ‘General Recommendation No 32 (on the meaning and scope of special measures)’, CERD/C/GC/32 https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fGC%2f32&Lang=en.

¹⁰⁰³ Parliament of Australia, PJCHR, *Guide to Human Rights*, June 2015, [1.175]-[1.176].

¹⁰⁰⁴ QHRC, ‘Fact Sheet on s 15’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/your-right-to-recognition-and-equality-before-the-law>.

¹⁰⁰⁵ QHRC, ‘Fact Sheet on s 15’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/your-right-to-recognition-and-equality-before-the-law>.

¹⁰⁰⁶ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [63]; *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [180].

principles of the Convention on the Rights of Persons with Disabilities (the Disability Convention) are relevant to the right to equal protection of the law contained in section 15 of the HRA. Key principles which underpin the Disability Convention include non-discrimination and ‘respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons’. As the Australian Human Rights Commission has observed:

[I]n the case of voluntary euthanasia, the same balancing of the right to life with the right to personal autonomy that occurs for people without disability applies under the Disability Convention for those with disability. The Convention makes clear that people with disability, like those without disability, have a right to respect for their physical and mental integrity, and privacy. People with disability are entitled to make choices as to their own welfare, and to be supported to do so where necessary. They enjoy legal capacity on an equal basis with those without disability, and are entitled to support in exercising that capacity. Any safeguards which are put in place in relation to people with disability exercising their legal capacity, to protect against undue influence and/or abuse, must respect the rights, will and preferences of the person.¹⁰⁰⁷

The Bill contains a range of important safeguards designed to ensure that people with disabilities can access the voluntary assisted dying scheme (for example those provisions that relate to how decision-making capacity is assessed). However, as discussed below, the criteria that limits access to voluntary assisted dying on the basis of terminal illness (prognosis of death within 12 months) may have a particular impact on the rights of persons with disability who may be experiencing intolerable suffering but deemed ineligible for assisted dying under the Bill.

5.1.3.2 Right to privacy and reputation

Section 25 of the HRA protects the right of a person not to have his or her ‘privacy, family, home or correspondence unlawfully or arbitrarily interfered with’¹⁰⁰⁸ and not to have their personal reputation unlawfully attacked.¹⁰⁰⁹ This right is based on Article 17 of the ICCPR and is broad in scope, intersecting with other rights protected in the HRA including the rights relating to families and children, as well as rights to freedom of expression.

The rights protected in section 25 can be subject to justifiable limitations when reasonably necessary to do so in a free and democratic society based on human dignity, equality and freedom.

The right to privacy includes a requirement that the state does not arbitrarily interfere with a person’s private and home life. The use of the term ‘arbitrary’ in section 25 denotes unlawful interference with privacy, but also actions which may be lawful but are ‘unreasonable, unnecessary or disproportionate’ in the circumstances. As the PJCHR has explained, ‘to be a proportionate limitation on the right to privacy, the limitation should only be as extensive as is strictly necessary to achieve its legitimate objective and must be accompanied by appropriate safeguards.’¹⁰¹⁰ In order for a limitation not to be arbitrary, it must pursue a legitimate objective, and be rationally connected to, and a proportionate means of achieving, that objective.¹⁰¹¹

Some commentators have described Article 17 of the ICCPR as protecting ‘that particular area of individual existence and autonomy that does not touch upon the sphere of liberty and privacy of

¹⁰⁰⁷ Australian Human Rights Commission, *Euthanasia, human rights and the law*, May 2016, p 32.

¹⁰⁰⁸ *Human Rights Act 2019*, s 25(a).

¹⁰⁰⁹ *Human Rights Act 2019*, s 25(b).

¹⁰¹⁰ Parliament of Australia, PJCHR, *Report 1 of 2020*, 5 February 2020, [1.80].

¹⁰¹¹ Parliament of Australia, PJCHR, *Report 1 of 2020*, 5 February 2020, [1.15]. See also, *Leyla Sahin v Turkey*, European Court of Human Rights (Grand Chamber) Application No. 44774/98 (2005); *Al-Adsani v United Kingdom*, European Court of Human Rights (Grand Chamber) Application No. 35763/97 (2001) [53]-[55]; *Manoussakis and Others v Greece*, European Court of Human Rights, Application No. 18748/91 (1996) [36]-[53]. See also the reasoning applied by the High Court of Australia with respect to the proportionality test in *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.

others'.¹⁰¹² This includes a person's physical (and mental) integrity. If this approach to understanding the scope of the right to privacy is adopted 'medical treatment without consent or against the will of the patient is to be deemed interference with privacy, as this term also covers the inviolability of one's own body'.¹⁰¹³ This approach was adopted by the European Court of Human Rights in *Pretty v United Kingdom*¹⁰¹⁴ when considering the similarly (but not identically) worded Article 8 of the European Convention Human Rights. In *Pretty v the United Kingdom*, the European Court observed:

... the ability to conduct one's life in a manner of one's own choosing may...include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned...even where the conduct poses a danger to health or, arguably, where it is of a life-threatening nature, the case-law of the Convention institutions has regarded the State's imposition of compulsory or criminal measures as impinging on the private life of the applicant within the meaning of Article 8 § 1 and requiring justification in terms of the second paragraph'.¹⁰¹⁵

In relation to a person's choice to refuse medical treatment, the European Court stated:

... the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention...a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life.¹⁰¹⁶

The Court further observed that the fact that the applicant in that case was 'prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life' constituted an interference with her right to respect for private life in Article 8. However, it was ultimately concluded that the legal prohibition on assisted suicide at the time was justified as 'necessary in a democratic society' for the protection of the rights of others, and therefore was a permissible limitation of the right.¹⁰¹⁷ The European Court has subsequently confirmed that the right to respect for private life includes the right to 'decline to consent to treatment which might have the effect of prolonging his or her life'.¹⁰¹⁸

5.1.3.3 *Right of the child*

Subsection 26(1) of the HRA protects the rights of families and children by stating that 'families are the fundamental group unit of society and are entitled to be protected by society and the State'.¹⁰¹⁹ Subsection 26(2) of the HRA provides that every child has the right to 'the protection that is needed by the child, and is in the child's best interests, because of being a child.' 'Child' is not specifically defined in the HRA but is broadly understood to be someone under 18 years of age.

¹⁰¹² Manfred Nowak, 'UN Covenant on Civil and Political Rights: CCPR Commentary', *NP Engel*, 2nd rev. ed, 2005, pp 385, 387.

¹⁰¹³ Manfred Nowak, 'UN Covenant on Civil and Political Rights: CCPR Commentary', *NP Engel*, 2nd rev. ed, 2005, pp. 385, 387.

¹⁰¹⁴ [2002] ECHR 427 [61]-[67].

¹⁰¹⁵ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [62].

¹⁰¹⁶ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [63].

¹⁰¹⁷ *Pretty v United Kingdom* (European Court of Human Rights, Chamber, Application No 2346/02, 29 April 2002) [63].

¹⁰¹⁸ *Lambert and Others v France* (European Court of Human Rights, Grand Chamber, Application no 46043/14, 5 June 2015) [180].

¹⁰¹⁹ *Human Rights Act 2019*, s 26(1).

The rights protected by section 26 of the HRA are based on Article 3 of the Convention of the Rights of the Child (CRC) and Article 24(1) of the ICCPR.¹⁰²⁰ Central to each of these rights is the principle of the ‘best interests of the child’. This principle applies to all actions concerning children and requires active measures to protect children’s rights and promote their survival, growth, and wellbeing.¹⁰²¹ For example, Article 3 of the CRC provides that:

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

When determining what constitutes the ‘best interests of the child’ the assessment must be conducted from the child’s perspective rather than from their parents or the state. The child’s ‘best interests’ must also be considered according to the specific situation of the child or children affected and consider their personal context and needs. The UN Committee on the CRC has explained that the child’s ‘best interest’ has three components: a substantive right (right to have his or her interests assessed and taken into account before a decision is reached); an interpretative principle (if a legislative provision is open to more than one meaning the one that most serves the child’s best interest should be chosen); and a rule of procedure (that is applied whenever a decision is made that will affect a specific child or identified group of children).¹⁰²² The CRC Committee has also explained that an assessment of a child’s best interest must include ‘respect for the child’s right to express his or her views freely’ and with due weight given those views in all decisions affecting the child.¹⁰²³

5.1.3.4 Right to health services

Section 37 of the HRA provides that every person ‘has the right to access health services without discrimination’¹⁰²⁴ and that a person ‘must not be refused emergency medical treatment that is immediately necessary to save the person’s life or to prevent serious impairment to the person.’¹⁰²⁵ This right draws from Article 12 of the International Covenant on Economic, Social and Cultural Rights,

¹⁰²⁰ QHRC, ‘Fact Sheet on s 26’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-of-families-and-children>. See also Convention on the Rights of the Child, Articles 5, 9, 12, 18, 20, 21, 22 and 40. The International Covenant on Civil and Political Rights Article 24(1) provides that: “Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.”.

¹⁰²¹ QHRC, ‘Fact Sheet on Right to Protection of Families and Children’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-of-families-and-children>.

¹⁰²² United Nations Committee on the Rights of the Child, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), [6].

¹⁰²³ United Nations Committee on the Rights of the Child, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), [42].

¹⁰²⁴ *Human Rights Act 2019*, s 37(1).

¹⁰²⁵ *Human Rights Act 2019*, s 37(2).

however, section 37 of the HRA is much narrower in scope than Article 12.¹⁰²⁶ The right to health services is not protected in any other human rights legislation in Australia making the scope of this right difficult to ascertain.¹⁰²⁷ As the QHRC has noted, the unique inclusion of this right within a human rights scheme means that limited guidance can be gained from looking to international cases, given the difference in wording in the Queensland Act.¹⁰²⁸

The explanatory notes accompanying the HRA when it was introduced to Parliament suggest that section 37 is not intended to encompass rights relating to underlying determinants of health, such as food and water, social security, housing and environmental factors.¹⁰²⁹ As with all other rights protected in the HRA, the right to access health care without discrimination can be limited, but only where it is reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom.

The intersection of this right with the broader guarantee to equal protection by the law contained in section 15 suggest that consideration should be given to legislative and practical barriers to equal access to health care in Queensland, including equal access to palliative care, and end-of-life decision making. As documented by McDougall and Pratt in their 2020 article in *BMC Medical Ethics*, ensuring equal access to voluntary assisted dying schemes goes beyond considerations of eligibility criteria and includes issues relating to accesses to appropriately qualified health professionals in regional and remote locations.¹⁰³⁰ These matters are not explored in detail in the statement of compatibility but are considered by the QLRC in its extensive report.¹⁰³¹

5.1.3.5 Nature of the purpose of the limitation

As noted above, the Bill limits access to the voluntary assisted dying scheme on the basis of criteria that distinguish individuals having regard to their decision-making capacity, the terminal nature of their illness or disease, their age and their residential status. The Queensland Government has made these legislative choices on the basis of detailed investigations and consultation conducted by the QLRC about the needs and views of the people of Queensland, the design of similar legislation currently in force in other parts of Australia and having regard to the need to comply with the human rights jurisprudence described above with respect to clauses 8-9.

The effect of the eligibility criteria prescribed in clause 10 is that a person who is diagnosed with an advanced, progressive disease, illness or medical condition that is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable cannot be given access to voluntary assisted dying, even if he or she has capacity in relation to voluntary assisted dying and otherwise complies with the request and assessment process in the Bill, if he or she is: under 18, is not expected to die within 12 months and/or does not meet the relevant residency and citizenship criteria. This limits the right of every person ‘to enjoy his or her human rights without discrimination’ and ‘to be

¹⁰²⁶ QHRC, ‘Fact Sheet on Right to Health Services s 37’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services>.

¹⁰²⁷ It is noted that there exists a federal Australian Charter of Healthcare Rights that states that – ‘everyone has the right to be able to access healthcare’.

¹⁰²⁸ QHRC, ‘Fact Sheet on Right to Health Services s 37’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services>.

¹⁰²⁹ QHRC, ‘Fact Sheet on Right to Health Services s 37’, <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services>.

¹⁰³⁰ McDougall and Pratt, ‘Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation’, *BMC Medical Ethics*, 2020, 21(38).

¹⁰³¹ QLRC Report, pp 124-127.

equal before the law'.¹⁰³² This gives rise to the question of whether the limits these criteria pose on the rights described above are proportionate and justifiable having regard to their purpose.

Each of the eligibility criteria prescribed in clause 10 has a distinct purpose and has been developed following extensive investigation and consultation by the QLRC. These purposes are briefly summarised below.

- A disease, illness or medical condition that is advanced, progressive and will cause death; is expected to cause death within 12 months; and is causing suffering that the person considers to be intolerable.

This eligibility criteria reflects the primary object of the Bill, namely to provide a lawful end-of-life option for people who are suffering and dying and makes it clear that 'a person is eligible for voluntary assisted dying only if they have an eligible condition that is very serious, is on a deteriorating trajectory and will cause death'.¹⁰³³

- Decision-making capacity (capable of understanding the nature and effect of decisions about access to voluntary assisted dying; freely and voluntarily making decisions about access to voluntary assisted dying; and communicating decisions about access to voluntary assisted dying in some way).

This is a fundamental safeguard in the Bill, which 'recognises and protects individual autonomy' and 'will help ensure that a person's decision is voluntary and protect people who might be vulnerable to coercion or exploitation'.¹⁰³⁴ The requirement for decision-making capacity is consistent with other jurisdictions and generally consistent with the requirements about capacity to consent to or refuse medical treatment.¹⁰³⁵ The Bill provides that a person is presumed to have decision-making capacity for voluntary assisted dying unless shown not to have that capacity. The QLRC report considers this 'consistent with the law about consent, the presumption of capacity operating in Queensland's guardianship legislation, and voluntary assisted dying legislation in other Australian jurisdictions'.¹⁰³⁶

- Age

Limiting access to adults is consistent with other relevant laws in Queensland, and the voluntary assisted dying legislation in other Australian jurisdictions.¹⁰³⁷ The requirement is 'designed to limit access to voluntary assisted dying to persons who are presumed, because of their age, to have access to sufficient understanding and intelligence to understand fully what is proposed, and to be able to give informed consent to a process that will end their lives'.¹⁰³⁸

- Residency (be an Australian citizen, a permanent resident or have been ordinarily resident in Australia for at least 3 years immediately before the person makes the first request; and have been ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request).

¹⁰³² As has been noted by the Victorian SARC when considering the Victorian voluntary assisted dying scheme, a disease, illness or medical condition that is incurable, advanced and progressive is a disability, regardless of the prognosis as to death.

¹⁰³³ QLRC Report, paragraph 7.273.

¹⁰³⁴ QLRC Report, paragraph 7.254.

¹⁰³⁵ QLRC Report, paragraph 7.255.

¹⁰³⁶ QLRC Report, paragraph 7.268.

¹⁰³⁷ QLRC Report, paragraph 7.365.

¹⁰³⁸ QLRC Report, paragraph 7.367.

This limitation is included to preserve access by Queenslanders who qualify for voluntary assisted dying and who are enduring great suffering¹⁰³⁹ and to protect and promote the individual rights of Queensland residents to ‘access high-quality, end of life care, including palliative care and the option of voluntary assisted dying, might be compromised by open access to voluntary assisted dying in Queensland’.¹⁰⁴⁰ However, in acknowledgement of the potentially harsh, and possibly unintended, consequences for individuals who have a substantial connection with Queensland and who might be thought to be deserving of access to the scheme, discretionary powers are included in the Bill to exempt such persons from the residency requirement on compassionate grounds.

5.1.3.6 The relationship between the limitation and its purpose

The explanatory notes provide that the eligibility criteria included in clauses 10-13 are ‘intended to provide a balance between enabling individual choice and access to the scheme with appropriate safeguards to protect vulnerable people from coercion and limit access to those who are suffering and dying.’¹⁰⁴¹ As the statement of compatibility notes, the criteria are ‘designed to exclude people’ from accessing lawful voluntary assisted dying and form an ‘important safeguard against abuse’.¹⁰⁴² Indeed, as noted above, it is the strict and exclusive nature of the eligibility criteria contained in these clauses that ensures the Bill fits within the legitimate space between actively protecting the right to life and not requiring that life be protected against the express wishes of those who may be suffering terminal illness. Without such restrictions, particularly those aimed at ensuring a person has capacity to voluntarily consent to voluntary assisted dying, the Bill may not be compatible with the requirements set out in the international jurisprudence discussed above. This suggests that there is a rational connection between the rights limitations described above and the purpose of the respective eligibility criteria.

5.1.3.7 Whether there are less restrictive and reasonably available ways to achieve the purpose

The voluntary assisted dying scheme proposed in the Bill is not designed to provide Queenslanders a right to die in the way they choose rather, it is intentionally designed to limit access to assisted dying to those who are diagnosed with an illness or disease that will lead to their death and to preserve the primary duty of health practitioners to provide professional medical advice in the best interests of their patients. This purpose is reflected in the eligibility criteria contained in clauses 10-13. As the QLRC concluded:

This combination of eligibility criteria clarifies that voluntary assisted dying is an option only for people at the end of life who are suffering and dying. It is not a choice between life and death; it is an option for those who are in the process of dying to exercise some control over how and when they die. This approach strikes the right balance between the fundamental value of human life and the values of individual autonomy and reduced suffering.¹⁰⁴³

The justification for this type of approach to voluntary assisted dying is described by White and Willmott in their publication ‘Assisted Dying in Australia: A Values based Model for Reform’ as follows:

A justifiable approach is to recognise that the state’s interest in preserving life is weighty where a person is healthy, well and free from pain. But that interest is outweighed by other values such as autonomy and reducing suffering when both: (1) the person has a condition that will inevitably cause death, and (2) the person too has formed the view that the value of his or her life is outweighed by the disvalue of his or

¹⁰³⁹ QLRC Report, paragraph 7.452.

¹⁰⁴⁰ QLRC Report, paragraph 7.453.

¹⁰⁴¹ Explanatory notes, p 6.

¹⁰⁴² Statement of compatibility, p 8.

¹⁰⁴³ QLRC Report, p 99.

her suffering ... In such a case, the value of life would yield to the collective weight of the values of autonomy (as expressed in that person's choice to die) and reducing suffering.¹⁰⁴⁴

This gives the Bill a different character to voluntary assisted dying schemes in other jurisdictions such as Canada and Belgium, where the justification is focused less on the shared public interest in relieving suffering and pain and more squarely on the right of individuals to make voluntary and informed decisions about how and when they die, based on the principles of self-determination, dignity and individual autonomy.

Given the purpose of the Bill, it is clear that including eligibility criteria that limits access based on terminal prognosis and age are reasonable and necessary and that other less restrictive measures would fail to align with the justifications for the Bill. However, it is important to note that other jurisdictions have adopted alternative approaches to legislative design and eligibility criteria in voluntary assisted dying schemes. These alternatives should be considered as part of the review of the Bill pursuant to clause 154, having regard to the effectiveness of the current provisions at meeting the stated objectives and principles contained in the Bill and any other relevant evidence.

The full range of alternative eligibility criteria imposed in other jurisdiction was canvassed in detail in the QLRC's Report. Some examples include:

- terminal illness likely to cause death within 6 months (SA and NZ)
- seriousness of suffering (rather than terminal prognosis) (Belgium, Luxembourg, the Netherlands, and Canada)
- incurable nature of a disease with a known rapid progression (recommended by The Australian and New Zealand College of Anaesthetists & the Faculty of Pain Medicine)
- no residency requirement (European jurisdictions eg Belgium and Netherlands)
- access to children over 16 or over 12 with parental consent (for example Belgium and the Netherlands).

5.1.3.8 *The balance between the importance of the purpose of the limitation and the importance of preserving the human right*

The eligibility criteria set out in clauses 10-13 of the Bill are connected to the broader rights-enhancing purpose of the Bill. To the extent that any criteria limit protected rights, those limitations constitute a proportionate and justifiable limitation in line with section 13 of the HRA. This is particularly clear when it comes to eligibility criteria relating to decision making capacity and citizenship and residency status.

The statement of compatibility acknowledges the tension between promoting and preserving the dignity and autonomy of all persons to make informed end-of-life decisions and the need to acknowledge the complex relationship between voluntary assisted dying and the right to life.

As discussed above, there appears to be consensus emerging from the international human rights jurisprudence as to the circumstances under which voluntary assisted dying legislation can legitimately coexist with the state's positive duties to promote the right to life. This consensus centres around the need for such schemes to have robust safeguards to protect vulnerable people from coercion and abuse and ensure voluntariness and decision-making capacity of individuals seeking to access assistance to die.

The consensus is less apparent when it comes to determining whether or not safeguards should be in place to limit access to assisted dying schemes to younger people, or to those experiencing extreme

¹⁰⁴⁴ Willmott and B White, 'Assisted Dying in Australia: A Values based Model for Reform' in I Freckelton and K Petersen (eds) *Tensions and Traumas in Health Law* (The Federation Press, 2017) pp 502–503.

pain, loss of autonomy, or anguish but not ‘foreseeable death’. For example, for some rights proponents any eligibility criteria based on age runs the risk of being arbitrary and contrary to the fundamental values of dignity and autonomy that underpin voluntary assisted dying schemes. However, as Cohen-Almagor observes in an article in *Perspectives in Biology and Medicine*, the arbitrary nature of selecting one age (for example 18) over another (for example 12) should not obfuscate the sound public interest in seeking to protect certain groups within the community from the risk of harm.¹⁰⁴⁵

We establish age of consent and limit the voting age as we believe that some issues are better reserved to a later stage of life, when we develop our mental and physical faculties and could cope with partnership, sexuality, desires, the raising of children and the duties of citizenship. The right to die is no less important than any of the above issues. Death brings to an end all other rights. Why should minors be allowed this right while other rights are denied? Indeed, if minors can consent to die, one may argue that they should enjoy the autonomy to drive, to vote, to bear arms, to marry, to have sex, to bring children to the world, and to do many other things that many of us believe minors should not have the right to.¹⁰⁴⁶

It is possible to view the rights described above (such as the right to equality and freedom from discrimination) and the broader concepts of dignity and autonomy that feature in the preamble of the HRA as demanding unrestricted access to voluntary assisted dying schemes for all Queenslanders who wish to exercise their right to a dignified death. However, this would be to misunderstand the relationship between the right to life (a supreme right attracting both positive and negative state duties) and the values of autonomy and dignity that underscore a strong public interest in individuals being able to make voluntary, informed end of life decisions (which must necessarily be subject to limitation). It would also discount the other important public interests sought to be achieved by this Bill, such as preserving the primary duty of health practitioners to provide professional medical advice in the best interests of their patients, which was explored in detail during the QLRC inquiry¹⁰⁴⁷ and which forms a central feature of the request process set out in part 3 of the Bill. As Jansen, Wall and Miller observed in their 2019 article in the *Journal of medical ethics*,

It can be countered that all patients with decision-making capacity should have the legal option to engage in PAD [practitioner assisted dying] provided that they are able to find physicians who are willing to assist them. This is the position of some writers who are strongly opposed to paternalism. But for young healthy patients, almost all physicians would refuse to do so, and rightly so. They would refuse to do so because they would judge that PAD is not in the best interests of these patients. Proponents of PAD sometimes express scepticism about our ability to judge objectively whether or not PAD is in the best interests of the patients who seek it. As one writer puts it, ‘there is no objective standard, but only the competent patient’s judgment of whether continued living is no longer a benefit’. But applied to young non-terminally ill patients ... this statement seems patently false. We can be confident that these patients are making a mistake, as they very likely have many years of healthy life ahead of [them].

Physicians would resist participating in PAD for such patients for another reason as well. They would suspect that these patients would in many cases change their minds. If we do not help them to end their lives now, then many of them would endorse our refusal to do so later when they were feeling better. With respect to terminally ill patients, matters are different. As their life expectancy is short, for them, it is much harder for others to determine where their best interests lie. We also have much less reason to think that these patients would change their minds later if physicians refused to aid them ...

¹⁰⁴⁵ Cohen-Almagor, Raphael 2018, ‘Should the Euthanasia Act in Belgium Include Minors?’, *Perspectives in Biology and Medicine*, vol. 61, no. 2, pp 230-248.

¹⁰⁴⁶ Cohen-Almagor, Raphael 2018, ‘Should the Euthanasia Act in Belgium Include Minors?’, *Perspectives in Biology and Medicine*, vol. 61, no. 2, p 238.

¹⁰⁴⁷ QLRC Report, pp 27-30.

The points also show that there is no sweeping fundamental moral right to determine with the assistance of others the time, circumstances and manner of one's death.¹⁰⁴⁸

Some jurisdictions, including Canada and the Netherlands, have extended access to voluntary assisted dying schemes beyond the criteria set out in this Bill and these extensions have been upheld as complying with both the right to life and the right to equality.¹⁰⁴⁹ However, the voluntary assisted dying schemes in Victoria and Western Australia that take a more restrictive approach to eligibility than this Bill have also been described as compliant with the human rights frameworks in those jurisdictions.¹⁰⁵⁰

In such circumstances, where the international human rights landscape is relatively dynamic and local legislative schemes relating to voluntary assisted dying are still relatively new, it is appropriate that a cautious approach to eligibility criteria be adopted - at least until more evidence can be collected about the local Queensland experience. This is particularly important given the range of end-of-life decisions that may be available to persons currently ineligible under the Bill, including palliative care and the right to refuse treatment or request withdrawal of treatment (considered in detail by the Parliamentary Committee's 2020 Report). Targeted, independent research should be conducted to determine the extent to which these alternatives preserve or limit the dignity and autonomy of persons who are ineligible under the Bill on the grounds of age or the non-terminal nature of their illness. For example, in its report, the QLRC concluded:

... there is a need to explore further the application of any voluntary assisted dying scheme, with modifications, to children. At present, there are gaps in the scientific, evidence-based research available to inform the development of policy in this area. For example, there would be benefit in future consultations being undertaken with children, child health and other experts, and medical practitioners practising in the field of paediatrics, particularly in the area of end of life care and the withdrawal or withholding of life sustaining measures.¹⁰⁵¹

The QLRC Report underscores the need to continue to collect evidence in this area and for that reason recommended the inclusion of clause 154 of the Bill which will provide for a review of the Act within three years and provide an opportunity to revisit the eligibility criteria contained in clauses 10-13.

The alternative approach (such as removing or diluting some of the eligibility criteria from clauses 10-13) may place the Bill at far greater risk of abrogating the rights protected in the HRA, particularly the right to life in section 16, and may place the Bill beyond the type of justifiable limitations described in section 13 of the HRA.¹⁰⁵² The decision in *Truchon and Gladu v Attorney General (Canada)* (which resulted in the removal of the requirement for an illness to result in 'foreseeable death') was made in the context of a differently constituted human rights regime, which includes explicit protection for rights associated with self-determination, dignity and autonomy. The decision in *Truchon* also prompted discussion within the Canadian Parliament as to whether additional medical assessments

¹⁰⁴⁸ Jansen, L.A., Wall, S. & Miller, F.G. 2019, 'Drawing the line on physician-assisted death', *Journal of medical ethics*, vol. 45, no. 3, p 190.

¹⁰⁴⁹ QLRC Report, pp 46-50; *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (Netherlands); *Euthanasia Act 2002* (Belgium).

¹⁰⁵⁰ QLRC Report, pp 50-53; see also *Voluntary Assisted Dying Act 2017* (Vic); *Voluntary Assisted Dying Act 2019* (WA). For further discussion see WA Ministerial Expert Panel Final Report (2019) p 20. See also B White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect Its Stated Policy Goals?' (2020), *University of New South Wales Law Journal*, 43(2), pp 417, 434.

¹⁰⁵¹ QLRC Report, paragraph 7.386.

¹⁰⁵² See *Truchon and Gladu v Attorney General (Canada)* and Attorney General [2019] QCCS 3792.

and waiting periods should be required for persons who were experiencing non-terminal decisions.¹⁰⁵³ Similarly, the voluntary assisted dying schemes that include more relaxed criteria with respect to age (such as that in force in Belgium and the Netherlands) also include additional assessments around decision-making capacity for younger people¹⁰⁵⁴ and have been accessed by persons under 18 only rarely. These examples illustrate that differentiated treatment of certain cohorts of individuals may be required under any voluntary assisted dying scheme and underscore the need to preserve a democratic ‘leeway of choice’¹⁰⁵⁵ for legislators in this area to respond to the evidence-based needs of local populations and to consider how voluntary assisted dying schemes fit within broader health services designed to preserve and promote dignified end of life choices.

Committee comment

The committee appreciates the carefully calibrated balance featured in the Bill between promoting and preserving the dignity and autonomy of all persons to make informed end-of-life decisions and the complex relationship between voluntary assisted dying and the right to life.

The committee considers that the Bill should be viewed as a whole and removing or diluting some of the eligibility criteria from clauses 10-13 would risk abrogating the rights protected in the HRA and therefore, any limitations to human rights raised by the eligibility criteria in the Bill are reasonable and justifiable.

5.1.4 The right to freedom of thought, conscience, religion and belief

A number of clauses in the Bill provide an opportunity for health practitioners to refuse to participate in voluntary assisted dying processes on the grounds of a conscientious objection. Clause 84 sets out the rights and responsibilities of a registered health practitioner who has a conscientious objection to voluntary assisted dying. Clause 84 requires that health practitioners who do not wish to be involved in voluntary assisted dying processes to register and disclose their conscientious objection to patients and take steps to make sure that patients have alternative pathways to seek information about the voluntary assisted dying scheme.

Other provisions within the Bill (such as clauses 16 and 26) explain in more detail when and how a medical practitioner can refuse requests by patients for information or to assess their suitability for assisted dying. For example, clause 26 provides that a medical practitioner with a conscientious objection to assessing a person who is requesting voluntary assisted dying must inform the person and the coordinating practitioner of their decision immediately after the referral is made.¹⁰⁵⁶ Clause 84 requires that health practitioners who do not wish to be involved in the voluntary assisted dying process must:

- inform the person that other health practitioners, health service providers or services may be able to assist the person; and
- give the person information about a health practitioner, health service provider or service who is likely to be able to assist the person, or the details of an official voluntary assisted dying care navigator service that is able to provide the person with information about a health practitioner, health service provider or service who may be able to assist the person.

¹⁰⁵³ Canada Criminal Code, RSC 1985, c C-46, s 241.2(3.1)(i). See also QLRC 245. Michaela Estelle Okninsk Why Death Need Not Be “Reasonably Foreseeable”—The Proposed Legislative Response to Truchon and Gladu v Attorney General (Canada) and Attorney General (Quebec) [2019] QCCS 3792, Michaela Estelle Okninsk, 15 January 2021.

¹⁰⁵⁴ QLRC Report, pp 53-54.

¹⁰⁵⁵ See Julius Stone ‘Leeways of Choice, Legal Tradition and the Declaratory Theory of Law’, *UNSW Law Journal*, 1986, 9(2), p 26.

¹⁰⁵⁶ Explanatory notes, p 80.

Clause 85 sets out the rights and responsibilities of a speech pathologist who has a conscientious objection to voluntary assisted dying.

Clause 90 of the Bill also addresses the circumstances in which a 'relevant entity' (such as a residential aged care facility) refuses to provide access to voluntary assisted dying request and assessment processes. In such circumstances, the relevant entity can refuse to participate directly in the voluntary assisted dying scheme but must not hinder the person's access at the facility to information about voluntary assisted dying; and must allow reasonable access to the person at the facility by a registered health practitioner or a member or employee of an official voluntary assisted dying care navigator service who is seeking to provide the requested information about voluntary assisted dying, or who has been asked to receive a request or to conduct an assessment with respect to that person. In addition, relevant entities are required to inform the public of the non-availability of voluntary assisted dying assessments and assistance at their facility.¹⁰⁵⁷

As noted in the Statement of compatibility these components of the Bill engage the right to freedom of thought, conscience, religion and belief (discussed below) as well as the right to health care and to equality before the law discussed above.

5.1.4.1 Nature of the human right

Section 20 of the HRA provides:

... [e]very person has the right to freedom of thought, conscience, religion and belief, including ... the freedom to demonstrate the person's religion or belief in worship, observance, practice and teaching, either individually or as part of a community, in public or in private.

This right is based on Article 18 of the ICCPR and has two distinct components: a freedom to think and believe whatever you choose, and a freedom to demonstrate your thoughts or beliefs publicly.¹⁰⁵⁸

As the QHRC notes, this right protects both religious and non-religious belief, so it includes freedom of religion and freedom from religion. It requires the state not to interfere with an individual's spiritual or moral existence. Like all rights in the Act, the right to freedom of thought, conscience and belief can be limited where it is reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom. However, under international law, the right to have or adopt a religion is considered to be absolute, while the right to demonstrate that religion can be subject to reasonable limits. In other words, once a belief is manifested (that is, implemented) in action, it leaves the sphere of absolute protection and may be the subject of legitimate limitations, because the manifestation of a religious belief may have an impact on others. The right to freedom of belief therefore 'does not always guarantee the right to behave in public in a manner governed by that belief'.¹⁰⁵⁹

The rights of doctors and other health professionals to exercise their freedom of thought, conscience, religion and belief has long been recognised through the principle of 'conscientious objection' which forms part of Australian codes of conduct and ethical standards for doctors, nurses, pharmacists and other health practitioners. These codes and standards recognise that a health practitioner may decline to provide or participate directly in a treatment or procedure to which the practitioner conscientiously objects. They also recognise that freedom of thought, conscience, religion and belief is not absolute and must be carefully balanced with other ethical duties, including the duty to act in the patient's best interest. As a result, under these codes and standards, an objecting practitioner is required to inform their employer, colleagues and patients of their objection and to ensure that a patient has alternative

¹⁰⁵⁷ Voluntary Assisted Dying Bill 2021, cl 98.

¹⁰⁵⁸ QHRC, 'Fact Sheet on s 24', <https://www.qhrc.qld.gov.au/your-rights/human-rights-law>.

¹⁰⁵⁹ Pichon and Sajous v France (European Court of Human Rights, Chamber, Application No 49853/99, 2 October 2001) p 5. See also Skugar and Others v Russia, (European Court of Human Rights, Chamber, Application No 40010/04, 3 December 2009).

care options or that their access to care is not impeded, including by providing information to enable a patient to obtain services elsewhere.¹⁰⁶⁰ For example, Queensland Health clinical guidelines about end of life care provide that in limited circumstances a medical practitioner may be excused from providing a patient with care that goes against their conscience. An objection must be 'declared as early as possible' so that the patient is not at risk of harm and their care can be appropriately handed over to another practitioner or treating team.¹⁰⁶¹

5.1.4.2 *Nature of the purpose of the limitation*

Identifying the precise nature of the rights limitation (if any) imposed by this provision is complex because the conscientious objection related clauses in the Bill engage different HRA provisions in different ways. On the one hand, the clauses seek to protect the rights of health practitioners to freedom of thought, conscience, religion and belief by allowing doctors to object to voluntary assisted dying and refuse to participate in the scheme. It may be possible to argue that the clauses designed to protect the rights of health practitioners to freedom of thought, conscience, religion and belief are insufficient and therefore limit this right. For example, it could be argued that the requirements associated with registering a conscientious objection are too onerous and/or that the subsequent responsibilities to notify patients and coordinating medical practitioners constitute a form of participation in the voluntary assisted dying scheme.

On the other hand, it could be argued that these clauses potentially engage and limit access to health care protected by section 37 of the HRA by creating a barrier to access to the voluntary assisted dying scheme for some patients. For example, a patient from a regional or remote area with limited access to a diverse range of specialists or other sufficiently qualified doctors or nurse practitioners could be left without practical access to the voluntary assisted dying scheme¹⁰⁶² if local health practitioners register a conscientious objection under these clauses, or if relevant entities refuse to provide access to voluntary assisted dying process.

The QLRC was aware of these potential arguments during its investigation and consultation. For this reason it recommended a range of detailed safeguards be included in the Bill that aim to ensure that vulnerable patients are not left with access to appropriately qualified medical practitioners and that health professionals have a range of options and opportunities to refuse to actively facilitate voluntary assisted dying.¹⁰⁶³ For example, a medical practitioner can refuse a person's first request for an assessment of eligibility for voluntary assisted dying but must inform the person of their decision. The medical practitioner must also give the person information about a registered health practitioner, health service provider or service who the practitioner believes will be able to assist the person with the person's request. Alternatively, the medical practitioner must provide the person with the details of an official voluntary assisted dying care navigator service that can provide the person with

¹⁰⁶⁰ QLRC Report, PP 133-140. See MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, October 2020, [3.4.6]–[3.4.7]; AMA, *Code of Ethics*, 2016, [2.1.13], [4.2.3]; AMA, *Position Statement: Conscientious Objection*, 2019, [1.2][1.3], [2.2]–[2.3]; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses*, March 2018, [4.4](b); Australian Nursing & Midwifery Federation, *Policy: Conscientious Objection*, November 2017, [1]–[2], [4]; Australian Nursing & Midwifery Federation, *Position Statement: Voluntary assisted dying*, November 2019, [12](a); Pharmacy Board of Australia, *Code of Conduct for Pharmacists*, March 2014, [2.4](f), (g); Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists*, February 2017, pp 12, 18.

¹⁰⁶¹ QLRC Report, pp 96-98; Queensland Department of Health, 'Care at the End of Life', <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life>.

¹⁰⁶² See e.g. Ben White, Lindy Willmott, Marcus Sellars, 'Victoria's voluntary assisted dying scheme is challenging and complicated. Some people die while they wait', *The Conversation*, online, 28 June 2021.

¹⁰⁶³ QLRC Report, paragraph 14.81.

information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person with the person's request.

5.1.4.3 The relationship between the limitation and its purpose

The conscientious objection clauses described above do not seek to limit the rights of health practitioners to hold a moral, conscientious or religious objection to voluntary assisted dying. Nor do they seek to limit a health practitioner's right to manifest that objection in public. To this end, the clauses are well within the boundaries of the rights protected by section 20 of the HRA. However, the clauses do impose certain consequences and obligations on health practitioners who manifest that objection. These consequences and obligations are designed to ensure that vulnerable patients are not left without access to appropriately qualified medical practitioners and other health professionals. This is a legitimate public interest that seeks to advance the rights of others to be able to freely access health care, and to promote the values of dignity and autonomy described above. As noted by Pesut, Thorne and Greig in the context of their article on the ethical duties of nurses in voluntary assisted dying schemes:

When clinical choices that reflect antithetical values and beliefs arise, the nurse must then decide whose values and beliefs are preeminent in the context of the nurse–patient relationship. If the patient believes that [voluntary assisted dying] is morally acceptable but the nurse does not, whose choice trumps? Or, are there ways to hold both choices concurrently? Although nurses are permitted to conscientiously object to participating in [voluntary assisted dying], how they convey that objection to clients is of paramount importance. As professionals, nurses are required to withdraw from care in such a way that their conscientious objection does not negatively impact their clients by communicating judgement or disapproval. Nurses must remain deeply concerned about the potential impact of their own values and beliefs on clients.¹⁰⁶⁴

To the extent to which the conscientious objection clauses may operate to limit equal access to health care, regard must be had to the nature and scope of the right protected by section 37 of the HRA and the permissible range of limitations of that right which has been described in international human rights law as capable of 'progressive realisation'.¹⁰⁶⁵ In the case of the proposed voluntary assisted dying scheme, it appears that any limitations imposed by the conscientious objection clauses on the rights protected under section 37 of the HRA are justified on the basis that they are necessary to protect and promote freedom of thought, conscience, religion and belief among those practitioners tasked with implementing the scheme. Such an approach is in line with well-established standards for ethical medical practice.

5.1.4.4 Whether there are less restrictive and reasonably available ways to achieve the purpose

The provisions in this Bill that facilitate the making of a conscientious objection by an individual health practitioner are patient-focused, due to the obligations placed on the health practitioner to ensure that the patient is able to access alternative sources of information about voluntary assisted dying or alternative health practitioners quickly and effectively. However, as noted above, the Bill also allows for relevant entities (including RACFs) to refuse to participate in voluntary assisted dying processes (subject to a range of important conditions). To this end, the Queensland approach is more facilitative of entity-based conscientious objection than the legislation in Victoria. It is noted however that a similar provision has been included in the recently-enacted South Australian legislation, providing a 'health service establishment operated by the relevant service provider' with the option to conscientiously object to the voluntary assisted dying scheme in that state.¹⁰⁶⁶

¹⁰⁶⁴ Pesut, Barbara, Thorne, Sally & Greig, Madeleine 2020, 'Shades of gray: Conscientious objection in medical assistance in dying', *Nursing Inquiry*, vol. 27, no. 1, p. e12308–n/a. p. 4.

¹⁰⁶⁵ See eg, Sheikh Mohammad Towhidul Karim, George F. Tomossy, 'Progressive realisation of the right to health: an opportunity for global development', *Waikato Law Review*, (2019), 27, pp 31-45.

¹⁰⁶⁶ *Voluntary Assisted Dying Act 2021 (SA)*.

5.1.4.5 The balance between the importance of the purpose of the limitation and the importance of preserving the human right

As noted by the QLRC ‘recognition of the right of an individual to freedom of conscience and belief warrants a provision about an individual’s conscientious objection to participating in voluntary assisted dying.’¹⁰⁶⁷ This right has been protected and promoted by the conscientious objection clauses contained in this Bill. The corresponding consequences and obligations on those who seek to utilise these provisions do not impermissibly limit this right. Those consequences and obligations have been imposed for legitimate purposes associated with promoting the rights of others to access health care, and to promote the values of dignity and autonomy. They are broadly consistent with:

- the approach taken in other jurisdictions, including Victoria and Western Australia
- the recommendations made by the Parliamentary Committee and the White and Willmott Model
- other legislation, such as the Termination of Pregnancy Act 2018
- codes of conduct and ethics applying to the medical profession or to particular health care organisations.¹⁰⁶⁸

In so far as the conscientious objection clauses may operate to limit the right to access health care protected by section 37, the limitation is within the scope of section 13 of the HRA. The access implications that may arise from individual health practitioners exercising their right to conscientiously object under the Bill point to the practical challenges associated with ensuring a diversity of specialist doctors and nurses are available in different regions and communities in Queensland. These challenges, while real and in need of urgent attention,¹⁰⁶⁹ do not render the impact of the conscientious objection clauses in the Bill disproportionate.

In addition, the obligations imposed on relevant entities that refuse to provide direct access to the voluntary assisted dying scheme are significant and are designed to ensure patients have access to practical, timely alternatives.

Committee Comment

While the provisions in the Bill that enable an individual’s conscientious objection to participating in voluntary assisted dying impose obligations which may limit the right to freedom of conscience and belief, those obligations promote the rights of others to access health care, and to promote the values of dignity and autonomy and as such, the committee considers the limitation reasonable and justifiable.

The committee is of the view that careful consideration should be given to the practical operation of the provisions which impose on relevant entities that refuse to provide direct access to the voluntary assisted dying scheme and similar clauses (recently enacted in SA) and their impact on residents of the facilities run by objecting entities ahead of the review of the Bill provided for in clause 154.

5.1.5 Other potentially rights engaging clauses

5.1.5.1 Clause 112 Review hearings by QCAT to be held in private

Part 7 of the Bill provides for the private review of certain decisions by QCAT. This feature of the Bill has the potential to engage the right to a fair and public hearing protected by section 31 of the HRA.¹⁰⁷⁰

¹⁰⁶⁷ QLRC Report, paragraph 14.81.

¹⁰⁶⁸ QLRC Report, p 432.

¹⁰⁶⁹ See e.g. Ben White, Lindy Willmott, Marcus Sellars, ‘Victoria’s voluntary assisted dying scheme is challenging and complicated. Some people die while they wait’, *The Conversation*, online, 28 June 2021.

¹⁰⁷⁰ Statement of compatibility, p 24.

Section 31 of the HRA provides protections designed to ensure that a person charged with a criminal offence or a party to a civil proceeding has access to a fair and public hearing, conducted by an independent and impartial court or tribunal.¹⁰⁷¹ Subsection 31(2) provides an exception to the public hearing aspect of this right where it is in the public interest and interests of justice to exclude media organisations, other persons or the general public from all or part of a hearing.¹⁰⁷² What constitutes a 'fair' hearing will depend on the facts of the case and will require a number of public interest factors to be weighed. As the PJCHR has observed,¹⁰⁷³ in exceptional circumstances proceedings may be conducted in private if it is necessary and proportionate to do so for reasons of public order, morals or national security, or the interests of the private lives of the parties require privacy.

Many other legislative schemes attempt to preserve the confidentiality of certain information and protect the interests of vulnerable parties by limiting fair hearing rights.¹⁰⁷⁴ Such measures include the use of closed courts, prohibitions of disclosure of sensitive information and modifications to rules of evidence. Where such schemes are subject to effective and sufficient safeguards, they have generally been found to constitute justifiable limitations on the right to a fair hearing.¹⁰⁷⁵

It is also important to note that clause 112 of the Bill does not exclude all members of the public from hearings as a blanket rule, and preserves QCAT's power to 'make directions, on its own initiative or on the application of a party, about the persons who may attend a hearing or a part of a hearing'.

Committee Comment

The committee considers that the limit on the right to a fair and public hearing in part 7 of the Bill is reasonable and justifiable.

5.1.5.2 Clause 124 - Eligibility criteria for members of the Voluntary Assisted Dying Review Board

Part 8 of the Bill provides for the establishment of the Board which will have important oversight functions. Clause 124 sets out eligibility and disqualification criteria for appointment to the Board. Clause 124(3), in particular, disqualifies a person who is in one of the categories below:

- an insolvent under administration under section 9 of the *Corporations Act 2001 (Cth)*
- has a conviction, other than a spent conviction, for an indictable offence
- a member of the Legislative Assembly.

The Statement of compatibility notes that by excluding certain classes of people from membership of the Board, clause 124 may engage the right of equal access to the public service under section 23(2)(b) of the HRA.

Section 23 of the HRA protects the right of every person in Queensland to have the opportunity, without discrimination, to 'participate in the conduct of public affairs, directly or through freely chosen representatives'.¹⁰⁷⁶ This includes the right to vote and be elected at State and local elections¹⁰⁷⁷ and to the right to access the public service and public office.¹⁰⁷⁸ It is this component of the right protected in section 23, namely the right to access public office, that is relevant to the clauses noted above.

¹⁰⁷¹ *Human Rights Act 2019*, s 31(1).

¹⁰⁷² *Human Rights Act 2019*, s 31(2).

¹⁰⁷³ Parliament of Australia, PJCHR, *Guide to Human Rights*, June 2015, p 24, [1.88].

¹⁰⁷⁴ See e.g. *Family Law Act 1975 (Cth)* Part XI, Procedure and Evidence; *Children's Court Act 1992*, s 20.

¹⁰⁷⁵ See e.g. Parliament of Australia, PJCHR, *Guide to Human Rights*, June 2015, p 24.

¹⁰⁷⁶ *Human Rights Act 2019*, s 23(1).

¹⁰⁷⁷ *Human Rights Act 2019*, s 23(2)(a).

¹⁰⁷⁸ *Human Rights Act 2019*, s 23(2)(b).

The right to participate in public life has been interpreted broadly at the international level, and in other Australian jurisdictions with human rights legislation.¹⁰⁷⁹ However, like all rights in the HRA, the right to access public office can be limited where it is reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom, for example when a limitation on this right is necessary to address disadvantage or exclusion by a specific group¹⁰⁸⁰ or where the particular functions and context of board or public office demand a particular set of eligibility criteria.

The reasoning provided in the statement of compatibility that any potential limitation imposed by clause 124 on the rights protected in section 23 of the HRA are ‘justified by the need to ensure that the Board is composed of suitable members who are independent and able to discharge the important oversight functions of the Board.’¹⁰⁸¹ The Board is tasked with providing oversight of the most significant decisions capable of being made (those of life and death). It is imperative that Board members meet the highest ethical and character standards, even if this limits equal access to this particular public office.¹⁰⁸²

Committee Comment

Given the need to ensure that the Board is composed of suitable members who are independent and able to discharge the important oversight functions of the Board, the committee considers that any limit on the right to participate in the conduct of public affairs, directly or through freely chosen representatives in clause 124 of the Bill is reasonable and justifiable.

Committee conclusion

The committee notes the Bill was developed following years of investigation into the issues relating to voluntary assisted dying and substantial community consultation by independent and parliamentary bodies, including the QLRC during 2020-2021¹⁰⁸³ and the former committee during 2018 to 2020.¹⁰⁸⁴ The comprehensive nature of these investigations and consultations support and affirm the key conclusions reached in the statement of compatibility concerning the compliance of the Bill with the rights protected in HRA.

The committee is satisfied that the human rights limitations identified are justified in the circumstances, having regard to section 13 of the HRA.

The committee considers that the Bill is compatible with the HRA. To the extent to which some clauses of the Bill limit specific human rights, those limitations to have been sufficiently justified.

5.2 Statement of compatibility

Section 38 of the HRA requires that a member who introduces a Bill in the Legislative Assembly must prepare and table a statement of the Bill’s compatibility with human rights.

The statement of compatibility was tabled with the introduction of the Bill and a sufficient level of information was provided to facilitate understanding of the Bill in relation to its compatibility with

¹⁰⁷⁹ For example, in *Slattery v Manningham CC (Human Rights)* [2013] VCAT 1869 the Victorian Civil and Administrative Tribunal found that a local council’s decision to prohibit a resident and ratepayer with a disability from attending any building that was council owned, occupied or managed breached the right to participate in public life as protected by the Victorian Charter of *Human Rights and Responsibilities Act 2006* (Vic).

¹⁰⁸⁰ International Covenant on Civil and Political Rights, Article 25.; United Nations Human Rights Committee, General Comment No 25 (Right to take part in public affairs) CCPR/C/21/Rev.1/Add.7.

¹⁰⁸¹ Statement of compatibility, p 25.

¹⁰⁸² Statement of compatibility, p 25.

¹⁰⁸³ QLRC, *A Legal Framework for Voluntary Assisted Dying*, Report No 79, May 2021.

¹⁰⁸⁴ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Report No. 34, 56th Parliament – *Voluntary assisted dying*, March 2020.

human rights. The statement included detailed references to and consideration of relevant international human rights jurisprudence and comparative law examples in other Australian jurisdictions. The statement also included detailed references to the extensive report undertaken by the QLRC which provided a strong qualitative basis for justifications of purpose and proportionality to be advanced.

Appendix A – Submitters

Sub #	Submitter	Sub #	Submitter
0001	Anita Taylor	0033	Name withheld
0002	Allan Choveaux	0034	Kathleen Evans
0003	Venchenza Wilkins	0035	Name withheld
0004	Davina Filie	0036	Gary Loblely
0005	Fiona Jacobs	0037	Joan Musumeci
0006	Jennifer Blake	0038	John Tucker
0007	Name withheld	0039	Chris Ennor
0008	Christine O'Connell	0040	Number not used
0009	Judith Baxter	0041	Frances Harper
0010	Michael Wilson	0042	Samantha Bryan
0011	Sonia Tesolin	0043	Evan Coombs
0012	Name withheld	0044	Peter Phillips
0013	Jan Logan	0045	Cris Geri
0014	Myles Collins	0046	Name withheld
0015	H Achilles	0047	Name withheld
0016	Gillian Callaghan	0048	Jonathan Farrell
0017	Linda Gardiner	0049	Jacqui Possingham
0018	Number not used	0050	Name withheld
0019	Sarah Deuble	0051	Jin Pian Tan
0020	Heather Taylor	0052	David and Gillian Lowe
0021	Name withheld	0053	Dr Theo Shemansky
0022	Carolyn Morgan	0054	Katherine Blundstone
0023	Amanda Ansell	0055	Lynne Hume
0024	Christians Supporting Choice for Voluntary Assisted Dying	0056	Leslie Cutter
0025	Colin Hylton	0057	Alon Barnes
0026	John Gregan	0058	Name withheld
0027	Naomi Taylor	0059	Jordan Ball
0028	Margaret Cassells	0060	Name withheld
0029	Robert Heron	0061	Ian Hamilton
0030	Alex Webling	0062	Ian Patterson
0031	Daniel Stewart	0063	John Lane
0032	Gang of Four (Group of individuals)	0064	Morag Roy

0065	Elizabeth Hallgath	0100	Noel Anderson
0066	Name withheld	0101	Vanessa Durand
0067	Beverley Young	0102	Name withheld
0068	Cheryl Sykes	0103	Johanna Mccahon
0069	Christine Briggs	0104	Margaret Downes
0070	David Nelson	0105	Faye Gobbert
0071	Huibrecht Lankester	0106	Yvonne Crome
0072	Thomas O'Grady	0107	Maggie Stanke
0073	Name withheld	0108	Name withheld
0074	Sylvia Fisher	0109	Malcolm Parker
0075	Name withheld	0110	David Youds
0076	John Dutton	0111	Queensland Directors Palliative Care Group
0077	Name withheld	0112	Alex Wittman
0078	Name withheld	0113	Ann Sale
0079	Mount Isa Baptist Church	0114	Jeffery Sale
0080	Brenton Nicholls	0115	Carol O'Connell
0081	Dr Timothy Coyle	0116	Carol and Ken Lester
0082	Spero Kartanos	0117	Philip Jamison
0083	Roy Douglas	0118	Kathleen Marti
0084	Confidential	0119	Ron Whalen
0085	Confidential	0120	Julie Walton
0086	Name withheld	0121	Margaret Cassells
0087	Name withheld	0122	Lorraine Cobcroft
0088	Julee Redgen	0123	Marilyn Bitomsky
0089	Sandie Wilson	0124	June Henderson
0090	Belinda Gilbert	0125	Sharon Brown
0091	Confidential	0126	Dorothy Peters
0092	Julie Clark	0127	Kathryn Blackburn
0093	Harry A Boniface	0128	Diane Lambropoulos
0094	Roslyn Savage	0129	John Brodie
0095	Digby Gotts	0130	Athol Brown
0096	Name withheld	0131	Janet Stoddard
0097	Trudy Gardner	0132	Gwendolene Klein
0098	Marja Visser	0133	David Slatyer
0099	Margaret Chandler-Cross	0134	Marjorie Lawrence

0135	Vicki Poyser	0170	Belinda Kuppens
0136	Kate Brooks	0171	Name withheld
0137	Name withheld	0172	Trudi Lomas
0138	Benita Orwell	0173	Valerie Wicks
0139	Heinz Quatembr	0174	Graham Dempster
0140	Tracey MacKenzie	0175	Julie Bathurst
0141	Carmel Yore	0176	Name withheld
0142	Dianne Buckton	0177	Marcia Cowle
0143	Kymerley Weaks	0178	Name withheld
0144	Susan Borer	0179	Suzie Lambert
0145	Donald Rogers	0180	Name withheld
0146	Margaret Robley	0181	John Ancliffe
0147	Loris Doessel	0182	Ineke Hartman
0148	Mark Abbott	0183	Name withheld
0149	Peter Sullivan	0184	Name withheld
0150	Barbara Wintringham	0185	Ronald Freyling
0151	Pieter Verhaart	0186	Name withheld
0152	Name withheld	0187	Peter Robertson
0153	Confidential	0188	Christine Zacharda
0154	Jo Normand	0189	Confidential
0155	Anne-marie Horvat	0190	Richard Graham
0156	Name withheld	0191	Name withheld
0157	Bernadette Whitney	0192	John Gregan
0158	Roslyn Blunden	0193	Name withheld
0159	Name withheld	0194	Mike Sackett
0160	Carol Palmer	0195	Raymond Wilson
0161	Ron Chivers	0196	Wayne Selfe
0162	Jill Denovan	0197	Confidential
0163	Name withheld	0198	Elizabeth Ivan
0164	Deidre Osborne	0199	Deborah Marshall
0165	Name withheld	0200	Tim Storey
0166	Melina Sarigiannis	0201	John Kent
0167	Graeme Furlong	0202	Name withheld
0168	Linda Laajunen	0203	Daniel Clemesha
0169	Vicki White	0204	Donna Greenslade

0205	Confidential	0240	Denise Sauer
0206	Tammy D'Addona	0241	Ian Robbins
0207	Alan Hider	0242	Sam Pinnell
0208	Lorraine Hider	0243	Julie Streatfield
0209	Gary Loblely	0244	Uniting Church in Australia Qld Synod
0210	Nick and Yvonne Bewes	0245	Confidential
0211	Alan (Bill) Cockram	0246	Ian Kilminsster
0212	Alan G. Hider	0247	Monica Thomson
0213	Garry Bolton	0248	William Smith
0214	Sue Leon	0249	Fiona Dempster
0215	Karilyn Ewings	0250	Julie Borger
0216	Lauryn Rockliff	0251	Malcolm McKellar
0217	Name withheld	0252	Laine Preston
0218	Rodney Lewis	0253	Allison John
0219	Ashley Davis	0254	Rev Dr Spencer Gear
0220	Joanne Mills	0255	Theresa Cluning
0221	Michael Pfeffer	0256	Lucille Kuster
0222	Anthony Nielsen	0257	Viviana Verheesen
0223	Denise Kapernick	0258	Dean K Wallace
0224	Christine O'Connell	0259	Phil Browne
0225	Confidential	0260	Australian Medical Association Queensland
0226	Confidential	0261	Ruth A Fletcher OAM
0227	David Neal Thompson	0262	Joy Bound
0228	Margaret Taylor	0263	Angela Lane
0229	Laura Quirk	0264	Trevor W Sullivan
0230	Confidential	0265	Warren Bray
0231	Name withheld	0266	Susan Tibbs
0232	Lorretta Aisthorpe	0267	Kevin Parsonson
0233	Name withheld	0268	Julianne Wallis
0234	Jean-Marc Dufourq	0269	Jessica Knight
0235	Kingsley Webster	0270	Siobhan Rathbone
0236	Jill Glenny	0271	Craig Vanderduys
0237	Name withheld	0272	Talia Allen
0238	Charles Bazley	0273	Michael Dwyer
0239	Toni Trevor	0274	Darryn Jensen

0275	Murray and Linda Buhse	0310	Donna Maddock
0276	Number not used	0311	Christina Reid
0277	Phyllis Wagner	0312	Donna Rhoda Cutts
0278	Dying with Dignity Queensland Inc.	0313	Name withheld
0279	Name withheld	0314	Marja Visser
0280	Joel Lowe	0315	Jenepher Bowler
0281	Dementia Australia	0316	Name withheld
0282	Chris and Diana Trynes	0317	Vicki White
0283	Vito and Lynette Cuzzubbo	0318	John Woodlock
0284	Wendy Caldwell	0319	Viv McLauchlan
0285	Ron and Suzanne Beattie	0320	Silvia Immoos
0286	Name withheld	0321	Confidential
0287	Peter Arney	0322	Vit Martinek
0288	Trish Madon	0323	Merrilyn Wasson
0289	Genevieve Alexander	0324	Tracey Brooks
0290	Shirley Faith Baigent	0325	Rhonda Todd
0291	Alan Corbett	0326	Owen Davies
0292	Name withheld	0327	Daisy Hansen
0293	Paul Harrigan	0328	Confidential
0294	Jenny Collins	0329	Name withheld
0295	Deborah McPherson	0330	June Leisten
0296	Julio Correa	0331	Name withheld
0297	Christine Benjamin-Young	0332	Mary Maloney
0298	Julie Walton	0333	Chantal Mcknight
0299	Margaret Woodhouse	0334	Glenda Miller
0300	James Blair	0335	Mariee Willett
0301	Carolyn Malley	0336	Julie Robinson
0302	Confidential	0337	Confidential
0303	Klaas Vandersluis	0338	Elaine Platt
0304	Shane Stace	0339	Lilyanna Medhurst
0305	Lynne Parkinson	0340	Wendy Jones
0306	Jill Ebdon	0341	Vicki Sakrzewski
0307	Frances Singh	0342	Kerry Primrose
0308	Debra Lynch	0343	Jan Logan
0309	Anthony Element	0344	Paulina Verhoeven

0345	Steven Percy	0380	Kerry Boettcher
0346	Tamra Betts	0381	Ray Bennett
0347	Cheryl Laizans	0382	David Brownlie
0348	Michelle Jenkins	0383	Krystal Lopez-Barahona
0349	Kim Spinks	0384	Brian Gough
0350	Deborah Sauviat	0385	Ashraf Saleh
0351	Name withheld	0386	Amanda Culhane
0352	Lyn Totman	0387	Judi van der Meer
0353	Name withheld	0388	Desiree McInnes
0354	Drew Jackson	0389	Michael Curtin
0355	Carolyn Bowser	0390	Murray Johnston
0356	Kaydee Artis	0391	Barbara Croucher
0357	Hayley Firth	0392	William Reid
0358	John Cooney	0393	Suzanne Pfister
0359	Julie Simonds	0394	Judy Theobald
0360	Carmen Thamm	0395	V Marando
0361	Glendowra Bean	0396	James Warren
0362	Joanne Webster	0397	Kathryn Elsworthy
0363	Karen Lawson	0398	Jackie Carlyle
0364	Ian Douglas Moncrieff	0399	Margaret S James
0365	Katrina Higgins	0400	Owen Hitching
0366	Debbie Zanetti	0401	David Magraith
0367	Glen Petersen	0402	Damien Ahern
0368	William and Sandra Tento	0403	James Tayler
0369	Jennifer Routley	0404	Mike Zweck
0370	Andrew Hardy	0405	Linda and Andrew Fulton
0371	Paula Townsend	0406	Robert Rawson
0372	Alan Adams	0407	Michael and Resi Fuessel
0373	Kieran O'Callaghan	0408	Daina Stedman
0374	Tim Young	0409	Lorna West
0375	Vernett Lauridsen	0410	Craig van Echten
0376	Todd Parkes	0411	Name withheld
0377	Kate Reilly	0412	David Shafer
0378	Lyn Dumke	0413	Confidential
0379	Rex Masters	0414	Right to Life

0415	Patricia Seng	0450	Sue Ure
0416	Doreen Wright	0451	Susan Malone
0417	Australian Care Alliance	0452	Merle Rowe
0418	Joy Pakulla	0453	Confidential
0419	Name withheld	0454	Confidential
0420	Confidential	0455	David Kirchoffer
0421	Name withheld	0456	Anna van den Brenk
0422	Vernon Grayson	0457	Ron Birch
0423	Name withheld	0458	Wendy Houston
0424	Michele Kempys	0459	Robin Vartan
0425	Pieter Verhaart	0460	Moya Jackson
0426	Christine Bridgman	0461	Name withheld
0427	Peter Hartinj	0462	Jeanette Scott
0428	Name withh0eld	0463	William Scott
0429	Marshall Perron	0464	Name withheld
0430	Sheila Sim	0465	Name withheld
0431	Alison Courtice	0466	Name withheld
0432	Denis Edwards	0467	Confidential
0433	Name withheld	0468	Stephanie Russell-Farnham
0434	Pauline Mcniece	0469	Ross McPherson
0435	John Renehan	0470	Nancy Stilianos
0436	Anne Coyle	0471	Denise Burke
0437	Andrew Painter	0472	Jeanette Gray
0438	Maritia Downes	0473	Mogana Moses
0439	Bernadette Davies	0474	Johanna Richards
0440	Rod Lougheed	0475	Louie L. Oldfield
0441	Name withheld	0476	Eric Quan
0442	Peter and Suzelie Connelly	0477	Anna Castrissios
0443	Number not used	0478	Caitlin Campbell
0444	Angela Moore	0479	Yvette Tan
0445	Frank Drew	0480	Michael Tudor
0446	Name withheld	0481	Mark Allen Vegar
0447	Helen Kness	0482	John R. Nolan
0448	Zoe Feather-Zillis	0483	Cassandra Ryttersgaard
0449	Margaret O'Shea	0484	Preshy Verghese

0485	Allan Lewis Ralph	0520	Bill Bramblet
0486	Clare Ciranni	0521	Shane Baxter
0487	Carolyn Hoopert	0522	Ken Battle
0488	Brian Hay	0523	Lynne Reeza
0489	Jenna-Eve Hitchcock	0524	Adam Marshall
0490	Kevin Jensen	0525	Edward Walker
0491	Jono Toweel	0526	William Stilianos
0492	Alison Jensen	0527	Danielle Davis
0493	Dianne Birmingham	0528	Warren McKenzie
0494	Kate Dunn	0529	Hien Nguyen
0495	June Verwayen	0530	Laura Haslem
0496	Robert Cowie	0531	Jack Bainbrigge
0497	Peter and Janet Lane	0532	Alan Bailey
0498	Julie Cordner	0533	Melanie Thompson
0499	Janice Kirby	0534	Janet Collins
0500	Rebecca Jungic	0535	Joanne Edwards
0501	Dorothy Kay Walsh	0536	Lyn Groth
0502	Connie Prill	0537	Brenda McAllister
0503	Luthis Angeles	0538	Mark Ossola
0504	Stella Faragher	0539	Robert Scott
0505	Elizabeth and Anthony Rodd	0540	David Weder
0506	Marg Watson	0541	Gwenyth Gutke
0507	Ralph Bartholomew	0542	Mary Mahon
0508	Anne Halford	0543	Deb Acaon
0519	Janet St John Wood	0544	Geoff Skerman
0510	Bernadette Ruby Hammar	0545	Gail Petherick
0511	Chris Bird	0546	Norton Sands
0512	Margaret Kalusevicius	0547	Deb Evans
0513	Maria Kerswell	0548	Helen Irvine
0514	Gabriel Foster	0549	John Brady
0515	Ellen Turnbull	0550	Terry Dwyer
0516	Bronwyn Harrison	0551	Bernadette Demonte
0517	James McPherson	0552	Alex Hoffman
0518	Veronica Garnier	0553	Guy Gibson
0519	Scott Young	0554	Name withheld

0555	Name withheld	0590	Barbara Leis
0556	Name withheld	0591	Mike Supel
0557	David Youds	0592	Kirsten A Anstey
0558	Name withheld	0593	Ronald Lindley
0559	Mark Herron	0594	Sven Nylander
0560	Sonya Finnigan	0595	Katie Atkins
0561	Name withheld	0596	Mark Young
0562	Hanny Rooyackers	0597	Jillian Lee
0563	Jodi Kersheya	0598	McKay Ieremia
0564	Ed Boast	0599	Madelein Venter
0565	Name withheld	0600	Name withheld
0566	Name withheld	0601	Colin Krueger
0567	Kim Newburn	0602	Madelyn Dearan
0568	St Kevin's Parish Pastoral Council	0603	Jeffrey Ball
0569	Dale Price	0604	Meryl Curtis
0570	Tanya Reedman	0605	Anne Fitzpatrick
0571	Confidential	0606	Hannah Berardi
0572	John Kurpiel	0607	Patricia McKenna
0573	Elizabeth Kurpiel	0608	Name withheld
0574	Adam Kurpiel	0609	Francis Shanahan
0575	Andrew Kurpiel	0610	Orien Duffy
0576	Name withheld	0611	Suzanne Halberstater
0577	Rhonda Boyle	0612	Daniel Warren
0578	Ann Beatie	0613	Julie Gordon
0579	Name withheld	0614	Phoebe Samuel
0580	Patricia Crowther	0615	Francis Xavier
0581	Janine Masters	0616	Anthony Tomarchio
0582	Bruce Wilding	0617	Geoff Eggins
0583	Maddie Lawrence	0618	Bev Lenton
0584	Karen Westbrook	0619	Rodney Huntington
0585	Eddie and Evelyn Free	0620	Wendy Drury
0586	Isabela De Souza	0621	Natalie McClatchey
0587	Mary Shelley	0622	Peter Kutuzov
0588	Majella Eva	0623	Dimi Stathopoulos
0589	Liz McCleary	0624	Elaine Cawley

0625	Paul Victor	0660	Danielle Nicholas
0626	Emily Tiavaasue	0661	Name withheld
0627	Carolyn and John Ahton	0662	Daryl Miechel
0628	Jennifer Kavanagh	0663	Name withheld
0629	Janine Brauer	0664	Tina Stevenson
0630	Name withheld	0665	Heather Ford
0631	Graham S Taylor	0666	Rebecca Pitt
0632	Audienne Watt	0667	Robert Murray
0633	Laura Gammon	0668	Jessica Lane
0634	Nicholas Crowther	0669	Lloyd Eickenloff
0635	Name withheld	0670	Name withheld
0636	Estelle Logan	0671	Name withheld
0637	John A Gates	0672	David Clark
0638	Benjamin Martin	0673	Name withheld
0639	Barbara Bluett	0674	Michael Mandikos
0640	Alex Comino	0675	Helen Irwin
0641	Nicole Hargreaves	0676	Peter Coulson
0642	Leslie Hawken	0677	John Pitt
0643	Graham Quinn	0678	Julie Lawson
0644	Bruce Morgan	0679	George Baldacchino
0645	Ian and Janelle Batten	0680	Joanne Rickards
0646	Cathryn Emerson	0681	Debra Watson
0647	Mary Harvey	0682	Name withheld
0648	Name withheld	0683	Katie Woolston
0649	Amy Frewen-Lord	0684	Richard Cathie
0650	Robert Crema	0685	Kellie Adams
0651	Rhonda Boyle	0686	Jessica Odgaard
0652	Sally Drechsel	0687	Deb M
0653	Sherree Johansson	0688	Kerry Boettcher
0654	Ruth Ferguson	0689	Lyndene Edwards
0655	Name withheld	0690	Wendy Xu
0656	Jerath Head	0691	Maryann Scriha
0657	Daniel Plumbe	0692	Karina Green
0658	Raymond Kruger	0693	Fiona Brown
0659	Penny Hackett	0694	Ian and Janelle Dowling

0695	Alice Watson	0730	Brendan Farrugia
0696	Robert Pritchard	0731	Jen Midkiff
0697	Pamela Ashby	0732	Kevin Leonard
0698	James Menteith	0733	Lance Peters
0699	Marjorie Lawrence	0734	Sue Innes
0700	Annie Grace	0735	Jemma Telleman
0701	Julie Callaghan	0736	Ruth Martin
0702	Susan Strydom	0737	Paula Whalley
0703	Jeanie Priestly	0738	Susan Lavender
0704	Simone Butler	0739	Adrian Prince
0705	Delma Browne	0740	Timothy Daniels
0706	Lance O'rourke	0741	Rosie Payne
0707	John Leisten	0742	Samuel Lim
0708	Barbara McLain-Henderson	0743	Wendy Schipper
0709	Christine Poole	0744	Naomi Jolly
0710	Shane Stripp	0745	Carolyn Hess
0711	Carolyn Waterson	0746	Krystal Walmsley
0712	Allen and Elin Thomson	0747	Michael Percy
0713	Diana Anderson	0748	Jennifer Hochmuth
0714	Colleen Blums	0749	Name withheld
0715	Michelle Ford	0750	Floyd Risser
0716	Adam Duffus	0751	Gary Willcox
0717	Sheryl Tulp	0752	Carolyn Pearce
0718	Julie Lumsdale	0753	Gail Osmak
0719	Sabina Sannen	0754	Margaret Somerville AM
0720	Doctors for Assisted Dying Choice	0755	Julie Wong
0721	Annette Spilsbury	0756	Robin Sellers
0722	Sharon Stretton	0757	Lester Cannon
0723	Janette Bliss	0758	Frank Spindler
0724	Sue Kozij	0759	Grant Tyler
0725	Cancer Council Queensland	0760	Deidre Osborne
0726	Frigga Herold	0761	Karen Eldridge
0727	Mercedes Adams	0762	Tracey Peterson
0728	Gail Blinston	0763	Patria Cardle
0729	Merran Wallish	0764	Lynne Hume

0765	Rhonda Stevens	0800	Clark Siemsen
0766	Barbara Armitage	0801	Ross Naddei
0767	John Taylor	0802	Theodora Adigun
0768	Jonathon Woodgate	0803	Name withheld
0769	Kieran Walsh	0804	Linda Fullerton
0770	Mary Lydon	0805	Joy Bola
0771	Errol Crone	0806	Confidential
0772	Dr Gail Tulloch	0807	Rosario Musumeci
0773	Dane Frick	0808	Philomena Morris
0774	Anne Iredale	0809	Karen Keough
0775	Mark Weaver	0810	Lenore Smith
0776	Bill Swan	0811	Brooke Bain
0777	Margaret Swan	0812	Jan Finlay
0778	Michael Robinson	0813	Emanuel Curea
0779	Name withheld	0814	Leigh Bell
0780	Helen Dolden	0815	Ivan Basanovic
0781	Carol McNally	0816	Ann Norris
0782	Lois Coetzee	0817	Max Godley
0783	Name withheld	0818	Bernie Gaynor
0784	Name withheld	0819	Corased Fishet
0785	Samuel Davies	0820	Karen Struthers
0786	Grace Elizabeth	0821	Margaret Batten
0787	Ann Kuiper	0822	Dawn Peel
0788	Marilyn Roach	0823	John Visser
0789	Mark and Sheyl Gore	0824	Michael Malouf
0790	Edward Pitt	0825	Stephanus van Tonder
0791	Michael Fletcher	0826	Peter Howard
0792	Alison Ade	0827	Rod Campbell
0793	Name withheld	0828	Name withheld
0794	Sarah Millar	0829	Jeff and Di Joyner
0795	Joanne Davies	0830	Confidential
0796	Bill Perry	0831	Annette Rogers
0797	Peter Williams	0832	Gretta Evans
0798	Samuel Fromm	0833	Peter Sullivan
0799	Name withheld	0834	Name withheld

0835	John O'Toole	0870	Neta Tait
0836	Donald Gaffney	0871	Henny Velthuis
0837	Elizabeth Hibel	0872	Bruce Cruickshank
0838	Robert Pendlebury and Miranda Howard	0873	Peter Allan
0839	Kymberley Weaks	0874	Jo Halliday
0840	Name withheld	0875	Gillian Humbert
0841	Ron Hunt	0876	Ines Pintos-Lopez
0842	Maureen Lorenzen	0877	Nick Ponting
0843	Name withheld	0878	Lillian Gray
0844	Christine Remington	0879	Danielle Svensen
0845	John Simpson	0880	Elizabeth Mason
0846	Marlene Browne	0881	Helen Jeffery
0847	Melville Noronha	0882	Bernard Malik
0848	Suzanne O	0883	Gerda Kolarik
0849	Glenda Miller	0884	Phelim Reilly
0850	Gary Loble	0885	Rachel Walmsley
0851	Ainsley Shepherd	0886	Judith Drew
0852	Eva Cusack	0887	Maureen Ewing
0853	John Shapland	0888	Stephen Lunn
0854	William Holm	0889	Confidential
0855	Name withheld	0890	Name withheld
0856	Camden McKenzie	0891	Dying With Dignity NSW
0857	Alan Lucas	0892	Denise Greenhill
0858	Patrick Quirk	0893	Winifred Arthur
0859	Christopher Stanley	0894	Bernard Gaynor
0860	John Ilies	0895	Ian Francis Fraser
0861	Terry Harding	0896	Name withheld
0862	Pamela Andrew	0897	Name withheld
0863	Greg Roy	0898	Suzanne Stubbs
0864	Laurence Manning	0899	Name withheld
0865	Gail Musch	0900	Stella Walker-Sharland
0866	Mark Northage	0901	Robert Leach
0867	Kevin Kirby	0902	Paul Swan
0868	Name withheld	0903	Name withheld
0869	Ray Pentti	0904	Sue Stackhouse

0905	Stuart Hoffman	0940	Mary Crabb
0906	Professor Lindy Willmott and Professor Ben White	0941	Brad Byquar
0907	Name withheld	0942	Frances Pepper
0908	Name withheld	0943	Merike Johnson
0909	Kate Erwin	0944	Raymond McCullough
0910	Name withheld	0945	Name withheld
0911	Confidential	0946	Joan Beattie
0912	Alan Johnson	0947	William Sybenga
0913	Name withheld	0948	Bernhard and Loretta Eppich
0914	Name withheld	0949	Patricia and Gino Nucifora
0915	Name withheld	0950	Ted Cheetahm
0916	Penny Tovey	0951	Phill Eschler
0917	Craig Glasby	0952	Elizabeth Kurpiel
0918	Mic Quinlan	0953	Gold Coast Retirees Inc
0919	Name withheld	0954	Frances Wiseman
0920	Confidential	0955	Vicki Whitfield
0921	James Wilson	0956	Jeffrey Eacersall
0922	Amanda Jeffery	0957	Bronwyn Vaughan
0923	Name withheld	0958	Louise Dutton
0924	Sophie Bond	0959	Lois Paterson
0925	Aaron Barlow	0960	Rebecca Anthony
0926	John Campbell	0961	Peter and Mary Davidson
0927	Tony Groom	0962	Philippa Westerman
0928	Susan Considine	0963	Gail Shorthouse
0929	Kingsley Webster	0964	Susannah Oldfield
0930	Renee Finnigan	0965	Teresa Gittins
0931	Sylvia Huxham	0966	Alicia Truter
0932	Name withheld	0967	Diane Kemp
0933	Jan Logan	0968	Dr Philip Deaner
0934	Chrys Pulle	0969	Sandra Vaughan
0935	Kylie Kilroy	0970	Lynette Brieffies
0936	Kim Power	0971	Michael and Laura Otto
0937	Queensland Nurses and Midwives' Union	0972	Name withheld
0938	Sandra Okalyi	0973	Heather Robinson
0939	Confidential	0974	Veronique Fomiatti

0975	Shirley Pitts	1010	Mavis Peacock
0976	Tony Bergin	1011	Jeanette Wiley
0977	Deborah Ernst	1012	Nerida Deamer
0978	Shane Maas	1013	Everald Compton
0979	Lucia Truter	1014	Jennifer Stirling
0980	Fay Dawson	1015	Susanne Vergers
0981	Derrick Hetschell	1016	Kevin Zagami
0982	Angela Ewing	1017	Claudia Ridley
0983	Name withheld	1018	Kenneth Thomason
0984	The Clem Jones Group	1019	Cecilia Prest
0985	Ingeborg and Bernard Helmer	1020	Nathan Turnbull
0986	Davina Rogers	1021	Arthur and Dorothy Begea
0987	Stephen Marshall	1022	Confidential
0988	Rachel Vilt	1023	Ruth Webster
0989	Bruce Beattie	1024	John and Traudi Leahy
0990	Graham Kerr	1025	Christine Parker
0991	Sujata Saha	1026	Morrison and Glenys Russell
0992	Gail Matthews	1027	Australian Lawyers Alliance
0993	Suzanne Ebert	1028	Liz Sanders
0994	Pamela Dougall	1029	Brian Baillie
0995	Scott Clark	1030	Kathleen Carman
0996	Mark Kajewski	1031	The Queensland Law Society
0997	Virginia Aquilzan	1032	Andrea Campbell
0998	Joan Musumeci	1033	Marylin Smith
0999	Judi Nommensen	1034	Trevor Bell
1000	Emeritus Professor Colleen Cartwright	1035	Donald Lithgow
1001	Rachel Gouws	1036	Sally Cherry
1002	Jacqui Halpin	1037	Brian Robertson
1003	Jill Lindley	1038	Dennis Cherry
1004	Queensland Council for Civil Liberties	1039	Mable Chung
1005	Jill Jennings	1040	Andrea Beevers
1006	Cara Medwin	1041	Ron Brennan
1007	MIGA	1042	The Royal Australasian College of Physicians
1008	Elizabeth Havenaar	1043	Maree Kilpatrick
1009	Louise Fairhurst	1044	Queensland Baptists

1045	Nora King	1080	Peter Temby
1046	Denis and Helen Bowman	1081	Name withheld
1047	Jenny Warren	1082	Name withheld
1048	Mavis Cottrell	1083	Mark Doyle
1049	Marshal and Carol Kloske	1084	Name withheld
1050	Jan Stuckey	1085	Name withheld
1051	Alana Phillips	1086	Jason Brew
1052	Australian Christian Churches	1087	Shayne Higson
1053	Fiona Cayford	1088	Confidential
1054	Australian Christian Lobby	1089	Ian Mccomb
1055	Aged and Disability Advocacy Australia	1090	Name withheld
1056	Dying With Dignity Victoria	1091	Name withheld
1057	Nicola Lowrey	1092	Viviana Roberts
1058	Ben Lawson	1093	William Allison
1059	Uta Lippmann	1094	Merle Ross
1060	Name withheld	1095	Jill Chamberlain
1061	Name withheld	1096	Jeanette Watson
1062	Kseniia Novakovich	1097	Name withheld
1063	Name withheld	1098	Name withheld
1064	Peter Lutze	1099	Name withheld
1065	Timothy Yarham	1100	Name withheld
1066	Liza Quinn	1101	Jan Sheppard
1067	Name withheld	1102	David Pieper
1068	Linda Gelding	1103	Brad Byquar
1069	Michael Roche	1104	Peter Kent
1070	Name withheld	1105	Confidential
1071	Seranna Shutt	1106	Australian Psychological Society
1072	Ann Kreger	1107	Frances Maw
1073	David Grace	1108	Wendy Martin
1074	Gordon Young	1109	Howard Deards
1075	Name withheld	1110	Nurses' Professional Association of Queensland
1076	Danielle Mutton	1111	Denise Fernance
1077	Sarah Cake	1112	Brenda Clean
1078	Angela Duff	1113	Jeffrey Pigram
1079	Confidential	1114	Name withheld

1115	Leslie Curl	1150	Catholic Health Australia
1116	Mark Vollmer	1151	Sherelle Carman
1117	Name withheld	1152	Bronwyn Reading
1118	John Berryman	1153	Name withheld
1119	Daryll Bellingham	1154	Rendle Hannah
1120	Linese Norrish	1155	Lara McMahon
1121	Carol Delnevo	1156	Mark Waller
1122	Cate Vitale	1157	Name withheld
1123	Eveline Goy	1158	Palliative Care Queensland
1124	Enid Newell	1159	Pamela Forte
1125	Suzanne Hatchman	1160	Reid Dryden
1126	Denise Sheehan	1161	Jennifer Phillips
1127	Trudy Gardner	1162	Name withheld
1128	Amanda Henry	1163	Sheryle Marshall
1129	Number not used	1164	Confidential
1130	Name withheld	1165	Plunkett Centre for Ethics
1131	Peter Cross	1166	Robyn Manoy
1132	Lyn Hill-Webber	1167	Judith Robinson
1133	Name withheld	1168	Name withheld
1134	Confidential	1169	Grant Conlon
1135	Gabrielle Walsh	1170	Michelle Clarey
1136	Confidential	1171	Anthony Reeves
1137	Janelle Briggs	1172	David Varady
1138	Name withheld	1173	Robyn Keene
1139	Michael Maw	1174	Name withheld
1140	Dr Ronald Day	1175	Confidential
1141	Name withheld	1176	Melissa Johnston
1142	Name withheld	1177	Ann McGregor
1143	Antonia Dick	1178	Name withheld
1144	Mark Freeman	1179	Susan Wollstein
1145	Confidential	1180	Confidential
1146	Fay Wise	1181	Name withheld
1147	Helen Evans	1182	Daniel Harnden
1148	Queensland Council of Unions	1183	Adrian Adams
1149	Name withheld	1184	Dianne Taylor

1185	Name withheld	1218	Right to Life Australia
1186	Lance Walk	1219	Margaret Farley
1187	Confidential	1220	Confidential
1188	Luke Lyall	1221	Name withheld
1189	Go Gentle Australia	1222	Timothy Falkenhagen
1190	Kathleen Ager	1223	Confidential
1191	Ian Brown	1224	Lynette Batchelor
1192	Name withheld	1225	Name withheld
1193	Name withheld	1226	Christian Medical and Dental Fellowship of Australia
1194	Name withheld	1227	Christina Reid
1195	Name withheld	1228	Health Professionals Say No!
1196	Margaret Whalen	1229	Riverlife Baptist Church
1197	Name withheld	1230	Zelle Hodge
1198	Daphne Saunders	1231	Name withheld
1199	Christopher McMahon	1232	Margaret Davoren
1200	Name withheld	1233	Selwyn Rayner
1201	Andrew Burke	1234	Roslyn Becke
1202	Colin Apelt	1235	Name withheld
1203	Tanya Holt	1236	Patricia Traill
1204	Lesley Hughes	1237	Name withheld
1205	Lee Jeffery	1238	Confidential
1206	Doug Purton	1239	Carolyn Crocker
1207	Name withheld	1240	Australian Health Practitioner Regulation Agency
1208	Stephanie Short	1241	Wade Garrard
1209	Paul Kennedy	1242	Queensland Advocacy Incorporated
1210	Name withheld	1243	Name withheld
1211	Joy Bound	1244	Australian and New Zealand Society of Palliative Medicine
1212	Fiona Hunter	1245	Janette Dobson
1213	Paul Clarence	1246	Tamerlan van Alphen
1214	Confidential	1247	MaryAnn Boros
1215	Vernon Birch	1248	Gabrielle Walsh
1216	Name withheld	1249	Ron Bennett
1217	Robert Jenkins	1250	Anne Nilsen

1251	Dr Richard Stuckey	1285	Dr Donna Purcell
1252	Jeana French	1286	Dr Gerard Purcell
1253	Mary Ranke	1287	Ethan Rostedt
1254	Carolyn Haynes	1288	Dr David van Gend
1255	Manuel Petavrakis	1289	Noelle Melrose
1256	Rachel Seaton	1290	Jocelyn Hall
1257	Lisa Stokke	1291	Nicole Grove
1258	Name withheld	1292	Jodie Guerrero
1259	Winifred Coghlan	1293	Ceara Rickard
1260	Vicki McGaw	1294	Damien Madden
1261	Name withheld	1295	The Public Advocate
1262	Joshua Haxell	1296	The Public Guardian
1263	Patrick Russell	1297	Paul Webb
1264	Helen Dowling	1298	Bryan Menhinnitt
1265	Luke Garske	1299	Dr William Church
1266	The Royal Australian and New Zealand College of Psychiatrists Queensland Branch	1300	Robert Ritter
1267	Name withheld	1301	The Australian Family Association
1268	Helen Halpin	1302	Catherine Dwyer
1269	Katy Haxell	1303	Central Presbyterian Church Ipswich
1270	Scott Muir	1304	Dr Eliana Close
1271	Voluntary Assisted Life Ending Group	1305	Shaun Bickley
1271	Shelley McDonald	1306	Ian Joyner
1273	Jennifer Loscher	1307	Ron Kupiak
1274	Joe Bennett	1308	Angus Doig
1275	Elaine Martin	1309	Cherish Life Queensland
1276	Noble Seaton	1310	Confidential
1277	Kathryn Seaton	1311	Bar Association of Queensland
1278	Sharndra Chapman Praying	1312	Wendy McMenamin
1279	Jodie Dean	1313	John Stella
1280	Olayinka Doherty	1314	Queensland Human Rights Commission
1281	Emma McKenzie	1315	Dr Terrence and Mrs Angela Kent
1282	Michelle Behrend	1316	Anne Rego
1283	Cara Whittred	1317	Anna Walsh
1284	Paul Barry	1318	Lyn Rankine

1319	Health Ombudsman	1353	Australian College of Nurse Practitioners
1320	Australian and New Zealand Society for Geriatric Medicine	1354	Jennifer and John Clarke
1321	Name withheld	1355	Health Consumers Queensland
1322	Name withheld	1356	Marshall Hanna
1323	Carol Pringle	1357	Robert Jenkins
1324	Chelsea Ryals	1358	Sandgate & Districts Mens Shed
1325	Christa Stienen	1359	Cheryle Clements
1326	Corene Crossin	1360	Lutheran Church of Australia
1327	Cornelius McCormack		
1328	Gary Flanigan		
1329	Irene Morrison		
1330	Jane Locke		
1331	Kevin Mitchell		
1332	Paulina Coleman		
1333	Margaret Walshaw		
1334	Noel Holmes		
1335	Roslyn Savage		
1336	Sehryn Belle		
1337	Sharon Haley		
1338	Name withheld		
1339	Sue Vince		
1340	Susan Munro		
1341	Terence Gladman		
1342	Joan Tucker		
1343	Fiona Webb		
1344	Shane Knuth		
1345	Andrew and Daniel Calabro		
1346	Pharmaceutical Society of Australia		
1347	Denise Sauer		
1348	Tom Clair		
1349	Barbara Trengrove		
1350	Leslie May		
1351	Cecily Mac Alpine		
1352	Neil Menzies		

FORM SUBMITTERS**FORM A**

Confidential (146)	Elizabeth McAnally	Josh Cole
Name Withheld (368)	Erin Phillips	Rosamund Thorpe
Sandra Abbott	Wendy Catlin	Linda Perry
Isabella Styles	Shirley Peacock	Karen McBurney
Stephanie Sadleir	Denise Jones	Natalie Stubbings
Christine McGuffie	Raymond Marendaz	Bronwyn Hawkins
Barbara Fulton	Yvette Kitchener	Elliott Monaghan
Wendel Moloney	Megan Marshall	Louisa Nicholson
Gail Bradley	Gillian Duncan	Wayne Brown
Chris Roles	David Knobel	Jane Hollway
Lesley Vanderwalt	Jenny Ruge	Shona Rushton
Kerry Gilchrist	Tamihana Johnston	Robin Nason
Michael Smith	Richard Sweetapple	Margaret MacLean
Corinne Myers	Rhonda Winterbon	Colleen Wright
Lucille Warland	Graham Clare	Ruth Stuart
Stuart Hall	Glenn Simpson	Joshua Kerswill
Pam Nolan	Jan Green	Debroha Taylor
Tanya Gosling	Judy Noble	Rhonda Stevens
Linda Woodfield	Margaret Anderson	John van Grieken
Vicki Griffin	Samantha Jones	Sue Benston
Anne King	Jon Adams	Fiona Cayford
Brian Desjardins	Richard Baker	Wendy Ryan
Neville Hood	Claire Adams	Penny Fuhlbohm
Helen Pollock	Tara Knight	Susan Ferguson
Nate Jennings	Shane Smith	Nicole Wallace
Jade Harding	Helen Carberry	Lorna van Ingen
Courtney Fersterer	Kathleen Ward	John van Grieken
Kay-Marie Taaffe	Robyn Morgan	Marcia Pertzell
Robyn Besley	Linda Robertson	Kylie Ashworth
Moira Turner	Simon Cork	Jane Greig
William Synnot	Mark Woodman	Patricia Shaw
Regina Ganter	Michael Champion	Melinda Morris
Justine McKee	Lisa Bell	Charlie Curtis

FORM A (continued)

Jonathan Peter	Glenda Rains	Rosalind Lester
Lewis Hertslet	Geoff Thompson	Barbara Helsby
Bob Simmons	Nancy Willis	John Lee
Elaine Kelly	Linda Holliday	Linda Mitchell
Janet Carter	Sandra Englart	Ann West
Ray Schmidt	Donna Dorey	Kylie Border
Hope Smart	Merilyn Enright	LeeAnne Farebrother
Hayley Tucker	Lynette Drummond	Lee Tonkin
Brad Sullivan	Jennifer Blake	Jill Glover
Tammie Caswell	Yana Bull	Noelene Barnes
Raymond Pentti	Chantel Devereaux	Elyse Duffy
Catherine Friend	Susan O'Connor	Tracey Mace
Olivia Mashett	Barbara King	Marilyn Guy
Kirrily Turner	Kelly O'Neill	Kate Murphy
Jason Foster	Carolyn Chaffer	Carol Edwards
Diane Cooper	Ann Asplin	John Collins
Gail Fleming	Lesley Jury	Carol Mastroieni
Audrey McCandless	Nikki Spencer	Julia Suarez
Alex Langton	Sonia Amos	Madison McKewin
Anika Lehmann	Elsbeth Lilburne	John Eurell
Mark Fairweather	Jessica Hines	Kerry Cavanagh
Murray Keys	Charmaine Wood	Neil Bosson
Janelle O'Neill	Linda Ritchie	Robyn Hilton
Philippa Archibald	Christine Sanders	Matthew Betts
Denise Cox	Julie Davies	Rex & Rae Suosaari
Sheila Bryden	Patricia Hubble	Robyn Hewitt
Maree Sutton	Victoria Nolasco	Barbara Lewis
Karen Taylor	Mary Weissman	Benjamin Bentson
Ian Lester	Trevor Walters	Kim-Lee Hare
Joanne Wood	Tony O'Brien	Arnold Broese
Sarah Barry	Deborah Moseley	Bob Simmons
Leanne Edwards	Micheala Krass	Madeline Wright
Anthea Whitwell	Ange Fairweather	Gregor Bain
Jane Hintz	Wendy Crabtree	Naomi Fillmore

FORM A (continued)

Leisa Batchelor	Howard Cassidy	Anne Mauger
Theresa Faamafu	Priscilla Davis	Stephen Rogers
Helena Rittmeyer	Greg Hodshon	Adrienne Mercer
Wendy Rae	Chiquita Morgan	Greg Bloom
June Schulz	Yvonne Carroll	Dylis Turnbull
Shana Flanagan	Jack Darnbrough	Petra Skoien
Josephine Prowse	Marguerite Bannerman	Christel Langridge
Cheryle O'Neill	Ronald Court	Patrice McCarthy
Sheree Kinlyside	Kylie Boswell	Deborah Cox
Debra Pringle	Majella Walker	Deborah Drummond
Ken Berry	Graham Dean	Edwina Peggie
Olivia Mitchell	Jacqueline Cuerton	Lindsay Williams
Joseph Mastroieni	Anne Dunn	Greg Davison
Joe Maw	Helen Mpofo	Norman Robb
Margaret Bargwanna	Ross Waket	Marion Bottger
Bec Ashby	Mieke Symon	Ailsa Cowan
David Cooke	Kym Yeates	Darryl Murray
Terri Faamafu Faamafu	Hermann Fischer	Janet Andersen
Shelley Andrews	Jacquelyn Prevett	Kerry Brady
Francoise Jewell	John Todd	Adrienne Myers
Meredith Telley	Helen Petersen	John D Bain
Sylvia Howard	Susan Clifton	Kurt Bruggemann
Vicky Mather	Gail Matthews	Mary Delgado
Pam Ettridge	Stefanie Lawton	Julie Homewood
Lachlan McKay	Trudi Cauley	Meredyth Woodward
Gustav Hofer	Skye Staples	Sherilene Blackburn
Kaye Hayes	Lachlan Massie	Gil Greig
Judy Filmer	Helen Risby	Lee Parkes
Dale May	Naomi Davis	Samantha Miller
Elizabeth Strydom	Joy Beck	Roy Masters
Kerry Triffett	Yvonne Mappas	Crystelle Anderson
Anita James	Elaine Platt	Lara Emerson
Helen Corneos	Paige Petersen	Karen Roser
Marguerite Bannerman	Jessica Alen	Helen Dolden

FORM A (continued)

Susan Carr	Donna Smith	Symantha Christie
Fiona Brown	Amanda Tangban	Zan Powell
Sandra Stewart	Janette Clark	Donna Maddock
Lois Furness	Maureen Yeats	Julie Walton
Gwendolene Klein	Vanessa Hartle	Andrew Reeson
Kerri Kickbusch	Craig Dunn	Andy Gorey
Shane Mills	Rhonda Cantrell	Jenny Coleman
Stuart Liston	Patricia Redknap	William Dowsett
Carol Langridge	Elise Sales	Debra Le Bhers
Ron Mantel	Judith Munro	Jodi Malane
Mrs Linda M Lane	Joseph Mashett	Lynn Collie
Sandy Schoenfisch	Megan McKerrell	Pauline Anderson
Colin Griffin	Murray Hass	Betty Masters
Janice-Diane King	June Henderson	Kate Bishop
Tracey de Vries	Jill Richardson	Katie Dobsa
Linda Garrett	Toni Simpson	Desiree Van De Kamp
Cec Pedersen	Cassandra Cover	Dorothy Finlayson
Elena Ragonese	Lorna Mead	Libby Prescott
Deborah Hermond	Barbara Cunningham	John Coleman
Meredith Jordan	Emily Mulroy	Robyn Johnson-Hunt
Heidi Michaels	Ally Beeden	Bradley Dewey
William Donald	Margherita Gregory	Susan Micallef
Wendy Oliver	Gerardine Downes	Julie Gorman
Jo-Anne Watson	Marjorie Sumbly	Sara Graham
Simone Johnston	Wayne Brown	Gae Pitman
Noeline Rayner	Sheree Kinlyside	Taisla Young
Debra Purdy	Debroha Taylor	Jacqueline Moon
Nic Kennedy	Cora Miller	Dianne Newell
Sharon Borg	Susan Hayhoe	Denise Fitzgerald
Ian Brooke	Maarten Semmelink	Pauline Clegg
Paul Harrigan	Renate Marek	Helen Feeny
Joan Butler	Judith Armstrong	Dennis Jelavic
Christina Vincent	Janice Bowman	Narelle Jones
Paul Smith	Chris Mahon	Gail King

FORM A (continued)

Cynthia Burnett	Sharon Stretton	Sally Higgins
Alexandra Arrtowsmith	Roslyn Sandmayr	Kerry Brady
Mark Elliott	Pam Harri	Sheryl Tulp
Marlene Browne	Jeanette Dimsey	Simon Coxen
Glenda Young	Beau Malone	Ailsa Cowan
Shauna Cameron	Catherine Frost	Ian Harris
Noreen Ballment	John Carter	Anne Mauger
Craig Ferguson	Susan Stern	Gary Heritage
Sophie Straton-Ferrier	John Vanlint	Cheryl Blake
Susan Murray	Michelle Robbins	Julie Ward
Adam Paul	Margaret Lyons	Rae Edwards
Lorna Craig	Heidi Hardisty	Jacqueline Marie Semmelink
Marion Webb	Sheridan Fittock	Michael Leah
Sherree Abraham	Judith DesJardins	Thea Politanski
Lester Cannon	Julie Hughson	Christine Keller
Leigh Fletcher	Joy Bauer	Michelle Daly
Fiona Pelling	Douglas Stetner	Bryony Cornes
Ann Williams	Janelle Lee	Leigh Ashenden
Jennifer Tonkin	Lisa Blackburn-Prout	Joshua Waterfall
Ebony Paton	Darryl Prout	Steven Kapernick
Judith Profke	Vanessa Durand	Ben Maw
Sidney Marshall	Alexandra Hurt	Harry Oshaw
Gavin Curbishley	Rachael Beyer	Michal Robinson
Jess Taylor	Michelle Roadley	Michel Ann Rybišár-Robinson
Ashley Watson	Karen Cabral Dutra	Ainsley Leaning
Richard Misior	Rebecca Skelton	Linda Simes
Debra Walker	Sam Sparrow	Cheryl Morgan
Kylie Border	Janelle Lee	Charmaine Maney
Carol Lawson	Maddison Rochford	Rosemary Baird
Helena Groen	Pam Dyer	Wayne Joyce
Sharon Broanda	Scott Moore	Dan Purcell
Joshua Gardiner	Collette Walsh	Natalie Sullivan
David 'Killer' Caldwell	Sanam Arthur	Wakefield Sykes
Tony Brennan	Adam Gilltrap	Marie Fraser-Byass

FORM A (continued)

Kimberlee Newman-Tyler	Ian Donaldson	Amanda Howcroft
Andrew Moon	Jodie Davis	Maxine Godley
Daniel Buzalski	Alan McDonald	Peter Stephenson
Rodney Bismire	Toni Mashett	Judy Capalija
Julie Newton	Judith McPhee	Kellie Butler
Michelle Kaplan	Mary Clarke	L Walker
Alison Adair	Jane Minor	Leanne McFadyen
Amanda Mergler	Vicki Stannard	Donna Howell
Cathriona Towey	Christine Stevenson	Tanya Bell
Adrian Schofield	Tony Glue	Mark McDonald
Natalie Carrington	Merilyn Keene	Darryl Rucker
Anthony Peaker	Leslie Ann Cutter	Paul Geake
Jean Weber	Greg Folan	Ro Koenig
Maree Evans	Robett Kerr	Jeanette Dimsey
Clive Riseam	Renée Patterson	Helen Pullin
Jemila Mckinnon	Megan Dewey	Graeme Baguley
Darryl Nelson	Brian Cluning	Lara Meyers
Lynda Schekoske	Barry Smith	Yvonne Butwell
Elisabeth Drew	Gita Smith	Shane Drinkwater
Beverly Clarkson	Linda Garrett	Jutta Rathgeber
Ursula Sterf	Michelle Richards	Karen Edden
Anne-Frances Watson	Paul Smith	Sarah-Jane Hipwell
Connie Allen	Lynne Ferguson	Jill Kean
Elizabeth Boyle	Carole Knott	Lesley Burgess
James Holmes	Maria Proctor	Lesley Titley
Maria Delaney	Jackie Grassel	Lynette Angus
Sharon Andersen	Delma Saltau	Helen Oliver-Field
David Rogers	Winnefred Grant	Zoltan Sekula
Greg Bayldon	Kerry Wilkinson	Claire Gilligan
Jen Midkiff	Shirley Gillard	Rebecca Bleasdale
Melinda Hassall	Susan Wolfe	Karen Knewstub
Katrina Shardlow	Lelsey Vanderwalt	Greg McEwan
Patricia Cranney	Maryanne Barnes	Nikki Jamieson
Julia Mizuno	Gwenneth Rose	Mark Bowers

FORM A (continued)

Therese Lavelle	Richard Douglas	Siobhan Tangney
Thomas Burnard	Barbara Griesau	Diana Deeley
Maria Element	Linda Cutmore	David Taylor
Lee McLean	Catherine Schouten	Tania Wissemann
Annji Rodgers	Tracey Buzalski	Sheree Pfeiffer
Erin Byrne	Laura Bannerman	Robyn Burgess
Sharryn Campbell	Russell Arnold	Johanna Van De Kamp
Sharon Stretton	Rob Martin	Lynda Chandler
Debra McDiarmid	Les Nicholson	Jill Byrnes
Robin Nason	Nicholas McKinnon	Malcolm McKellar
David Jacobson	Ashelia Storm	Peter Graham
Marjorie Dean	Mark Gobessi	Melinda Morris
Terrina Biddlecombe	Joanne Chippendale	LaRaine Clarke
John Biddlecombe	Kerstin Somenek	Yvonne Wegmuller
Bruce Taylor	Margaret Jackson	Jennifer Mckinnon
Lynne Walsh	Jodie Osborne	Allen Brown
Colin Hale	Melita Taylor	Max Poyser
Mark Stretton	Beverley Morgan	Barbara Copper
Boyd Craig	Karen Smallcombe	Elizabeth Einarsen
Gerald Houska	Patricia Arigho	Marina Morale-Percy
Allison Aldridge	Gary Stipanov	Eleanor Shaw
Jennifer Gray	Don Scott	Marion Martin
Michael Donnarumma	Nathan Chapman	Silvia Dumpmanis
Wendy Oliver	Elizabeth Russell	Gail Strongman-O'Brien
Yvonne Butwell	Michelle Hardie	Kerrie Daley
Michelle Richards	Angela Gibson	Deenita Morton
Sheree Campbell	Rosalind King	Helen Patricia Simpson
Patricia Carroll	Jacob Haberley	Stephen Cumberlidge
Stephen Coxen	Emma Arthurs	Allen Wait
Odette Cook	Karen Bones	Jacqueline Trewin
Sandra Mason	Andre Smit	David McPhee
Brianna Rogers	Joanne Daly	Kegan Scherf
Raymond Massey	Vikki Uhlmann	Melissa Macourt
Nicholas Harris	Terry Heiner	Anthony Sexton

FORM A (continued)

Shane Day	Juanita Van Dam	Maria Heenan
Kate Jacobsen	Andy Gardner	Sue Gilbert
Sue-Ellen Pashley	Katleen Meyer	Sarah Burgess
Natalie Martin-Booker	John Gage	Tracey Ramsay
Lisa Frohloff	Michael Farmer	Tania Bell
Rachael Thompson	Ben Wright	Rowena May
Frances Davies	Lynn Robson	Jacob Tobin
Karen Seymour	Hayden Vanderkruk	Kath Russell
Theresa Savina	Karen Sauffs	Kate Cronin
Lorna Janssen	Chelsea Clancy	Barney Bakos
Eva Jouvencon	Christine Lee	Lee Kennedy
Trent McCartney	Maria Offermans	Jeffrey Clement
Yasmin Reiser	Dane Moloney	Kaia Torv
Elaine Potts	Esha Haines	Katrina Crompton
Tiffany Sullivan	Suzanne Breeze	Vivienne Jurie
Mary Leonie Curran	April Lyons	Lucinda Canning
Kate Howes	Alex Sey	Linda M Lane
Mary Garner	Steve Nelson	Kristin Perissinotto
Phoebe Wood	Kara Burns	Tracy Duffield
Annette Ryan	Ivan Phillips	Jenepher Bowler
Shelley Evans	Kim Watson	Sarah Gunning
Michelle Shaw	Megan Jones	Luka Meads
Alyce Kelly	Debra Dragonheart	Maurice Lang
Lyndall Moore	Jenny Hurley	David Clarke
Jodie Wright	Ian Nichols	Caterina Pagano
Wolf Messthaler	Marie-Louise Robson	Susan Stewart
Cassandra Munro	Leanne Dyer	Mignon Bonwick OAM
Tom McCartney	Bernadette Dal Ponte	Joe Fiteni
Saskia Dobe	John Weaver	Carol Reid
James Cook	Wendy Oliver	Anthony Patteson
Robert Kennedy	Michelle Smith	Luz Stanton
Jane McFarlane	Lucy Dale	Bronwen Williams
Debra Jenkin	Darrin Davies	Lesley Lamont
Angela Brandenburg	Aaron Johnston	Tracie Mckenzie

FORM A (continued)

Renee Bullock	Steven Orel	Keith Allan
Mandi Hurkett	Jana Mader	Celena Ross
Tracey Wilson	Christine Stainer	Eleanor Cappa
Julie Webster	Kathleen Richardson	Judy James
Jolyon Bond	Beverley Grant	Kym Richter
Marcella Valenti	Tracey Scully	Serge Verhoeven
Lynndall Dwyer	Steven Oliver	Kym Brown
Rebecca Bowen	Marinda Swarbrick	John Mcnamara
Stella Wheildon	Madeleine LuckGrillon	Taleah Colemam
Michelle Chittick	Ruth Martin	Emma Smith
Marguerite Dunlavy	Shanna Antrim	Matthew Carrick
Narelle Stewart	Nicole Maggs	Kim Morris
Marinela Motika	Sandra Baxendell	Hermann Fischer
Lesa Griffiths	Monique Scholte	Janita Morrow
Justine Burns	Randy Parella	Brian Wilson
Marlene Browne	Beverly Hadfield	Jo McGrath
Colleen Thompson	Helen Knight	Josanne Falla
Andrew Duguid	Bernard Gallen	Louise Saal
Sandie Wands	Christine Bennett	Donna Thompson
Mandy Leslie	Paul Jacob	Raymond Hansford
Craig Glasby	Alan Hill	Leonie Henricks
Jade Saegenschmitter	Jordan Vollmer	Jules Edwards
Brian McNally	Theresa Patteson	Stephen Rhodes
Elaine Wentworth	Jon Temby	Jana Visnovska
Chantal Hochstrasser	Steven Kapernick	David Pearson
Tiena Patton	Erin Mellifont	Alison Twemlow
Steve Riley	Mary Mannison	Tracy Handley
Tim Marshall	Keava Lucas	Sharon McClements
Marilyn Wilkinson	Alysia McNaughton- Mackintosh	Vanessa Phillips
Bernard Jean	Patricia James	Jessica Nichols
David Arthur	Tristan Meade	Alan Peverell
Kathryn Reynolds	Catherine Chambers	Corralie Wharerau
Gary Boden	Al Wathen	Vanessa Honzatko
Cheryl Strickfuss	Brigit Steindl	Stephen List

FORM A (continued)

Jenny Allom	Amanda Bartolic	Natasha Parnaby
Roger Stierli	Janice Monroe	Walter Gottfried Immoos
Simonne Kelly	Jenny Brown	Lorraine Mcloughlin
John Kirkland	Alan Blackman	Janet Simpson
Ashley Nichols	Nick Charles	Astrid de Ruiter
Brooke Barrett	Neil Moller-Nielsen	Paul Justin
Vicki Griffin	Skye Staples	Jennifer Nichols
Colin Griffin	Sharon France	Richard Gooch
Lynette Cameron	Donna Blacklock	Katherine Lingard
Jaylene McArthur	Brooke Warner	Matt Wray
Jamie Walmsley	Judith Croft	Don Standen
Sue Brooks	Michael Wiech	Douglas Cora
Katie Dobsa	Emma Johnson	Peta Straw
Kym Musumeci	Rebecca Girard	Jennifer Edwards
Alana Pellowe	Dan Anders	Debbie Wynne
Graham Wilmont	David Walters	Graham Ellis
Alba Vignolo	Brittany Nicolas	Andrew Ramsay
Kylie Strudwick	Libby Jones	Heidi Joseph
Cheree Clarke	Jacqueline Briody	Daniel McGaw
Deborah Woodland	Sharon McNally	Katharine Bridgeman
David Freeland	Jancine Hurst	Marjorie Barrett
Rebecca Pini	Megan Hickey	Nadia Braden
Paul Broughton	Neil Page	Josie Fennell
Anthony Foxcroft	Cherie Weaver	Carmel Murphy
Brian Cavanagh	William Allen	Mione Haak
Glenn Seage	Wayne Forshaw	Kerri Parr
Anna Jackson	Kerry Currell	Heather Caithness-Scurr
Dave Crowley	Hannah Watts	Robyn Salt
Cheryl Cleeland	Janice Francisco	Lynda Giddings
Ebony Paton	Theresa Jansen	Katherine Gordon
Susan Reid	Gail Johnston	Justin Fenton
Roberta Albrecht	Michelle Boxall	David Gleeson
Eva-Marie Seeto	Michele Zavaglia	Sonya Russ
Rachelle Wicks	Leanne Weber	Elizabeth Donaghy

FORM A (continued)

Margot Eremenco	Sam Drummond	Jan Baum
Kathrin Peck	Prue Bartels	Dave Kay
Mary Christie	Violet Aitkenhead	Sandra Bach
Graeme Fitzpatrick	Sheila Sams	Sally Davies
Debbie Mapson	Emma Green	Sally Castles
Lachlan Hurse	Lauren Morgan	Antony Edwards
Pauline Bowden	Karlee Schmitz	Jean Fry
Benjamin Sorrell	Piers Foley	Mary Ann Skewes
Gena Glasby	Catherine Levy	Andrew Lyall-Watson
Wayne Blake	Luke Duffus	Joanna Seczkowski
Cynthia Chua	Stephen Whale	John Bayliss
Christine Whitelaw	Susie Levy	Helen McCallum
Russell Smith	Suzanne Millar	Amber Barber
Maureen McDonald	Juliette Aizier	Colin Taylor
Karen Chalmers	Karen Fraser	Julie Blinkhorn
Lynda Millerd	Pamela Walsh	Robert Watkins
Lisa Mitchell	Noeleen Parsons	Donovan Carr
Venette Roberts	Gayel Backer	Jean Sexton
Andrew Bairnsfather	Margaret Healy	Alyson Sampson
Shaun Hanlon	Deborah Bird	Christine O'Connell
Janet Walder	Dorothy Sweeney	Janet Walter
Errol Crone	Jaime Johnston-Smith	Christine Poole
Michelle Schoots	Vicki Sinclair	Pauline Ashford
James McBroom	Hayley Booth	Gail Tulloch
Amber Edwards	Erin Hilton	Rikki Scott
Trish Radke	Debbie Hazelton	Ayden Stout
Diane Lucht	Kiara Bell	Terence Gladman
Tania Bell	Simona Beaton	Jeni Walters
Christine Rayner	Kym & Graham Cockram	Lindy Creighton
Tina Barnes	Valerie Ovenden	Lynn Krueger
Alice Chao	Stuart Yeaman	Christina Anne Rose
Cathie Dancek	Toni Baker	Carol Skyring
Sophie Hoffman	Libby Power	Margaret Davidson
Guy Elliott	Julie Kranauer	Rhonda Gale

FORM A (continued)

Jessica Cosh	Pamela Thomas
John Greig	Kelly McKendry
Kay Lefevre	Leeanne Clarry
Diana Greig	Jill Ferguson
Reg DesJardins	Tracey Mace
Judith Zygmont	Shanae Horsburgh
Caroline Ross	Jessica Mellish
Desiree Van De Kamp	Anne Bartuschat
Helen Feeney	Justine Porter
Geoffrey Robinson	Jo-Anne Watson
Jillian Hill	Bonny Rogers
Everdina Van Bergen	Kristen Matthews
Judy Brett	Eva Paschalidis
Luke Nowlan	Sally Djokic
Carolyn Whitting	Katherine Brown
Debbie Angus	
Cathryn Brown	
Debbie Mccallum	
Michelle Foley	
Fabienne Drinkwater	
Anastasia George	
Gary O'Connor	
David Dean	
Merran Williams	
Christine Jackson	
Dawn Gridley	
Desiree Shaw	
Jenny Kemp	
Kristen Matthews	
Leigh Ashenden	
Robin Flannery	
Sylvianne Delaney	
Kylie Hunt	
Neil McPhillips	

FORM B

Confidential (11)	Alan Swadling
Name Withheld (28)	Kamalarani Subramaniam- Vanderneut
Kathleen Carman	Chris Gierak
Susan Janson	Susan Guy
Alexander Klimson	Debbie Gorman
Christina Doyle	Debbie Golding
Margaret O'Hagan	Katja Protheroe
Andrew Lawson	Dalby Christian Outreach Centre
Don Heazlewood	Kylie Hanson
Ken Fraser	Richard Hanson
Lois Henning	Bernadette Davies
Fred Bramich	Brendan Palmer
Karen Gordon	Melissa Ke
Linda Freeman	Daphne Santos
Duncan Reddell	Lourdes Shanks
Anthony Cassimaty	
Maryanne Davidson	
Steve Evans	
Donna Hallam	
Laura Panarello	
Caleb Chandra Moha	
Dufourq Josie	
Alan Wills	
Shane Knuth	
Flora Young	
Peter Middendorp	
Rosemary Dowling	
Bianca Westall	
Andrew Parsons	
Norman Clark	
Maureen Gordon	
Heather Webber	
Catherine Santos	

FORM C

Confidential (4)

Name Withheld (3)

Andrew Calabro

Simone Schmierer

Anthony Poutsma

Wendy Marshall

**FORM D including variation to
FORM D**

Charles Edward Lamb	Aaron Pitt	John Young
Dennis Cleary	John Pietila	Doug Morrison
Peter Vorgias	Desmond Cherry	Shawna Trebble
Kylie Leahy	Bradley Laing	Malcolm Glover
Charles Cameron	Walter Nock	Beverley Flegg
Paul Fordyce	Paul Thompson	Sharelle Sue Yek
Siahn McQualter	Sally Unwin	Danny Dugdell
Lyn Rankine	Maggie Roe	Racheal Cameron
Roslyn Casey	Ben Boland	Nancy Noble
Yvette Mealing	Grace Cooke	Kerry Boulton
Joel van der Horst	Dean & Cathy Cooke	Jacqueline Hallam
Jennifer Nicholas	Hugh Cookson	Shirley Chappell
Martina Schell	Jeffrey Reid	Giuliana Campbell
Malcolm Lyle Goschnick	Alan Harris	Ezekiel Murphy
Jane Warren	Kerry Noola	Mark Reed
Richard David Clements	Lyndene Edwards	Jim Tsang
Mike Marsh	Jeannette Iakin	Gang Jia
Bruce Hayes	Clement Fryer	Marie Lawrie
Erica McDonald	Greg Burns	Lea Kerola
Joseph Palamoodan	David Reller	Elizabeth Sands
Trudy Hobson	Jason Weule	Mary-Anne Higgins
Sharon Hickey	Desley Kahler	Helen Toai
Charles Simonds	Vern Heazlewood	John Attard
Penny Martenson	Jonathon Hooper	J Rae Timmins
Sandra Coombs	Greg Burns	Janusz Plantos
Richard White	Rick Barnard	Kristy Riesenweber
Sandra Hass	Janet Duncan	Ezekiel Bozikis
Shana Grozdanovic	Caroline Robertson	Frances Nicholls
Melanie Hubbard	Robyn Emery	Dahna Redding
Patricia Gauvin	Lara Mae	Christine Viljoen
Linda Murray	Linda Lou Gorman	Mary-Anne Gill
Peter S Marks	Gary and Pam Hine	Margaret Farley
Jason Bennett	Helen Smith	Samuel Chamberlain
Sonia Kenny	David McMahon	Rita Durez-Suomalainen

**FORM D including variation to
FORM D (continued)**

Paul Jacques	Stephen Woolley	Christine Moore
Karry-Anne Slingerland	Adetokunbo Alege	Desmond Aikens
Patricia Achterberg	Vivien Kells	Sophia Goulis
Rodney Ballard	Maria Mears	Kate & Lawrie Hawkins
Nerida Rouvray	Evelyn Shepherd	Moira Kent
Heather Clayton-Callaghan	Melinda Keller	Michele Macaulay
Beryl Diggles	Christopher Calvert	Rosemary Farrell
Andrew Burr	Shannan Flaherty	Rachel Buntrock
Francis Claven	Kathryn Evans	Patrick Mackie
Jag Ace	Janet Aston	Tobias Winterburn
Erin Jane Long	Hailey Chamberlain	Tanya Eldridge
Paula c	Holly Price	Sandra Caswell
Chris Galinovic	Jendy Smith	John Velcek
John Young	Jennifer Beattie	Peter Harris
Katy Maltry	Scott Castree	Gemma Meeks
Kevin Hegerty	Stephen Holmes	Helen Selke
Karen Nicholson	Carolyn Grieve	Kelly Stassi
Todd Parkes	Paul Groves	Robyn Chandler
Ingrid Finch	Keith Osborne	Camion Drews
Elizabeth Thorburn	Meghan Deam	Hugh Cartmill
Wanda Fell	Alan Ling	Mark Robinson
David Scott Roberts	Lynette Volker	Melinda Sue Rattenbury
Laurie Rasmussen	Golda Bentley	Michele O'Farrell
Lucy Beaton	Martin Brose	Gabriel McAnthony
Elisabeth Methers	Henk Holtzhausen	Jennifer Cockburn
Charmaine Turner	Harriet Remy-Maillet	Sarah Drummond
Anthony Nightingale	Leo and Bernadette Hammar	Alan Richardson
Michelle Edwards	Ricky Chang	Lesley Tuinona
Clarit John	Duncan Croxon	Sam Wilson
Leanne Jordan	Dallas leslie	Richard Joseph
Ruth Ferguson	Timothy Francis Coyle	Adrian Gunton
Michael Hu	De Battaglone	Maarit Harden
Catherine Abraham	Jennifer Harvey	Jean Paradine
Donald McAlpine	Caleb and Karina Hotz	Alexander Lapthorne

**FORM D including variation to
FORM D (continued)**

Audelena Magalhaes	Ron Lawrence	Steve Pearce
Phillip Eschler	Carlene Simmons	Brigitte Jones
Helen Mays	Mary Donjerkovic	Karen Chin
Brian Ambrose	Ljubica Cvetic	Alex Banks
Peta Moses	Gerard Wilkes	Grace O'Brien
Fiona Yarrow	Don Heazlewood	Desiree Hutcheon
Denis Smith	Dawn Goldsmith	Jill Hoskins
Marion Carter	Kevin Fidock	Julie Cooper
Heather Jones	Douglas White	Lyn OBrien
Miroslav Pola	Anne Hilder	Ian Sarah
Robyn Maciejewski	Jon Stewart	Elsie de Beer
Timothy Emms	Daniel Lanzon	Frances Tilly
Matthew Shedden	Christine Gregory	Theresa Martin
William Riley	Rhonda Jamieson	Thomas Linder
Claudia Pallasपुरo	Phillip Grieger	Quinn Larnach-Jones
Robert Webber	Glynis Osborne	Angela Lawson
Susan Cleary	Sharyn Wilbraham	M Vankan
Eduardo Portillo	David Holmyard	Nicolla Jolly
Eunice Rhoades	Carol Allen	Mel Salazar
Derek McKinnon	Joanne Venz	Margaret Darch
Rees Rowlands	Bernard Pohlner	Simon Cox
Lynette Lloyd	Tim Powers	Kellie Ewart
Leh Tang	Britt Riddell	Peter Williams
Penelope McCowen	Allan Fuller	Mae Dowling
Stephen Boyd	Cherie Sweet	Greg Perren
Kym Stendrup	John Patrick Gilbert	Alicia Wareham
Velma McInnes	Patrick Cain	Ruth Smith
Jordan Hamlet	Leanne Erian	Debbie Read
Ian Thomson	Deb Rogers	Ming-Je chiu
Ling Eckermann	Kelly Harwood	Christel Wilkie
Phil Hunter	Sanna Butler	Lynn Rendle-Short
David Baker	Alta Buchanan	Tamara Odgaard
Ross Davie	Jeanine McDougall	Brian Peirce
Claire Barton	Anne & Kim Koster	Denise Johanning

**FORM D including variation to
FORM D (continued)**

Elizabeth Chapman

Deb Rowling

Bernadette Macnaught

Laura Dioth

Mary Timbrell

Roger Jaensch

Joanna Goodall

Ivan Basanovic

Lesley Corfield

**FORM E including variation to
FORM E**

Keryn Hull	Serena White	Rosemary Hill
Donald Hardgrave	Jeremy Searle	Karen Schwarz
Terry Wyborn	Kerstin Schmidt	Nick Pecze
Fay Harper	Kylie Shepherd	Karen Jackson
Dawn Peel	Jeremy Blake	Charlie Lacey
Yvonne McAskill	Liz Mcclenary	Virginia Hunter
Gabrial Eleveld	Cindy Fraser	Louise Northcott
Jenny Green	Ruth Dearden	Ian Foster
Grace Vine	Sarah ten Bruggencate	Gail Martin
Rosemary McClintock	Phil Lewin	Lorraine Richards
Thelma Ewart	John Campbell	Jennifer Ernst
John Weber	David Kraus	Esther Herschell
Lyn Hatch	Helen Magnussen	Debra Pearson
Harry Leesment	Jensen Tan	Katrina Rooney
Katherine Andrezza	Jayne Coward	Losif Ilies
Ray Laidlaw	Jean Muldoon	Elisha Paynter
Piers Furness	Jane Milward	Allan Bray
John Dempsey	Christine Cockroft	Jeanne Venz
Sarah-Jane Morris	Darrel Griffiths	Marlene David
Karel Jansen	Janette Dobson	Delma May Lithgow
David Donges	Lyle Venz	Karina Green
Fluer Baird	Kellie Rymer	Meredith Bognar
Max Fletcher	Richard & Jan White	Anita Young
Lynn Back	Bill Purcell	Darrell Holden
Andrew Mayne	Anne M Smeeton	Warren Westacott
Marieta Swanepoel	D'Wayne Wigley	Sarah Saunders
Matthew Corser	Julie Elliott	Johanna Schaefer
Brian Gough	Elizabeth Rodger	Jenny Coburn
Dennis Hewitt	Jen Harvey	Sandra Saunders
Patrick Sheehan	Suzanne Martin	Sam Stanley
Robert Harrison	Peter Law	Joanne Dieters
Veronica Garnier	Brett Crealy	Nina Willcox
Sindy Yoo	John Lucas	Amy Handy
Marianne Wickham	Kerin Hosking	Shelley Cassidy

**FORM E including variation to
FORM E (continued)**

Naarah Hampton	Zdenek Bedrich Robes	Gary Nicholls
Ena Busstra	Traian Costovschi	Greg Peacock
Renee Moody	Marjorie Bradley	Rachael Fletcher
Jessica Greenwood	Peter Pearce	Darren Painter
Michelle Bullivant	Graeme Furlong	Elizabeth Hatton
Angela Wilson	Kim Yetman	Sue Heck
Elizabeth Scott	Ian Parkyn	Luke Perrett
Roelofina Van Abkoude	Zara Goodman	John O'Gorman
Caroline Codner	Danielle Kohen	Carole Lauder
Paola Contador	Terry Riley	Anthony Dobbie
Georgina Batty	Robert Rodger	Chris Breytenbach
Charles Brown	Ruth Bails	Fred VanStaden
Naomi Tavake	Jan Finlay	Sheena Maree Mcconville
John McNab	Howard & Patty Shepherd	Marilyn Schache
Phylis Pona	Peter Middendorp	Adele Huntington
Nick Twidale	John Lyons	Norman Phillips
Erin Domrow	Marie Audibert	Rebecca Boyle
Karen Vella	Avinash Ramchandani	Matthew Hall
Kathy Falla	Ruth McConaghy	Brad Jackson
Nicolette Ralfe	Agnes Gibson	Ronda Johnson
Lyn Viero	Robert Thompson	Betty Dykes
Kate Campbell	Glenys Day	Lyn Zeuschner
Mark Heilbron	Anne Myatt	Grace Cairns
Andrea Thiele	Charles Cribb	Peter Torlach
Ada Van dder Woude	William Petterson	Louise Fordyce
Deborah Woodward	Lachlan Chadwick	Christine Hodgkinson
Margaret Maag	Brett Seib	Eve Gellatly
John Pennington	Graeme Rouillon	Melissa Haigh
Mossy Pinchback	Ray Winnington	Helena Plant
Gabriella Ambrey	Kathy Richards	Claire Wilkie
Bria Behrendorff	Martina Pook	Claire Vogler
Pearl Lambert	Jane Bell	Gloria van Donge
Richard Whittle	Guy Wood	Richard and Michelle Daveson
Catherine Tan	Camille Kunde	Lyndall Croft

**FORM E including variation to
FORM E (continued)**

Ian and Diane Coker	Sheree Alderton	Stacey Haynes
Wendy French	Debra Lambeth	June Poole
Carol Ordish	Jussara Downie	Tahlia Rentell
Denise Hill	Jenny Balboni	Carin Van Der Walt
Mary Ann Killian-Dover	William Wiersma	Jonathan Urlich
Dean Dwyer	Jean Smith	Tanya McKenna
Steve Finlay	Amanda Hall	Amanda Bray
Robert van der vos	Barry Fullard	Barbara Pecze
Hannah Gibson	Jeanette Glasgow	Emily Coombes
Suzanne Pfister	Susan Chapman	Katherine Marsh
Paul Stewart	Zel Lowien	Zane Howel
Helen Kent	Bernie Chan	Tina Gilbert
Steve Watson	Norman Buntrock	Jason Kerlin
Greg Richmond	Collette Graf	Jennifer Bigalla
Renee Worsfold	Kim Bayley	Bernice Allan
Pat Paine	Beatrice Borns	Su Woods
Elizabeth Rowlands	Fran Schwarz	
Marsha Song	Carol Northcote	
Stirling C Hart	Donna Redden	
Anne Cameron	Justin Lane	
Rachael Hoffmann	Patricia Hicks	
Yvonne Schoenmaker	Melissa Richards	
Sheila Leotta	Elvira Di Nicola	
Jason Abraham	Robert Spence	
Helen Halpin	Pauline Cole	
Margaret Simmonds	Keith Osborne	
Matilda Polanetz	Jeanette Gray	
Theresa Seiuli	Samuel James Kennedy	
James Walker	Carolyn Cerezo	
Simon Dauncey	Sherlene Klemens	
Oli Gunn	Yvette Grant	
Shirley Reiser	Michael Vico	
Suzanne Callan	Anastasia Gallard	
Daniel Bosshard	Vicki Beutel	

**FORM F including variation to
FORM F**

Grahame Colley	Tammy Sooveere	Lauren Drews
Leonie Michelle	Lorraine Seagrott	Mary Parr
John Kroeze	Megan Knight	Robert Davey
Roy Pickering	Jessie Doyle	Luba Bowden
Dawn Hannan	Mark Northage	Billy Rafferty
Faye Kriedeman	Bronwyn Vaughan	Bernice Graham
Jocelyn Luhrs	Helen Mary Connell	Joseph Howard
Graeme McIntyre	Daniel de Bruyn	Joanne Davies
Peter Mau	Yvonne Wawrzyniak	Carol Dubery
William Cosgrove	Greg Doyle	Lenny McInnes
Debra Butters	Maleah Cook	Paul Newman
Janice Morris	Marilyn Oliver	Joy Emms
Gary & Julie Barwick	Margaret King	Helen Forrester-Brown
Alyce Tuita	Raywyn Roberts	Neil Lehmann
Gwenda King	Shaun O'Keefe	Heather Bradicich
Robyn Cassidy	Jayne Coward	Elizabeth Lombaard
Patricia de Bruyn	Norton Sands	Fred Cramer
Marion Gray	Michael Mangos	Kseniia Novakovich
Sylvia Nowlan	Steve Mason	George Elferink
Luke Gregory	James Mueller	Phillip Luamanu
Martin Storey	Samuel Pentsa	Naomi Richardson
Domenica Musumeci	George Embrey	Terence Edmund Hill
Glenice Fisher	Mark Allen Vegar	Nicchia Nash
Kim Doughton	Bernard Richards	Kathy Bannister
Sue Potter	Elizabeth Perkins	Lisa Kendall
Douglas Murray	E Lanyon	Andrea Hanselmann
Michael Augustus	Mladen Davidovac	Matthew Chivers
Karl Alolod	Paula Townsend	Janelle Reeves
Daniel Foster	Jeffrey Mayfield	Conrad Newbery
Allison Crouche	Carol Thornton	Dolour Vogler
Heath Riddle	Ryan Degroot	Dave St Henry
Catherine Beattie	Charles Gullo	A & L Houtaha
Alan Adams	Tamara Jobling	Paul Liggins
Dani Kahika	Christopher Wood	Cassandra Walters

**FORM F including variation to
FORM F (continued)**

Rob O'Donnell	Clare Goodwin	Leanne Burrell
Doug Baigrie	Danielle Tibbs	Mary Zepina
Trisha Hicks	Lynne Ashcroft	Donald Many
Keith Windus	Jessica Doust	Ashleigh Holmyard
Mark Priebbenow	Dierdre Ashiq	Danielle Hubbard
Zipporah McBurney	Jan Simpson	Pritika Wilson
Jeff Cripps	Karen Evans	Jeltje Verdouw
Malcolm Donald	Be an Grant	Elizabeth Verley
Alex Perry	Pauline Finelli	MaryAnn Boros
Name Withheld	Melva Alford	Stephen Wanmer
Daniel Lowe	Alan Johnson	Janice Seymour
Cheryl-Ann Hamel	Peter Gerry	Lena Holloway
David McNabb	Craig Dakers	Kenneth Wright
Jennifer Challenger	Helen Pearson	Lawrence Bulbert
Marie Kann	Esther Knights	Peter Bellas
Edgar Phillips	Claire Jolliffe	Mary Gaffney
Anna Church	Harvie Ladlow	Vee McLeod
Sharon Hoschke	Sarah Jackson	Paul Flomersfeld
Col Coenraad	Lyndsay Hall	Susan Cummings
Michelle Lalonde	Meg Baldwin	Nev Collins
Martin A''Bell	Trudy Buckley	Jan Johnson
Greg Wright	Mary Lynch	Anna Stanley
Sherif Takla	Stephen Schooling	Lolita Lampton
Darryl Siggers	Alan Scott	Angela Boyd
Annalise Felkel	Lois Lewis	Dianne Fraser
John Parker	Margy Smith	Peter Rodgers
Sandra Davidson	Lin Southam	Janice Armstrong
Kevin Clarke	Stan Mccarthy	Colleen Oberle
Roger McKnight	Paul Fordyce	Marie Hall
Carolyn Thomas	Jennifer Smith	Rayleigh Winten
Debbie & Scott Golding	Joanna Barletta	Debbie Langton
Linda Beattie	Kirstie Young	Caroline Richards
Mina Hempstead	Sandra Lawrence	Marie Thuresson
Alf G	Linda Keen	Qing Ling

**FORM F including variation to
FORM F (continued)**

Karen Bell	Jonathan Lanham	Kim Gourley
Sonia McLean	Kate Ruthenberg	John Evans
David Edkins	Emma Murray	Jorgie Hudson
Elizabeth Epstein	Ian Bell	Lorraine Cavill
Shirley Prato	Jennifer Crocker	John Dixon
Russell Hamlet	Ruth Edwards	Leanne Daniell
Jennifer White	Heather M	Penelope Howchin
Michelle Hines	Andrew Wicks	Kathleen Bromell
Naomi Smith	Kathryn Hawkins	Elizabeth Chapman
Dorothy Clarke	Eric Hall	Joan Apthorp
Kelli Kozicka	Pamela Kroon	Wendy Macdonald
Billi Wright	Christine Lanyon	Irene Hucker
Jeanette Linde	Stanislaw Iwinski	Pieter van Waveren
Andrew Shepherd	Katie Balfour	Samantha Lilley
Christopher Stanley	Kylie Lowery	Virginia Marando
Katherine Manuel	Colin Molloy	Colin Goodsell
Sandy Rudge	Sharon Mason	Sharon Mckenzie
Carmel Morrison	Susan Richardson	Jonquil Burn
Sunny Perera	Priscilla Pitiroi	Steve Riley
Richard E Gulliford	Kim Furst	Glenda Cavanagh
Daphne Hay	Ric Brooking	Anita Ogden
Jenny Hughes	Sylvia de Jongh	Paul Pardede
Nicole Thomson	Elaine Murray	Wayne Martin
Melissa Doyle	Trevor Cotterill	Anne Kratzmann
John Stevens	Lelly Freeman	Penny Lai
Wendy Streeter	Marisa Nowland	John Avery
Leanne Fry	Dana Row	Sara Sidor
Jill Hall	Susan Lavender	Julianne Hultgren
Stephen Spano	Eve Stefan	Lauren Wade
Mrs Lee Scott	Greig Nichols	Sue Rhodes
Daniel May	Anne Love	
Helen Englert	Sandra Ferhad	
Doreen Wheeler	Joyce Hodgson	
Tola Lynch	Kerry Nolte	

**FORM G including variation to
FORM G**

Graham Wirth	Matthew Madryga	Hayley Emms
Pat Jones	Betty Honeyball	Ess Grubb
John Morgan	Fiona Nunn	Michael Case
Edward Dancewicz	Gayle Rose	Daryl Thurston
Esther Armstrong	Jean Antill	Alison Appleby
Gina Peters	Cherry Gordon	Alyce Niesler
Carol Sams	Dawn Sorensen	Bruce Uebergang
Mary Martin	Denis Lloyd	Deidre Thom
Terry Kriedeman	David Horton	Pauline Brownlie
Amanda Ford	Milly Hancock	Cathy Hawkins
Carla Pappas	Catheryn Robertson	Lisa Worlin
Joanna Mikkelsen	Michelle Young	Brad Joyce
Ann Perkins	Matthew Byl	Graham Morgan
Peter O'Donnell	Matthew Routley	Douglas Parker
Grace Heskes	Dale Skinner	Christine Valerie Harris
Thomas Woolley	Amy Bruce	Robyn Gardiner
Maureen Bartolo	Veronica Verner	Kenneth Rudge
Kelly Hetherington	Stephen Russell	Robin Kerr
Linda Miller	Sonya Leembruggen	Steve Follent
Victoria Alexander	Mary Flynn	Rod and Helen Douglas
Carol Pain	Catharina Wiesenekker	Geoffrey Anthonisz
Merle Ross	De Jager	Mrs Sandra Lewis
Anthony Tomlinson	Reg Williams	Carleigh Kenward
Dorothy King	Robert McDermott	Leanne Kilian
Rowena Cornell	Alfio Petralia	Joanna Wotton
Jack Leung	Joshua Price	Linda Fury
Catherine Brown	Libi Maxwell	Nerida Beard
Ron Jones	Bob Beasley	Peter Lewis
Deborah Gangur	Jared Allen	Janet Kraus
Renee Griffin	C. H. Cheah	Soly Raj
Julie Van Dongen	Norma Robson	Elaine Batson
Julie Priebbenow	Alyson Shepherd	Alexis Christenson
Judy Slade	Kerry Olsen	Robynne Rankin
John Spencer	Bryan & Heather Lambert	Danyelle Stapleton

**FORM G including variation to
FORM G (continued)**

Sandra Mitchell	Margie Tomlinson	Helen Palmer
Milfred Simpson	Steve Goode	Daniel Aquino
James Walsh	Wendy Francis	Allan ten Bruggencate
Edgar Askew	Lexia Mackin	Elisabeth Barnes
Peter Schmitt	Madonna Powers	Colin Gibson
Rachel Burnes	Arthur Hall	Wayne Clinton
Maurice McNally	Vili Sotutu	Bronwyn Olson
Cheryl English	Judy Webber	John Anthony Aquilina
Robyn Cormack	Wayne Winter	Damien Martin
Gary Willcox	Joy Bound	Graham White
Mary Wicks	Joy Durant	Shirley Guhl
Judith Harland	Craig Cornish	George Hood
Darryl Witherington	Vivian Bruton	Sharon Taylor
Robin Alderton	Julie Chalmers	Robert Scott
Mark Paterson	Sonya McMahon	Alice Kelly
Joel Cork	Chris and Nola Attwood	Rachael Basanovic
Steven Brecht	Robert Williams	Thomas Popovic
Maree Ferris	Michael Cox	Lorraine Peterson
Neil Hutchinson	Don Reynolds	Kathleen Owen
Mick Alexander	Mary Brady	Magdalena Katsoufros
Gary McGinty	Mark and Sheryl Gore	Suzanne Lotteriet
Hermanus Ruyters	Denise O'Malley	Kerry Pearson
Edward Walker	Kylie Hanson	Philip Auld
Peter Pearce	Andrew Eckermann	Sandra James
Dianne Willis	Benjamin Fien	Joanna Ernst
Linda de Beer	Amanda Pitman	Judy Smith
Stuart Parry	Joan Searles	Joyce Cocksedge
Brenton Nicholls	Darlene Tarran	Dawn Murphy
Tony Stewart	Gloria fisher	Sylvia How
Choi Fan	Bev Green	Lorna Grant
Wendy Nix	Jill Marx	Barry Raymond
Charles Morze	Jan Rudorfer	Ellen Eschler
Chris Noorbergen	Hannah Christie	Murielle Taylor
David Rolfe	Ken Joslin	Vanessa Kirk

**FORM G including variation to
FORM G (continued)**

Joanna James	Carlo Dyer	Denise Konig
Sue Black	Janene Martin	Elizabeth Broad
Janet Lassig	Michelle Brennan	Rebecca Stephens
Lola Shuey	Sean Greenacre	Ian Gunton
John Waddell	Gert de Bruijn	Steven McElveney
Leanne Annett	Peter & Sue Barrett	John Nicolle
Elizabeth Phillpotts	Susan Braggins	Anu Johnson
Matthew Cook	Marlene Balla	Jeffery Goldthorpe
Paul Modra	Marie Scaife	Ludy Charles Sweeris-Sigrist
Wendy Van Hassel	Anthony Nielsen	Greg Stickler
Mark Handy	Rose Kahika	Chelsea O'Neill
Hannah Bickell	Melanie Zambelli	Jordan Campbell
Bernice Woodland	Kathy Bosua	Christine Wall
Berneen Gardiner	Frank Evans	John Daniell
Laura Butler	Kara Moseley	John Porter
Cathryn Emerson	Hannah Smith	Hannah Cox
Esmay Woods	Bonnie Trevanion	Gary Khoo
Christine Heigan	Lyn Quinlan	Moana Roberts
Irene Salapatas	Rebecca Parks	Darren Gregory
Bob Jeffrey	David Manson	Daniel Zimmermann
Shane & Wendy Reddell	Sue Lederhose	Sheldon Lindsay
John D'Alton	Dianna Holloway	Kim Edwards
Brenda Marsh	Elaine Appleby	Carol Klemm
Alan Gray	Beverley Trigg	Melanie Horton
Sian Hayes	Vito & Lynette Cuzzubbo	Judith Searle
Taryn Hayes	Sean Kluyts	Anneliese Quintus
Christine Hess	Bronwyn Edwards	Nerida Moore
Eden Bradbury	John Apostolides	Jutta Johnson
Robyn Young	Stephanie Johnson	Rebecca Mkoka
Diane Fuller	Janet Eiby	Penelope Sholl
Josh Plumbe	Sylvia J Huxham	Conrad Townson
Michelle Hardingham	Aaron Linder	Amy Attwood
Colleen Deane	Anne Roberts	Charles Harrison
Darrell Woods	Mich Daniell	Joel Bolitho

**FORM G including variation to
FORM G (continued)**

Andrew Correll

Pat Casanovas

Chris Morris

Mariana Simule

Derick Cook

Robyn Woods

Colette Cutler

**FORM H including variation to
FORM H**

Sarah Berry	Mario Todaro	Frank Petraglia
Brian Finnigan	Steven Carl Baum	Matti Koskelainen
Linda Behan	Julie-Anne Hopkins	Valerie McVety
Margaret Cooper	Maureen Kennedy	Robert Osmak
Julie Stack	Tania Jesse	Deborah Watts
Chrysostom De Silva	Jadee Lewis	Susan Strydom
Alenna Peff	Joanne Wong	Shaun Adams
Tanya Strydom	Kaylah Searles	Don and Lynn Lawson
Robyn Gough	Nancy and Deryck Thomas	Johanna Geoghegan
Andrew Painter	Len England	Callum Burns
Jenny Wooldridge	Emmanuel Alfa	Mark Hassall
Janine Trommel	Lorraine Brandle	Salote Bangura
Patrick Coyle	Amanda Smith	Nicole Anderson
Carmel Coutman	Ray Muller	Nick Tyler
John Gallimore	Linlee Ogden	Tess Schibrowski
Thieu Vu	Rebecca England	Sandy Sharp
Rodney Huntington	Louise Keppler	Sharon Madden
Gillian Reid	David Bannister	Graham Thompson
Daniel Feeney	Peter Farley	Caroline Jones
Ettienne McClintock	Stephanie Jones	Jen Lyons
Grace Morris	Ruth Heazlewood	Ruth Curtis
Shandell Robinson	Mclver Norma	Karen Maloney
Chris Roberts	Stuart Millar	Brett O'Donnell
Rob Davidson	Graham Wheatley	Violet Hart
Kerry Petrus	Anne Norris	Susanna Hardy
Diane Abood	Nathanael Grieger	Allan Mackenzie
Robert Smith	Esther Thomas	Alan Beardall
Alana Halsey	Julie Arthur	Denise Landers
Margo King	Ofelia Luscombe	Bernard Wright
Alan & Beverley Skelton	Peter Blake	James Maher
Theresa Simshauser	Jason Kerlin	Carolyn Field
Bogdan Konicanin	Ian Parkyn	Chris Taylor
Nicholas White	Ben Morrison	Alan Hughes
Anna Ferszt	Andrew Horn	Anthony Willis

**FORM H including variation to
FORM H (continued)**

Katrina Cameron	Wendy Cumming	Dorothy Holmans
Bruce Fuller	Jack Bainbrigg	Ruth Ferguson
Les Ritchie	Alan Molen	Faith Bound
Elisabeth Chandler	Uta Lippmann	Colleen Mohan-Druce
Nicola Enslin	Michael Kaddatz	Peter Willison
Ellen Grierson	Lois Paterson	Robert Moloney
Hannah Cato	Rochelle Miller	Rosemary Blyth
Royston Satterthwaite	David Clegg	Yvonne Lang
Paul Rumballe	Karen Coe	Deborah Soanes
Sue McGinty	Michael Christie	Chris Huppatz
Alan Young	Natalie Roy	Hannah Krause
Hui Teng Tin	Mrs Jean Koch	Peter Liljeqvist
Leanne Scott	Lauren Williams	Dennis Lockhart
Stephen Finger	Ananda Jacobs	Deanne Britton
Flora Wu	Edward Merlehan	Sue Garry
Neil Westgarth	Jennifer King	Mona Black
Caleb J Stott	Trish Hafner	Karen Bowden
Jodie Lynch	Lyn Quinlan	Zenice Wilkins
Robyna Boland	Michael Holtzhausen	Paul Argent
Antony Hunter	Eleanor Asmussen	Erica Martin
Franci Ferriggi	George Wallace	Michael Abbott
Marilyn Wegner	Larry Martin	Peter Segato
Tracy Cocker	Tracey Curtis	Sandra Forman
Douglas Maggs	Noeline Wallis	Glenis Batten
Catherine Black	Alice Malone	Gerry Kluyt
James Travers Vote	Sharyn Werner	Robert Edser
Renato Bocxe	Glyn Reinbott	Leslie Le Gallez
Filomena Araujo	Elizabeth Schulz	Lyn Dimond
Ros Johnson	Eleanor Kirkham	Robert A. Biggs
Carol Wormald	Elizabeth Timms	Caroline Bird
Karen Lee	John Watts-Thomas	Anastasia Whale
Diane Linda Whittle	Fiona Manser	Jan Rickert
Dalma Whitmore	Gordon Lewis	Luke Hyland
Leora Swenson	Lorna Osborne	Simon Joanknecht

**FORM H including variation to
FORM H (continued)**

Kara Moseley	Paul Ninnes	Jenny Guy
Bernard P Smith	Rachael Heaton	Jessica Green
Kirsten Archer	Patricia Byrnes	Anne Elliott
Jan Litzow	Robert Gynther	Heather Jones
Jennifer Grieger	Susan Leggo	Bev Miskin
Mary Crowley	Richard Roberts	Rachel Trevatt
Vivi Rooney	Linda Jobson	Carol Williams
Amanda Neilsen	Donna Simard	Norm Evans
Janette Heit	Desley Roydhouse	Valerie Pym
Desley Finedon	Annette Sutton	Wendy Horne
Chelsea Hagen	Kim Walmsley	Laurie Polinelli
Wendy Lyttle	Anthony Priddle	Alex Sintonen
Cathy Emerson	Jennifer Johnstone	Lyn Saunders
Malcolm LeMasurier	Lyndell Cavanagh	John Gibson
Alison Young	Paul Banks	Grafton Van Veelen
Caroline Andrew	Katrina Pullella	Geoff Dickson
Ngaire Flaxman	Summer Mischke	Jeremy Galbreath
Tanya Broadwater	Andrew Peers	Miranda Pugh
Robyn Curtin	Ruth Cahill	Cornelis Prinsloo
Noel Huxham	Anita Turner	Marjet Bedi
Veronique Douillard-Fomiatti	Gay Bell	Margaret Lucas
Keirra Mushett	Amanda Hill	Joy Drennan
Barbara Borham	Daphne Fry	Rodney Hutcheon
Deborah McConnell	Evonne Carr	Charmaine Brown
Jared Nichol	Elizabeth Godden	G S Kumar
Graham Taylor	Beverley Napier	Joshua Harris
Mrs Lorelle Saul	Allison Kelly	Matthew Chivers
Erica-Ruth Talitha Murray	Paula Snow	Geraldine Callaghan
David Ensinger	Daniel Nolan	Janique Evert
Jennifer A Bensted	Carol Feige	Catherine Murphy
Suzanne Fisher	Ian Bennett	Christian Marland
Dee Jurgs	Charmaine van Heel	Ken Broomfield
Ettienne McClintock	Jon Thollar	Carol Castillo
Frances Shortland	Anel Fourie	Shari Blunt

**FORM H including variation to
FORM H (continued)**

Meredith Caruana

Georgette Lowseck

Mathew Di Lorio

Marguerite Cameron

Joseph Rillera

Maleah Cook

Kimberly Shaw

Phillip Matthews

Geoffrey Rees-Thomas

Zorica Srnec

Karina Cheetham

Angela Fitzgibbon

Jennifer Cooper

Claire Gawne

Joshua Scott

Teena Putt

Maryanne O'Brien

Rose Homan

Georgette Lowseck

Janis Judge

**FORM I including variation to
FORM I**

Cyril Muller	James Madden	Paula Borchardt
Barry Binnie	Dana Strydom	John R Armstrong
Simone Cotton	Nathan Blake	Abilio Ferreira
David Secomb	Judith Wilson	Peter Buttery
Norma Sturdee	Deb Alfred	Belinda Thorne
Izak van der Merwe	Ross Lindsay	Dean Freeman
Isaac Harrison	Lorraine McGinnis	Leo Garbellotto
Michelle Moss	Anita Foster	Frances Shortland
Tim Turner	Beverley Faulkner	Deborah Stone
Geoffrey Joyner	Gary Ingram	Ira Dawson
Jamie Scerri	Rose Andruska	Kelly Bouzige
Rhonda Jackson	Tim Heppell	Karen Eldridge
Kerry Cody	Henrietta Jordaan	Anna M Peterson
Claudia Murphy	Grace Martin	Jenny Richardson
Lorraine Kublick	Steven Wellington	Joy Sargood
Graham Cole	John Smith	Mark L'Huillier
Uta Compton	Michelle Hoult	Jason Laurence Schneider
Phil Evans	Peter Horn	Rod Murray
Robyn Vardy	Leonie Eastlake	Jane Silcox
Tony Paterson	Kaye Stuart	Rohan Shanmugarajah
Errol and Janelle Boettcher	Aleisha Johnson	Sandra Ferhad
Ruth Robertson	Rhonda Fletcher	Michael Cody
Andrew Peck	Lynette van der Meulen	Caroline Gerrard
Michael Higgins	Paul Shelden	Ruth Kislitsa
Naomi Heckathorn	Natalie Holmyard	Joanne Blowes
Anastasia Nicolaou	Jess Hagemeyer	Elizabeth Cornford
Shane McCasker	Michelle Martin	Sue Leckenby
Cheryl Reid	Brett Hann	Steve MacFarlane
Jo-ann Moriarty	Tomoko Kelly	Jan van der Meulen
Dolores Wilson	Craig Thomas	Luke Vella
Viive Thompson	Amelia Neundorf	Colette Gold
Paul Wheatley	Jodie Burton	Les O'Gorman
Dana Simpson	Paul Unwin	Chris Guyler
Michelle Scovell	Anderson Greville	Christine Kriel

**FORM I including variation to
FORM I (continued)**

Kevin Evans	Ronda Roy	Leslie Bowman
Wayne Pascoe	Bob and Ann Loveys	Lynette Winter
Harri Korhonen	Waka Kahika	Heidi Parkes
Jeanie Priestly	Darrel Smithstone	Rebekah Brice
Adelina Marolla	Richard Chander	Kerry Boettcher
Troy Morris	Joanna Simmonds	Dennis Sayer
Lois Payne	Peter Evans	Gordon Jackson
Warren Woodland	Cynthia Silooy	Wendy Ponsen
Leanne Erian	Duncan Sherriff	Warren Saal
Jodi Forward	James Livingstone	Natalie Gilbert
Jackie Soper	Wayne Ritter	Chris Davis
Natalie Dean	Peggy Van Buuren	Janelle Fox
Lilia Barajas	Lynne de Vos	Amber Foy
Patricia Doyle	Graham Wildermuth	Kathy McComber
Daphne Liu	Louise Cox	Pam Caswell
Veronica Moore	Sue Crook	Leigh D Stebbins
Garry Cavanagh	David Morrison	Maynessa Lloyd
Lara Engelbrecht	Jennifer Smith	Karen Hunter
Ray Wong	Kevin Murphy	Suzette de Jager
Angela Rodgers	Joan Clancy	Anastasia Nicolaou
Ben Burton	Bill Edwards	Helen Hill
Andrew Petrus	Earle Johnston	Lorna Neale
John Spellman	Nerina Callaghan	Leigh McKnight
Jason Stehn	Janet Tohme	Lexia Edwards
Donna Greenslade	Krystelle Harvey	Jemma Mitchell
Monica McNamara	Stephanie Pringle	Sharon Hindley
Ralph Hultgren	Bianca Stewart	Mani Hirovanaa
Russell Hampson	Frank Atkinson	Robert Ellem
Keith Crews	Genevieve Gall	Vicki McGaw
Catherine Isobel Colquhoun	Michael Marlow	Philip Richmond
Faye Roberts	Veronika Teurer	Karen Crossley
Madelyn Jensen	Wendy Phillpotts	Maria Noad
David Martin	Andre Fouche	Lynette Cox
Danielle Davis	Gregory Paxton	Marion Naidoo

**FORM I including variation to
FORM I (continued)**

Justin Morgan	Vicki McKinnon	Shon-Leigh Manning
Jamie Klein	Naomi Cartner	Ulrie Reid
Margaret Jasch	Rebecca Duerkop	Suzette Torti
Matthew Hodge	Keith Watson	Karen Smit
Lorrin Kirkpatrick	Mrs. E. Tanttari	Margaret Lucy Murray
Jenny Chappel	Jaana Pitkanen	Belinda de
Jae French	Peter Harding Stacey	Maureen Nally
Marilyn Rowsome	Shirley Vico	Philippa Smith
Shaun Fisher	Greg Twidale	Carl Fullee
Josh Easton	Cam Drews	Marina Pollock
Wae Jae Tan	David Holloway	Neal Hillyard
Geoffrey Adams	Coral Smith	Elaine Leggatt
Susan Page	Leonie Poole	Susan Schilder
Dianne Bentley	Rodney Greive	Kim Lee
Lesley Barton	Ken Coppard	Ian Lersa
Linda Hupfeld	Viorel Bradea	Lynn Farmer
Carmelo Rubio	Gerard Drew	Leah Perrin
Lorinda Stiles	Helen Elliott	Tanya Kerlin
Rebekah Finch	Bernadette Nicolosi	Wayne Lee
Janet Fasuis	Paul Faigl	Helen Konz
Kayla Hana	Lyn Nowland	Mark Barry
Eddy B Ensing	Bob Wilson	Barbara Vuleta
Sue Neubronner	Ken Conwell	Julienne Doran
Sabina Halnin-Hopkins	Michael McAuliffe	Amber Engstrom
Ivan Moraes	Annette Marshall	Lyndene Edwards
Chris Shillingford	Vicki Harland	Janelle Patch
Rita Corby	Rebecca Jones	Alina Opris
Laurence Trigg	Martha Di Costanzo	Terry Stanley
Joyce Lee	David Hawke	Barry Mortensen
Peter Scott	Rosalie Stubbin	Evan Shelton
Heinrich Rusterholz	Kara O'Donnell	Marjorie Entermann
Joe Casey	Teresa Kattenberg	Stephanus van Tonder
Peter and Karen	Margaret Parks	James Hensley
Andrea Bristow	Diane Dwyer	

**FORM J including variation to
FORM J**

Kathryn Watt	Susan Lavender	James Thomson
Tamara Manley	Brett Schultz	Xavier Koen
Wendy Carter	Helen Skinner	Geoff Bauer
Amy Willis	Vanessa Hain	John Edward Billman
Ming-Je Chiu	Evelyn Scheuber	Jacqueline Weber
David Mulliss	Barbara Pecze	Dennis Verner
Mark Hayes	Susan Dickens	Liudmila Johnstone
Lyn Davis	Heather Campbell	Ann Phillips
Shane Botting	Jana Swanepoel	Victoria Knipe
Jessica Howard	John Hallpike	Gloria Hamilton
Barb Charge	Aileen Tan	Tim Young
David Oei	Sharyn Lituri	Debra Straatmans
Linda Logan	Grahame Martin	Christine Lammermann
Angela McIntyre	Desmond Oatridge	Sophie Lingam
Humphrey Isaak	Annette Smith	Jennifer Barrow
John Sayer	Joachim Harazim	Aaron Ford
Flora Young	Karen Vella	Peter Francis
Curt Ammann	Darren Crisp	Anthony Wetmore
Jessica Knight	Richard Campbell	Robyn Riley
John O'Brien	Ethan Murray	Anna Barkrr
Cornelius McCormack	Jason Hey	Jeanette Glasgow
Garry Brown	Ann A Endres	Peter Thomas
Heidi Evans	Tony Neale	Barry Stone
Libby Hayes	John Bolitho	Majella Stephen
Mary Beck	John Merriweather	Angela Beggs
Beena Saju	Kim Wainwright	Melissa Bates
Raelene Robinson	Carina Ivins	Don Wilson
Joyce Dotollo	Coleen Chong	Doreen Wheeler
Elizabeth Novic	Dr K Kjelsaas	June Genat
David Jonsson	Tim Wallace	Matt Osberger
Gary Buckle	Peter Smartt	Scott Clifford Grimley
David Nelson	Phylis Pona	Hannah Mala
Natalie Howells	Bronwyn McDonnell	Robert Usher
Nicholas Jackson	Naomi Pettett	Kylie Ransley

**FORM J including variation to
FORM J (continued)**

Peter Brown	Mal and Caroline Pollock	Janelle Watson
Anne Smith	Mitch Sala	Catherine A Agius
Carol Neilsen	Rhonda Sawyer	Theresa Joslin
Letitia Breytenbach	Lachlan Herbert	Chris Doughty
Heather Rutherford	David Weekes	Leona McCamley
Lancia Hall	Judith Bolin	René Taylor
Brian Robertson	Dr Eleasa Sieh	Mark Davey
Marnie Blythe	Kevin Francis	Ruth Gibson
Jude Aaron Legg	Deb Acaison	Matthew Popovic
Liz Page	Michael Palmes	Peter Flatt
Marilyn Ricardo	Adrian Prince	Joy Aquilina
Robyn Kingsford	Heather Ahrens	Hannah Bickell
Cathryn Zarnke	Pamela Alick	Heather Bowcher
Yvonne Cronin	Darren Trinder	Jon Thollar
Helen Moran	Irina Ruja	Zhenghao Dai
Talita Minnie	Mary Ravenscroft	Angela McGuigan
Sandra Wild	Paul Botha	Sam Cumming
John Pesch	Shirlene May	Jeannette Mijolovic
Dorothy Elizabeth Smyth	Janice Cotterill	Tanya Willyan
Dianne Pattemore	Janette Corcut	Marisa A Aikens
Stephen Strachan	Genevieve Cooke	David Wallis
Suan Yee	Desley Barba	Michael Hooper
Joan Koskela	Ruth Curtis	Suzanna Greenwood
Janelle Morrison	Brendon Power	John Lane
Hilary Jasch	David h Walker	Kathryn Martindale
Christelle Holland	Anne Hartshorn-Smith	Alexander Dorr
Carol Pressey	Zoe Tkal	Julie Keil
Shane Nelson	Sandra Sofo	Anita Riley
Julie Coles	Jeff Jorgensen	Theresa Martin
Leanne Christian	Lynette Harrison	Beverley Gregory
Christopher Muller	Sneha George	Julie Curran
Vicki McNair	Leigh Brown	Rachel White
Joyce Coffey	Finnley Vandersee	Savanna Labuschagne
Melanie Newbery	Kim Ostman	Wendy Farley

**FORM J including variation to
FORM J (continued)**

Ruth Fea	Rhnda Banditt	Pamela Hando
Trevor Jessop	Katrina Hartley	Christine Hacon
Anthony Barra	Daniele Colthup	Roslyn Belz
Cathy O'Gorman	Geraldine De Silva	John and Fay Lowe
Vincent Barwinski	Lorna Weir	Megan Knight
Jim Rogers	Shirley Mitchell	David Beisler
Concerned Citizen	Mal Forman	Tina Black
Sally Fraser	Beryl Smith	Lance Goodall
Eileen Lindberg	Keith Cruickshank	Rory Bowler
William Crans	Nora King	Tiahney Erkkila
Doug Howard	Ruth Casale	Cheryl Myers
Greg Stewart	Amanda Butcher	Susie de Graaf
Christine Robinson	Judy King	Val Delaney
Jan Scriven	Aldona Jerlstrom	Joan Cansdale
Jennifer Ann Heckathorn	Desley Kahler	Jeanette Pearson
Edwin Medlyn	Mei Cheah	Peter Mcpherson
Patricia Riddle	Susanne Taylor	Gary Ingram
Yula Donovan	John Leebeek	Robyn Cosford
Felice Cortese	Marion Harvey	Jaime Kerr
Kerri-Anne Sadler	Ruth Fernandez	Bronwyn Young
Kim Wainwright	Bradley Hill	Joy meek
Janet Papalii	Margaret Hayes	Samuel Pickering
Nicole Berghuis	Carole Lauder	Debbie Dunstan
Jenny Rickards	Lynette Warnock	Wesley Thompson
Jeff Keily	Glenda Barnard	Jeff Pitman
Linda Weatherhead	Judy Odgers	Michael Higgins
Jo Jo	Annette Gallagher	Ramsay Singho
David Renderos	Carmel Jordison	Maria hawes
Bronwyn Taylor	Reuben Carroll	Maria Toumbas
Gary Radford	Carole Armstrong	Mark Thomas
Judy Chapman	Jennice Begg	Tegan Roberts
Linda Phillips	Natalee D'Aquino	Anna-Maria Loibl
Karen Stewart	Rosemary Farrell	Clare Osborne
Isabelle Carey	Dyan Tilbrooke	Melody Pereira

**FORM J including variation to
FORM J (continued)**

Elizabeth Kurpiel

Christine Stace

Stacey Ware

Philip Metcalf

Katrina Simmons

Vagaga Laulua

Lilia Palmes

Rebecca Pitt

Barbara Richardson

Patty Chegg

Noel Simento

Chelsea Hagen

Bernice Allan

Jessica Puddle

Jenali Collier

Candice Matthews

Andrew Hughes

Hanli Uys

Majella Stephen

Nereece Markert

Robyn Sherwell

Maria Doig

**FORM K including variation to
FORM K**

Andrew Schache	John Seuntjens	Casey de Lyster
Jayayla Doyle	Kathy Lacy	Valentina Vilshansky
Jillian Jennings	Cecily Mac Alpine	James Norman
David Koina	Caroline Heckathorn	Philip Brady
Merlene Johnson	Roberto De Souza	Cornelia McCallum
Peter Thompson	Helen Nixon	Renier Oosthuizen
Linda Servus	Terry O'Grady	Duncan Moody
Bob Crosland	Merida Binning	Helen Warren
Nick Cremona	Dorothea Gasu	Susan McGuire
Ronnie Harris	Joan Aphthorp	Barbara Clark
Anja Simukka	Leigh Scott	Mark Duprez
Zac Whyte	Sarah Brodie-Fraser	Serena Hung
John Hughston	Peter Farrington	David McInnes
Pam Finlay	Stefany Smallman	Wendy Cowan
Richard Dart	Natasha Andersen	Mercia Van Antwerp
Karen Moreton	Sylvia Huxham	Rex Hill
Marlene Prinsloo	Jean Edwards	Michelle Thomas
Lirna Amos	Margaret Caddies	Peter Roberts
Darryn Flood	Dennis Mehling	Judith Lovely
Paul Victor	Glen Fountain	Anthony Smith
Karen Willcocks	Lynn Preece	Ian Jagger
Joe Patuto	Anne Window	Ashley Schneider
Carolyn Bourne	Kelsey Rickman	Damian Cato
Russell Wilkins	Eric Williams	Stephen Toby
Kirsten Adcock	Alinta Herrington	Clyde Dennis Coombes
Nick Di Cesare	Natasha Erkkila	Annie Williams
Carol Mann	Sarah Skillern	Richard Londt
Hilda Mangos	Alida McConnel	Susie Stack
Heather Hewitt	Terry Farrell	Maureen Bannister
Shirley Cashel-Campbell	Michael Beecher	Stephen Holmes
Marion Heim	Brendan Anderson	Dawn Schelberg
Jessica Puddle	Greg Doyle	Greg Alder
Judith Nightingale	Garth Gundry	Mat Thomson
Mariana Simule	Marion Dodds	Dale Brooks

**FORM K including variation to
FORM K (continued)**

Heather Hall	Ron Schmid	Ian Auld
Jacqui Keller	Ryno Holtzhausen	Elaine Howard
Peter Bosker	Sherylle Wells	Marie Lawrie
Lorelle Smith	Mark Donovan	Greta Blatch
Noel Wallace Cane	Helen Curtis	Tessa Buckley
De Regt	Russell Schafer	Helen Thomason
Shane Bell	Angela Lane	Joel Lister
Rosemary Morgan	Kat Maltry	Matthew Dubery
Ivan Sinclair	David A W Miller	Loretta Rehbein
Tamra Risser	Jan McCloskey	Simon Bedville
Edwin Pomfrett	Darren Hammerton	Jane Thornton
Ross Coffey	Amanda Macaulay	Cathy Bunn
Allan Thygesen	Josiah Riley	Genevieve Swan
Alana Wilcox	Lani van Dalsen	Lakhbir Carroll
Alison Jones	Christine Burrell	Chris Wong
Isobel Murray	Susan Smith	Melinda Hannam
Julie Mann	Michele Mitchell	Christoph Danell
Glenda Turner	Maggie O'Keeffe	Karen Minter
Karen Bolden	Anita Elliott	Martin A'Bell
Brian & Annette Bernays	Hope Rix	Susan Johnson
Mardi Nitscke	Joshua Symes	Laureen Lusby
Angela Woodward	Joyce Hodgson	Catherine Johnston
Susan Austin	Elizabeth James	Kelvin and Sue Jones
John Belik	Keith E Kiely	Grace Randall
Lewis Beard	Elizabeth Kurpiel	Suzanne Dawson
Rachel Fisher	Russell Grigg	Tanya Shliahov
Laureen Rautenbach	Janette Mercer	Catherine Smart
Susan Kirk	Mary Zweers	Sandra Stapleton
Peter McInnes	Chris Saayman	Brad Gannon
James Barrett	Wendy Holm	S Pearce
Shirley Baxter	Jeffrey Gerrard Keioskie	Jean Quinlan
Gwen Smith	Sharyn Wilson	Rachel Harbison
Glen Currie	Fiona Tann	Rodney Eime
Judith Baker	Julia Wagner	Wilma Millington

**FORM K including variation to
FORM K (continued)**

Anne-Marie Hryniuk	Daniela Ruegg	Sheila Wells
Tony Stewart	Carole Green	Karen Gregory
Name Withheld	Bridie Meredith	
Judth Smith	Steven Sornachalam	
Bev Lenton	Gwen Papworth	
Noelene Sharp	Linda Paul	
Jeff Reid	Brendon Winters	
Doug Cooper	Ruth Crowe	
Gaylene Grummitt	Elise Wisnewski	
Robyn Hardina	Garry Cavanagh	
Kaylene Gardner	Heath Jefferis	
Petyer Earnshaw	Vicki Jackson	
Rodney Huntington	Nick Maskell	
Pamela Merwood	Jenni Johnston	
Josie Rigney	Val Pym	
John O'Brien	Rebecca Emery	
Joanna Wotton	Pamela Butel	
Kathryn Hohnberg	David Allenby	
Rebekah Batley	Kate Hall	
Glenda Spencer	Stella v	
Ruth Monteith	Andrew McCracken	
Ron Jones	Likai Mao	
Jacklin K	Lois Coetzee	
Maureen Price	Kirk Zylstra	
Kim Grayson	Elisabeth Green	
Geoff Skerman	Geoffrey Key	
Jodelene Walker	Leonie Rickard	
Linda Servus	Susan Garmeister	
Decima Jones	Sandra Dale	
Rosemary Hill	Slav Shapialevich	
Julie Douglas	Cyranowicz Barbara	
Daniel Oakes	Melissa Gray	
David Schilder	Margaret Hyytinen	
Gary De Lasalle	Rachel Kingwell	

**FORM L including variation to
FORM L**

Gloria Klemm	Lyndal Corcoran	John Shaw
Joanne Hobbs	Joy Wii	Gordon Chapman
Kerrie Chandler	Marian Rossouw	Lesley Nettlefold
Stephen Ward	Rod Hallett	Colleen Keats
David and Alison Murray	Shawn Day	Grace Frazer
Pamela Merwood	Geoff Steffen	Robert Hobson
Alan Bailey	Lesley Parker	Edward Young
Carol Morton	Glenda Barnard	Ian Hamilton
Desiree McInnes	Claire Byl	Similafutupeua Puhotau
Brenda Savage	Kirrily Wasserman	Karen Lawley
Deborah Scott	Rodney Hutcheon	Tim Weber
Terence Lally	Ruth Shepherd	Raj Fernando
Pam Simon	Mark Carpenter	Eddie and Evelyn Free
Terri-Ann Clifford	Ian Brown	Rowan Young
Ruth Peckman	John Moman	Ian Bishop
Leanne Harper	Ian Gunton	Lynn Bocquee
Rebecca Kiely	June Poole	Greg Eiby
Susan Ching	John Evans	Kevin Petrie
Frances Leddick	Michael Adamson	Margaret Anderson
Nathan Reinbott	Fiona Niemann	Julie Booth
Val Smith	Colleen Deane	Karen Smith
Nicole Murr	Anna Warwick	Miriam Wentworth
Darren Lawson	Meron Walsh	Rex Wilkie
Felicity Jensen	Michael Meyer	Bruce Lawrie
Brendan Palmer	Ian Hartley	Jennifer Daniels
Ross Evans	Cecilia Villanueva	Chris Clark
Helen Irwin	Graham Quinn	Ian Scott
Christine Dalgliesh	Nathan Nancarrow	Marilie Bester
Ian Wilkinson	Greg Reinhardt	Sylvia Waszaj
Allison Quayle	Marion Thompson	Paul Richards
Rev. Dr Julia Pitman	Rodney Hall	Andrew Simon
Joanna Gibson	Laura Priebbenow	Jackie Mortimer
Robyn Harcourt	Kathryn Jorgensen	Lee Williamson
Bernard Pattison	Matthew Back	Jane Gibson

**FORM L including variation to
FORM L (continued)**

Melody Crawford	Judy Lucas	Debbie Hopper
Heather Johnson	Nicholas Thamm	Keith Knight
Ken Page	Sharon West	Cheryl Harrold
Michele Cauchi	Cielita Ilao	Carmel Russell
Mary Read	BJ Perrett	Debbie A Haines
Atina Hill	Andrew Hodge	Chris Sullivan
Lee Maginnis	David Crowther	Tracy Lech
Wendy Munday	Theresa Comerford	Linda Fioraso
Grant van Staden	Barb Kingston	Faye Kriedeman
Meredith Caruana	Jacinta Birchley	Margaret Wales
Brendan Hannah	Brian Waldeck	Joanna Hernandez
Karen Mackie	Rachel van der Walt	Max Contador
Angela Slack	Robert Crema	John Zienius
Dorothy Scurr	Bill Laver	Harry Iedema
Bronwyn Fay Cooke	Don Allen	Bev Tozer
Mark Trebble	Thomas Healy	Linda Curtain
Gina Valderrama	Nadine Kucks	Sonia Regan
Teresa Uittenbosch	Neng Soon Pang	Barbara Zahmel
Maria Kerswell	Inyika Nadredre	Valda van der Meulen
David Knox	Tamasin Scott	Sandra Wicks
Carly Urquhart	Rhonda Palmer	Marlene Bokma
Lance Cowan	Andrew Storrs	Rosemary Gotts
Robyn Gower	John Moss	Penny Jarman
Dennis. Monroe	Sujata Saha	Nicole Beasley
Jennifer Perry	Richard Weston	Halie Parke
Nathan Sepecan	David Anderson	Lindsay Trigger
Ravi Kancherla	Brenden Arthur Briese	Trevor Victor- Gordon
Cheyne Reilly	Christine McDougall	Colleen Addison
Ken Hooper	Charmaine Radke	Renee Brunne
Kaye Hollings	Jamie Little	Erin Neill
Denise Grrebert	Tessa Viljoen	Rebekah Hendy
Liz Waldeck	Michael de Vries	Vivienne Cooper
Julie Rose	Irene Johnston	Joseph Francis
Jemma L Lawrence	Jovada Stevens	Janine Van Blerk

**FORM L including variation to
FORM L (continued)**

Anne Neisler	Laraine Tanzer	Gwenda Jayawardhana
Colin Hoy	Richard Meyer	Shubhada Rozario
Joanna Harvison	Joel Johnson	Glenn Hegge
James Walker	Terry Farrell	Caroline Kettle
Sue Gallagher	Jeanie MacNamara	Rebekah Ruth Batley
Barry Bailey	Carina Richards	Jeffrey Lawson
June Genat	Katriina Hyytinen	Julie Wells
Elissa Hooper	Sarah Charlton	Barry & Janice Howe
Natalie Thompson	Shelley Summers	Paula Snow
Graham Smith	Tim Harry	
Russell Field	Jessica Everingham	
Bonita Mills	Rachelle Farrell	
Phillip Gosper	Joanne Lindsay	
Kristy Scott	Bernice Woodland	
Lolita Johnson	Kurian Mannicherry	
Thalia Kerr	Hannah Kumar	
Linda Monteith	Lisa Steel	
Christine Clow	Madeleine Ambrey	
William Moore	Chantelle Rolfe	
Vicki Woolston	Robert Barry	
Rosemary Chandica	Rodney and Kristina Milne	
Sarah Weber	Noralyn Jowett	
Dorothy Phua	Lisa Wolff	
Alan Webb	Caroline Cavanagh	
David Cummins	Desiree de Azevedo	
Tracy Fleming	Carmel King	
Jake Ketelaar	Leanne Hall	
Lyle Peddell	Jacoba Lowry	
Ashley Standish	Dianne Holbrook	
Regina Govett	Norm Latham	
Darlene Tarran	Donna Clarkson	
Judy Woodson	Harry Job	
Kassie Grayson	Jenette Lyn	
Stacey Birchley	Sandra Challacombe	

**FORM M including variation
to FORM M**

Jodie Nash	Jennifer May
Mary Nolan	John Joseph Sully
Kevin Carmody	Greg Perren
Pamela Merwood	Grace Heskes
Sylvia Waszaj	Lorelei Rivera
George W Latimer	Patricia Grueshaber
Diana Johnson	Mark Hess
Maddie Anderson	Dexter Jong
Albert Zomer	Paul Rumballe
Peter Knight	Angela Woodward
Patrice McKay	Chris Novak
Mike Duffy	Mason Feltoe
Suzette Ross	Steven Carl Baum
Philip Beggs	Sean Hall
Georgina Lynch	Isa Millar
Ian Bishop	Michael and Carolyn Gaschk
Deanne Abrahams	Kevin Shorthouse
David Cecil	Ray Strickland
Melody Apurel	Robert Collins
Jo Cousins	Grace Fogarty
Cameo Bauer	Kevin & Suzie Banner
Cara Strydom	John Fogarty
Ronald Birch	Fiona Pires
Anna Jones	Amber Richardson
Vilma Simbag	Carmel Ahern
Anna Fabian	Heather Limpus
Alan Baker	Paul Osmak
Marlene Corbin	
Joan Gilmartin	
Jessica Lucaciu	
Paul Gatehouse	
Rebekah Butler	
Stephen Samson	
Melissa Den	

**FORM N including variation to
FORM N**

Jennifer Cannon	Diane Mahon	Esther Murphy
Charmaine	Glen & Lindsay Williams	Catherine Levy
Trent Daw	Robert Grace	Jonathan Peter
Geoffrey Fergusson	Diane Mahon	Rhonda Mayoh
Duncan Stuart	Courtney Henderson	Allison Dale
Inge Ruder	Lynn Smith	Frances Harris
Julie Gorman	Vivienne Ruffles	Elizabeth Power
Victoria Pickard	John Collins	Diane Finbin
Sylvia Thomas	Margaret Downes	Allan Ross
Jacinta Godfrey	Yvonne Crome	Darryl Nelson
Stan Gorman	Glen and Justine Porter	Max McDonald
Paul Crosby	Kay Twigg	Kay E Lang
Anthea Whitwell	Lorraine Woolley	Sean Corrigan
Trent Daw	Petra Van De Kamp	Deena Sherwin
Volker Herzig	Sally Keleher	Renny Oparah
Vicki & Marty Pickering	David Slatyer	Kathy Mcdonald
Jean Kelly	Julie Clark	Berit Tegg
Meredyth Woodward	Eric Hebron	Lesley Hardy
Shell Craig	Susy Cannon	Priscilla Clare
Donna Denovan	David Willis	Marjorie Lawrence
Julie Gorman	Vicki Griffin	Lance Tegg
Ronny Silvester	David Harding	Paul Bennett
Wade Ruffin	Debbie Pringle	Rosamund Thorpe
Margaret Anderson	Jenny Gilbertson	Robert Luther
Julia Venning	Anne Mauger	Harry Boniface
Stan Gorman	Sally Keleher	Cynthia Workman
Tony Glue	Sue Cordell	Belinda Smith
Margaret Anderson	Sara Graham	Suzanne Hall
Karen Anne	Elaine Platt	Kathleen Holcombe
Barry Growden	Evelyn Hedges	Ian Hartshorn
Greg Bloom	Gill Birch	Peter Turner
Melita Taylor	Sandra Englart	Graham Mayberry
Tracey Peterson	Tracey de Vries	Kerry Willett
Jen Hebron	Andres Jaramillo	Butler Clan

**FORM N including variation to
FORM N (continued)**

Stuart & Rhonda Flynn	Bryan Milner
Geoffrey Dillon	Shirley Goss
Judith Armstrong	Barbara Lester
John Joseph Hall	David Pickering
Linda Garrett	Lucille Kuster
Joan Butler	Berit Tegg
Desiree Foster	Kaye Harms
Kerry Jackson	Diane Fletcher
Joan Butler	Anne Bourke
Tatjana Koczanowski	Evelyn Hedges
Phyllis Wagner	Catherine Levy
Fiona Cayford	Tara Lemin
Anne Nilsen	Karen Neubauer
Lothar Jantos	
Katy Pryde	
Peter Gillespie	
Yolanda Gillespie	
Rosemary Arrowsmith	
Curtis Arrowsmith	
Tara Lemin	
Vivienne Aird	
Roberta Cava	
Geoff Arnell	
Bob McCathie	
Vesna McCathie	
Joanna Wyatt	
Charmaine Lindsay	
Peter Verhaart	
Gillian Duncan	
Ann Fenton	
Matthew Hamilton	
Joan Smith	
Andrea Weatherill	
Cathi Zanevra	

Appendix B – Officials at public departmental briefing

Department of Justice

- Ms Kim Chandler, Director, Strategic Policy and Legal Services
- Mrs Leanne Robertson, Assistant Director-General, Strategic Policy and Legal Services

Department of Health

- Ms Eve Gibson, Manager, Social Policy and Legislation Branch
- Mr David Harmer, Senior Director, Social Policy and Legislation Branch
- Ms Tricia Matthias, Director, Social Policy and Legislation Branch
- Professor Keith McNeil, Acting Deputy Director-General and Chief Medical Officer, Chief Clinical Information Officer, Prevention Division

Appendix C – Witnesses at public hearing

Townsville – 12 July 2021

Townsville Aboriginal Islanders Health Services

- Dr Stephen Hagan, Chief Executive Officer

James Cook University

- Dr Gracelyn Smallwood OAM, Adjunct Professor, Division of Tropical Health & Medicine
- Professor Sarah Larkins, Dean, College of Medicine and Dentistry

Doctors for Assisted Dying Choice

- Dr Heather McNamee, Queensland State Convenor Group

Anglican Church of North Queensland

- The Right Reverend Dr Keith Joseph, Bishop

Individual Speakers

- Dr Will Cairns OAM
- Father Dr Rod Ward
- Ms Royalie Walters
- Ms Lindy Collins
- Mrs Marj Lawrence
- Miss May Glaney

Rockhampton – 13 July 2021

Fitzroy Community Hospice (working group for the establishment of a hospice)

- Mr Stephen Richards, Board member
- Ms Paula Ryan, Board Member
- Mr Mark Thompson, Board Member

Central Queensland and Wide Bay Hospital and Health Service

- Professor Alan Sandford AM, Director, Medical Academic Development

Visiting Members

- Mr Barry O'Rourke MP, Member for Rockhampton
- Ms Brittany Lauga MP, Member for Keppel

Individual Speakers

- Ms Catherine Herbert
- Mr John Campbell
- Mr Maurice McNally
- Reverend Dr Andrew Chase

- Mr Peter Belz
- Mr Max McDonald
- Mr Darren Blackwood
- Mrs Merle Ross
- Ms Rhylla Webb
- Mr Chris Hooper
- Dr Terrence Kent
- Ms Faye Tomlin

Brisbane – 14 July 2021

Go Gentle Australia

- Mr Andrew Denton, Founder

Dying with Dignity Queensland

- Ms Jocelyn Hall, President
- Dr Craig Glasby, Vice President
- Ms Jeanette Wiley, Committee Member

Queensland Advocacy Inc.

- Ms Matilda Alexander, Chief Executive Officer
- Ms Sophie Wiggans, Systems Advocate

Health Consumers Queensland

- Ms Melissa Fox, Chief Executive Officer

Queenslanders with Disability Network

- Ms Michelle Moss, Director Policy and Strategic Engagement

Aged and Disability Advocacy Australia

- Mr Geoff Rowe, Chief Executive Officer
- Ms Karen Williams, Principal Solicitor

Dementia Awareness Advocacy Team

- Mr Douglas Taylor, Dementia Advocate with Dementia Australia

Queensland Human Rights Commission

- Mr Scott McDougall, Human Rights Commissioner
- Mr Sean Costello, Principal Lawyer

Uniting Church in Australia, Queensland Synod

- Reverend Andrew Gunton, Moderator
- Reverend Dr Adam McIntosh, Associate Director of Mission, Pastoral Care, UnitingCare Queensland

Lutheran Services

- Mr Nick Ryan, Chief Executive Officer

Queensland Baptists

- Reverend Stewart Pieper, Director of Queensland Baptist Services

Australian Christian Churches, Queensland & Northern Territory

- Mr Gary Swenson, State Ministries Director

Australian Christian Lobby

- Ms Wendy Francis, Queensland and Northern Territory Director

Cherish Life Queensland

- Ms Teeshan Johnson, Executive Director
- Dr David van Gend, Spokesperson

The Right to Life Australia Inc.

- Dr Brendan Long, Vice-President

Health Professionals Say No!

- Associate Professor Megan Best, Associate Professor of Bioethics, Institute for Ethics and Society, University of Notre Dame Australia
- Associate Professor Maria Cigolini, National Coordinator
- Dr Judith McEniery, Queensland Representative

Brisbane – 15 July 2021

Queensland University of Technology

- Professor Ben White, Professor of End-of-Life Law and Regulation, Australian Centre for Health Law Research, Faculty of Business and Law
- Professor Lindy Willmott, Professor of Law, Australian Centre for Health Law Research, Faculty of Business and Law

Bond University

- Associate Professor Wendy Bonython, Faculty of Law

Southern Cross University

- Emeritus Professor Colleen Cartwright, Chair of the Human Research and Ethics Committee

Queensland Law Society

- Ms Elizabeth Shearer, President
- Ms Rebecca Anderson, Chair, Elder Law Committee

Society of Trust and Estate Practitioners Queensland

- Ms Chris Herrald, Chair
- Ms Jennifer Sheean, Deputy Chair

Queensland Council for Civil Liberties

- Mr Michael Cope, President

Australian Lawyers Alliance

- Ms Sarah Vallance, State Committee Member

Royal Australian and New Zealand College of Psychiatrists

- Dr Kym Boon, Psychiatrist

Australian and New Zealand Society of Palliative Medicine

- Professor Leeroy William, President
- Professor Phillip Good, Palliative Medicine Specialist

Australian & New Zealand Society for Geriatric Medicine

- Dr Chrys Pulle, Council Member

Australian Medical Association, Queensland

- Dr Chris Perry, President
- Dr Bav Monoharan, Vice President

Royal Australasian College of Medical Administrators

- Professor Alan Sandford, President

Palliative Care Queensland

- Ms Margaret Adams, President
- Ms Shyla Mills, Chief Executive Officer

Doctors for Assisted Dying Choice

- Dr Jenny Brown, Queensland State Convenor Group
- Dr Sid Finnigan, Queensland State Convenor
- Professor Malcolm Parker, Queensland State Convenor Group

Australian College of Nurse Practitioners

- Ms Catherine Smith, Board Member

Australian College of Nursing

- Adjunct Professor Kylie Ward FACN, Chief Executive Officer
- Distinguished Professor Patsy Yates AM, Chair of End of Life Policy Chapter

United Workers Union

- Mr Robert Hartley ESM, Member

Queensland Council of Unions

- Ms Jacqueline King, Assistant General Secretary

Queensland Nurses and Midwives' Union

- Mr Dan Prentice, Professional Research Officer
- Mr Jamie Shepherd, Professional Officer—Team Leader

Speech Pathology Australia

- Ms Nicola Gearon, Adult/Aged Care Project Officer

Australian Psychological Society - Queensland State Committee

- Dr Alexandra Murray, Senior Policy Adviser

Exit International

- Mr Philip Nitschke

Individual Speakers

- Dr Kristin Cornell
- Dr Phillip Parente
- Professor Jane Turner

Brisbane – 16 July 2021

Office of the Health Ombudsman

- Mr Andrew Brown, Health Ombudsman

Australian Health Practitioner Regulation Agency

- Ms Heather Edwards, State Manager
- Ms Michelle Garner, Chair, Queensland Board of the Nursing and Midwifery Board of Australia; Executive Director of Nursing and Midwifery Services, North West Hospital and Health Service
- Dr Susan O'Dwyer, Practitioner Member, Medical Board of Australia; Executive Director of Medical Services, Metro South Hospital and Health Service
- Dr Jamie Orchard, General Counsel

Australian Catholic University

- Dr David Kirchoffer, Director, Queensland Bioethics Centre

Catholic Health Australia

- Ms Rebecca Burdick Davies, Director, Strategy and Mission

St Vincent's Private Hospital Brisbane

- Professor Phillip Good, Director of Palliative Care

Clem Jones Trust

- Mr David Muir AM, Chair

Individual Speakers

- Ms Theresa McClean
- Ms Beverley Young

Statement of Reservation and Dissenting Reports



Stephen Andrew MP

State Member for Mirani

Colonial Corner
1-3, 73 Broad Street
PO Box 56 Sarina Qld 4737

Phone: 07 4806 0700
Toll Free: 1800 812 340
Mirani@parliament.qld.gov.au

Queensland Politics and Economy - Kickstart Queensland



19th August 2021

Health and Environment Committee
Via email: HEC@parliament.qld.gov.au

DISSENTING REPORT: Voluntary Assisted Dying Bill 2021

As a Health and Environment Committee Member I oppose the Voluntary Assisted Dying Bill 2021 (the Bill hereafter) as it is fatally flawed by its very intention to legalise assisted suicide and euthanasia in Queensland and it fails to fulfill Principles 5 (a), (b), (d), (e), (g) and (h) outlined in the Bill.

Our recent inquiry hearings failed in exploring the fundamental question of: What would be the likely consequence of enacting this Bill in Queensland?

My understanding; informed by the submissions and those that gave evidence, is that the highly likely consequences are on balance extremely negative. They include:

- The unfair burden placed on institutions with a conscientious objection to euthanasia and assisted suicide under s97 of the Bill to be complicit with the killing of one of their residents or patients could see the withdrawal of some of these health care facilities, and/or discouragement to open new premises and expand. This is of critical importance as about one in four beds is supplied by the private or semi-private Christian sector.
- The unfair burden placed on individual doctors with conscientious objections to euthanasia and assisted suicide under s97(2) to be part of the euthanasia process would mean some leave medicine, others decide not to study medicine, and other doctors are discouraged to go to regional areas as they may be the only doctor in the area and are concerned, they will be called upon to help with a euthanasia or assisted suicide request.
- Wrongful deaths would occur from incorrect diagnosis and prognosis, coercion and elder abuse - there is no argument about this.
- The experience of other jurisdictions which have legalised euthanasia and assisted suicide shows that it is likely that Queensland would experience an increase in the overall suicide rate of close to 60% over the next 10 years.

In addition, the Bill does not attempt to correct Queensland's dire palliative care funding deficit, nor the huge health service delivery problems particularly experienced in regional Queensland, which was raised by a significant number of people who gave evidence. If enacted, the legislation would lead to a continuation of this under-funding and under-resourcing as euthanasia and assisted suicide is cheaper than investing in a world-class palliative care system. There's also grave concern that if enacted some terminally ill people in regional Queensland would opt for euthanasia or assisted suicide because they didn't have access to palliative care, feeling they had no other "choice", ironically.

At present the best determinant of whether a Queenslanders will get palliative care in the event of a terminal illness or end of life suffering is their postcode, and this inequitable access to an essential medical service would only be exacerbated if this Bill were passed. Another lack of parity exists in the fact that, even in regions where there is access to palliative care, normally a person won't be able to access palliative care assistance until three months before their expected death date, yet the Bill proposes to allow terminally ill patients access to euthanasia or assisted suicide up to twelve months of their expected death date. So people can access assisted suicide or euthanasia nine months earlier than palliative care. This alone could incentivise, and even subtly coerce, people into opting for euthanasia or assisted suicide.

While palliative care is the gold standard for end-of-life care, as many medical witnesses advised the Committee, this Bill doesn't reflect that in any way. In fact, there is a high risk it would undermine and demoralise an already fragile palliative care service.

The lack of specialist involvement required by this Bill is also concerning and characteristic of its alarmingly broad scope. There's no doubt that not requiring euthanasia / assisted suicide seekers to have a free consultation with a palliative care specialist, a specialist in the patient's suspected illness and a mental healthcare specialist would lead to extra wrongful deaths. During a public HEC hearing it was noted that mandating specialist involvement in the Bill would limit access to "VAD" because of the lack of specialists in some areas. The sad irony of what was being said seems to have been lost on some of the HEC members – the truth of a massive public health fail of providing of sufficient specialist doctors in the regions – yet they want these people to have access to euthanasia / assisted suicide. How insulting and grievous.

The Bill also does little to protect vulnerable from coercion, particularly if it is subtle. Elder abuse is real, as different inquiries have revealed time and again, and so too is loneliness and mental issues, perhaps even more so during the pandemic.

The threat of seven years' jail if someone tries to encourage a loved one not to have euthanasia or assisted suicide is deeply divisive and a prime example of the state over-reaching into familial relationships.

As an Australian South Sea Islander, I also have concerns about the lack of consultation with indigenous Queenslanders on this critical public health life and death issue. The barriers many indigenous Australians face in getting timely, quality medical care is tragic. This Bill if enacted would do nothing to improve medical care for vulnerable groups like indigenous Australians.

As a Christian committed to helping people and as a parliamentarian, it deeply grieves me to see such a reckless piece of legislation before the House. It should not be enacted in Queensland; it would only lead to more deaths and the further corruption of our already struggling health system.

There's no debate that euthanasia of any kind is poor public policy, and the extreme nature of this Bill means that this would be even more so. If passed, it would also be a gross abdication of the first role of government which is to protect human life.



Stephen Andrew MP

Member for Mirani

Health and Environment Committee Member

Queensland Parliament

VOLUNTARY ASSISTED DYING BILL 2021

Queensland Parliament

Dissenting Report

19 August 2021

Prepared by: Dr. Mark Robinson MP

Member for Oodgeroo

VOLUNTARY ASSISTED DYING BILL 2021: DISSENTING REPORT

The *Voluntary Assisted Dying Bill 2021* was introduced into Parliament on 25 May 2021 by the Hon Anastacia Palaszczuk MP, Premier and Minister for Trade and referred to the Health and Environment Committee for detailed consideration.

This dissenting report considers the “*main purposes*” of the Bill, as set out in Clause 3 (the “*main purposes of this Act*”). It does so in the light of the detailed provisions of the Bill, the submissions and evidence presented to the Committee and the experience with similar legal schemes in other jurisdictions.

Contents

WHY THIS DISSENTING REPORT?	3
OUTLINE OF FINDINGS	5
RECOMMENDATIONS	5
“MEDICAL ASSISTANCE TO END THEIR LIVES”: ESTABLISHING “A LAWFUL PROCESS”	6
An exception to the law on murder.....	6
An exception to the law on aiding suicide	6
An exception to the law on counselling suicide	7
IMPACT ON SUICIDE PREVENTION	9
“ACCESSED ONLY BY PERSONS WHO HAVE BEEN ASSESSED TO BE ELIGIBLE”	11
“A DISEASE, ILLNESS OR MEDICAL CONDITION THAT IS ADVANCED, PROGRESSIVE AND WILL CAUSE DEATH IS EXPECTED TO CAUSE DEATH WITHIN 12 MONTHS”: DIAGNOSIS AND PROGNOSIS	12
“THE TREATMENT OPTIONS AVAILABLE TO THE PERSON AND THE LIKELY OUTCOMES OF THAT TREATMENT”	13
“SUFFERING THAT THE PERSON CONSIDERS TO BE INTOLERABLE”: PALLIATIVE CARE	14
“THE PERSON HAS DECISION-MAKING CAPACITY”	16
“THE PERSON IS ACTING VOLUNTARILY AND WITHOUT COERCION”; “PROTECT VULNERABLE PERSONS FROM COERCION AND EXPLOITATION”	17
RISKS OF SELF-ADMINISTERING OR BEING ADMINISTERED A POISON OF SUFFICIENT DOSE TO CAUSE A PERSON’S DEATH	19
NOT FIT FOR PURPOSE AND NOT SAFE	21
“TO PROVIDE LEGAL PROTECTION FOR HEALTH PRACTITIONERS WHO CHOOSE NOT TO ASSIST PERSONS TO EXERCISE THE OPTION OF ENDING THEIR LIVES IN ACCORDANCE WITH THIS ACT”	21
INSTITUTIONS PROVIDING CARE	22
PREVENTING SUICIDE SHOULD NOT BE AN OFFENCE	23
COUNSELLING, INCITING AND INSTRUCTING IN SUICIDE USING A CARRIAGE SERVICE	23

WHY THIS DISSENTING REPORT?

This Bill, if passed, would introduce into Queensland practices that the World Medical Assembly (WMA), after extensive international consultation with the **115 national medical associations** which constitute it, reaffirmed as recently as October 2019, were **contrary to medical ethics** and should be firmly opposed.

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.¹

The Australian Medical Association likewise affirms that:

that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.²

End of Life medical experts – Palliative Care Queensland, the Queensland Directors Palliative Care Group (Submission 1158) and other palliative care specialists – point out that if palliative care was adequately funded, and there was equitable access for all Queenslanders regardless of where they live, then terminally ill Queenslanders would have an improved quality of life, “*through the prevention and relief of suffering*” including the “*treatment of pain and other problems whether they are physical, psychosocial, emotional or spiritual*”:

Palliative care improves the quality of life of people while they are living with a life-limiting illness and their families as they collectively confront the issues and challenges associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems whether they are physical, psychosocial, emotional, or spiritual. (Submission 1158 – Palliative Care Queensland).

Sadly, as an alternative to high standards and availability of palliative care that relieves suffering, the ending of life through the self-administration and practitioner administration of a poison in a sufficient dose to cause death is being promoted through the *Voluntary Assisted Dying Bill 2021* as a solution for those who may be suffering due to a terminal illness.

¹ <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>

²

https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf

In his evidence to the Committee, Dr Philip Nitschke, who was the only medical practitioner to end the lives of patients under the Northern Territory's *Rights of the Terminally Ill Act 1995*, called for the adoption of a "non-medical" model that would facilitate access to a substance to be used to cause death for virtually anyone who wanted it, including those who are simply "tired of life."³

Once the euthanasia genie is out of the bottle it doesn't go back in.

The flow on affect from initial legalisation has proven to be **unstoppable and irreversible** once introduced. What is initially proposed as a measure to help a very small number of people, said to be in intolerable physical pain, is progressively broadened to apply to thousands of people, including those with no physical medical condition. Initial procedural safeguards are also relaxed. Once you **lift the lid on Pandora's box**, there's no going back.

Many vulnerable people experience subtle pressure to take their own life – some are made to feel almost duty bound to their family or to society to end their life prematurely. When **elder abuse is combined with legalised access to the administration of life-ending poisons**, it inevitably leaves the most vulnerable at risk of being **coerced into ending their lives by assistance to suicide or euthanasia**. This results in **wrongful deaths**, whereby people's lives are taken from them without their full cognisance or consent. Wrongful deaths have followed these laws everywhere they are introduced.

Most Queenslanders, when they understand that "voluntary assisted dying" is actually death by poison – either by lethal injection or swallowing a poison cocktail – don't support it. Of **the 5,672 submissions** received by the Committee a **majority of 3,217 (57%) were OPPOSED** to the *Voluntary Assisted Dying Bill 2021*, while **only 2,455 (43%)** were for it. To say that there was "strong support" for the Bill by way of the submissions and hearings is not a factual statement. Much evidence presented to the Committee of the failures, dangers and risks of euthanasia and assistance to suicide as experienced in other countries like Canada and the Netherlands - eg. mounting numbers of wrongful deaths, increase in suicide numbers – does not appear in the Committee's report.

Committee reports are adopted by vote of the committee. Where a vote is tied, the Parliament of Queensland Act provides that Chairs have a casting vote. I expect that Statements of Reservation and dissenting reports attached to the committee's report will provide readers with some indication as to how the committee voted. **This dissenting report recommends that the Bill NOT be passed.**

Many Queenslanders from diverse cultural and faith backgrounds – **first nation peoples, migrant and ethnic communities, multi-faith and majority Christian communities** – **oppose** euthanasia and assisted suicide. For many of them human life is sacred. For others it is contrary to good medical practice and the proper role of a medical practitioner to intentionally end a human life. These individuals and institutions shouldn't be forced to participate in the taking of human life against their medical judgment, conscience, or religious beliefs.

Individual medical and health care practitioners and medical facilities and aged-care centres should be able to **opt-out** from participating in a practice or providing a "service" that **goes against their strongly held convictions** – whether based on ethics, religion or their understanding of good medical practice. Individuals should not be "forced" to adopt a practice that takes a human life. Hospitals, like the Mater, should not be "forced" to operate against their clear convictions. Should these laws pass, as many as 1 in 4 hospital beds in Queensland would be put at risk of closure. This would be crippling to the Queensland Health System which is already considered a basket case.

³ <https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/trns-15Jul2021.pdf>

The Committee process of the Bill was rushed from the beginning – with only 5 days of Stakeholder Hearings, only 2 of those days outside Brisbane. Members of the committee should have been provided with much more time to consider the committee’s 236 page report. The time provided to consider the report was completely inadequate for a Bill of such complexity, controversy and magnitude. No doubt others will consider that matter further when time allows.

This dissenting report takes us **beyond the deeply felt and personal views** held in the community that naturally occur upon the sad loss of loved ones and asks people to consider all of the findings and facts that show this legislation is fatally flawed and will not achieve what its advocates, backers and promoters promise. The taking of a poison that deliberately causes death, is not the best form of relief from suffering that is available. If the best we can hope to offer terminally ill Queenslanders suffering intolerable pain is a poison, instead of the highest standard of palliative care, we are in serious trouble as a society.

I invite all readers, especially MPs, to read this dissenting report to the end with an open mind, before deciding a final position on the *Voluntary Assisted Dying Bill 2021*.

OUTLINE OF FINDINGS

This Dissenting Report makes the following eight “Findings”:

FINDING 1:

The Bill would make it legal for one person to take the life or help end the life of another person, or to counsel or help another person to take their life.

FINDING 2:

The Bill would increase the number of suicides in Queensland as opposed to reducing them.

FINDING 3:

The Bill fails to ensure that only eligible people will be able to access assisted suicide or euthanasia.

FINDING 4:

The Bill fails to ensure that patients are offered all options to manage their illness prior to the commencement of any life-ending procedure.

FINDING 5:

The Bill fails to adequately define “suffering” to limit it to intolerable physical pain.

FINDING 6:

The Bill provides inadequate protection to those affected by a mental illness.

FINDING 7:

The Bill fails to protect the vulnerable from coercion and undue influence.

FINDING 8:

The Bill fails to safeguard the vulnerable from a prolonged, complicated or painful death as a result of the administration of a poison prescribed under the Bill’s provisions.

RECOMMENDATIONS

This Dissenting report makes five “Recommendations”:

RECOMMENDATION 1: That the Voluntary Assisted Dying Bill 2021 NOT be passed.

RECOMMENDATION 2: If, notwithstanding Recommendation 1, the Bill is passed it ought to be amended to remove Clause 16 (4) and Clauses 84 and 85, and leave all health practitioners (and speech pathologists) in Queensland free to exercise good practice in accordance with internationally recognised medical ethics prohibiting actions intended to cause the death of a person or any referral directed to that end.

RECOMMENDATION 3: If, notwithstanding Recommendation 1, the Bill is passed then all such provisions in Division 2 of Part 6 of the Bill should be removed, apart from those in Clause 98.

RECOMMENDATION 4: If, notwithstanding Recommendation 1, the Bill is passed then the reference to revoking a request should be removed from Clause 141.

RECOMMENDATION 5: That Recommendations 2 and 3 of the Chair’s Report be opposed.

“MEDICAL ASSISTANCE TO END THEIR LIVES”: ESTABLISHING “A LAWFUL PROCESS”

The Bill if passed would establish a “*lawful process*” for people to “*end their lives*”.

This “*lawful process*” would create exceptions to the current comprehensive prohibitions on murder and counselling and aiding suicide.

An exception to the law on murder

Section 302 (1) (a) of the *Criminal Code* defines murder to include acts where a person “*intends to cause the death of [another] person*”.

The Bill creates an exception to this by making it lawful, under certain circumstances, for a medical practitioner, nurse practitioner or registered nurse to administer to a person a S4 or S8 poison “*of sufficient dose to cause death*” with the intention of causing that person’s death.

As well as the exemption from the law on murder for the practitioner or nurse who administers the lethal dose of poison, other people, who would otherwise be liable to a charge of murder under Section 7 of the *Criminal Code*, would also be exempt, including:

- the “*coordinating practitioner*” who prescribes a poison “*of sufficient dose to cause death*” (Clause 53 (2)) and
- the “*authorised supplier*”, a pharmacist, who supplies the poison (Clause 53 (4)).

An exception to the law on aiding suicide

Section 311 (b) of the *Criminal Code* comprehensively prohibits aiding a person “*to kill himself or herself*”.

The Bill would create an exception to this prohibition **by authorising the following defined persons to lawfully aid a person to kill himself or herself.**

The “*coordinating practitioner*” who prescribes a poison “*of sufficient dose to cause death*” by self-administration of the poison by a person for the purpose of ending the person’s life (Clause 52 (2)); the “*authorised supplier*”, a pharmacist, who supplies the poison (Clause 52 (4)); the *contact person* or an *agent* of the person who receives the poison from the “authorised supplier” and supplies the poison to the person (Clause 52 (4)-(6)); any person who, at the request of the person who takes the poison with the intention of ending the person’s life, prepares the poison and supplies the prepared poison to the person (Clauses 52 (7)).

The only qualification for a “*contact person*” is that the person be 18 years of age or older. There are no qualifications, including no age qualifications, for an agent of the person or a person who is requested to prepare the poison and supply it to the person to self-administer with the intention of ending their lives.

The Bill would explicitly authorise a person to ask any other person (**including a child**) to prepare a poison for the person to self-administer with the intention of ending the person’s life.

An exception to the law on counselling suicide

Section 311 (c) of the *Criminal Code* comprehensively prohibits counselling a person “*to kill himself or herself*” and “*thereby induc[ing] the other person to do so*”.

The Bill would create a broad exception to this prohibition.

Clause 8 of the Bill would provide that “*For the purposes of the law of the State ... a person who dies as the result of the self-administration of a*” poison prescribed under this Act of a sufficient dose to cause death “*does not die by suicide*”.

[Note: This Clause also provides that when a person dies from *administration* of such a poison the person “*does not die by suicide*”. This is a nonsensical provision as under existing law the person would die by murder, not by suicide.]

By creating a **legal fiction** that a person who dies as a result of the self-administration of a poison prescribed under the Bill “does not die by suicide”, it would become legal for:

- any person to counsel (suggest, encourage, persuade, recommend, urge) a person to take steps to end the person’s life by self-administration of a poison, including requesting a prescription from a medical practitioner, filling a prescription and, once supplied, self-administering the poison for the purpose of causing the person’s death;

Clauses 141 and 142 create new offences for inducing a person to request or to self-administer a poison under the Bill but only if this is done “*dishonestly or by coercion*”. However, the maximum penalty for these new offences is 7 years imprisonment – compared to liability for imprisonment for life.

- any health care worker – including a personal care worker - to “*suggest*” (counsel, encourage, persuade, urge) that a person takes steps to end the person’s life by self-administration of a poison provided the person requests “*information*” (Clauses 7 (1) and (3))

For example, a personal care worker for a person with a disability could, if the person says “I hear there is a new voluntary assisted dying law, what’s that all about?” could then initiate a

discussion and actively suggest that the person ought to pursue ending the person's life using the Bill's provisions – "*Don't you think you would be better off dead?*"; and

- any medical practitioner or nurse practitioner – without any further qualifications whatsoever, any requirement to have undergone the approved training under Clause 165 of the Bill, or any requirement to document or report the discussion – to "*initiate discussion*" with a person and actively "*suggest*" (counsel, encourage, persuade, urge) that a person takes steps to end the person's life by self-administration of a poison provided the practitioner also "*informs the person about the treatment options available to the person and the likely outcomes of that treatment; and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment*".

This would allow any such practitioner who believes a person would be better off dead to **actively steer the person towards ending the person's life**. In many cases the practitioner will not have the requisite qualifications or experience to provide comprehensive and accurate information on treatment options and likely outcomes (this is usually the role of a specialist) nor on palliative care (also a specialised role).

The prohibition under s311 (b) of the Criminal Code against counselling suicide was the subject of comment by judges of the Queensland Court of Appeal in its 19 June 2020 decision in the case of *R v Morant [2020] QCA 135* in which Graham Morant's appeal against his conviction for aiding the suicide of his wife was rejected on all four grounds of appeal and the sentence of 10 years imprisonment was upheld as fair.

Morant was convicted on two counts under s311 of the Queensland Criminal Code. The first was that he had counselled Ms Morant to kill herself and thereby induced her to do so. The second was that he had aided her in killing herself.

One of the grounds of appeal was the belated discovery of two emails Ms Morant had exchanged with Dr Philip Nitschke. The emails presumably showed that she had suicidal ideation and was actively considering means of suicide.

However, these things were already apparent from evidence presented at Mr Morant's trial. As Sofronoff P concluded (at 38):

*The evidence could not have helped the appellant. It would, instead, have reinforced Ms Morant's **vulnerability** to the appellant's inducements.*

Sofronoff P explains (at 47):

It was implicit in the jury's verdicts that the appellant had counselled Ms Morant to kill herself with the intention that she should commit suicide. It also follows that the jury found that the counselling was effective to induce her to commit suicide so that, but for the appellant's counselling, she would not have gassed herself on 30 November 2014.

Morant stood to benefit from three life insurance policies to the total of \$1.4 million.

His efforts to induce his wife to commit suicide included recounting to her a story about "*a customer of his [who] had taken out policies of insurance in favour of his wife and had then killed himself.*" Mr Morant told his wife that that was "*an amazing and wonderful thing*" to have done. He encouraged her to do the same for him.

Sofronoff P concluded (at 64-65):

*The present case is a paradigm case that exhibits **the wickedness of the offence of counselling and thereby inducing a victim to kill herself**. The offence was committed against **a woman who was vulnerable** to the appellant's inducements. His actions were premeditated, calculated and were done for financial gain... The offence was a serious one that involved a killing of a human being.*

Another of the judges, Boddice J summarised (at 248-249) the case against Graham Morant:

*[T]he deceased was **a vulnerable person with difficulties with her physical health, who was already suffering depression**; and the fact that the appellant, by his conduct, **took advantage of those vulnerabilities in order to persuade her to kill herself** and then assisted her to do so.*

*In addition to those matters, **the more serious aspect of the offences, counselling suicide, occurred over a period of months**. Its seriousness was aggravated by the fact that the appellant had also aided the deceased to kill herself, being the end result of that extended period of counselling.*

If the "lawful process" for persons to "end their lives" which it is a "main purpose" of this Bill to effect, had been in place in the months leading up to Ms Morant's death then Graham Morant could have avoided any liability by counselling his vulnerable wife to request, and then to subsequently self-administer, a lethal poison. Indeed, he could have prepared the lethal poison for her to take.

Moreover the prospect of a medical practitioner concluding that Mrs Morant was being coerced by her husband, and therefore not acting voluntarily and was ineligible, would be remote.

The current comprehensive prohibitions of murder and of aiding or counselling suicide protect every person in the community. The Bill limits those prohibitions by providing exceptions permitting acts that would otherwise be unlawful. It is one of the main purposes of the Bill to do so.

FINDING 1: The Bill would establish a lawful process for a person to have the person's life ended by a medical practitioner, nurse practitioner or registered nurse administering a lethal poison (by creating an exception to the law on murder) and a lawful process allowing other persons to counsel and aid a person to end the person's life by self-administration of a lethal poison (by creating broad exceptions to the prohibition on counselling and aiding suicide).

IMPACT ON SUICIDE PREVENTION

Queensland has a goal of reducing the suicide rate by 50% by 2026 through a comprehensive commitment to suicide prevention.

As stated in *Our Future State*⁴

Suicide has devastating impacts on families, friends and communities. Over the past decade, an average of more than 600 Queenslanders each year have died by suicide. Suicide is the leading cause of death for Australians between 15 and 44 years of age. As an example in 2015, the number of deaths by suicide (746) in Queensland was three times greater than the Queensland road toll (243).

⁴ <https://www.ourfuture.qld.gov.au/assets/custom/docs/gov-objectives.pdf>

What do we want to achieve? Reduce the suicide rate by 50% by 2026.

Some of the proponents of the Bill claim that if passed it would **prevent** suicides by terminally ill Queenslanders by providing medical assistance – a prescription for self-administration or practitioner administration of a poison in a dose sufficient to cause death - for them to end their lives rather than using do-it-yourself measures. Clause 8 of the Bill would mean that these cases, including those of self-administration of a lethal dose of poison, **would not be counted as suicides**.

Such measures should lead to a decrease in the official number of suicides.

This claim can be tested by examining the evidence from Victoria.

In debate on the Victoria's *Voluntary Assisted Dying Bill 2017*, then Victorian Minister for Health and Human Services, the Hon Jill Hennessy, claimed that:

*Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.*⁵

If this claim was correct **a decrease of around 50 deaths by suicide each year** ought to have occurred once the Act came into operation on 19 June 2019.

According to the Coroners Court of Victoria there were 694 deaths by suicide in Victoria in 2017, which would have included the 50 or so deaths per year of people with a terminal illness referred to by the Minister.⁶

In 2020 – the first full calendar year in which the *Voluntary Assisted Dying Act 2017* was in operation – there were 698 suicides recorded. There is no evidence of the anticipated decrease of 50 suicide per year.

In that same year, 2020, a total of 144 people ended their lives by self-administration of a poison prescribed under the *Voluntary Assisted Dying Act 2017* – nearly 3 times the number of suicides by terminally ill people that the Act was supposed to prevent.

Putting aside the legal fiction of not considering these deaths as suicides, a total of 842 Victorians intentionally ended their lives at their own hands in 2020, with or without a permit from the State of Victoria. This is an increase of 21.2% from 2017.

Another 31 Victorians died in 2020 by practitioner administration of a poison prescribed under the *Voluntary Assisted Dying Act 2017*. While these were not acts of suicide, they were acts which were reportedly **carried out by a medical practitioner at the request of the person with the intention of causing that person's death**. If these deaths are included, then the total for 2020 would be 873 deaths of Victorians through acts intended by the person to cause the person's death - a 25.8% rise since 2017.

FINDING 2: If passed the Bill is likely to lead to an increase in the total number of Queenslanders who die by officially recorded suicides as well as by acts of self-administration or practitioner

⁵ https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

⁶ <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-01/Coroners%20Court%20Monthly%20Suicide%20Data%20Report%20-%20December%202020.pdf>

administration of a poison under the Bill's provisions with the intention of causing the person's death. The Bill would lead Queensland away from, and not towards, the goal of reducing the suicide rate by 50% by 2026.

“ACCESSED ONLY BY PERSONS WHO HAVE BEEN ASSESSED TO BE ELIGIBLE”

Another “*main purpose*” of the Bill is “*to establish safeguards to ensure*” the “*lawful process for people to “end their lives”*” is “*accessed only by persons who have been assessed to be eligible*”.

It is worth noting that the safeguards aim only at ensuring persons have been “*assessed to be eligible*” before they are assisted to “*end their lives*”.

The scheme established by the Bill hinges on the two assessments carried out against all the eligibility criteria by:

- the coordinating practitioner (“*first assessment*” (Clause 19 (1)); and
- the consulting practitioner (“*consulting assessment*” (Clause 30 (1))).

Additionally, in the case of “*practitioner administration*” only, the “*administering practitioner*” must be satisfied, at the time of administering the prescribed poison to cause the death of the person, that the person has “*decision-making capacity*” and is “*acting voluntarily and without coercion*” (Clause 53 (6)).

The Queensland Civil and Administrative Tribunal (QCAT) may, in limited circumstances, review an assessment by a coordinating practitioner or by a consulting practitioner that a person meets the eligibility criteria related to decision-making capacity, acting voluntarily and without coercion, and residency. (Clause 99)

In the case of positive assessment that a person has decision-making capacity and is acting voluntarily and without coercion it is unclear how such a matter would come before QCAT as it would first require that a third party – neither the medical practitioner, the person or the person who may be exercising the coercion – know that such a positive assessment has been made, be aware of the possibility of an application to QCAT and be accepted by QCAT as a “*person who has a sufficient and genuine interest in the rights and interests of*” the person who is the subject of the assessment.

QCAT cannot review assessments related to the other criteria nor can it review an administering practitioner’s decision that he or she is “*satisfied*” of certain matters.

It is important to note that the Voluntary Assisted Dying Review Board’s role relevant to ensuring access only to eligible persons is limited to verifying that the coordinating practitioner and consulting practitioner **have completed forms** indicating that they have carried out the assessments and found the person to meet the eligibility criteria; and where applicable, the administering practitioner has completed a form indicating that he or she is satisfied on the relevant matters.

There is no mechanism under the Bill for verifying the accuracy, reliability or honesty of the assessments.

It is within this overarching perspective on how the “*safeguards*” operate that this report now considers the five core eligibility criteria set it in Clause 10 (1) (a) – (c) of the Bill.

“A DISEASE, ILLNESS OR MEDICAL CONDITION THAT IS ADVANCED, PROGRESSIVE AND WILL CAUSE DEATH IS EXPECTED TO CAUSE DEATH WITHIN 12 MONTHS”: DIAGNOSIS AND PROGNOSIS

Diagnosis is the process of determining what “*disease, illness or medical condition*” a person has. It can be a challenging process and is subject to errors even by experienced specialists.

Prognosis is the process of determining the likely outcome or course of a disease, including the likelihood of death and the possible timeframe in which death may occur. It is always just a rough estimate or best guess based on a range of factors.

Clause 10 (1) (a) requires that a person “*has been diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death*” and clauses 19 (1) and 30 (1) assign to the coordinating practitioner and the consulting practitioner the duty of assessing whether a person meets this criterion.

Neither “*advanced*” nor “*progressive*” are defined in the Bill and have no precise medical definition. The phrase “*will cause death*” appears to require that a condition be definitively terminal although this expectation may be modified by the additional criterion that the condition be “*expected to cause death within 12 months*”.

The lack of any requirement for either the coordinating practitioner or the consulting practitioner to have any qualifications or experience relevant to the treatment and care of a person with the specific “*disease, illness or medical condition*” that he or she assesses the person as having been diagnosed with, makes it inevitable that there will be **some errors** made in the accuracy of the diagnosis and, even more so, in the accuracy of the prognosis.

The legal fiction (or **mandated falsification**) required by Clause 81 of the “*cause of death certificate*” to state that “*the cause of death of the person was the disease, illness or medical condition mentioned in section 10(1)(a) from which the person suffered*” and the preclusion, by Clause 171, of deaths caused by the self-administration or practitioner administration under the provisions of the Bill of a poison of a sufficient dose to cause death from being “*reportable*” to the Coroner, would have the effect of making it virtually impossible to determine posthumously that an error in diagnosis was made.

And it will, in every case, be impossible after a person dies by self-administration.

There is, however, evidence of errors in diagnosis and prognosis from other jurisdictions that allow self-administration of a prescribed lethal poison.

For example, after the family of retired Italian magistrate Pietro D’Amico, aged 62, insisted on an autopsy that he was found not to have a terminal illness at all, despite being given such a diagnosis by both Italian and Swiss doctors prior to undergoing assisted suicide in Switzerland.⁷

In Oregon, in 2018 one person ingested lethal medication 807 days (2 years 2 ½ months) after the initial request for the lethal prescription was made. The longest duration between initial request and

⁷ <https://www.thelocal.ch/20130711/assisted-suicide-in-question-after-botched-diagnosis>

ingestion recorded is 1009 days (that is 2 years and 9 months).⁸ Evidently in these cases the prognosis of only six months to live was inaccurate/

The example of Jeanette Hall, who is still alive today after commencing the process of seeking assisted suicide in Oregon in 2000, illustrates the danger of making assisted suicide available to people when first diagnosed with a terminal illness. Thankfully for Jeanette her doctor refused to collaborate in assisting her suicide and helped her find hope – and effective treatment – instead.⁹

Clauses 21 (1) (a) and 32 (1) (a) do allow for a coordinating practitioner or consulting practitioner who is “unable to determine whether or not” a person “has a disease, illness or medical condition that meets the requirements of section 10(1)(a)” to “refer the person to a registered health practitioner who has appropriate skills and training to determine the matter” and they “may” adopt the “determination of the referee”.

This provision depends entirely on the coordinating or consulting practitioner recognising and acting on a self-assessment of his or her inability to determine these matters, and then on his or her decision to adopt or ignore the determination by the referee.

There is no explicit requirement in the Bill for the coordinating or consulting practitioner to inform the Voluntary Assisted Dying Review Board that in making an assessment they sought but then chose to ignore a determination by a referee.

FINDING 3: The Bill fails to meet one of its “main purposes”, namely “to establish safeguards to ensure” the “lawful process for people to “end their lives” is “accessed only by persons who have been assessed to be eligible” because it provides for determinations of diagnosis and prognosis to be made by medical practitioners who may lack the requisite qualifications and the relevant experience to make such determinations accurately.

“THE TREATMENT OPTIONS AVAILABLE TO THE PERSON AND THE LIKELY OUTCOMES OF THAT TREATMENT”

Clause 22 (1) sets out a list of matters that the coordinating practitioner must inform a person about **after** he or she is satisfied that the person is eligible, including “the treatment options available to the person and the likely outcomes of that treatment” (Clause 22 (1) (b)).

Given the coordinating practitioner is not required to have any specialist qualifications or experience relevant to the particular “disease, illness or medical condition” nor may he or she ever have met the person before carrying out the first assessment, there is no guarantee that the information given to the person will be comprehensive and accurate. Advances in treatment options for many medical conditions occur all the time and a non-specialist medical practitioner cannot be expected to be fully informed about these developments. That is one of the reasons in normal medical practice for referring patients to a relevant specialist for diagnosis, prognosis, information on treatment options and treatment.

⁸ Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1*, p.13
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf>

⁹ <https://www.dailysignal.com/2015/05/18/assisted-suicide-how-one-woman-chose-to-die-then-survived/>

Under the Bill's provisions it is inevitable that some people will proceed through the process and end their lives through self-administration or practitioner administration of a poison in sufficient dose to cause the person's death, when there was an available, effective treatment that the person was never offered.

FINDING 4: The Bill fails to ensure that before a person's life is ended by self-administration or practitioner administration of a poison intended to cause the death of the person, the person is offered all effective, available treatment for the person's disease, illness or medical condition.

"SUFFERING THAT THE PERSON CONSIDERS TO BE INTOLERABLE": PALLIATIVE CARE

Clause 10 (1) (a) (iii) of the Bill would provide that to be eligible a person must be "*diagnosed with a disease, illness or medical condition that ... is causing suffering that the person considers to be intolerable*". Clauses 19 (1) and 30 (1) assign to the coordinating practitioner and the consulting practitioner the duty of assessing whether a person meets this criterion.

Clause 10 (2) provides that the "*su^{ffering}, caused by a disease, illness or medical condition, includes physical or mental suffering; and suffering caused by treatment provided for the disease, illness or medical condition.*"

The inclusion of "*mental suffering*" and the phrase "*that the person considers intolerable*" expand eligibility well beyond cases where there is actual physical suffering that cannot be relieved.

From jurisdictions where some data on the reasons for which a person requests the prescription of a poison for self-administration (Oregon and Victoria) or physician administration (Victoria and Canada) in order to cause the person's death it is apparent that:

- few cases relate to actual physical suffering; and
- most cases relate to existential issues such as feeling like a burden, a loss of autonomy or an inability to participate in enjoyable activities.

The Voluntary Assisted Dying Review Board's Report on Operations January-June 2020¹⁰ states that in Victoria "*Loss of autonomy was frequently cited by applicants as a reason for*" requests, with other commonly reported reasons including "*being less able to engage in activities that make life enjoyable, losing control of body functions, and loss of dignity*". Notably physical pain was not mentioned in this report.

The Oregon annual reports indicate that physical suffering is not a major issue for those requesting prescription of a lethal dose of poison.

Of the 1905 people who had died from ingesting a lethal dose of poison between 1998 and 2020 just over one in four (27.4%) mentioned "*inadequate pain control or concern about it*" as a consideration.¹¹

¹⁰ https://www.bettersafecare.vic.gov.au/sites/default/files/2020-08/VADRB_Report%20of%20operations%20August%202020%20FINAL_0.pdf

¹¹ Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1*, p.11, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

Earlier annual reports noted that *“Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.”*¹²

However, in 2019 nearly 6 out of 10 (59.2%) of those who died after taking prescribed lethal medication cited concerns about being a *“Burden on family, friends/caregivers”* as a reason for the request.¹³

More needs to be done to address these existential concerns rather than resorting to measures to cause a person’s death as an appropriate means of responding to concerns such as loss of autonomy and feeling a burden on others.

In his evidence to the Committee, Dr Philip Nitschke, who provided euthanasia to four people in the Northern Territory in 1995-96 under the Rights of the Terminally Ill Act, explained that a law facilitating direct ending of life for the *“extremely sick”* was only ever a first step and that any consistent approach required provision of assistance to those who, for whatever reason were simply *“tired of life”*.¹⁴

The Bill’s approach to *“suffering”* already points in this direction.

Clause 22 (1) sets out a list of matters that the coordinating practitioner must inform a person about **after** he or she is satisfied that the person is eligible, including *“the palliative care and treatment options available to the person and the likely outcomes of that care and treatment”* (Clause 22 (1) (c)).

Given the coordinating practitioner is not required to have any specialist qualifications or experience in palliative care and treatment, there is no guarantee that the information given to the person will be comprehensive and accurate. Advances in palliative care and treatment options occur all the time and a medical practitioner who has no specialist qualifications or experience in palliative care cannot be expected to be fully informed about these developments.

Clause 5 (e) of the Bill states as one of the *“principles that underpin this Act”* that *“access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland”*. However, there is no equivalent guarantee that access to gold standard palliative care and treatment will be available regardless of where a person lives in Queensland.

Palliative Care Queensland in Submission 1158 pointed to a \$247 million per year shortfall in adequate funding for palliative care in Queensland. The submission stated:

In Queensland, a person’s choice to explore voluntary assisted dying should never be based on a lack of access to palliative care – however we fear that limited funding and access, as well as equity issues, could make this the case.

Submission 111¹⁵ from the Queensland Directors Palliative Care Group indicates that funded positions for specialists in palliative medicine falls well short of the benchmark set by Palliative Care Australia

¹² Oregon Health Authority, *Sixth Annual report on Oregon’s Death With Dignity Act*, 2004, p. 24
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf>

¹³ Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1*, p.12,
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

¹⁴ <https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/trns-15Jul2021.pdf>

¹⁵ <https://www.parliament.qld.gov.au/documents/committees/HEC/2021/VADB2021/submissions/111.pdf>

in 2018 of 2.0 FTE per 100,000 population. To meet the benchmark – aimed at ensuring adequate access to palliative care for all who need it – there ought to be 100.22 FTE funded positions for specialists in palliative medicine in Queensland but in 2021 there are only 43.40 – a shortfall of 56.82.

The Bill is premised on Queenslanders only choosing to end their lives by self-administration or practitioner administration of a poison when suffering cannot be relieved. While a significant shortfall in funded positions for specialists in palliative medicine exists unnecessary suffering will continue.

It will be inevitable if the Bill becomes law that some people will end their lives by self-administration or practitioner administration of a poison in sufficient dose to cause the person's death when the person's physical and mental suffering, including the person's existential concerns, could have been relieved through appropriate palliative care and treatment.

FINDING 5: The Bill fails to meet one of its “main purposes”, namely “to establish safeguards to ensure” the “lawful process for people to “end their lives” is “accessed only by persons who have been assessed to be eligible” because it provides for determinations that a person has “suffering that the person considers intolerable” by medical practitioners who may lack the requisite qualifications and the relevant experience in palliative care and treatment that would enable them to relieve the person’s suffering.

“THE PERSON HAS DECISION-MAKING CAPACITY”

Clause 10 (1) (b) of the Bill includes in the eligibility criteria that “*the person has decision-making capacity*”.

Clause 11 (2) provides that “*A person is presumed to have decision-making capacity ... unless there is evidence to the contrary.*”

Clause 21 (1) (b) and (2) and Clause 32 (1) (b) and (2) provide that if a coordinating practitioner or consulting practitioner considers that he or she is “*unable to determine*” if the person “*has decision-making capacity*” then he or she must refer the person to “a registered health practitioner who has appropriate skills and training to determine the matter” and **may** adopt the determination of the referee.

Evidence from Victoria and Oregon suggests that where optional referral for assessing decision-making capacity is part of the scheme it is seldom used by assessing practitioners, who seem to be reluctant to conclude that they are unable to make a determination of decision-making capacity without assistance from another practitioner with the appropriate skills.

In Victoria, the Report on Operations July-December 2020¹⁶ states that 17 people (3% of 562 applicants) had been referred for a specialist opinion on their decision-making capacity. There is no information available on the outcome of the referral.

¹⁶ https://www.bettersafecare.vic.gov.au/sites/default/files/2021-02/VADRB_Report%20of%20operations%20Feb%202021_FINAL.pdf

In Oregon in 2019 only one person out of 191 people (0.52%) who died under the Oregon law was referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.¹⁷

A study in Oregon found that one in six applicants who died under Oregon's law had clinical depression.¹⁸ Over the 23 years of Oregon's law it is likely that around 250 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

Clause 13 (1) (a) of the Bill provides that people with a mental illness as defined in *Mental Health Act 2016*, section 10 – which would include clinical depression and other conditions such as bipolar disorder which profoundly affect decision-making capacity – are eligible under the Bill to request and be prescribed for self-administration or practitioner administration a poison in sufficient dose to cause the person's death.

Given the likely low rate of referral to an expert based on evidence from other jurisdictions with optional referral, it is inevitable that some people will die under the provisions of this Bill who had impaired decision-making capacity, including impairment due to treatable clinical depression or another mental illness, but who are wrongly assessed as eligible.

In the case of self-administration there is no provision for any further assessment of decision-making capacity once the prescription is written and filled. At the time it is "self-administered", which may be weeks, months or even years later, the person may have lost decision-making capacity and lack full awareness or understanding of the nature of the poison and its intended effect.

In the case of practitioner administration, the administering practitioner, who may be a registered nurse, is required by Clause 53 (6) (a) to assess the person "*at the time of administration*" as "*having decision-making capacity*". There is no option at this point for a referral to an expert and the presumption, in Clause 11 (2), in favour of a person having decision-making capacity still applies.

It is inevitable that in some cases a registered nurse, legally required to presume in favour of the person having decision-making capacity, will in the absence of any obvious evidence to the contrary, assess a person as having decision-making capacity when the person lacks it.

FINDING 6: The Bill fails to meet one of its "main purposes", namely "to establish safeguards to ensure" the "lawful process for people to "end their lives" is "accessed only by persons who have been assessed to be eligible" because its provisions relating to determining whether a person has "decision-making capacity" are insufficient to guarantee that no person lacking decision-making capacity is wrongly assessed as eligible, including persons with treatable mental illnesses such as clinical depression.

"THE PERSON IS ACTING VOLUNTARILY AND WITHOUT COERCION"; "PROTECT VULNERABLE PERSONS FROM COERCION AND EXPLOITATION"

¹⁷ Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1*, p.11, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

¹⁸ Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, <http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf>

Another main purpose of the Bill is to “*protect vulnerable persons from coercion and exploitation*” (Clause 3 (c) (ii)).

Clause 10 (1) (c) of the Bill includes in the eligibility criteria that “*the person is acting voluntarily and without coercion*”.

Clause 21 (3) and Clause 32 (3) provide that if a coordinating practitioner or consulting practitioner considers that he or she is “*unable to determine*” if the person “*is acting voluntarily and without coercion*” then he or she must refer the person to “another person who has appropriate skills and training to determine the matter” and **may** adopt the determination of the referee.

As well as the evidence cited above from Oregon, evidence from Canada and from Washington State confirm that feeling a burden on family is a reason for requests to have a person to be prescribed a lethal dose of poison to self-administer or have administered in order to end the person’s life.

The 2020 annual report from Canada states that 35.9% of people reported as a reason for their request to end their lives feeling that they were a “burden on family, friends or caregivers”.¹⁹

The data from Washington State²⁰ shows that in 2017 more than half (56%) of those who died from prescribed lethal drugs cited concerns about being a “*Burden on family, friends/caregivers*” as a reason for the request.

The obvious question to ask is whether this concern may be influenced by comments or behaviour from family, “friends” and caregivers - including health care practitioners - who find the person to be a burden or a nuisance or just taking too long to die.

Motives for family members to communicate such a message could include “inheritance impatience” or other selfish factors. Not all families are happy families.

The provisions of the Bill **are manifestly insufficient to lead to the identification of every case** where a person is not “*acting voluntarily and without coercion*”.

Clauses 20 and 31 of the Bill require the assessing practitioners to undergo “*approved training*” and section 165 (2) (c) would provide that this includes “*identifying and assessing risk factors for abuse or coercion*”.

The corresponding approved online training for medical practitioners in Victoria contains a total of **just over 5 minutes** (a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read) on assessing voluntariness, including assessing the absence of coercion.

Claims that any practitioner who undergoes the “*approved training*” under the Bill will become capable of always identifying a lack of voluntariness or the presence of coercion are naïve and irresponsible.

In the case of self-administration there is no further assessment of whether a person is “*acting voluntarily and without coercion*” once poison of a sufficient dose to cause the death of the person is prescribed. Nor is a witness required to be present.

¹⁹ <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2020/annual-report-2020-eng.pdf>

²⁰ <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf>

At the time of “*self-administration*” the person may be subject to coercion – overt or subtle – to take the poison. The poison may be administered surreptitiously, or the person may even be physically forced to take the poison. We will never know.

In the case of practitioner administration, the administering practitioner – who may have never met the person before and who may be a registered nurse – is required to determine at the time of administering the prescribed poison in a dose sufficient to cause the death of the person that the person is “acting voluntarily and without coercion” (Clause 53 (6) (b)).

Clause 54 (2) (a) requires that a witness – who may be a person aged 18 years or more – is required to certify that “*the person appeared to be acting voluntarily and without coercion*”.

There is nothing in the Bill to prevent this witness being the very person who, for selfish motives, is coercing the person to proceed with the administration of the poison.

FINDING 7: The Bill fails to meet another of its “main purposes”, namely to “protect vulnerable persons from coercion and exploitation” because its provisions relating to determining whether a person is “acting voluntarily and without coercion” are insufficient to guarantee that no person subject to coercion is assisted to end the person’s life.

RISKS OF SELF-ADMINISTERING OR BEING ADMINISTERED A POISON OF SUFFICIENT DOSE TO CAUSE A PERSON’S DEATH

Proponents of the Bill often appear to believe that any death brought about under the Bill’s provisions would be both rapid and peaceful. However, the Bill itself hints that this may not be the case.

Clauses 22, 65 and 70 all include provisions requiring a person to be given information about one or more of the following matters:

- the potential risks of self-administering or being administered a ... substance likely to be prescribed under this Act for the purposes of causing the person’s death;
- that the **expected** outcome of self-administering or being administered [such a] substance is death;
- the expected effects of self-administration of the substance;
- the period within which the person is likely to die after self-administration of the substance;
- the potential risks of self-administration of the substance;
- the expected effects of administration of the substance; and
- the period within which the person is likely to die after administration of the substance.

Period of time between administration of the poison and death

The Oregon Revised Statute at 127.897²¹ requires a person, before being prescribed a lethal dose of poison under Oregon’s law, to certify that “I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.”

Data from Oregon’s annual reports shows the time from ingestion to death has been as long as 104 hours (4 days and 8 hours) in a person who ingested pentobarbital, the substance used in Victoria for self-administration. In 2019 one person took nearly two days (47 hours) to die after using a combination of substances known as DDMP2 and another person took 19 hours to die after using DDMA.²² In 2020 one person took 8 hours to die after using DDMA, and another two people took more than 6 hours to die.²³

Of 978 deaths between 2001-2020 for which data on the duration between ingestion and death is available 74 (7.6%) took more than 6 hours to die.

Other risks

The longest time to loss of consciousness has been four hours.

There are reported complications each year, with an overall failure rate of 0.42% (8 people recovered consciousness out of 1905) and an overall complication rate of 6.3% (52 out of 827 people for whom this data is available).

In 2020 there were five cases of complications out of 72 – 6.94% of those for whom information about the circumstances of their deaths is available. This included one case of seizures and 3 cases of difficulty ingesting or regurgitating the poison.²⁴ In 2019 nearly one in ten (9.84%). In 2018 nearly one in eight (12.12%) had complications and additionally, one person failed to die and regained consciousness.²⁵ Two people had seizures in 2017.²⁶

²¹

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx>

²² Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1*, p.13, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

²³

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

²⁴ Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1*, p.12 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>

²⁵ Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1*, p.12 , <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf>

²⁶ Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017, Table 1. Characteristics and end-of-life care of 1,275 DWDA patients who have died from ingesting a lethal dose of medication as of January 19, 2018, by year, Oregon, 1998-2017*, p.10, <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

As a recent article in the journal *Anaesthesia* found:

*Complications related to assisted dying methods were found to include difficulty in swallowing the prescribed dose ($\leq 9\%$), a relatively high incidence of vomiting ($\leq 10\%$), prolongation of death (by as much as seven days in $\leq 4\%$), and failure to induce coma, where patients re-awoke and even sat up ($\leq 1.3\%$). **This raises a concern that some deaths may be inhumane.**²⁷*

FINDING 8: The provisions under the Bill may lead to slow, inhumane deaths from the self-administration or administration of a poison in sufficient dose to cause the death of a person.

NOT FIT FOR PURPOSE AND NOT SAFE

In the light of this detailed consideration of the Bill in the light of its main purposes as set out in Clause 3 of the Bill and the eight findings set out above, it is the conclusion of this dissenting report that the Bill is not fit for purpose, that it would fail to ensure that access to the prescription for self-administration or administration of a poison in sufficient dose to cause the death of the person was limited to eligible persons; would fail to protect vulnerable people from coercion and exploitation and would fail to ensure a rapid, peaceful, humane death in every case.

Although amendments could be envisioned that **may reduce** some of the weaknesses in the Bill, there is no evidence from any jurisdiction in the world that a legal regime can be designed that could exclude medical errors and a failure to identify lack of decision-making capacity, voluntariness or freedom from coercion and exploitation.

Accordingly, Recommendation 1 of the Chair's Report, that "*the Voluntary Assisted Dying Bill 2021 be passed*" is OPPOSED and the following alternative recommendation made:

RECOMMENDATION 1: That the Voluntary Assisted Dying Bill 2021 not be passed.

"TO PROVIDE LEGAL PROTECTION FOR HEALTH PRACTITIONERS WHO CHOOSE NOT TO ASSIST PERSONS TO EXERCISE THE OPTION OF ENDING THEIR LIVES IN ACCORDANCE WITH THIS ACT"

There are a variety of reasons why a health practitioner may want to choose not to assist a person to access a poison for the purpose of ending the person's life.

Some may have an in-principle ethical objection – whether based on a religious belief or otherwise – to any act intended to cause the death of a person, even at the request of the person.

After all, that is the principle to which the current law against murder gives effect. It is a principle which has been a core foundation of ethics and law across civilisations for millennia.

Health practitioners may also uphold the Hippocratic tradition which is expressed in the position of the World Medical Assembly, which it reaffirmed after extensive international consultation as recently as October 2019:

²⁷

https://assets.nationbuilder.com/australiancarealliance/pages/139/attachments/original/1551911256/Sinmyee_et_al-2019-Anaesthesia.pdf?1551911256

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.²⁸

Clause 16 (4) of the Bill would, while not requiring a formal referral, nonetheless require a medical practitioner in every case where he or she for whatever reason refused a “first request” for access to a prescribed poison to be self-administered or practitioner administered in order to cause the death of the person, give the person information that would facilitate such access.

This provision would inappropriately force a medical practitioner to choose between medical ethics – as affirmed by the WMA – and a Queensland statute.

Consider a psychiatrist treating a person with a serious mental illness that includes suicidal ideation. If the person has a possible diagnosis of a condition that is expected to cause death in 12 months and makes a first request to the psychiatrist, the psychiatrist would be legally required to facilitate the person's pursuit of ending his or her life through self-administration or practitioner administration of a poison.

It is an unconscionable, unjustifiable provision and should be removed.

RECOMMENDATION 2: If, notwithstanding Recommendation 1, the Bill is passed it ought to be amended to remove Clause 16 (4) and Clauses 84 and 85, and leave all health practitioners (and speech pathologists) in Queensland free to exercise good practice in accordance with internationally recognised medical ethics prohibiting actions intended to cause the death of a person or any referral directed to that end.

INSTITUTIONS PROVIDING CARE

Similarly, the Bill would impose on entities such as residential aged care facilities and hospitals – including those formed and operated by free associations of people sharing an ethical approach that excludes facilitating any acts intended to cause the death of a person – requirements to actively facilitate or at least to allow on their premises such acts.

It is particularly egregious to empower a coordinating practitioner to be the deciding practitioner in relation to whether actions under the Bill, including the administration of a poison in a sufficient dose to cause the death of a person, will take place on the premises of a facility which is operated by a free association of persons who are opposed to any such acts under any circumstances.

Submission 260 from AMA Queensland proposed this change:

²⁸ <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>

We recommend this section of the Bill be changed to include organisational conscientious objection as we believe that some health care facilities which provide care may have a distinctive mission or ethos which should permit it to refuse to provide particular services due to an 'institutional conscientious objection'. In that situation, the institution should inform the public of this so that patients can seek care elsewhere.

RECOMMENDATION 3: If, notwithstanding Recommendation 1, the Bill is passed then all such provisions in Division 2 of Part 6 of the Bill should be removed, apart from those in Clause 98.

PREVENTING SUICIDE SHOULD NOT BE AN OFFENCE

Clause 141 of the Bill would, for the first time in Queensland, make it an offence to try to persuade a person not to end the person's life.

While the offence of inducing a person to revoke a request for "access to voluntary assisted dying" formally only applies where the person acts "dishonestly or by coercion", it may nonetheless deter some people from earnestly pleading with a loved one or family member not to take this irrevocable step.

"Please Mum don't end your life now. We will look after you," could be seen as a potential crime. A family member intent – perhaps for selfish reasons such as inheritance impatience - on Mum ending her life as soon as possible – may potentially threaten other concerned family members who want to talk Mum out of requesting or self-administering a poison to cause her death.

While coercing someone to end their lives could be done for a range of selfish motives, this does not apply to pleading strongly with a loved one not to end their lives.

RECOMMENDATION 4: If, notwithstanding Recommendation 1, the Bill is passed then the reference to revoking a request should be removed from Clause 141.

COUNSELLING, INCITING AND INSTRUCTING IN SUICIDE USING A CARRIAGE SERVICE

Under the *Constitution of Australia*, the Commonwealth Parliament has the "power to make laws for the peace, order, and good government of the Commonwealth with respect to ... postal, telegraphic, telephonic, and other like services" (Section 51 (v)). These services are collectively referred to as "carriage services".

Section 109 of the Constitution provides that "When a law of a State is inconsistent with a law of the Commonwealth, the latter shall prevail, and the former shall, to the extent of the inconsistency, be invalid."

In 2005, the Commonwealth Parliament acted wisely in passing the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005*. This Act introduced prohibitions, with appropriate penalties, into the Commonwealth Criminal Code, on the use of a carriage service to access, transmit or distribute "suicide related material", defined to cover material that counselled or induced suicide or instructed in a method of suicide.

The Chair's Report, in its Recommendation 2 proposes that "the Commonwealth Government amend the *Criminal Code Act 1995 (Cth)* by inserting a definition declaring that "suicide" does not include voluntary assisted dying carried out lawfully pursuant to a law of a State or Territory."

Its Recommendation 3 proposes “*that as a matter of urgency the Commonwealth Director of Public Prosecutions issue prosecutorial charging guidelines indicating that the offences in sections 474.29A and 474.29B of the Criminal Code Act 1995 (Cth) will not be prosecuted where a doctor or other person is acting in accordance with the procedure outlined in State voluntary assisted dying laws*”.

Finding 1 (above) states in part that the Bill, if passed, would establish “**a lawful process allowing other persons to counsel and aid a person to end the person’s life by self-administration of a lethal poison (by creating broad exceptions to the prohibition on counselling and aiding suicide)**”.

Finding 2 (above) states in part that the Bill, if passed, “**would lead Queensland away from, and not towards, the goal of reducing the suicide rate by 50% by 2026**”.

It is good public policy to prevent suicides. The Commonwealth Parliament has acted wisely, and in accordance with its constitutional responsibility for laws in relation to carriage services, by seeking to prevent the facilitation of suicides by that means. I note that in August, 2021 both the Prime Minister and Federal Leader of the Opposition have indicated they have no plans to weaken these Federal protections.

RECOMMENDATION 5: That Recommendations 2 and 3 of the Chair’s Report be opposed.

Finally, I would like to thank the Parliamentary Secretariat/Staff of the HEC Committee for their hard work and assistance in the scrutiny of this Bill. They were put under unusual time-pressure by the haste to push the Bill through. Any criticisms of content of the Committee Report and of the process of the Committee should not be seen as a reflection on them, their hard work and dedication. I thank them.

Again, I call on all MPs to reject this Bill.

Sincerely,

A handwritten signature in blue ink that reads "Mark Robinson". The signature is written in a cursive, flowing style.

Dr Mark Robinson MP

Statement of Reservation

Voluntary Assisted Dying Bill 2021

Author: Rob Molhoek, State Member for Southport, Queensland Parliament

Date: Friday, 20 August 2021

Definition of voluntary assisted dying¹

“The administration by a medical practitioner, or self-administration by the person, of a lethal dose of medication, with that person’s informed consent, with the intent of relieving pain and suffering by hastening death.”

VAD schemes allow people suffering from life-limiting illness to choose how and when they die.

¹ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, 56th Parliament, Report. No. 34 – Voluntary assisted dying, p vii, March 2020.

Voluntary Assisted Dying Bill 2021

At the outset I want to state that I write this statement in my capacity as Deputy Chair of the Queensland Parliament Health and Environment Committee. I am the State Member for Southport and a member of the Liberal National Party (LNP) but the views expressed in this report or my personal reflections and not necessarily those of my colleagues or the LNP party room.

The LNP party room has in accordance with our party's constitution has already determined that each elected Member may exercise a conscience vote in respect of the Bill.

My goal in presenting this report is to provide an overview of the benefits, key issues, concerns and objectives of the proposed legislation as presented and to highlight potential and requested amendments that have been suggested in submissions by stakeholders and witnesses over the past three months during the committee's deliberations.

Broadly speaking I believe there are many concerns and issues that should be could be considered in determining whether or not the Bill should be passed and they are contained in the following six chapters of this report.

1. The appropriateness of the proposed laws;
2. The principals of freedom, choice and personal responsibility;
3. The Capacity of the Health Care System;
4. Unconsidered recommendations
5. Access to Palliative Care, and;
6. The legislation itself.

While there are some aspects of the proposed legislation that give rise for concern I do however want to put on the record my appreciation of the work undertaken by the Queensland Law Reform Commission, Queensland Health, The Human Rights Commission, members of the Technical Scrutiny Secretariat, the parliamentary staff of the current Health and Environment Committee Secretariat and parliamentary members of our committee.

Furthermore, I also want to acknowledge and thank the thousands of Queenslanders and representative organisations who made time to express their views either in person or by written submission to our current committee of the 57th Parliament and the previous Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the 56th Parliament.

The issue of assisted suicide which is the primary focus of the Bill is as galvanizing as it is emotive. I am so privileged to have been a member of this committee and while the responsibility has been at times burdensome and heart wrenching it has also been incredibly humbling.

I especially want to thank all those who have shared their very personal stories and experiences. In the closing hours of the committee's public hearing we heard from the "Gang of Four"; Theresa McLean, Tanya Battel, Lyn Baily and Beverly Young. I want thank them for their courageous contribution. You touched our hearts, moved us to tears and reminded us so poignantly why consideration of this Bill and the delivery of better palliative care are just so important. You also reminded us that voluntary assisted dying is for many Queenslanders a deeply personal issue.

It is also a deeply personal issue for me. One Saturday afternoon about ten years ago I received a telephone call from my cousin, he was calling to say goodbye. At first I was a little confused and then as we continued to speak it became clear that he and his partner were planning to terminate their lives at home among friends on Monday.

My cousin and I grew up a world away from each other but became good friends when my job in the late 1990s frequently took me to Holland on business. His father and my father were close as young men but sadly his father was lost to the terrors of the war in Europe while my dad survived 4 years in Stalag IV, Brux. For my cousin life has been pretty bloody tough, after losing his dad he ended up as a house-boy and lived with a priest for almost 30 years only to be dumped when his abuser retired and left him on the street.

By the time we re-connected almost 20 years ago, he was in a new relationship, settled in a town near Amsterdam and building a new life. But sadly just a few years later both he and his partner were diagnosed with cancer and continued to battle this terrible disease for best part of a decade, living with the knowledge they both only had a matter of months to live.

After the shock of that Saturday phone call, I called back Sunday and we talked for about an hour, there were tears and farewells and then as I hung up an overwhelming sense of loss. Until then I had never thought much about the concept of euthanasia, except that I had always held a fairly conservative position on the subject.

I learned that weekend, it is one thing to hold certain views and opinions but quite another to be confronted with the reality of another person's lived experiences. I loved my cousin, I still feel incredibly sad when I consider the circumstances of his life, but I'm also so grateful for the rich experiences we shared. I cannot comprehend what he and his partner Wim faced, their journey, the treatments, their late-night deliberations, their decision and that final week of farewells.

In March 2009 we scattered the ashes of my parents and my eldest sister Thea in the Southport Broadwater. My parents lived full and remarkable lives, they loved the Gold Coast, having migrated here in the early 1950s. Dad survived four years in a German Prisoner of War Camp, Stalag IV Brux, a town in Czechoslovakia. Mum and Dad came to Australia looking for a better and safer life as far away from war ravaged Europe as possible.

It was bone cancer which finally took dad out but he enjoyed an amazing quality of life right up until the morning of his passing. He had been up a ladder painting the guttering at home. He went inside for a cup of tea and decided to take a short nap, he never woke up and passed peacefully. My mother's eventual passing some ten years later was similarly as uneventful.

Sadly, however I can't say the same for my elder sister Thea. She died all too young leaving after a two-year fight with terminal cancer, she truly wanted to live. She came and lived with us for the most part. Melinda and our boys, loved her, cared for her, and supported her right up to her last breath. Melinda was incredible, an angel, the boys not so much! Her daughters and dear friend Liisa Stanley similarly cared for her, took her to medical appointments and provided respite.

It was truly a family experience. We were all involved, we shared the rollercoaster of hope and heartache. It was sad and raw, but it was also special. Thea was surrounded by family, her last 48 hours were in palliative care and we were there as she took her final breaths. I am so thankful for the amazing health care workers, nurses and doctors who worked with us to make her final passing as comfortable and pain free as could be.

At end-of-life I believe no one should ever be left to die alone nor in pain. The concept of voluntary assisted dying is as perplexing as it is simple. I believe each of us deserve to die with dignity, free from pain and with choice. I understand there are a diversity of views.

Fundamentally I support the principal of choice, but it's not that simple.

The Queensland Law Reform Commission have done an incredible job of seeking to express in law the sentiments and wishes of Queenslanders in preparing the *draft Voluntary Assisted Dying Bill 2021*. But law is such a blunt instrument. Laws provide guidance, determine right from wrong and outline penalties for failures in compliance. But there are always unintended consequences. Laws provide barriers and boundaries for living. But laws are not particularly redemptive, you cannot legislate hope, joy peace and love, you can possibly legislate for forgiveness but I'm not quite sure how well law deals with grace and restoration.

There are aspects of this legislation that are particularly blunt. While a majority of Queenslanders and my local constituency support the principal of voluntary assisted dying I fear many will be disappointed that the legislation doesn't deliver as comprehensively as many expect.

Under the legislation the eligibility criteria essentially only provides for those facing "end of life" terminal death within twelve months. It doesn't present "tired of life" as an option, nor does it make provisions for the terminally young, dementia sufferers, advance health directives and non-residents.

Fundamentally the legislation looks at when and how a person should be permitted to access voluntary assisted dying and death. It considers issues of conscience, decision making capacity and processes, who should supply and administer the substance that brings about final death, the roles of health practitioners and entities and institutions like hospitals and aged care facilities.

It is hard to be pragmatic or clinical about such a sensitive topic but that is what we must be in navigating the principals, laws and pathways for or against voluntary assisted dying.

My role as Deputy Chair of the Queensland Parliamentary Health and Environment Committee has been to provide everyone with a fair and compassionate hearing. My role as the elected Member for Southport is to be a voice for my community.

To reduce this debate down to a firm 'YES' or an absolute 'NO' is challenging and somewhat disrespectful. It is my goal in this report to provide the reader with an overview of the divergent views and concerns worthy of further consideration.

Finally, it needs to be said that voluntary assisted dying cannot be considered in isolation, it would be remiss of me not to highlight the need for more and better palliative care. True choice requires true options, no Queenslanders should have to face end-of-life with voluntary assisted dying as an only option, government must work harder to deliver better and more palliative care to every Queenslanders regardless of where they live.



Rob Molhoek

State Member for Southport
Deputy Chair, Health & Environment Committee
Assistant Shadow Minister Families & Seniors
Assistant Shadow Minister Mental Health
Assistant Shadow Minister Drug & Alcohol Treatment

1. Appropriateness of the proposed laws

Much has been said about the appropriateness of adopting or passing legislation that supports the idea of voluntary assisted dying. Indeed some would argue that life is sacred and to be cherished, that it is the responsibility of governments and legislators to pass laws that “protect people from themselves”, others have suggested that assisted suicide is in fact a form of state sanctioned murder. It is indeed an passionate and galvanising debate. It is also a challenging theological debate and while I have read many views and opinions purporting to express the right Christian worldview I have also come to learn that there are many differing views on offer.

There are so many groups, Doctors for VAS, Doctors opposed to VAD, Nurses for, nurse against, Christians for and Christians against.

In looking at the bill I personally find it a little disturbing that the best the drafters could come up with in describing human life was to describe it as “of fundamental importance”.

Human life [Part 1, Division 2, Section 5a]

- a. Human life is of **fundamental importance**; and

I find Wendy Francis’s description to be somewhat more wholesome and comforting.

“We believe in the inherent worth of every individual human being specially created in the image of God and therefore cannot measure the value of a person in terms of their usefulness or ability, or their cost to society. This belief also causes us to accept that our lives are not our own to dispose of.”

It has also been suggested that Members of Parliament have legislated obligation under the Queensland Constitution to protect life before all else.

Sadly our constitution and Oath of Office are relatively silent and for that matter broad.

“Act on behalf of and in the best interests of the people of the State”.

Worldview’s aside the fundamental role of our committee was not to assess if Voluntary Assisted Dying is or is not appropriate but rather to review the legislation on its merits or otherwise.

As it is for all elected members to exercise a conscience vote, the moral and ethical issues are for each us to assess and either support or reject the proposed Bill in accordance with our own values, beliefs and in accordance with the views and expectations of the communities we each serve.

2. Principals of freedom, choice and personal responsibility

The Bill in its Introduction and preamble highlights the importance of Choice, describing it fundamentally as “the option of request”

the Option [Part 1, Division 1, Section 3a]

- a. to give persons who are suffering and dying, and who meet the eligibility criteria, **the option** of requesting medical assistance to end their lives; and
“the option”

[Part 1, Division 2, Section 5h]

- h. a person’s **freedom of thought, conscience, religion and belief and enjoyment of their culture** should be respected.

There are many views about the principal of choice, in fact the constitutions of both the Labor Party and Liberal National Party support the same or similar principals as expresses in the bill.

While many would argue that voluntary assisted dying is not an option up for choice, others would equally argue in favour of this principal as a matter of being permitted to take responsibility for one’s own decisions in respect of life. The concept of “personal responsibility” is a core life principal that my parents and so many others parents have long spruiked as a fundamental life principal.

I’m challenged by some of these concepts in the context of the Bill but at heart believe in the fundamental principles of **freedom of thought, conscience, religion and belief and enjoyment of their culture**.

It’s been said it’s a Human right to Choose, I would also argue it’s a Human right that all Queenslanders be free to Choose but also all Queenslanders should also expect as a basic Human right equitable access to health services and palliative care.

Email from Benowa constituent June 8 2021

Subject: Assisted Dying Bill - TERMINALLY ILL PEOPLE NEED THIS CHOICE Some dying people face terrible suffering, even with the best of palliative care. I should have the choice and have directed my powers of attorney to maintain my wish that includes my wife.

3. The Capacity of the Health Care System

Notwithstanding my belief that each of us deserve to die with dignity, free from pain, and with choice over our actions, there is a certain absurdity that the Labor Government would choose this exact moment to introduce a mechanism for voluntary assisted dying. Despite the simplicity of the concept, the introduction of voluntary assisted dying in Queensland would add additional cost and complexity to our state's already-overburdened health system through increased regulatory requirements, service delivery, the review board mechanisms and dispensation of the substance, as well as other measures outlined in the Bill.

Put simply, it is an odd choice of priorities given the plethora of issues that need to be addressed in Queensland's already failing health system to manage existing care requirements across our state. In the current environment of the global pandemic, where COVID-19 testing and vaccinations have become part of the core business of Queensland Health, Queensland's Hospital and Health Services (HHS) have never been under so much pressure.

The evidence of this is laid out most clearly in the *Health 2020* report of the Queensland Audit Office (QAO).² In this report, the QAO outlined its concerns that the ongoing financial sustainability of HHSs continues to decline, observing that 11 out of 16 HHS reported operating losses for the financial year, up three on the previous financial year.³ Indeed, nearly half of all HHSs in Queensland have now made an overall loss since they were first formed in 2012.⁴ Put simply, the Labor Government are struggling, and will continue to struggle, to pay for the cost of health care in Queensland, and financial pressure continues to mount on our HHSs.

In a later report, the QAO also expressed ongoing concerns over the sustainability of Queensland's health services.⁵ In this report, QAO identified that the Labor Government's 10-year strategy "does not have a clear implementation roadmap of how its health service plans and enabling plans (for example, workforce plans) contribute to achieving the objectives in this strategy."⁶

QAO also found that the Department of Health "has not developed state wide plans for all services that have a large number of patients. Without these plans, there is a risk that planning by HHSs will be fragmented."⁷ In addition to their looming financial crisis, Queensland Health is also failing to plan effectively to ensure their long-term sustainability. This should be of concern to every Member and Queenslanders who relies on the services provided. By failing to effectively plan, Queensland Health are planning to fail, which will result in significant detrimental outcomes for patients.

The QAO's ongoing concerns over sustainability and financial pressures are evident in the service delivery issues Queenslanders are experiencing each and every day. This is Queensland's Health Crisis. There is currently a lack of sufficient funding for palliative and hospice care in Queensland, and despite

² QAO, *Health 2020*, Report 12 (2020-21).

³ *Ibid*, at page 1.

⁴ *Ibid*.

⁵ QAO, *Planning for sustainable health services*, Report 16 (2020-21).

⁶ *Ibid*, at page 1.

⁷ *Ibid*.

Labor's promise of \$171 million of increased money, the Labor Government's own budget papers contain no reference to palliative care, making many question when, or even if, that additional funding will materialise for much-needed improvements to end-of-life care in Queensland.

The Labor Government is also failing Queensland by allowing bed shortages and ambulance ramping in our hospitals to run rampant, creating significant concerns in Queensland Health's capacity to care for patients due to an ongoing and persistent lack of funding. I am sure Members right across Queensland are also hearing issues from their local constituencies with patient management systems and the inequities in care that exist between South-east Queensland and rural and remote Queensland. Labor Members might ignore these issues raised by Queenslanders, but Members of the LNP are acutely aware of Queensland's Health Crisis that the Labor Government can't get under control.

Queensland Health's history of poor implementation of new systems, in particular those in information technology (IT), are long-documented. No one can forget Queensland Health's IT payroll debacle that has cost Queensland taxpayers in excess of \$1 billion. In *Health 2020*, the QAO also identified issues with the ineffectiveness of systems and processes, many of which were also identified in previous reports,⁸ this time an issue implementing a new finance and supply chain management system. Queensland Health's inability to successfully implement new IT systems without exorbitant and unnecessary costs to the taxpayer are a concern in their ability to provide effective service deliver to patients across the state.

So, in the context of these ongoing and significant issues in Queensland's hospitals, can you really trust Labor to implement and fund a mechanism for voluntary assisted dying? In my view, there are many unanswered questions about the Labor Government's capacity in this respect. While this does not fundamentally change my view on the broader concept of voluntary assisted dying, the consideration of Labor's capacity to implement such a scheme is something I believe is worth reflecting on, both for Members voting on the Bill and for Queenslanders more broadly. There was nearly no consideration given by the Government members on the committee about how the introduction of the Bill would impact on Queensland's already struggling health system, and questions about the increased financial cost and service delivery burden to the state as a result of this Bill remain unanswered.

⁸ Above n2, at page 1.

4. Unconsidered recommendations

The committee's inquiry into this Bill was initiated by the Queensland Parliament on 27 May 2021, with a reporting date of 20 August 2021; essentially almost a three month inquiry into the Bill. Across the inquiry, I believe at time Labor members of the committee have been disingenuous in their approach to consultation and collaboration. Instead of listening to the feedback and suggestions of amendments from stakeholders, professional bodies, ordinary Queenslanders and previous reports, they have pushed ahead with a recommendation to proceed with the QLRC's draft legislation, unamended.

They have held up the QLRC's Bill as the gold standard, without any detailed consideration of the Bill's shortcomings in the eyes of some stakeholders, and consideration of potential amendments for improvement of the Bill. This statement is not to diminish the work of the QLRC – they have achieved a strong foundation for the introduction of voluntary assisted dying in Queensland, considering many issues across the breadth of proposed scheme. However, the committee has considered the QLRC's beliefs to be infallible and unchallengeable, without strong consideration of alternative views to the QLRC.

This inquiry comes after the predecessor committee's 15 month inquiry into voluntary assisted dying more broadly in the previous term of the Parliament.⁹ The outcome of that report involved 21 recommendations about the implementation of voluntary assisted dying in Queensland, mostly centred around the draft legislation submitted to the inquiry by Professors Lindy Willmott and Ben White, which the committee endorsed in their recommendations.¹⁰

Of these recommendations, a number made in the committee's initial report are either contradicted in the Bill being considered by this inquiry, or are not adequately addressed or considered in my view. I've considered some of these recommendations with some commentary below:

Recommendation 5: *The committee recommends that any voluntary assisted dying scheme in Queensland should not propose precise timeframes for a person's anticipated date of death within which voluntary assisted dying may be accessed due to the complex, subjective and unpredictable nature of the prognosis of terminal illness.*

In the Bill currently being considered by the committee, a timeframe of 12 months has been proposed by the QLRC when drafting the legislation. In my view, the committee has not adequately considered or discussed why it previously supported no timeframe being established per recommendation 5 but now believes that a 12 month timeframe is more appropriate.

Recommendation 13: *The committee recommends that safeguards should be included in any voluntary assisted dying scheme in Queensland to ensure that participation in voluntary assisted dying does not nullify life insurance, funeral or health insurance held by a person accessing voluntary assisted dying.*

⁹ Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, 56th Parliament, Report. No. 34 – Voluntary assisted dying, March 2020.

¹⁰ Ibid, pages x-xii.

The QLRC did consider this issue in their report, concluding that it was mostly a matter for the federal regulatory system, who already legislate insurance. The committee should have considered this issue in this report, noting that they already make recommendations to the Commonwealth Government on other matters. However no consideration has been given by the committee at all to this matter.

Recommendation 15: *The committee recommends that the Minister should consider including flexibility in any voluntary assisted dying scheme in Queensland for applicants in rural and remote areas on Queensland where a doctor or second doctor are not available, to permit a registered nurse who meets the training and other requirements to participate in the scheme to assess an applicant for voluntary assisted dying and to administer the voluntary assisted dying medication.*

Recommendation 18: *The committee recommends that any voluntary assisted dying scheme in Queensland ensures that voluntary assisted dying is genuinely accessible to people with a life-limiting condition whose local doctor has a conscientious objection to voluntary assisted dying.*

No flexibility or consideration has been given to these Recommendations 15 and 18 in the Committee's report. This issue is two-fold. The first is that there already exists an inequity between the metropolitan and rural and regional parts of Queensland. Many stakeholders expressed their concern that access to voluntary assisted dying in rural and regional Queensland could be more difficult, especially where a doctor has a conscientious objection to voluntary assisted dying. The Bill does not consider access to a registered nurse to assist in for regional areas, nor does the committee consider it. Secondly, the committee relies on the Commonwealth Government changing their carriage laws to accommodate this outcome, without consideration for what would happen if the Commonwealth Government does not acquiesce.

Recommendation 20: *The committee recommends that any voluntary assisted dying scheme in Queensland requires that health practitioners involved in administering or conducting assessments for voluntary assisted dying complete mandatory training developed by the Department of Health in conjunction with peak professional bodies.*

While the Bill does provide for the existence of training in clause 165, it only provides for it to be approved by the chief executive. In contradiction to the original recommendation 20, the Bill does not stipulate the involvement of peak professional bodies, nor does the committee consider or discuss this departure from the initial set of recommendations.

In addition to ignorance of these five previous recommendations, the committee also failed to take into account the matters raised in the Dissenting Report written by the LNP members of the committee. In that report, they raised some significant issues in relation to the first report, these being:

Opposition concerns

- *Not a priority whilst the issue of palliative care is so poorly funded, understood, barely accessible and neglected. VAD should not be debated in isolation.*
- *No explanation why the committee determined to separate the reports into VAD and Aged care, end-of-life care and palliative care. It could be argued the VAD report had a predetermined outcome.*

- *It could be argued that a combined assessment would have achieved greater balance between the desperate needs for improved palliative care and equally determined the value of palliative care in today's modern society and its relationship to VAD.*
- *The separate report could be read to advocate VAD over palliative care, and that is a great travesty.*

Public Opinion Polls

- *Throughout the previous inquiry, Members were continually told that overwhelmingly Queenslanders endorse VAD.*
- *However no analysis was undertaken into any of the opinion polls, they were not analysed to establish if the questions were well framed and if unbiased information was provided so respondents could give fully informed answers.*
- *The lack of vigour in assessing opinion polls is a worrying point and the question must be raised, was the Committee in part, led to a conclusion based upon questions that do not provide solid basis for assessment.*

Again, the issues raised were not considered significantly as part of this inquiry. Given these issues were already raised in the initial inquiry into voluntary assisted dying, it beggars belief that they have also been thrust aside during this inquiry.

In addition to ignoring swaths of the previous committee report into voluntary assisted dying, the committee also failed to take into consideration the views and recommendations of the many stakeholders that took the time to draft and make submissions to the Bill. Across just 30 submissions from a range of organisation stakeholders that made submissions to the committee, nearly 200 recommendations were made that were all but ignored by the Labor members of the committee.

Amongst those making recommendations that were ignored by the committee were Professors Willmott and White, whose draft legislation into voluntary assisted dying was initially endorsed in the committee's report to the 56th Parliament. To this inquiry, they made seven recommendations for improvement to the Bill that were ignored by the committee.

It beggars belief that Labor refuses to listen to the stakeholders or consider amendments or recommendations for improvement to the Bill. Labor just doesn't listen.

I believe the Minister needs to address the following questions:

- Why is VAD legislation being rushed ahead of aged care, end-of-life and palliative care reforms?
- How equitable access to all Queenslanders will be delivered?
- Why entities are being penalized and how will they comply if a majority of their employees choose to be conscientious objectors?
- Coercion 'meaning at law' and how does it apply to nurses, counsellors, pastors, family members and friends?
- How training will be delivered?
- What substance will be prescribed and delivered for administering death?
- How VAD laws will apply to First Nations peoples and their cultural practices?
- Who does the term Health Practitioner apply to, why does it overlook the import role of Nurse practitioners especially in rural and remote Queensland?

5. Palliative Care

Queenslanders Deserve Quality Palliative Care - AMAQ

An ageing population requires greater availability of quality palliative care services. However, it is clear that current palliative care services are not adequate to meet the needs of the elderly and dying in Queensland.

Palliative Care Queensland

A person's choice to explore VAD should never be based on a lack of access to palliative care.

Palliative Care [Part 1 Division 2, Section 5d]

- d. **Every person** approaching end of life should be provided with **high quality palliative care** to minimise the person's suffering and maximise the person's quality of life; and

COMMENT: I am concerned that this Bill apart from a single reference in Section 5, Clause d. completely ignores all 77 recommendations of the 56th Parliament's Report 33 into Aged care, end of life and palliative care. The findings of the previous inquiry have been shelved in spite of the chair stating, "*the current Coronavirus pandemic highlights the importance of ensuring our aged care sector is properly funded, resourced and regulated*"

It's somewhat ironic that fast-tracking legislation for Voluntary assisted dying should be a priority at time when the Queensland Government is focused on preservation of life during the pandemic with mandatory vaccinations for health care workers, lockdowns, economic measures and border closures.

There has been no explanation why the committee determined to separate the reports into VAD and Aged care, end-of-life care and palliative care. It could be argued the VAD report had a predetermined outcome.

It could be argued that a combined assessment would have achieved greater balance between the desperate needs for improved palliative care and equally determined the value of palliative care in today's modern society and its relationship to VAD.

The separate report could be read to advocate VAD over palliative care, and that is a great travesty.

Mark McArdle, former Member for Caloundra

Should the Voluntary Assisted Dying Bill 2021 be passed Queenslanders deserve to hear more fulsomely from the Government on their plans to guarantee delivery of more and better Palliative Care for all Queenslanders.

In a Research Brief provided by the Queensland Parliamentary Library and Research Service, prepared at my request, some of the challenges in delivery of palliative care services to all Queenslanders come into sharp focus. (see tables below)

Of note are the Tables in respect of Employed palliative care medicine physicians, palliative care nurses, palliative care beds and units and trend data on the number of end of life and palliative care hospitalisations to public and private hospitals around Queensland.

Employed palliative care medicine physicians	49
Palliative care nurses	681
Palliative care beds and units	139
End of life and palliative care hospitalisations	10400

It's also concerning to note that of the sixteen Hospital and Health Services (HHS) across Queensland, seven have no dedicated palliative care designated beds or units.

According to the research brief provided the following Hospital & Health Services have no dedicated palliative care beds or units; Cairns & Hinterland, Central Wets, Queensland Children's Hospital, Mackay, North West, South West, Torres and Cape and Wide Bay.

Queensland Health Budget 2021-22

Searches conducted of this year's budget documents identified that "no" specific references to the term palliative care were contained in either Budget Paper 2: Strategy and Outlook nor Budget Paper 5: Service Delivery Statement, Queensland Health.

While the government has been only too happy to churn out countless media releases about increased funding for palliative care (\$171 million over the next five years, it strikes me as strange that no references to increased palliative care funding made it into the Budget Papers.

While Queensland Health have commenced the development of the Palliative Care and End-of-Life Strategy, nothing as yet has been presented to the parliament for consideration nor debate.

PALLIATIVE CARE QUEENSLAND in their submission have flagged significant concerns in respect of service delivery and made six recommendations in respect of voluntary assisted dying which have been completely ignored by Labor members of the Health and Environment Committee.

REQUESTED AMMENDMENTS: Palliative Care Queensland

Palliative Care Queensland's recommendation 1: (12 month access)

To ensure equal access to specialist palliative care and to VAD, the Parliamentary Committee make specific recommendations to the Government to fund access to specialist palliative care at a minimum to the same level as access is proposed to VAD in clause 10: "A person is eligible for access to specialist palliative care if – That person has been diagnosed with a disease, illness or medical condition that – (i) is advanced, progressive and will cause death; and (ii) is expected to cause death within 12 months; and (iii) is causing suffering that the person considers to be intolerable"

Palliative Care Queensland's recommendation 2:

To ensure equal access to specialist palliative care as to VAD, the Parliamentary Committee make specific recommendations to the Government aligning the principle that "every person approaching the end of life should be provided with high quality care and treatment including palliative care, to minimize the person's suffering and maximize the person's quality of life" with PCQ, the AMA Qld and Qld Palliative Care Medical Directors Group's specific **funding request for an additional \$275million per year**

Palliative Care Queensland's recommendation 3:

Clause 5 (d) be amended to include the words "Every person and their families should have access to **bereavement care** from diagnosis of a life-limiting illness to a minimum of 12 months after the death"

Palliative Care Queensland's recommendation 4:

S85 should be amended to include social workers and provide a definition of that activity in line with the definition outlined in S85 (5).

Palliative Care Queensland's recommendation 5:

Greater statutory reporting requirements of the Attorney-General or Health Minister requiring them to report to parliament on the amount the Queensland Government spends on palliative care during the financial year, and **the aggregated amounts spent by Queensland on palliative care during the preceding five financial years**

Palliative Care Queensland's recommendation 6:

The Voluntary Assisted Dying Board be required by law to report to the Parliament every six months (as well as produce an annual report) and that this be an ongoing reporting requirement

Palliative Care QLD. Submission No 1158. Page 2.

REQUESTED AMENDMENTS QNMU

QNMU has made three recommendations. In any discussion about voluntary assisted dying, it is important to also acknowledge palliative care. The QNMU makes the distinction that voluntary assisted dying is not an alternative to palliative care and the QNMU will continue to lobby for adequate resourcing of palliative care, including suitably qualified and adequate numbers of nurses for those requesting and/or requiring palliation. Part of a state palliative care strategy must be the commitment to ensuring high-quality palliative care services are delivered in a range of settings and that there is better and more equitable access to high-quality palliative care not only in the south-east corner of Queensland but also extending to regional, rural and remote areas.

Mr Dan Prentice, Professional Research Officer, Queensland Nurses and Midwives' Union. Brisbane Transcript Day 2. Page 60

REQUESTED AMENDMENT: Cherish Life**AMENDMENT 4 Cherish Life**

EVERY PATIENT TO BE ASSESSED BY A PALLIATIVE CARE SPECIALIST (FOR FREE). The right for anyone who is suspected of having a terminal illness to be seen and treated by a palliative care specialist, for free, from the point of terminal diagnosis should be written into this Bill.

Table 1 presents the following data in relation to employed palliative medicine physicians in all Australian jurisdictions, including Queensland, in 2018:

- number of staff and Full-time Equivalent (FTE)
- average total hours worked
- average clinical hours worked
- rate of FTE staff per 100 000 population, and
- rate of clinical FTE per 100 000 population.

Table 1: Employed palliative medicine physicians, all Australian jurisdictions, 2018

Jurisdictions	Number of palliative medicine physicians	Average total hours worked per week	Average clinical hours worked per week	FTE number	Clinical FTE	FTE per 100,000 population ^(a)	Clinical FTE per 100,000 population ^(a)
New South Wales	91	39.9	30.0	90.9	68.3	1.1	0.9
Victoria	61	35.5	24.7	54.1	37.6	0.8	0.6
Queensland	49	40.6	34.5	49.8	42.3	1.0	0.8
Western Australia	30	37.0	31.8	27.8	23.8	1.1	0.9
South Australia	20	35.0	28.5	17.5	14.3	1.0	0.8
Tasmania	10	36.7	27.8	9.2	7.0	1.7	1.3
ACT	5	43.2	30.8	5.4	3.9	1.3	0.9
Northern Territory	5	36.6	34.8	4.6	4.3	1.9	1.7
Total ^(b)	271	38.3	29.7	259.2	201.4	1	0.8

- Source: Compiled by Queensland Parliamentary Library, data sourced from AIHW, *Palliative care workforce in Australia*, [Table Wk3: Employed palliative medicine physicians, average total hours worked per week, FTE and FTE per 100,000 population, states and territories, 2018](#). Notes: (a) Crude rates are based on the preliminary Australian estimated resident population as at 30 June 2018. See Technical Information. (b) Numbers and percentages may not sum to the total due to missing data, rounding and/or confidentialisation.

Table 2 presents the following data in relation to employed palliative care nurses in Australian jurisdictions, including Queensland, in 2018 number of staff and FTE, average total hours worked, average clinical hours worked, rate of FTE staff per 100 000 population, rate of clinical FTE per 100 000 population

Table 2: Employed palliative care nurses, all Australian jurisdictions, 2018

Jurisdictions	Number of palliative care nurses	Average total hours worked per week	Average clinical hours worked per week	FTE number	Clinical FTE	FTE per 100,000 population ^(a)	Clinical FTE per 100,000 population ^(a)
New South Wales	1047	34.8	31.8	958.9	875.2	12.0	11.0
Victoria	999	31.6	29.0	831.8	762.2	12.9	11.8
Queensland	681	32.3	30.1	579.0	538.7	11.6	10.8
Western Australia	375	30.8	28.9	304.1	284.8	11.7	11.0
South Australia	230	32.5	29.9	196.6	180.7	11.3	10.4
Tasmania	94	32.2	31.4	79.7	77.8	15.1	14.7
ACT	65	35.6	31.9	60.9	54.6	14.5	13.0
Northern Territory	37	37.4	36.4	36.4	35.4	14.7	14.3
Total ^(b)	3528	32.8	30.3	3047.4	2809.3	12.2	11.2

- Source: Compiled by Queensland Parliamentary Library, data sourced from AIHW, *Palliative care workforce in Australia*, [Table Wk9: Employed palliative care nurses, average total hours worked per week, FTE and FTE per 100,000 population, states and territories, 2018](#). Notes: (a) Crude rates are based on the preliminary Australian estimated resident population as at 30 June 2018. See Technical Information. (b) Numbers and percentages may not sum to the total due to missing data, rounding and/or confidentialisation.

Table 3 presents the number of palliative care beds and units that are located within Queensland Health public hospitals, as identified from searches of the following sources:

- Queensland Health, [Hospital and Health Services](#) (HHS), Annual reports 2019-20
- Queensland Parliament, Record of Proceedings (Hansard)
- Queensland Parliament, [Palliative and community care in Queensland: toward person-centred care](#), Health and Community Services Committee, Report No. 22, May 2013
- Queensland Health, [Palliative Care Services Review – Key Findings](#), March 2019.

Table 3: Palliative care beds and units, Queensland HHS, public hospitals

Hospital and Health Service (HHS)	Palliative care beds (number)	Source
Cairns and Hinterland	-	
Central Queensland	24*	S Miles, ‘Question On Notice No 894’ , [Questioner: D Frecklington], Queensland, 21 August 2018
Central West	-	
Children's Health Queensland ¹¹	-	
Darling Downs	4*	S Miles, ‘Question On Notice No 894’ , [Questioner: D Frecklington], Queensland, 21 August 2018
Gold Coast	16*	S Miles, ‘Question On Notice No 894’ , [Questioner: D Frecklington], Queensland, 21 August 2018
Mackay	-	
Metro North	32*	
Metro South	18*	
North West	-	
South West	-	
Sunshine Coast	12*	
Torres and Cape	-	
Townsville	20*	
West Moreton Health	13	West Moreton Hospital and Health Service, Annual Report, 2019-20 , 2020, p 17
Wide Bay	-	

- Source: Compiled by Queensland Parliamentary Library, data as hyperlinked. Notes:
*Designated beds

¹¹ Palliative care services for the Children's Health Queensland Hospital and Health Service are provided by the [Paediatric Palliative Care Service](#) which provides paediatric palliative care services to children living in Queensland and northern New South Wales. The number of paediatric palliative care beds has not been located.

Palliative care patient data

The AIHW reports on the number of palliative care patients in public and private hospitals in Queensland, with the latest data for 2017-18 in the *Palliative care services in Australia*, updated on 26 May 2021.

Table 3 displays the number of hospitalisations and annual percentage change in palliative care and other end-of-life hospitalisations for public and private hospitals from 2013-14 to 2017-18.

Table 3: Hospitalisations and annual percentage change, palliative care and other end-of-life hospitalisations, public and private hospitals, Queensland, 2013-14 to 2017-18

Hospitalisation type	Sector	2013-14 (number)	2014-15 (number)	2015-16 (number)	2016-17 (number)	2017-18 (number)	Average annual change (per cent) 2013-14 to 2017-18
Palliative care	Public hospitals	8051	8379	8488	8438	8899	2.5
Palliative care	Private hospitals	2349	2396	1897	2234	2544	2.0
Palliative care	All hospitals	10 400	10 775	10 385	10 672	11 443	2.4
Other end-of-life care	Public hospitals	0	0	1211	1837	2054	..
Other end-of-life care	Private hospitals	0	0	1043	1350	1265	..
Other end-of-life care	All hospitals	0	0	2254	3187	3319	..
Hospitalisations for all reasons	Public hospitals	1 087 073	1 202 798	1 293 125	1 394 557	1 486 922	8.1

On 14 June 2021, Queensland Health provided data relating to the forecast investment for palliative care by HHS region from 2021-22 to 2025-26 (not including the new \$171 million allocation).

ABF and Non ABF Forecast on 2020-21 projected investment (does not include the new \$171M GEC)	\$,000				
	2021-22	2022-23	2023-24	2024-25	2025-26
HHS					
Cairns and Hinterland	\$ 11,592	\$ 11,882	\$ 12,179	\$ 12,484	\$ 12,796
Central Queensland	\$ 6,225	\$ 6,380	\$ 6,540	\$ 6,703	\$ 6,871
Central West	\$ 493	\$ 506	\$ 518	\$ 531	\$ 544
Children's Health Queensland	\$ 4,818	\$ 4,939	\$ 5,062	\$ 5,189	\$ 5,318
Darling Downs	\$ 7,156	\$ 7,335	\$ 7,519	\$ 7,707	\$ 7,899
Gold Coast	\$ 14,749	\$ 15,117	\$ 15,495	\$ 15,883	\$ 16,280
Mackay	\$ 2,403	\$ 2,463	\$ 2,525	\$ 2,588	\$ 2,653
Mater Public Hospitals	\$ 4,296	\$ 4,403	\$ 4,513	\$ 4,626	\$ 4,742
Metro North	\$ 25,577	\$ 26,216	\$ 26,872	\$ 27,543	\$ 28,232
Metro South	\$ 30,479	\$ 31,241	\$ 32,022	\$ 32,822	\$ 33,643
North West	\$ 1,612	\$ 1,652	\$ 1,693	\$ 1,736	\$ 1,779
South West	\$ 1,146	\$ 1,174	\$ 1,204	\$ 1,234	\$ 1,265
Sunshine Coast	\$ 14,610	\$ 14,976	\$ 15,350	\$ 15,734	\$ 16,127
Torres and Cape	\$ 490	\$ 503	\$ 515	\$ 528	\$ 541
Townsville	\$ 11,553	\$ 11,841	\$ 12,137	\$ 12,441	\$ 12,752
West Moreton	\$ 8,656	\$ 8,873	\$ 9,095	\$ 9,322	\$ 9,555
Wide Bay	\$ 7,766	\$ 7,960	\$ 8,159	\$ 8,363	\$ 8,572
Grand Total	\$ 153,621	\$ 157,462	\$ 161,398	\$ 165,433	\$ 169,569

Figure 1: Estimated projected and forecast investment on palliative care, based on historical spend, by HHS, Queensland. Figure sourced from Queensland Parliament, Health and Environment Committee, Voluntary Assisted Dying Bill 2021, Questions - Taken on Notice and Responses, Queensland Health, [Response from Queensland Health to Questions Taken on Notice at the public briefing on 14 June 2021](#), p 2.

Transcripts and Submissions of note: Palliative Care

Dr Will Cairns OAM: GP in Townsville. President of the Society of Palliative Medicine. Established a palliative care service in Townsville. Page 7 – 8 of transcript from Townsville.

When I was president of the Society of Palliative Medicine, we created a position statement which said that VAD is not part of palliative care. Since that time, Palliative Care Australia has found more or less the same thing—that voluntary assisted dying is not a component of palliative care. While we may have views on it, they should not interfere with our ability to do what we do; nor should palliative care be construed as either promoting or opposing voluntary assisted dying, because we felt that that would distract from our ability to do what we do; and nor that palliative care should be a solution for avoiding request for voluntary assisted dying.

Over my career I have noticed that the relationship between doctors and our patients has changed significantly. Patients now make their own decisions from the options they are offered by their doctors. Advance care planning and consent are now at the core of medical practice, even though, and appropriately, the default position is to engage in life-prolonging treatment without instruction from the patient. However, patients do have the right to refuse or to withdraw from treatment. Perhaps one of the best examples of that is people who have been having renal dialysis for a period of time, maybe even decades, and then decide that they have come to the point where they have had enough of the life they have been leading and their time has come to let go. They know they can stay on dialysis and it might draw out the end of their life but their quality would be severely diminished. They are in a position where they have an exit ticket, if you like. They can stop their dialysis and within about two weeks, on average, they will die from kidney failure, often very peacefully with sedation just from their disease. Many people accept that as a very reasonable behaviour. People who do not have renal failure do not have the same option to control the timing of their death. They may not have anything to withdraw from that is sustaining their life.

Finally, most importantly, for those of us who work in palliative care, we have promoted the normalisation of death and the acceptance of dying so that our patients can find a place of peace. We encourage and support people to make the transition from pursuit of cure and avoidance of death that has characterised much of modern medical practice to the acceptance of the normality of death and dying. For me, it is not really surprising that, without fear and in an era where people have decided they have the right to control their own lives, some may decide that the time has come for them to end their life, that they would like to opt out of the unpleasant bit at the end, not just for themselves but also for the sake of their families who they feel responsibility for, to sometimes step aside.

Professor Sarah Larkins, Dean, College of Medicine and Dentistry, James Cook University. Experienced GP with clinical experience in rural and regional areas with both Indigenous and non indigenous patients. Page 18 transcript from Townsville.

Dr Larkins: You are right: it is a difficult problem. It is an intractable problem that has been taking some time to sort out. JCU graduates are doing a great job at getting out there and filling gaps and delivering services. It is one of those questions. In a perfect world, we would have access to top quality palliative care in every corner of this country and this state. I heard Dr Cairns talking about some of the limitations in terms of access. What we do have is very friendly and accessible specialist positions in the regional centres and very skilled generalists of a number of persuasions in the rural and remote areas and they are linked by phone and video. There are various ways of getting that expertise to the people where they are. I think exactly the same applies to education and support and access to voluntary assisted dying. Just because we are not 100 per cent confident that we have it all absolutely solved is not a reason to stop trying. We just have to try and do the best we can and make sure that we write it into the legislation—as it is, I note. We have to keep trying to execute that as well as possible. It would be a travesty to say that because we cannot do it perfectly the first time then we have to not do it at all. That would be a shame.

Mr Mark Thompson, Board member, Fitzroy Community Hospice – a not-for-profit charitable organization committed to establishing CQ's first hospice

Our primary concern with the VAD legislation as proposed is that the core principles of voluntary assisted dying in clause 5 are not being met. We see the core principles as the foundation for the whole legislation. I will quote the clauses. Clause 5(d) states— ... every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life— The second clause that we believe is not being met is 5(e), which states— ... access to voluntary assisted dying and other end of life choices should be

available regardless of where a person lives in Queensland. That particularly applies to regional, rural and remote areas. As this health committee has previously acknowledged, access to high-quality palliative care and end-of-life choices is not currently available to all people living throughout Queensland, and here in CQ it is no different. This includes access to hospice care, which is inequitably distributed throughout Queensland, with all hospices currently located in the south-east corner.

Dr Chrys Pulle, Council Member. Australian & New Zealand Society for Geriatric Medicine. Brisbane Transcript Day 2. Page 30.

ANZSGM's view is that policymakers and funders of health care can best help patients nearing the end of their life by ensuring adequate provision and funding of high-quality community care, palliative care and geriatric medicine services. The society acknowledges the wide-ranging perspectives and ethical views held in the community on voluntary assisted dying, likewise with ANZSGM members, but they do hold some concerns with this proposed legislation. There are three most important concerns. The priority should be for all Queenslanders, no matter where they live, to have timely access to controlled pain relief to alleviate their suffering—not VAD. A person with intolerable suffering that cannot be relieved in the manner that the person considers tolerable should have a referral to a palliative care consultation prior to accessing VAD and have access to specialist assessment in the field of terminal illness. This will allow improvements in things such as prognosis, new available treatments or other palliative options. The specialist should be a consulting medical practitioner for VAD, as legislated in Victoria. This is to ensure that all patients are given all potential management options at the end of life or no treatment.

Dr Kym Boon, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists. Brisbane Transcript day 2. Page 31.

My second point is also consistent with my colleagues'. There is inadequate, underfunded and inequitable palliative care. I work in the biggest hospital in Queensland and we do not have dedicated palliative care beds. There is inadequate, underfunded older aged care, especially for dementia, mental illness in older persons, resourcing to support the elderly at home, staffing and aged care. We only have 10 to 12 beds in the biggest hospital in Queensland for elderly psychiatric patients. There cannot be a genuine choice until mental health and older aged care is equitably funded. Mental health needs to be a core factor in end of life. There is late, inadequate access to palliative care, older aged care and psychiatric care. It is much more challenging then to deal with psychological, spiritual distress and suffering.

Ms Rebecca Burdick Davies, Director, Strategy and Mission, Catholic Health Australia. Brisbane Transcript. Day 3. Page 15.

Lastly, the bill presents a problem no amendment will address, and that is a promise that every person requesting VAD will have the choice of palliative care. It is a promise that cannot be delivered on due to the inadequate funding and access to quality palliative care in Queensland. I am joined today by Professor Phillip Good, who is an eminent palliative care expert who can speak on these issues. Our commitment to caring for the vulnerable, including the terminally ill, will of course never waver. We ask the committee to offer Queenslanders a better choice. I am open to any questions.

Australian Christian Lobby. Submission No 1054. Page 13/14

The ACL acknowledges the extensive inquiry that the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) undertook prior to the tabling of this Bill. What became clear through this inquiry was how inadequate palliative care services in QLD currently are and how much needs to be done to make them satisfactory, let alone exemplary.

Queenslanders deserve the best end-of-life care. The ACL notes with concern that the Committee raised the following issues with current palliative care in Queensland:

1. Access to local palliative care is severely lacking, with little access for remote Queensland communities;
2. There are no palliative care hospices outside of South East Queensland;
3. Queensland lacks a consistent and coordinated approach to palliative care provision throughout the State, with individual Hospitals and Health services conducting their own piecemeal approach;
4. Palliative care in residential aged care facilities is not meeting the need in these facilities;

5. There is insufficient access to after hours palliative care in rural Queensland, which can be the source of significant distress to patients;

6. There is not enough funding, and even the available funding is inefficiently applied and even sometimes misappropriated to other sub-acute services; and

7. Palliative care in Queensland is suffering a large workforce shortage which will only worsen as the demand increases with an ageing population.

Associate Professor Natasha Michael is an expert in palliative care and is concerned that a misunderstanding of palliative care has created an enthusiasm for physician assisted suicide. She writes:

“Palliative care is deeply misunderstood. It is viewed simply as the care of the dying, without understanding the totality of what it can offer, when it is done well, Stories of bad deaths arise not simply from the memory of the repugnance of death, but from one of ill preparation and failure of professionals and society to help families delve deeply into what matters most.”

The Government should be prioritising the critical improvement of palliative care in Queensland. This Bill undermines this priority. Palliative care is necessary to provide needed care to Queenslanders who are terminally ill. Making VAD an option creates a perverse disincentive for the Government to focus instead on the cheaper option of ending the lives of the terminally ill, rather than providing them with much needed comfort and care in their final days.

The Australian Medical Association’s 2016 position statement on Euthanasia is very clear that the Australian medical community sees palliative care as a top priority in the provision of end-of-life care and that it should be prioritised above access to VAD.³ The ACL agrees with the AMA’s statement that as a matter of highest priority, governments should strive to improve end of life care for all.

The AMA has stated that the government should prioritise palliative care through:

1. the adequate resourcing of palliative care services and advance care planning;
2. the development of clear and nationally consistent legislation protecting doctors in providing good end of life care; and
3. increased development of, and adequate resourcing of, enhanced palliative care services, supporting general practitioners, other specialists, nursing staff and carers in providing end of life care to patients across Australia.

Doctors have taken the Hippocratic Oath and should be providing healing medical care to their patients. Doctors should not be co-opted into assisting the vulnerable to commit suicide. The AMA has said that doctors should not be involved in medical interventions that have as their primary intention the ending of a person’s life.

Queensland Human Rights Commission. Submission No. 1314. Page 11. Independent statutory body established under the Queensland Anti-Discrimination Act 1991. Handles complaints and training on discrimination, vilification, victimization and sexual harassment in accordance with the act.

A voluntary assisted dying scheme must not be a replacement for adequate palliative care services throughout Queensland including in regional and remote areas. The former Health Committee’s report regarding voluntary assisted dying noted that that palliative care ‘needs to be adequately resourced and supported irrespective of whether voluntary assisted dying legislation is introduced’. Further, the Committee noted that, ‘if it is introduced, it is imperative that people have the full range of options available to them so that they can make an informed choice’.

The QLRC supported the Committees’ recommendations, 16 and similarly noted that ‘greater public resources will be required to address the demand on public hospitals and health services to provide end of life treatment, palliative care and voluntary assisted dying’. Further, the QLRC recommended that ‘any scheme for voluntary assisted dying should complement, not detract from, the provision of high quality and accessible palliative care and treatment.’¹⁸ In its submission to the QLRC, PalliativeCare Queensland recommended ‘legislation supporting and enshrining palliative care should be considered at the same time as VAD legislation’.

The QHRC therefore welcomes the Queensland Government’s announcement for additional funding to palliative care services. Nonetheless, such funding commitments are necessarily subject to budgetary cycles, and we note that some non-government organisations have suggested this additional investment is not sufficient.

The QHRC does not have the expertise to assess the need for additional services, but suggests **the government must demonstrate that there is sufficient palliative care services available to ensure in every instance**, the person is truly making a voluntary decision to opt for assisted dying.

We note that PalliativeCare Queensland suggests that palliative care frameworks continue to be separate from VAD.²¹ On the basis it would not put that approach in jeopardy, the QHRC suggests that in consultation with key stakeholders, the government develop an additional safeguard to ensure palliative care services are adequate throughout Queensland. **One option would be to expand the functions of the new independent review board created by the Bill to monitor palliative care services in Queensland, as a safeguard against voluntary assisted dying being used as a replacement. The Board could be renamed the 'Dying with Dignity Review board' to reflect this broader role.**

In introduction, we would like to emphasise the following: VAD legislation has around it a great deal of public misinformation, falsely creating an illusion and promise to relieve suffering. This sidelines the real societal and healthcare actions required to compassionately address the causes of the suffering. For example, the legislation as framed is for a prognosis of up to 12 months, well before a person is actually dying, while community palliative care service provision—palliative care being the evidence based standard of care to improve quality of life and dying—is only funded by this government for the last three months of life. Making VAD legal without reforming the palliative care sector—and again I refer to the postcode lottery—that fosters dignity and eases suffering means there is no choice, especially for those anxious and under duress about their care.

Dr Judith McEniery. Queensland Representative. Health Professionals Say No. Brisbane day 1 transcript. Page 48

VAD is not a medical treatment. It is not part of evidence based health care and introducing it creates an ambiguous environment leading to moral distress among patients, healthcare and other service providers and families. Reports of the distress among staff and patients in Victorian hospitals and the exit of many doctors and nurses from Canadian hospitals and hospices since VAD was introduced—or MAID, as they call it—support this. Health professionals and institutions should not be forced by VAD legislation to act against their ethical standards

Dr Judith McEniery. Queensland Representative. Health Professionals Say No. Brisbane day 1 transcript. Page 48

Ms Shyla Mills, Chief Executive Officer, Palliative Care Queensland. Brisbane Transcript. Day 2. Page 42

Unfortunately, the current funding of palliative care just is not enough. It is between \$100 million to \$155 million per year—it is really difficult for us to get an accurate figure on the current spend of funding and our palliative care physicians across the state are not aware of the current palliative care spending—plus the additional new funding of approximately \$28.5 million per year over six years. It is just not enough to ensure the whole-of-system and societal response that has been identified out of your wonderful Queensland inquiry into aged care, palliative care, end-of-life care and VAD—the whole of system.

Palliative Care Queensland is neutral on VAD. It is up to society and politicians to create laws. We firmly believe that VAD is not part of palliative care practice, but, just as we coexist with curative treatments, we can coexist with VAD.

6. The legislation - Voluntary Assisted Dying Bill 2021

The proposed legislation is assembled in 12 parts or chapters, I will seek to address concerns, proposed amendments raised by submitters in the same order as the draft Bill.

I have summarised the concerns by category, the order of which is outlined below.

- A. Name of the Bill
- B. Main purposes of the Act
- C. Coercion
- D. First Nations Culture
- E. Telehealth Access
- F. Eligibility
- G. Requests – first, second and final
- H. Timing and administering of the substance
- I. Eligibility requirements for health practitioners
- J. Conscientious objection – health practitioner
- K. Participation by entities
- L. Facilitate transfer to and from
- M. Inducing a person to request or revoke a request
- N. Approved training

Each issue is considered individually and in isolation below.

PART 1: Preliminary [Title & Objects]

A. NAME OF THE BILL

Section 1: Short Title

This Act may be cited as the ***Voluntary Assisted Dying Act 2021***.

COMMENT: Some groups have raised concerns about the title Some have suggested the name be changed. Section 8 of the bill the draft legislation states; **Voluntary assisted dying not suicide.** For the purposes of the law of the State, and for the purposes of a contract, deed or other instrument entered into in the State or governed by the law of the State, a person who dies as the result of the self-administration or administration of a voluntary assisted dying substance in accordance with this Act— (a) does not die by suicide; and (b) is taken to have died from the disease, illness or medical condition mentioned in section 10(1)(a) from which the person suffered.

REQUESTED AMENDMENT: Cherish Life

Cherish Life suggested the Bill name change to: *Euthanasia and Assisted Suicide Bill 2021* or *Medical Killing Exemption Bill 2021*. The current Bill's name is deceptive "Voluntary assisted dying" makes it sounds like some sort of palliative care when it is actually intentional killing either by a doctor facilitating the suicide of someone through a poison cocktail or directly by via a lethal injection or drip. The Bill's name should be changed to *Euthanasia and Assisted Suicide Bill 2021* or *Medical Killing Exemption Bill 2021* to accurately reflect the intention of the Bill.

B. Main Purposes of the Act

Section 3(a) to give persons who are suffering and dying, and who meet eligibility criteria, the option of requesting medical assistance to end their lives;

COMMENT: While the Bill addresses significant terminal conditions, public perception and that of the media is that the application of the Bill would be broader in respect of other ‘end-of-life’ or ‘tired-of-life’ choices.

Committee evidence:

Mr MOLHOEK: Broadly, do you think the Queensland legislation is right? Have we got it right?

Dr Nitschke: There is a question about ‘right’, meaning in some ways people say that a law that passes is the right law. I can see that there are real political constraints on these legislative strategies. I have spent some 20 years trying to get legislative initiatives through the various states of Australia, all of them failing. We had some 20 failed attempts following the overturning of the Northern Territory law I was involved in. It was so damn difficult so I was thrilled when Victoria finally came up with a model that actually got through the parliamentary process. I am not sitting around saying, ‘Oh, well, I know what’s best,’ because I know there are real constraints in terms of trying to find a model which is going to be acceptable, and by ‘acceptable’ I mean something that will pass. I have seen so many of these bills rejected. In that sense, you probably have a very good model there which will probably pass.

I note with some interest that an issue that was considered to be political poison for so many years has now become something which is almost seen as a political plus. We have almost seen a stampede of the states of Australia now to join in. Since the dam was broken by Victoria, all other states want to join in and it is seen that it is actually positive politically to be part of one of these legislative initiatives. **My concern, though, is that the model that is being adopted, rather slavishly followed, is this rather problematic medicalised model which prioritises disease as the only available access point. That is an issue which is not going to be solved here, but ultimately you will find yourselves being confronted with it in years to come.**

Mr MOLHOEK: I was just having a quick look online at the ‘tired of life’ legislation you mentioned in Holland. I have to say that I find that concept quite disturbing. That is just a whole other step further. In some respects, I wonder if our ability to keep people alive so well and advances in modern medicine have in no small part created some of the ethical dilemmas that we have now with people saying, ‘I don’t want to be kept alive any longer. Can you please stop helping me?’ I would appreciate your comment on that.

Dr Nitschke: Many people will say—and I think it is quite correct—that many of the issues we find ourselves discussing and debating are effectively a by-product of modern medicine which has allowed people to be kept, if you like, technically alive but with a rather decreasing quality of the life that is being experienced. In these societies where life expectancy has been pushed up thanks to the developments and advances in modern medicine, there are people who are effectively now saying, ‘I’m living, but I don’t want to live.’ That leads to this issue of ‘tired of life’. It is not an issue, but we only have to go back a century to see that everyone is dying at the age of 50 from infectious disease, but now it is being played out and people are demanding this option. As I said, they are seeing it as a right. I am afraid that the legislative models that are going through are prioritising it as a medical privilege for the very sick. It is a product of modern medicine, modern Western society and access to Western medicine that we are seeing this. Dr Philip Nitschke, Exit International (via videoconference). Brisbane Transcript. Day 2. Page 75.

--

Dr Van Gend: I always tell my medical students that we cannot get rid of all suffering in dying, any more than we can get rid of all suffering in childbirth or in any life event in between—major illness, major accident, sporting trauma. **Suffering is part of life.** The question is: why should this committee and this parliament be approving suicide as a response to suffering at that phase of life, in the last year, but not for equal suffering or greater suffering at other times of life? That is the question. Dr David van Gend. Cherish Life Queensland Spokesperson. Brisbane Day 1 transcript. Page 41.

If the bill prevails and if there is that goodwill, it must at least be amended so it does not coerce the conscience of your fellow citizens who cannot and will not collaborate with intentional killing. It must be amended, please, to protect our patients from their own depression, their own lack of information at such a crisis time, by stipulating input from a psychiatrist, a palliative specialist and a specialist in the patient’s diseases. Anything less than that is negligent.

Committee members, this bill is both reckless and unjust, in my considered opinion, but at least may it have the dignity of not succumbing to a lack of integrity as far as informed consent goes and a certain malice in terms of coercion of conscience.

Dr David van Gend. Cherish Life Queensland Spokesperson. Brisbane Day 1 transcript. Page 39.

The essential thing is that we must protect patients from themselves. When you are in an advanced diseased state, your brain chemistry is gravely altered. It is very difficult for us as doctors to tell between a brain depression, which we have a duty to treat because it is disturbing the person's perception, and just the reaction of grief and existential distress of being a terminal patient.

I would put it to you that this bill is negligent in permitting some junior doctor who is only five years out of university—typically two years as a junior house officer in a hospital and three years as a GP trainee—to qualify under this bill to issue a 'tick' that this person knows all about the palliative care options, tick that this person knows all about the new treatment possibilities in the special field of their disease and—worst of all—'tick' that they can say that this patient is not affected by depression, by dissociative states, by the cognitive changes of these powerful medications. They cannot. I promise you. I lecture these students—these GP trainees. They are not competent to do that. Under this bill they are allowed to do it. That is a gross piece of negligence, which I am sure you can fix. Please let there be a psychiatrist. Only they can protect the patients from their altered brain state. Let them make their true decision, not their distorted decision.

Please let there be a palliative specialist. It is a profoundly complex field of medicine. Some GP or junior doctor simply does not know what is possible. Surely this patient should be freed from unrealistic fears and returned to a state of reasonable expectation of how hard it will be—not an unreasonable one. That is what the palliative doctors can do. Finally, the specialist in the field is vital. Without that, it is a wrongful death.

Dr David van Gend. Cherish Life Queensland Spokesperson. Brisbane Day 1 transcript. Page 42.

C. COERCION

Section 3 & 5 Safeguards & Principles

3 (c) to establish **safeguards** to –

- i. only accessed by eligible persons; and
- ii. **protect vulnerable persons from coercion and exploitation;** and

5 (g) a person who is vulnerable should be **protected from coercion and exploitation;** and

COMMENT: Many groups raised concerns about coercion. The definition of coercion needs to be more fully explained in respect of its meanings at law. When the definition of coercion lacks clarity it's makes it difficult for people to provide balanced or reasonable advice.

ADVICE: Professors White and Willmott

At the hearing Professors White and Willmott were asked to provide advice on this aspect of the Bill. Their advice is below:

... the wording of s 141 requires dishonesty or coercion, and [it is] our view that this would not be breached by a person having an open discussion about options at the end of life.

We have considered this issue further and our view remains that the circumstances flagged by Mr Molhoek would not be captured within s 141, because:

- a) To be captured by s 141, the person must have dishonestly, or by coercion, induced another person to revoke a request for VAD. This requires something more than simply having a discussion that involves VAD.
- b) 'Induce' and 'dishonesty' are not defined in the VAD Bill and have their ordinary meanings. However, coercion is defined in the dictionary of the VAD Bill and includes 'intimidation or a threat or promise, including by an improper use of a position of trust or influence'. Our view is that a genuine conversation about options at end of life or support provided to a family in a time of crisis, as contemplated by Mr Molhoek, would not be considered to be 'dishonestly' or 'by coercion' inducing a person to revoke a request to access VAD because: the person is not

attempting to persuade the person to take a particular course of action (i.e. leading them to access or to not access VAD); there is no intimidation, threat or promise; and there is no dishonesty.

- c) A hypothetical situation we do believe could be captured by s 141 is where a church pastor, during a discussion with a person who has made a first request for VAD, states that if they do not revoke their request they will be excommunicated from the church. This is because such a discussion involves a threat by a person in a position of trust and influence to take a particular course of action. This kind of situation is clearly distinguishable from the circumstances flagged by Mr Molhoek.
- d) One of the key principles reflected in s 5(c) of the VAD Bill is respect for an individual’s autonomy at end of life. The hypothetical situation described at 9.d is contrary to this principle, and we believe it is appropriate for these kinds of situations to be captured by the criminal offence provisions in the VAD Bill.

Committee evidence:

Inducing a person to revoke a request for voluntary assisted dying.

The most objectionable provision in the current Bill is a.141 where a person who by ‘coercion induces’ (each of which may be interpreted widely) another to revoke their decision to access VAD is guilty of an indictable offence punishable by up to seven years imprisonment. The penalty is identical for inducing a person to access VAD.

This means that a person (an aged care chaplain, or a social worker, or a member of the clergy or indeed a family member) who counsels a person who has applied for VAD that there are other options for them may be guilty of an indictable offence.

If the bill is passed in its current form, the following serves as a comparison for other indictable offences.

<i>Maximum Sentence</i>	<i>Offence</i>
<i>2 years imprisonment</i>	<i>Going armed to cause fear, threatening violence, indecent acts, negligent acts causing harm.</i>
<i>3 years imprisonment</i>	<i>Riot (simpliciter), fake declarations, observations, or recordings in breach of privacy, distributing intimate images or prohibited visual recordings, or threatening to do so, dangerous operation of a vehicle, common assault, deprivation of liberty, leaving a child under 12 unattended, possession of things used in connection with unlawful entry, forgery, uttering.</i>
<i>5 years imprisonment</i>	<i>Unlawful drink spiking, grooming children under 16, stealing, fraud, willful damage.</i>
<i>7 years imprisonment</i>	<i>Inducing a person to revoke a request for VAD (if legislated), Official corruption, attempting to pervert justice, procuring engagement of prostitution, carrying on business of providing unlawful prostitution, serious animal cruelty, choking, suffocation or strangulation in a domestic setting, wounding, assaults occasioning bodily harm, serious assaults, kidnapping, abduction of child under 16, cruelty to children under 16, unlawful use or possession of motor vehicles, aircraft, or vessels, receiving tainted property.</i>

There is no justification whatsoever in the May 2021 Queensland Law Reform Commission Report (A legal framework for voluntary assisted dying) for this provision other than general discussions on ‘voluntarily’ or ‘without coercion’ on page 145-146.

In effect the adoption of the Bill in its current form ensures the right of the individual to seek VAD and, alienated the rights and practices of aged care providers and health care providers who do not support the scheme or may support it for others but seek to conscientiously object to participate.

Unless amended it is reasonable to predict that Queenslanders will be convicted and punished under the provision up to and including periods of imprisonment.

-We recommend the exclusion of ‘revoke’ from s. 141 and retain the prohibition and subsequent penalty for inducing a person to request VAD.

There need to be safeguards to ensure that the scheme will always be voluntary. If medical practitioners are able to suggest VAD, it opens the door to subtle coercion by well-meaning practitioners not fully aware of palliative care options. When VAD is initiated by a patient, their medical practitioner should inform the patient of other treatments and palliative care options

Dr Chrys Pulle, Council Member. Australian & New Zealand Society for Geriatric Medicine. Brisbane Transcript Day 2. Page 30

D. FIRST NATIONS CULTURE

Section 5. Aboriginal & Torres Strait Islanders

(e) Access to voluntary assisted dying and other end of life choices should be available **regardless of where a person lives in Queensland;**

COMMENT: The bill fails to address cultural and other First Nations practices.
Committee evidence:

Need to engage more strongly with Aboriginal and Torres Strait Islander organisations and communities to ensure the legislation and implementation meets their needs and concerns.

Health Consumers QLD. Submission No 1355. Page 4 Health Consumers QLD

Broach community engagement is essential for the success of Voluntary Assisted Dying in Queensland. We are not clear about what engagement has been undertaken to date with Aboriginal and Torres Strait Islander communities. We recommend the need to engage strongly with First Nations organisations and communities to ensure this Bill meets their needs and concerns.

Health Consumers QLD. Submission No 1355. Page 11 Health Consumers QLD

As you all know, my religion and culture have been around for 60,000 years. Our people have a very strict lore. Voluntary assisted dying was dealt with very culturally appropriately. There was no fuss. There were people not saying no or yes, because we had a team of elders and traditional healers and what we call ngangkaris who always dealt with that. If twins were born—and I am talking as a midwife—if the weaker one was very sick then the weaker one was sent to the creator. In saying that, with the controversy around this bill, I have had a lot to do with Christianity and I know the Bible inside out as Christianity was introduced to my people under the colonial act. However, I do understand why Christians are saying that they do not want this, that it is God's will.

Townsville Transcript, Dr Gracelyn Smallwood OAM. Adjunct Professor, Division of Tropical Health and Medicine, James Cook University

Synod Concerns

Section 5 of the Bill contains the principles of voluntary assisted dying, specifically 5(h) states that a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected. There has been a lack of consideration for First Nations communities about the cultural appropriateness of voluntary assisted dying and the various processes detailed in the Bill. There is a need for consultation with First Nations communities to hear their perspective on voluntary assisted dying and to be informed about the cultural impact of the Bill.

The Uniting Church in Australia. Queensland SYNOD. Submission No 0244. Page 30

Recommendation 9 from The Uniting Church in Australia. Queensland Synod.

That a dedicated consultation with First Nations communities be undertaken to inform and develop culturally appropriate processes for voluntary assisted dying in the Bill. That the Principles outlined in section 5 of the Bill includes specific reference to considerations for First Nations peoples.

The Uniting Church in Australia. Queensland SYNOD. Submission No 0244. Page 30

Dying is communal not individual

We have lore. We have totems. We have the positive totem and then we have the negative one. Twenty-four hours before she passed away, she called us all to the bed and said, 'The death totem visited me last night and I don't want my spirit floating around my house. Could you take me to the hospital?'

Townsville Transcript, Dr Gracelyn Smallwood OAM. Adjunct Professor, Division of Tropical Health and Medicine, James Cook University.

Indigenous Advisory Board

We have to establish a state Indigenous advisory body on this topic because it is such a sensitive topic. Many of my people are born-again Christians. I even went to church yesterday and sang in church and spoke to them all and told them what I was doing tomorrow and they all laid hands on me, calling out to Jesus. That was not making a mockery, because my sister is the local pastor there. I spoke to Dr Rod Wall, I spoke to many Catholic priests and nuns—all people that I totally respect. But this death and dying—each and every one of us who look very healthy today, just picture yourself if you have cancer or MS or HIV or COVID, gasping for breath, and your beautiful children and grandchildren are sitting there holding your hand and watching you deteriorate and screaming in pain for help and going on for quite some time when they all know you as very active members not only in the family but in the community.

Ms KING: *As you have looked at the legislation you will have seen that we have the care navigator service that is an important part of the legislation. Would you like to see a First Nations voice included in that care navigator service to make sure it has that sensitivity?*

Dr Smallwood: *Absolutely—without a doubt, as I talked about the Indigenous advisory committee.*

I believe that we must have respected cultural advisers, not just in palliative care but right across the board. I believe it is happening but, yes, palliative care does need a lot more funding.

Townsville Transcript, Dr Gracelyn Smallwood OAM. Adjunct Professor, Division of Tropical Health and Medicine, James Cook University.

E. TELEHEALTH ACCESS

Section 5. Access

- e. **Access** to voluntary assisted dying and other end of life **choices** should be available **regardless of where a person lives in Queensland**; and

COMMENT: The Premier has already written to the Prime Minister seeking an exemption for VAD under Federal carriage laws. The advice is that there will be no change. Both Morrison and Albanese have indicated there is no appetite for change. The committee has adopted two recommendations seeking changes or clarification to the laws for the purpose of supporting tele-health services in regional and remote Queensland. In the absence of these changes there are significant concerns about equitable access to VAD. Telstra's Universal Service Obligation doesn't cover this.

Committee evidence:

The issue of telehealth again is one close to my heart. I have been providing telehealth services since 2013 across Queensland and in other states. We have to be able to use telehealth for this and we have to be able to do that confidently, without being concerned that we are going to be prosecuted under Commonwealth law. I am not common amongst my profession: I believe that my oath to do the best by my patients is more important than laws I may not agree with. Most of my colleagues would not subscribe to that. They are absolutely terrified of any sort of prosecution or legal redress, so the fact that the QLRC suggested that the Commonwealth DPP brings in

prosecutorial guidelines whilst they address the Criminal Code on the use of carriage services is really to be highly commended and needs to be addressed with urgency before implementation.

Heather McNamee, Queensland State Convenor Group, Doctors for Assisted Dying Choice. GP for 25 years in Cairns, Torres Strait and Cape York. VAD in relation to rural and remote patients. Page 14 transcript Townsville

Rob Molhoek: It is good to see you again, Professor. We had the pleasure of catching up at the hospital probably two months ago now. In this public forum I would like to congratulate you for your passion to **train and develop healthcare practitioners**, specialists and carers in the regions. We know how difficult it is to get good people here and how so many who do end up going to university want to drift into the big cities. I am looking forward to cutting the ribbon with you maybe one day when we open a Central Queensland University school of medicine and we no longer have to send doctors and other specialists to Brisbane for training. I want to ask a question about telehealth particularly. I take on board your comment that it is certainly a significant development. It is a huge step forward in that it does mean that people in isolated and remote areas can often get access to better medical advice, and often that would be lifesaving or very significant in terms of the impact that has in perhaps preventing a loss of life. In terms of providing that sort of service around end-of-life decisions, do you think **telehealth** is an adequate forum for people in isolated areas to have a conversation with a complete stranger, perhaps in a far-flung centre, about the sorts of choices and the process they would need to engage in if they wanted to take up the opportunity of voluntary assisted dying at end of life? Also, how does a practitioner on the other end assess where the person is really at in terms of their pain and their emotional state? Just broadly, how efficient can that be in that sort of setting?

Prof. Sandford: I think the question you ask is a complex one, and indeed that is a hallmark of the debate currently before us. We are living in a COVID era, one which has led to separations. Not only is there the geographic separation that we are currently experiencing but also the other separations. Telehealth and other vicarious mechanisms by which we come together and share are very much in our domain. I must say that at the end of the day I do feel as if I am a 'Zoombie'. There is not the same fidelity of interaction as there is when one gets together face to face with a gathering of people. Telehealth is an adjunct; it is not a replacement. It is a judgement or an assessment which varies, and it varies depending on the individuals. It depends on the culture and a variety of other things as to the adequacy or otherwise of that interaction.

SANDFORD, Prof. Alan AM, Director, Medical Academic Development, Central Queensland and Wide Bay Hospital and Health Service. Transcript Rockhampton p7-9.

I also would like to address telehealth. We introduced telehealth in Emerald when it was very new. Putting telehealth in place is a wonderful thing and it is a wonderful tool in many instances. However, you need to have on-ground support at the time in rural areas. When we put it in Emerald, it meant me having to get funding, write a business case, to get registered nurses who were trained in medical help to sit there with the patient and interpret what was happening in the telehealth scheme. It is not just a matter of picking up a phone; it is a matter of really good interpretation of the information that is given and the care that is given. Telehealth clinics are not things you can just pluck out of the air. You have to have good support, good funding, good training and nurses particularly who are able to interpret what is happening and support the patient and their family. Ms Rhyalla Webb. 53 years as a registered nurse. 25 years as director of nursing in rural, remote and regional facilities. Ministerial appointment to the Beattie government to the rural health advisory council.

Issue of clash of state VAD legislation with Commonwealth law on carriage services Telehealth consultations are now a commonplace in ordinary medical care. In a dispersed state such as Queensland, it will be extremely difficult or impossible for some patients and doctors to communicate face-to-face in the circumstances of VAD contemplated by the Bill. We endorse the positions taken by the QLRC in relation to the possibility that the Criminal Code Act 1995 (Cth) ss 474.29 (A) and (B) pertaining to "Offences relating to use of carriage service for suicide related material", may impede access of some of these patients and doctors to a lawful service.

Doctors for Assisted Dying Choice. Submission No 0720

While Telehealth will not always be necessary – or appropriate – for assessing VAD, it is clear from these examples (supported by testimonies from Victorian doctors) that its absence as an option is causing unnecessary suffering to people who have already suffered too much. In a state as geographically vast as Queensland, the problem presented by the Commonwealth Criminal Code (which was written before VAD was legal) will be even more acute. We support the view put forward by the QLRC that VAD is not suicide. And we support the use of Telehealth in assessing for VAD where appropriate. However, regardless of how these questions are addressed by Queensland's parliament it

is clear that only a change to the Code will provide guaranteed protection to medical practitioners who use a carriage service to discuss VAD.

Go Gentle Australia. Submission No 1189 page 20. Established by Andrew Denton in 2016 to improve the national conversation around dying and to work for the introduction of safe VAD laws.

Voluntary assisted dying and the legality of using a telephone or internet service: the impact of Commonwealth carriage service offences. It is reported in the Monash University Law Review.

Mr MOLHOEK: Professor White, it would be helpful to understand the carriage laws more broadly. Why do we have that legislation federally, and what other things does it cover? I cannot imagine there is a whole act that just talks about not using the phone to talk about suicide.

Prof. White: This was initially prompted by concerns about suicide promotion groups. The activities of Phillip Nitschke were also a trigger for the Commonwealth to include this in there. There are a range of other provisions dealt with as well. As far as voluntary assisted dying is concerned, that was the original impetus for it. That was passed at a time when voluntary assisted dying was unlawful throughout the country. That was the context in which it occurred.

Mr MOLHOEK: How long ago was that?

Prof. Willmott: The Criminal Code Act itself was enacted in 1995 and it is very big legislation. This amendment was made subsequent to the enactment. As Ben said, it was to target pro-suicide websites, internet chat rooms and online cyberbullying that may incite vulnerable people to suicide. It has been some time since I looked at that legislation, but when I did I noticed that these particular provisions, sections 474.29A and 474.29B, which were passed in 2005, are nestled in between other provisions. My recollection is that one relates to child pornography, so it clearly was not designed to make actions under a voluntary assisted dying regime unlawful.

Professor Lindy Willmott. Australian Centre for Health law Research, Faculty of Business and Law, QUT. Brisbane Day 2 Transcript. Page 4.

Ms PEASE: Thank you both for appearing today. I really appreciate your submissions and your wise words. We have discussed and we are aware of the issue around the carriage service. Professor Bonython, you have talked about your experiences in the territories not even being able to discuss such matters. Can you offer some suggestions around any other potential ways we might be able to overcome this?

Prof. Bonython: I think this is the intractable problem that arises, particularly in the context of Queensland. To me, the practical solution is to view VAD as part of a spectrum of end-of-life care. I note that accompanying this bill there is an announcement for increased funding to support palliative care services. To my mind, VAD should be one of those—not the favoured, not the only, not an alternative. It should be part of a broader suite of end-of-life care provided to practitioners.

I note that historically there have been issues with people accessing palliative care in remote and regional areas in Queensland that are in fact a model of the sorts of access issues that are envisaged with this bill. **I think the telecommunications issue may prove to be insurmountable**, based on observations with the attempts to revoke the Andrews bill previously. I suspect perhaps what needs to happen is planning for a whole of end-of-life outreach program to operate in those areas. One advantage of this bill is that it does open up that opportunity outwards to 12 months, which at least means you have a little bit more time for things like outreach programs to travel to some of those remote and rural areas. It will not solve all of the problems, but at least it gives something to provide some degree of access to Queenslanders who are not located in inner metropolitan areas in the time that it is likely to take to get the necessary Commonwealth amendments through.

Associate Professor Wendy Bonython, Faculty of Law, Bond University. Brisbane Transcript Day 2. Page 12.

We repeat our earlier calls for the Commonwealth Government to amend the Commonwealth Criminal Code prohibition relating to 'suicide' and a carriage service. Our views on how the Code could be very simply amended to avoiding the risk of criminalising otherwise lawful activity authorised under state VAD legislation are set out in this

article: Katrine Del Villar, Eliana Close, Rachel Hews, Lindy Willmott, Ben White, 'Voluntary assisted dying and the legality of using a telephone or internet service: The impact of Commonwealth "Carriage Service" offences' (2021) Monash University Law Review (forthcoming). We recognise this is not a matter that the state of Queensland can resolve as this is Commonwealth law but urge continued advocacy from the state government during the implementation period.

Professor Lindy Willmott, Professor ben White, Australian centre for Health Law. Submission No 0906. Page 15.

Equity of Access

If we cannot use telehealth for VAD, anyone north of Cairns is not going to be able to access it. A lot of the communities do not even have a doctor; they have a fly-in flying doctor service. You are not going to get two doctors who have the time to travel up there to the cape. I do not know if any of you have been to Thursday Island, but it is a whole day journey just to get there. It is really essential for this to be equitable across metropolitan and rural areas that the telehealth issue is cleared up.

Heather McNamee, Queensland State Convenor Group, Doctors for Assisted Dying Choice. GP for 25 years in Cairns, Torres Strait and Cape York. VAD in relation to rural and remote patients. Page 14 transcript Townsville

Our primary concern with the VAD legislation as proposed is that the core principles of voluntary assisted dying in clause 5 are not being met. We see the core principles as the foundation for the whole legislation. I will quote the clauses. Clause 5(d) states —

... every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life—

The second clause that we believe is not being met is 5(e), which states —

... access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland

That particularly applies to regional, rural and remote areas. As this health committee has previously acknowledged, access to high-quality palliative care and end-of-life choices is not currently available to all people living throughout Queensland, and here in CQ it is no different. This includes access to hospice care, which is inequitably distributed throughout Queensland, with all hospices currently located in the south-east corner. Mr Mark Thompson, Board member, Fitzroy Community Hospice – a not-for-profit charitable organization committed to establishing CQ's first hospice. Fitzroy Community Hospice will operate a 12 bed hospice near the Rockhampton Base Hospital and by providing dedicated in-home palliative care.

Page 1 of Rockhampton transcript.

F. ELIGIBILITY

10. Eligibility

- (1) A person is eligible for access to voluntary assisted dying if—
- (a) the person has been diagnosed with a disease, illness or medical condition that—
 - (i) is advanced, progressive and will cause death; and
 - (ii) is expected to cause death within 12 months; and
 - (iii) is causing suffering that the person considers to be intolerable; and
 - (b) the person has decision-making capacity in relation to voluntary assisted dying; and
 - (c) the person is acting voluntarily and without coercion; and
 - (d) the person is at least 18 years of age; and
 - (e) the person is an Australian citizen; or permanent resident of Australia; or
 - (f) the person has been ordinarily resident in Queensland for at least 12 months

COMMENT: Many groups expressed concern about eligibility criteria, some suggesting it was not broad enough and other suggested it be more restricted both in terms of access and timeframes. The AMAQ suggested adding the word “incurable” while ACL have suggested access to VAD should not be available if a person has not be first provided access to palliative care and other treatments.

REQUESTED AMENDMENT: AMAQ Submission

Recommendation 1 The word “incurable” be added to the eligibility criteria for patients wishing to access the proposed VAD scheme.

REQUESTED AMENDMENT: Australian Christian Lobby (ACL) Submission 1054

Recommendation 10 the criteria should be amended so that a person is ineligible for access to VAD if that person has not first been informed and tried palliative care or other medical treatments intended to relieve pain or distress.

Committee evidence:

The eligibility criteria should be amended so that a person is ineligible for access to voluntary assisted dying if the person has not first been informed and tried palliative care, or other medical treatments intended to relieve pain and distress.

If a person receives care focussed on symptom relief, the prevention of suffering and an improvement of quality of life, they may no longer have any desire to seek access to voluntary assisted dying. The ACL notes that the AMA’s position that doctors have a responsibility to initiate and provide good quality end of life care.

The eligibility criteria should be further amended so that a person is ineligible for access to voluntary assisted dying unless the person has, within the month before a first request is made, had a mental health assessment by a psychologist, ensuring that the person is not suffering from any undiagnosed mental illness or distress affecting their ability to request voluntary assisted dying.

Virtually all people facing death or battling irreversible, debilitating disease suffer depression at some point. Overseas experience shows that requests for assisted dying are revoked if a person’s depression and pain are satisfactorily treated.

Australian Christian Lobby. Submission No 1054. Page 5/6.

Choice

I make the point that today, currently, end-of-life decisions are being made by doctors and patients in a whole lot of different contexts, including withholding and withdrawing life sustaining treatment, provision of palliative medication which can hasten death and decisions about palliative sedation. These decisions are being made. We trust our doctors to be able to recognise (a) does a person have decision-making capacity around these decisions and (b) are they being coerced? Currently we trust doctors with those decisions.

I realise that this a different kind of medical decision. I would point to the very heavy regulation and the safeguards in the legislation which surround this kind of practice and are not there for other end-of-life decisions. I think we can take some comfort in the very regulated nature of voluntary assisted dying. I would also add that there is mandatory training under this legislation which specifically flags issues around capacity assessment and flags for coercion.

Professor Lindy Wilmott. Australian Centre for Health law Research, Faculty of Business and Law, QUT. Brisbane Day 2 Transcript. Page 6

Mental Health Assessment

There is no apparent requirement in the legislation for those requesting assisted death to be assessed by a mental health expert like a psychiatrist or psychologist. As data from other jurisdictions has demonstrated, mental pain, anguish and depression can be prominent drivers for requests for VAD. Published data shows that requests for VAD may be withdrawn once depression is treated.

There is no requirement for a person requesting VAD to be seen by a specialist in the area of the patient's suffering, e.g. an oncologist for cancer patients. Neither is there a requirement for a patient to be seen by a palliative care specialist. Thus, the patient may not be aware of the specifics of other options for their ongoing treatment.

Queensland Baptists, Submission No. 1044. Page 1

Health Directives

The Council notes that the Bill fails to address its position on advance health directives under the Powers of Attorney Act 1998 (Qld).²² The Council's position is that a person who made the decision to access VAD services prior to their loss of capacity should be eligible to access VAD. This position is supported by the common law as stated by Lord Donaldson MR in Re T:

"An adult who... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered... The right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."²³ - Re T [1992] 4 All ER 649 at 652-3 (per Lord Donaldson MR)

Queensland Council of Civil Liberties. Submission No. 1004. Page 4.

Permit patients who have in their Advanced Health Directive a request to access the proposed VAD scheme but subsequently loses their capacity, for their wishes to be followed.

The draft Voluntary Assisted Dying Bill 2021 indicates that patients wishing to access the scheme should have capacity at all times. AMA Queensland believes that if a patient who is in the process of accessing VAD, has an advanced health directive and subsequently loses capacity, their wishes in their advance health directive should be followed. The purpose of having an advance health directive is for the patient to maintain their autonomy once they lose their capacity, and this should apply to accessing VAD. AMA Queensland's position on this issue is also justified by the Powers of Attorney Act 1998 (Qld) (see chapter 3, part 3), which governs advanced health directives in Queensland. Importantly, an advance health directive can only be revoked while the patient has capacity to do so (section 48(2)). This is why it is encouraged that reviewing advance health directives should occur every 2 years AMA Queensland. Submission No. 0260. Page 2

Psychiatrists and Mental Capacity

The first point I want to address is concerns about capacity and the voluntariness of the assessment process. Capacity is a critical consideration in the application for VAD. It is not just thought content and processes but also the effects of emotional factors on capacity. Assessing capacity to consent, make treatment decisions, withdraw from treatment and voluntariness is not always easy. Sometimes it is very difficult. Psychiatrists find it challenging and it is often our bread and butter. I work in the field of liaison psychiatry in the medical and surgical settings. Old age psychiatrists also often do these assessments. We are often asked to provide second opinions when the treating specialist teams struggle to really know. The flowchart with capacity criteria in the 30-minute online training modules for the VAD process and the consent rituals do not adequately predict understanding. Medicine not a tick-the-box process. The best learning is years of experience, which is what we and old age psychiatrists have in these kinds of assessments. **Assessing capacity for these VAD decisions can be a lot more nuanced than is able to be applied in a tick-the-box 30-minute online assessment.**

With respect to voluntariness, **none of us make decisions that are free from influence. It can be very hard to know where influence ends and undue influence starts.** People who are very ill are prone to undue influence. The negative effect of profoundly devalued lives, an ageist and ableist society, consumerism, the risk of unconscious economic motives, and children who want to inherit now can cause undue influence. Our view of the individual now is so individualised and so focused on the notion of autonomy, but our decisions about ourselves are made in the context of relationships. We have become autonomous in the context of friends, family, culture and society. There is some anecdotal evidence from Victoria that there is coercion from family for people who are asking for VAD. Voluntariness is not a tick-the-box exercise. Choice may appear voluntary but it may be made on the basis of coercion. There are a variety of ways, implicitly and explicitly, that coercion can impact on a patient's request
Dr Kym Boon, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists. Brisbane Transcript day 2. Page 31.

My third point is that somewhere in the legislation there should be a role for psychiatrists or an acknowledgment of the role of psychiatrists—not mandated—but it should be recognised that mental health is a core factor in end-of-life care and a request for voluntary assisted dying. Mental health should be funded in health services for this practice. The motivation to access VAD reflects multidimensional distress. There are many pathways to unbearable suffering, including: depression, demoralisation, communication problems within treating teams, within families, families are stressed, loneliness and the dire meanings of symptoms that patients do not understand. Patients may want to re-establish a sense of control and request VAD for symptoms that may mean something dire to them but may not mean end of life, which means there is a risk that people request VAD in error.

Depression and demoralisation are underdiagnosed, particularly in the older age and palliative care communities. There are established links between depression and euthanasia. There are established links between depression and suicidality. Depression and demoralisation affect people's competency and the relative weighting patients give to positive and negative aspects of their situation, so that can drive someone's request for voluntary assisted dying when they have a treatable condition. For depressed patients, the request for death may be part of their illness, the correct response being treatment rather than assistance in dying. Psychiatrists have a unique ability to explore the reason for the VAD request and possibly do something about it such that the VAD request goes away and the patient does not really want it.
Dr Kym Boon, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists. Brisbane Transcript day 2. Page 31

Committee evidence:

The Bill limits eligibility to people diagnosed with a medical condition that:

1. Is expected to cause death within 12 months and
2. Is causing what the persons considers to be intolerable suffering.

We would prefer to have a wider range of people eligible to take advantage of the scheme:

1. First, the bill limits the right to only individuals who are expected to die within 12 months. In our view, the right should be extended to people who are experiencing unbearable pain and suffering, with no prospect of improvement. There are many illnesses which cause terrible suffering, but are not terminal nor will cause death.

2. Secondly, the right should be extended to individuals suffering from mental illnesses or psychiatric conditions. There are many individuals suffering from psychiatric conditions who have the same capacity as those who are not suffering from such conditions. Instead, a distinction should exist between the persons who, notwithstanding their psychiatric condition, are able to make informed decisions and have capacity, and, persons who do not have capacity as a consequence of the nature of their psychiatric illness.

3. Thirdly, the right should be extended to minors under the age of 18 who are Gillick competent. Minors who have sufficient understanding and intelligence to understand fully the consequences of VAD should not be denied the right to access it. Although it has been argued that care is required not to equate the capacity to consent and the capacity to withhold life-saving treatment, such an argument fails to respect the personal autonomy of individuals who have capacity to make their own medical decisions.

However, we do not press these issues here, preferring to see this Bill pass as an important first step in the process. We will instead concentrate on aspects of the Bill, which in our view need amendment.

Queensland Council for Civil Liberties. Submission No. 1004. Page 2

There are however, some parts of the draft Voluntary Assisted Dying Bill 2021 which we recommend the Health and Environment Committee consider in their deliberations on the draft Bill.

Add the words incurable to the eligibility criteria for patients wishing to access the proposed VAD scheme.

In the eligibility section the draft bill indicates; “the person must have been diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death.”

*AMA Queensland recommends this section of the Bill change to “the person must have been diagnosed with a disease, illness or medical condition that is incurable, advanced, progressive, and will cause death.”
AMA Queensland. Submission No. 0260. Page 1.*

PART 3: Requesting access to voluntary assisted dying and assessment of eligibility

G. Requests – first, second & final [Part 3, Division 1, 2, 3, 4, 5]

COMMENT: How can doctors provide professional advice and competency without full access to medical history and records. If someone wants to commit suicide society assumes there’s something wrong BUT a when someone wants to kill them-self we assume their capacity to make an informed decision is not impaired. The only person qualified to assess capacity is a Psychiatrist. A Psychiatrist should be required to tick off on this, that’s the safety net.

On valid informed consent (which is an absolute legal and medical requirement)

REQUESTED AMENDMENT: Dr David Van Gend

On valid informed consent (which is an absolute legal and medical requirement)

Informed consent is not valid unless the subject is legally competent and in possession of the relevant information. Valid informed consent in this Bill requires amendments to ensure the patient is assessed: by a *psychiatrist* (to properly assess legal / mental competence) or by a *palliative specialist* (to ensure informed decision making re the possibilities of relief of suffering)

Without specialist psychiatric assessment, there can be no confidence in the Explanatory Notes’ objective (p.5) “to ensure a person has decision-making capacity”.

Such capacity may be profoundly affected by depression, dissociative states or any of the subtle and profound mental aberrations that so often occur under the pressure of major physical illness, powerful medications (with the attendant side effects on mood and cognition), and the emotional / existential turmoil of a terminal diagnosis. Specialist assessment is vital if valid consent is to be given by such patients.

Without assessment by a specialist in palliative care, there can be no confidence that the patient possesses sufficient information to counter the fear of unrelieved suffering that might be driving the request for VAD.

To allow euthanasia / assisted suicide to proceed without the priceless input of a palliative specialist is a trivial, negligent response. It makes a mockery of the stated objective in the Explanatory Notes: "to ensure a person makes choices that are informed about other end of life options, such as palliative care".

At present, the Bill allows for any medical graduate of a mere five years' experience (like some of the trainee GPs in my practice) to tick the boxes for legal capacity and full possession of relevant information - even though I can vouch for the fact that the fifth year graduates in our practice lack the required expertise in psychiatry and palliative care.

Such a cavalier approach to legal capacity and informed consent is legally unsafe and medically negligent. It means people will be wrongfully put to death when their legal capacity and level of relevant information was inadequate.

REQUESTED AMENDMENT: Dr Van Gen DIVISION 2 First assessment

Proposed wording: DELETE (1) to (4) and REPLACE with (1) to (4):

Section 21 Referral for determination

(1) The coordinating practitioner must arrange consultation, in person or by telecommunication, with a registered psychiatrist to determine whether the person has a disorder of mood or cognition that would invalidate consent to VAD.

(2) The coordinating practitioner must arrange consultation, in person or by telecommunication, with a registered specialist in palliative medicine to ensure the person is adequately informed of the capacity of palliative care to relieve symptoms in terminal illness.

(3) The coordinating practitioner must arrange consultation, in person or by telecommunication, with a Legal Aid Queensland lawyer with the Seniors Legal and Support Service (SLASS) to determine whether the person is subject to pressure from interested parties or any other form of coercion that would invalidate consent to VAD.

(4) The coordinating practitioner must adopt the determination of the referee under subsection (1) (2) and (3) in relation to the matter in respect of which the referral was made.

(5) The referee must not be—

PART 4: Accessing voluntary assisted dying and death

H. TIMING and ADMINISTRATION OF the SUBSTANCE

Division 1 Administration of voluntary assisted dying substance

COMMENT: There are significant safeguards in place in respect administration of voluntary assisted dying substance covered by Section 49 but no cooling off period as determined by other jurisdictions. A person may self-administer or request practitioner administration of the substance by an approved VAD health practitioner. Concerns have also been raised about what course of action a health practitioner should take were the substance not work, the training of practitioners and the oral or intravenous options for administration.

REQUESTED AMENDMENT: Australian Christian Lobby (ACL) Submission 1054

This division should be amended to include a mandatory cooling off period of 14 days before a person may self administer, or have administered a voluntary assisted dying substance. This would be consistent with the law in Victoria and overseas jurisdictions.

Committee evidence:

VAD Substance

Dr ROBINSON: How does palliative care relieve extreme or intolerable pain compared to VAD treatment? The legislation is supposed to be about relief of suffering of those with a terminal condition who are also in intolerable pain. How do both treatment regimes achieve that?

Dr McEnery: I am not sure how many of you are familiar with how VAD is actually administered. There are two options that are offered to people who are seeking assistance in their dying. The first is an oral—they call them ‘medication’, but they are not; they are drugs. They are substances that are provided to the person or to their delegated agent. It consists of three substances. One is a relaxant; one is an antiemetic, which stops you from being sick; and the third is basically a sedative. There is no pain relief currently in Victoria’s system. The major substance has an action of diminishing your awareness and your nervous system until you stop breathing and functioning at all. In other countries, there are alternative medications.

The second option is for a doctor—they also allow nurse practitioners—to administer intravenously. That is actually as a push. Sometimes that is given as a sedative and then somebody is given a relaxant. By the way, this is supposed to be secret, but it is on the internet if anybody is interested—how to commit suicide and how it is done as euthanasia.

Dr Judith McEnery. Queensland Representative. Health Professionals Say No. Brisbane day 1 transcript. Page 50

Part 4 – Division 1 – Administration of voluntary assisted dying substance

This Division should be amended to include a mandatory cooling-off period of 14 days before a person may self-administer, or have administered, a voluntary assisted dying substance. This is consistent with the law in Victoria and overseas (the law in Oregon, USA requires a 15 day coolingoff period, with limited exceptions, and Canadian legislation provides for a 10 day cooling-off period).

Australian Christian Lobby. Submission No 1054. Page 9

What if the medication does not work

We join with the Uniting Church of Australia in saying there is a significant risk to there not being a medical practitioner or a witness for self-administration in the event that the medication does not work. The bill is wholly silent on the question of the medication not working. There are instances in capital punishment, say in the United States, where the administration of medications is not successful. Of course, I do not know what a medical practitioner would do in the event that the medication does not work. Do they revive the person in order for that to be attempted again? What other actions would the law prescribe or, even more importantly, what other actions would the law prohibit in the event that the medication does not work?
Nick Ryan, CEO Lutheran Church. Brisbane Day 1 transcript. Page 28.

Part 5 Eligibility requirements of health practitioners

I. Eligibility requirements for health practitioners [Part 5, Division 4, Section 82]

COMMENT: Concern has been raised about the potential for doctors to lose sensitivity should they chose to make a career of being a VAD specialists.

REQUESTED AMENDMENT: Cherish Life

AMENDMENT 7 CAPPING THE NUMBER OF PATIENTS, A DOCTOR CAN APPROVE OR SECOND FOR ‘VAD’. That no one medical doctor can be the co-ordinating doctor or the second approving doctor for more than five (5) patients accessing euthanasia or assisted suicide in any 12 month period. This will mean no one doctor can make their primary occupation managing or seconding assisted suicide or euthanasia cases, as it should never be the primary intention of a doctor to take the life of their

patient. There is also the added risk that if a doctor routinely manages and / or approves euthanasia and assisted suicides there is a loss of sensitivity to the fact they are helping to kill someone.

Training

Minimum training

If the Government can justify why these options are not possible, then the training undertaken by medical practitioners is critical. Under the Bill, coordinating practitioners and consulting practitioners must also meet any additional requirements approved for this purpose by the chief executive of the Department (the 'approved medical practitioner requirements'). The medical practitioner requirements must be made publicly available on the Department's website.

Given these issues, at a minimum, we suggest the Minister must confirm that all relevant practitioners will be required to undertake specialist training in palliative care and assessing capacity. As clause 31 does not appear to include a direct sanction (eg it is not a penalty provision) the QHRC suggests consideration be given to requiring a practitioner to formally declare they meet the training requirements approved by the Chief Executive. Queensland Human Rights Commission. Submission No. 1314. Page 17. Independent statutory body established under the Queensland Anti-Discrimination Act 1991. Handles complaints and training on discrimination, vilification, victimization and sexual harassment in accordance with the act.

Mr MOLHOEK: *Kristin, thank you so much for coming online and sharing your experience with us. I wanted to ask some questions about the actual training. You said it is basically a one-day course. Can you tell us a little bit about what that training covers and how you participate in that training?*

Dr Cornell: *We all thrashed it out in an hour. I did one of the mobile roadshows that they started. I am not sure whether they have been able to do any more with COVID-19 up and down in the last few months. There were about 15 of us. We did the first three modules at home and then we all met up. We would do a module at a time, with the VAD coordinators floating around the room and doing brief talks at the beginning and end. Then we could all discuss any little questions we had around things. There was a lot of ethics covered. There were a lot of specifics around persuasion; exactly who qualifies and the criteria around that; how to recognise when people might be being pressured by family; and who needs second opinions and who does not. Doing it with colleagues was fantastic because we could turn to each other and say, 'What about this specific instance?' As we had the VAD coordinators with us in the room and also one of the leaders from Geelong hospital who was involved in the legislation, it was a great network. We had speakers come in. We had pharmacists come in for a talk on this from their perspective. We had the guys from VAD who do the final sign-off come in and talk to us around little problems they have on the website—things like, 'This is the most common thing that people stuff up or do not put in or it bounces back. If you do this, it does not.' It was a fantastic day. I say day, but I do not know whether you could do it in less than five or six hours. There is a quiz at the end. I thought it was a great way to do it. There was a lot of support in and around the day and how it is done.*

Dr Kristin Cornell, advocate for VAD. Her father had MND. Brisbane Day 2 Transcript. Page 25

Nurse Practitioners

We cannot restrict health professionals involved in this to doctors. As you all know, there is a chronic shortage of doctors in rural areas, and our nursing colleagues carry a lot of the responsibility that in other countries would be carried by doctors. To limit it to nurse practitioners would be equally restricting because there are a minimum of nurse practitioners present again in remote areas, so it is very important that the legislation also says that registered nurses can take part in this process.

Heather McNamee, Queensland State Convenor Group, Doctors for Assisted Dying Choice. GP for 25 years in Cairns, Torres Strait and Cape York. VAD in relation to rural and remote patients. Page 14 transcript Townsville

We support this inquiry and the open and evidence based discussion around voluntary assisted dying; however, ACN suggests some key changes to strengthen the Queensland VAD Bill. Without discussing and addressing our concerns, we fear there may be **unintended consequences. We believe that nurses, including nurse practitioners,**

are uniquely placed to provide trusted, compassionate and professionally competent care to patients making end-of-life decisions, noting that we are bound by the Nursing and Midwifery Board of Australia's professional standards, code of ethics and code of conduct. We strongly advocate for nurse practitioners, advanced practice registered nurses and clinical nurse consultants to act as a coordinating or consulting practitioner and assess eligibility requirements. Effectively and economically utilising these valuable members of our nursing and health workforce is important to CAN, as detailed in our white paper *A new horizon for health services: optimising advanced practice nursing*. **This utilisation of this workforce is especially beneficial in rural and remote areas, which often have a shortfall in health practitioners. It is the nurse who is almost always readily accessible and available to the patient and who almost always knows their patient best of all, having spent the most time with them.**

The eligibility requirements and conditions as set out in the Queensland bill to access the VAD program are appropriate. Our concerns include that the role of nurse practitioners, advanced practice nurses and clinical nurse consultants in administering or assisting in the voluntary assisted dying process is largely overlooked. This bill would put barriers in place for those under nurse practitioner led palliative care, and issues regarding inequities across VAD in rural and remote areas of Queensland would occur. The bill inhibits both the therapeutic and the medical role a nurse provides to a patient and, as a consequence, a patient may not receive all the necessary knowledge and options in order to consider the right of choice for them.

Adjunct Professor Kylie Ward, FACN, Chief Executive Officer, Australian College of Nursing (via videoconference). Brisbane Transcript. Day 2. Page 54.

As a nurse practitioner I am a highly qualified nurse. I have undertaken enormous amounts of study. I work collaboratively, autonomously and independently in my role. I am a well-considered practitioner in the work that I do. When I was reading through this legislation I suppose I just sat back with my own discomfort at really being overlooked as a qualified and passionate healthcare provider who could assist and work collaboratively with my medical colleagues in the assessment process for people who wish to determine eligibility for this voluntary assisted dying legislation. I hope nursing is not overlooked. I really passionately ask you to consider. There must be certain qualifications that a nurse reaches, but certainly I have been working as a nurse for 27 years. Even in my role in palliative care I must determine somebody's capacity, on a daily basis, whether they have that ability to move forward. In palliative care I liaise with psychiatrists on a regular basis because the journey towards dying is never easy. People do not fear death, in my experience; they fear living and they fear suffering. We are all part of this journey together as health professionals. I rely heavily on my colleagues and they respect me. I provide for them insight into the journey and it is one that you can only anticipate and understand having done this work every single day. I ask you to consider the role of the nurse. I am a highly qualified healthcare professional who could undertake assessment in this role.

I would like to see some respect for the advanced practice role in nursing and to be encouraged to join and collaborate with our medical colleagues in this. We must be together if this is going to be successful. *Ms Faye Tomlin. Nurse practitioner specializing in palliative care. Has been witness to over 500 deaths. Rockhampton Transcript p 31.*

Health Practitioner

Clause 82 – Eligibility to act as coordinating practitioner or consulting practitioner

As mentioned above (see our comments on clause 21), a person is able to act as coordinating practitioner or consulting practitioner without sufficient experience and without any expertise in the disease, illness or medical condition suffered by the person. This is unacceptable. Clause 82 should be amended to require: 1. a coordinating practitioner to have at least 10 years' clinical experience; and 2. a coordinating practitioner to have an existing doctor/patient relationship with the person, unless the practitioner has a conscientious objection; and 3. a consulting practitioner to have at least 10 years' clinical experience in the disease, illness or medical condition suffered by the person. Further, if an overseas-trained specialist, the practitioner should not be eligible to act as a coordinating or consulting practitioner if the practitioner only holds provisional registration. *Australian Christian Lobby. Submission No 1054. Page 10.*

Speech Pathologists

Speech pathologists are university trained allied health professionals with expertise in communication and swallowing, both of which are very often compromised toward the end of life. For example, the majority of people with motor neurone disease will experience a communication impairment and a swallowing disorder. As such, speech pathologists are essential and will be essential for many people who wish to access voluntary assisted dying, to assist them to communicate their wishes accurately and effectively in making that informed choice. The speech pathologist may assist the medical practitioner to help the individual with communication strategies. This may be during the determination of decision-making capacity and also during the necessary VAD conversations. The speech pathologist may also assess swallowing to determine if the person is able to ingest the medication orally for self-administration.

Speech Pathology Australia provides the only professional self-regulation of speech pathologists nationally to assure safety and quality in the provision of services. A Speech Pathology Australia member, or a non-member, who provides evidence of recency of practice and continued professional development may meet the requirements. This would be worded as ‘a speech pathologist is a person who holds the credential Certified Practising Speech Pathologist, CPSP, under the professional self-regulation framework of the Speech Pathology Association of Australia’. I would be happy to provide further details regarding those requirements if you wish.

Ms Nicola Gearon, Adult/Aged Care Project Officer, Speech Pathology Australia. Brisbane day 2 Transcript. Page 66. Rural Speech pathologist who works closely with the demographic who may wish to access VAD, including those with neurodegenerative disease and those with cancer on the palliative care program.

Mandatory Support and Debriefing of Medical Practitioners

I also advocate strongly for mandatory psychological debriefing for any health professional who participates in this type of work.

I think it is really important and I advocate—whether it is a doctor doing this work or a nurse—that we must have mandatory debriefing, otherwise we all become a little bit too desensitised to the experience of dying. Ms Faye Tomlin. Nurse practitioner specializing in palliative care. Has been witness to over 500 deaths. Rockhampton Transcript p 32.

Part 6 Participation

Division 1 Conscientious objection and Duty to Inform

J. Conscientious objection – health practitioner [Part 6, Division 1, Section 84]

COMMENT: MP’s have a conscience vote on legislation. Health Care Practitioner’s may exercise conscience. But obliged to provide information about services & providers. Also in respect of the duty of doctors to inform at Section 84 there is a contradictory obligation and conflict between Clauses 1a and 1b.

- Clause 1a says you have a right to refuse and therefore do not have to provide information
- Clause 2b says you must give a seeking person information

REQUESTED AMENDMENT: AMAQ

On conscientious liberty (which is a fundamental human right, unlike the so-called ‘right to die’)

AMAQ Recommendation 2: Genuine freedom of conscience for individual doctors and nurses: we must not be compelled to collaborate in any way with an act (intentional killing) that we consider the gravest possible violation of medical ethics and moral principle. To this end:

- Delete 84 (2) (b)

- Keep 84 (2) (a) where a conscientiously objecting doctor “informs the person that other health practitioners, health service providers or services may be able to assist the person”.

The statement of fact contained in **84 (2) (a)** is ethically neutral: it does not usher the patient along the path towards the act of intentional killing or assisted suicide. By contrast, **84 (2) (b)** does usher a patient along that path and should be removed from the Bill.

No doctor who considers intentional killing and assisted suicide to be gravely wrong should be compelled by law to oil the cogs of mercy killing, compelled to “give the person information about a health practitioner or service (including name and contact details) who, in the practitioner’s belief, is likely to be able” to commit that gravely wrong act. We would, of course, ensure the patient is in possession of all their relevant health information should they choose to move away from our care, but we will not refer them to somebody who we know will kill them.

AMAQ submission recommendation 2

Recommend the section of the bill that deals with conscientious objection be amended to include organisational conscientious objection as they believe some health care facilities which provide care may have a distinctive mission or ethos.

Committee Evidence:

Archbishop Fisher, the Catholic Archbishop of Sydney, in a statement last Friday, 9 July, reminds us that the Catholic Church is the oldest and largest provider of health and aged care in the world. He reminds us that the Catholic Church has long operated to uphold the dignity of the elderly and the dying and compassionately to relieve their suffering, never entertaining killing them or collaborating in bringing about their early death. He is urging that in any legislation there should be clear guarantees that no institution, no professional, no sick person and no family member would be required to participate in or refer for euthanasia. This is a view that I strongly support and recommend to this committee for inclusion in any proposed legislation

Death is not the intended side effect of giving medication to relieve symptoms. If the sense is that the possible side effect of that medication does shorten life, it is still acceptable to give the medication to give that person relief. Father Dr Rod Ward, Medical practitioner and Catholic priest. Page 28 transcript Townsville

I would like to address conscientious objection. I have been so fortunate in my life to be in the profession I was in. Invariably it is a nurse who, with the mother, first hears the fetal heartbeat and rejoices. Invariably it is a nurse who feels the last pulse beat and grieves with the family. Throughout our nursing career, we are always faced with complex issues—complex things that could go against our own consciences. Yes, within the bill people can conscientiously object, but it is not that simple. The impost upon a nurse or any health professional in a team who has a conscientious objection to what is occurring in a unit they are working on makes their life very difficult, because the thing that binds a healthcare team together is that common goal. The common goal has always been alleviation of suffering and support of life. To see that, you only have to work in an emergency department. To see that, you only have to be out as the sole practitioner in a place like Boulia, where you and the QAS paramedic are the two working as a team. Understand very clearly: conscientious objection for a healthcare professional is not done in a bubble. It is not done in isolation. This bill—for or against it—I do not think has been fully considered in relation to the impost upon healthcare professionals.

Ms Rhyalla Webb. 53 years as a registered nurse. 25 years as director of nursing in rural, remote and regional facilities. Ministerial appointment to the Beattie government to the rural health advisory council.

Ms Garner: *I do not think you would have conscientious objection through an entity that an entity would put in place, but most certainly if people employed within the organisation conscientiously object then the organisation would put things in place. Again, going back to the termination of pregnancy, it was very clear from the start who were conscientious objectors and so systems were put in place. Telemedicine is an extremely beneficial and viable method of being able to bring the south-east corner to rural and remote areas. There are ways to work within this and still stay within the regulatory space. GARNER, Ms Michelle Garner, Chair, Queensland Board of the Nursing and Midwifery Board of Australia; Executive Director of Nursing and Midwifery Services, North West Hospital and Health Service, Australian Health Practitioner Regulation Agency. Brisbane transcript. Day 3. Page 4*

Conscientious objection by individuals

DWDQ strongly supports the right of individuals to conscientiously object to Voluntary Assisted Dying. DWDQ therefore supports the proposed legislation as drafted regarding registered health practitioners' and speech pathologists' right to conscientious objection.

Institutional conscientious objection

DWDQ finds the thrust of the proposed legislation does meet the needs of those persons wanting to access Voluntary Assisted Dying in institutions. DWDQ accepts the even-handedness of the accommodations made to the perceived rights and interests of entities against the rights of the individual. The proposed legislation's detail to the balance of competing rights and interests of individuals and entities, depending on the person's permanent residency status in a facility and the different rules for the different stages of the Voluntary Assisted Dying process, is particularly helpful in giving clarity to those accessing Voluntary Assisted Dying and those delivering Voluntary Assisted Dying. DWDQ urges Members of Parliament to embrace the careful and considered balance of individual rights and entity rights in the proposed legislation and to strongly resist any calls to amend it. Any watering down of this aspect of the legislation would have inevitable consequences in the practical application and access to Voluntary Assisted Dying. Some possible consequences are; persons not being able to access Voluntary Assisted Dying just because their home happens to be in a care facility; transfer to another facility results in increased pain and suffering; increased medication to allow a transfer to another facility results in loss of decision-making capacity; transfer to another facility results in undue delay in accessing Voluntary Assisted Dying resulting in prolonged suffering; lack of suitable facility to which to transfer a person, stops that person accessing Voluntary Assisted Dying. Dying with Dignity Queensland Inc. Submission No 0278 p6

From the point of view of medical leaders, I would like to stress that we do not believe there should be any legislation or compulsion by law that a doctor be required to participate in voluntary assisted dying. This is a matter of choice. It is a matter of choice for the community and those within the community, but it also is a matter of choice for the doctors who may be involved and/or implicated one way or another, whether in an organisational setting or their professional setting. I emphasise that we would not support anything that would compel any medical practitioner to be put in that position. It is a matter of choice.

To refer to somebody else is a common practice amongst the profession. If one does not feel they are in a position to make a particular clinical judgement and/or participate in a particular procedure, then it is custom and practice to then refer to an alternate, but there must be that choice, and that is the key underlying principle in this setting. SANDFORD, Prof. Alan AM, Director, Medical Academic Development, Central Queensland and Wide Bay Hospital and Health Service.

Division 2 Participation of entities & institutional conscientious objection

Subdivision 1 Preliminary

K. Participation by entities [Part 6, Division 2, Subdivision 1, Section 86]

COMMENT: Catholic Health Australia, Uniting Care, Lutheran Church of Australia and others have expressed concerns about the inability of entities to practice institutional conscientious objection. Furthermore entities have raised concerns about guidelines in respect of accreditation and access of VAD qualified health practitioners. How does the proposed legalisation impact on requirements of the Australian Commission on Safety and Quality in Health Care as set out in the National Model for Clinical Governance Framework. Do the requirements to provide access for VAD practitioners and services conflict with accreditation, certification and duty of care obligations of health services organisations?

Catholic Health Australia raised concerns about what the Queensland Bill does for hospitals?

- For not-for-profit healthcare providers such as Mater, the proposed laws take away our right to operate our hospitals and community health services according to the ethos on which we were founded in Queensland more than a century ago.
- That ethos is one of compassionate care, from the beginning to the end of life.
- The Bill, unlike any other laws introduced or considered elsewhere in Australia, forces our hospitals and aged care facilities to cooperate with VAD.
- The Bill requires our hospitals and aged care providers to allow VAD practitioners access to our facilities at any stage of the VAD process.
- It overrides our accreditation process that ensures the safety of our staff and patients by requiring that the doctors and practitioners allowed into our hospitals are credentialed specialists who adhere to our professional and ethical requirements.
- The Bill also allows VAD practitioner to override any decisions made by our own admitting clinician: that is, the medical practitioner who is directly responsible for the person's care and wellbeing.
- This is a breach of duty of the care and goes against the high quality and safe care we expect in Australia. It is a scenario not permitted by any other field of clinical practice.
- Circumstances where drug storage protocols require the central storage of medicines and other substances (including VAD substances) for reasons of safety would also mean our staff must also directly facilitate VAD, in some situations.

REQUESTED AMENDMENT & COMMENT: Catholic Health Australia

At minimum, the Bill should be amended to do the following:

- Ensure new residents or patients understand and accept that we do not offer VAD, and agree not to seek access to VAD at our facilities
- Require residents and VAD doctors to inform our facilities where they intend to pursue VAD, and give them the right to refuse to authorise or permit VAD on their premises and offer transfer
- Require our facilities to undertake *reasonable steps to transfer* the patient to another facility that offers VAD

What about choice?

- Any person entering one of our facilities would be respectfully informed about our ethic of end-of-life care and stance on VAD
- If someone in one of our facilities were to request VAD, we would respond respectfully to that request.
- We would arrange transfer, with our own clinicians (not a VAD doctor – as the Bill currently requires) assessing whether this is reasonable

What has happened in other jurisdictions?

- Other jurisdictions have recognised the unique offering and ethic of care provided by Catholic facilities and have protected that ethic when passing VAD laws – e.g. the *Voluntary Assisted Dying Act (SA) 2021*

REQUESTED AMENDMENT & COMMENT: Catholic Health Australia

Rename

- Division 1 - Conscientious objection by health care practitioners
- Division 2 - Conscientious objection by entities

Delete original section 86 (a) and (b), replace with;

- deciding practitioner, for a decision about the transfer of a person, means a senior medical practitioner employed by a relevant entity whom the entity has authorized to make decisions concerning the transfer, or possible transfer, of a person from that entity to a health service which provides, or which may provide, services relating to voluntary assisted dying.

REQUESTED AMENDMENT: Dr van Gend

Genuine freedom of conscience for associations of individuals who operate an “entity” (e.g. church hospital / hospice / nursing home) which is built around moral principles and tenets of faith that prohibit intentional killing. To this end:

- Delete subdivisions 1, 2, 3 of Division 2.

- Keep subdivision 4 of Division 2 (98)

Subdivisions 1,2,3 of Division 2 amount to an assault on the moral structure and ethos of care of church institutions. It is an assault by the state on the conscientious liberty of every member who built up these faith-based associations over generations and works to uphold its ethos of care.

Subdivision 4 of Division 2 (98) is a clear and reasonable advertisement to consumers that this entity does not provide ‘VAD’ and should be required in the interests of informed consent in seeking admission to such a facility. Let the consumers make their own arrangements elsewhere, should they seek VAD.

Committee evidence:

Protections for Organisations Health institutions or organisations, and there are many, whose charter is opposed to voluntary assisted dying, due to deeply held convictions and values upon which those organisations were in fact founded, would under the current proposed legislation, be compelled to refer patients who qualify for assisted dying upon request. In the case where the patient is a permanent resident of a facility, such as an aged care home for example, the institution would be forced to bear the responsibility to transfer the person, or allow the assisted dying to take place on the premises by an outside health practitioner coming in to administer the lethal substance to the patient, or on occasions, have the substance being delivered to the facility for self administration by the patient. To require an institution or organisation to violate the very core values and beliefs upon which it was built and has successfully and effectively operated in the delivery of invaluable health services, in many cases for decades, is a serious breach of fundamental freedoms, and an imposition that we consider unacceptable.

Australian Christian Churches. Submission No 1052. Page 3

CHAIR: On balance, do you think the human rights—

Dr Perry: There are human rights on both sides of the argument.

CHAIR: Conscientious institutional objection—

Dr Perry: Yes.

CHAIR: I think it was declared that they do not have a conscience.

Dr Perry: That is unfortunate. Hopefully it is just a blip.

CHAIR: I will let you debate that with the Human Rights Commissioner. He appeared before us yesterday.

Dr Perry: They are people.

Dr Manoharan: I think there should be a balance struck between the public health and the public good, and also individual conscientious objection. If we are talking about equity of access to health care, we have to consider that equity of access to aged-care services is also an important factor and that is not just provided by Queensland Health; that is provided by private providers. We need to find that balance.

Mr MOLHOEK: *Dr Perry, I would assume that most of the directors of the organisations that you are referring to would be volunteer directors and not paid?*

Dr Perry: *I am not sure.*

Mr MOLHOEK: *Therefore, they would be very nervous about their liability?*

Dr Perry: *They would be quite liable. People are saying that if an institution does not do it they will go to the court and get a court order that they have to do it. If they have to do it against their conscience, they may well feel that they need to get out of that space and we certainly do not want that. That is a bigger disaster than the occasional person—we are only looking at about 100 or 200 people a year in Queensland accessing this. How many people are going to want to do this in a church run facility when they have no way that they can go somewhere else to have this done? A quiet room in a public hospital—we have those all over the place. We have prayer rooms with a green arrow pointing towards Mecca. Those places do exist. You do not have to force it on institutions that find it morally a serious problem.*

Dr Chris Perry, President, Australian Medical Association, Queensland. Brisbane transcript Day 2. Page 41

Add Organisational Conscientious objection to the Bill AMA Queensland is pleased with the conscientious objection section of the draft Bill that a doctor who has a conscientious objection has the right to refuse to:

- Provide information about VAD*
- Participate in the request and assessment process*
- Participate in an administrative decision*
- Prescribe, supply or administer a VAD substance*
- Be present at the time of the administration or self-administration*

However, we recommend this section of the Bill be changed to include organisational conscientious objection as we believe that some health care facilities which provide care may have a distinctive mission or ethos which should permit it to refuse to provide particular services due to an 'institutional conscientious objection'. In that situation, the institution should inform the public of this so that patients can seek care elsewhere. AMA Queensland. Submission No. 0260. Page 2.

Our members have provided cradle-to-grave care for Queenslanders, as I said earlier, in many cases for more than a century. We can be trusted. That is something I would like to repeat a few times today: we can be trusted to provide compassionate care for every person in every circumstance. What I think is extraordinary about this bill is that it dismantles our members' ability to pursue that mission of compassionate care. It requires our hospitals and aged-care facilities to allow access to VAD doctors, most of whom or all of whom they would not have any existing relationship with, from the first assessment right up to administration of the lethal substance.

Ms Rebecca Burdick Davies, Director, Strategy and Mission, Catholic Health Australia. Brisbane Transcript. Day 3. Page 15.

We have had many people go through every stage of the VAD process within our member organisations in Victoria, and I can confidently say that those people have experienced compassionate care at each stage of that process. We have had that advice from members that have large operations in Victoria. They have established protocols about respectful care for people undergoing VAD. They have established protocols for helping their staff have conversations with people about VAD. I guess what I am saying is that we need to have the same level of trust from Queensland MPs and the Queensland government that we can provide compassionate care in your state. We can be trusted to do this. We do not need to have prescriptions laid down in legislation to force us to make decisions about VAD. My colleague Phillip Good can add more about what happens from a clinical perspective when someone requests VAD.

Ms Rebecca Burdick Davies, Director, Strategy and Mission, Catholic Health Australia. Brisbane Transcript. Day 3. Page 16.

L. Facilitate transfer to and from [Part 6, Division 2, Subdivision 1, 2 & 3]

COMMENT: Amendments remove “must allow reasonable access” with “take reasonable steps to transfer to and from.” CHA

REQUESTED AMMENDMENT: Catholic Health Australia

Rename Part 6, Division 2

Conscientious objection by entities

Delete Section 86, clauses (a) & (b) and replace with;

deciding practitioner, for a decision about the transfer of a person, means a senior medical practitioner employed by a relevant entity whom the entity has authorized to make decisions concerning the transfer, or possible transfer, of a person from that entity to a health service which provides, or which may provide, services relating to voluntary assisted dying.

Amend Section 93 with the addition of a new Clause 3

Amend Section 90 with the addition of a new Clause 3

(3) a registered health practitioner or a member or employee of an official voluntary assisted dying navigator service to whom access is granted by the entity for the purposes of sub-paragraph (2) above must not take any step incidental to the voluntary assisted dying processes prescribed by this Act other than to provide information requested by the person about voluntary assisted dying.

- **Rename Part 6, Division 2, Subdivision 3**
- Steps by entities to enable access to voluntary assisted dying

Amend Section 92, delete original clauses 2 & 3, replace with new Clause 2

- (2) The relevant entity and any other entity that owns or occupies the facility must
- take reasonable steps to facilitate the transfer of the person to and from a place where the person’s relevant request may be made to—
- (a) a requested medical practitioner; or
- (b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

Amend Section 93, delete original clauses 2 & 3, replace with new Clause 2

The relevant entity and any other entity that owns or occupies the facility must

- take reasonable steps to facilitate the transfer of the person to and from a place where the person’s second request may be made to
- (a) the coordinating practitioner; or
- (b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

Amend Section 95, delete original clauses 2 & 3, replace with

- (2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must take reasonable steps to facilitate the transfer of the person to and from a place nominated by the person or the person’s agent where the person’s assessment may be carried out by a medical practitioner who is eligible and willing to act as a relevant practitioner.
- (3) If the person is not a permanent resident at the facility the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place nominated by the person or the person’s agent where the person’s assessment may be carried out by a relevant practitioner for the person;

Amend Section 96, delete original clauses 2 & 3, replace with

(2) If the person is a permanent resident at the facility

(a) the relevant entity and any other entity that owns or occupies the facility must take reasonable steps to facilitate the transfer of the person to and from a place nominated by the person or the person's agent where the person's administration decision may be made in consultation with, and on the advice of

- (i) the coordinating practitioner; or
- (ii) another medical practitioner who is eligible and willing to act as the coordinating practitioner for the person.
- (3) If the person is not a permanent resident at the facility the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place nominated by the person or the person's agent where the person's administration decision may be made in consultation with, and on the advice of, the coordinating practitioner for the person;

Amend Section 97, delete original clauses 2, 3 & 4 replace with

- If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must take reasonable steps to facilitate the transfer the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;
- (3) if the person has made a practitioner administration decision the relevant entity must take reasonable steps to facilitate the transfer of the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;
- (4) If the person is not a permanent resident at the facility the relevant entity must take reasonable steps to facilitate the transfer of the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;

Amend Section 97, delete original clauses 2, 3 & 4 replace with

- If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must take reasonable steps to facilitate the transfer the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;
- (3) if the person has made a practitioner administration decision the relevant entity must take reasonable steps to facilitate the transfer of the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;
- (4) If the person is not a permanent resident at the facility the relevant entity must take reasonable steps to facilitate the transfer of the person to a place nominated by the person or the person's agent where the person may be administered or may self-administer a voluntary assisted dying substance;

Part 8 Voluntary Assisted Dying Review Board

Reporting

[Part 8, Division 4, Section 134]

- Annual reporting
- To the Minister 3 months after end of each financial year
- Tabled in the Parliament 14 **sitting days** after receiving it.

Reporting should be 6 monthly and tabled 7 sitting days after receiving it. Victoria reports six monthly

- Should also encompass and report on Palliative care delivery and improvements to services, accessibility and meeting of demand

[Recommendations 5 & 6 - Palliative Care Queensland]

- Should be independent of Queensland Health
- Statutory reporting requirement should be overseen by the Attorney General with a requirement that reporting occurs every six months to the parliament in respect of VAD, palliative care delivery and spending.

Committee evidence:

The Lutheran Church of Australia supports a full review of the Act and any VAD scheme within 3 years as per s. 154

The Lutheran Church of Australia supports the establishment of a Review Board with statutory oversight of any VAD scheme.

Ideally the Board would be located within a portfolio other than health so that there are reduced risks of VAD being seen, or practiced, as a 'normal health service'.

The Lutheran Church of Australia likewise supports the requirement for strict timelines for annual ministerial reporting and subsequent tabling in the Parliament.

We recommend the following professionals be included in the eligibility criteria for the Board in s. 124: persons with expertise in aged care, gerontology, disability services and holistic care.

Lutheran Church. Submission 1360. Page 7

Mr Ryan: *Our final recommendation would be that the voluntary assisted dying scheme not be conducted within the health portfolio. As a former senior bureaucrat in the Queensland government and as the Commonwealth aged-care regulator for five years, I know what happens in the budget process within government. I know what happens around departmental tables and in ministerial offices. If the state of Queensland wishes to enact the scheme, the state should stand up an independent capability outside of the health portfolio. We do agree to the establishment of a board with clear obligations to report.*

Nick Ryan, CEO Lutheran Church. Brisbane Day 1 transcript. Page 28

Part 9 Offences

M. Inducing a person to request or revoke a request

Section 141

(1) A person must not, dishonestly or by coercion, induce another person to make, **or revoke**, a request for access to voluntary assisted dying.

Maximum penalty—**7 years imprisonment.**

COMMENT: Many groups expressed concerns about excessive penalties for coercion but in particular the principal of persuading a person to fight on. The maximum penalty appears excessive when

compared to other penalties in various criminal codes. It's hard to comprehend a family member, nurse, counsellor, pastor, health professionals or friends facing prison time for talking someone out of accessing VAD. While the meaning at law of "coercion" clearly indicates there would need to be dishonest or deliberate attempt to exert unreasonable pressure on a person, clarification of this has been sought by various groups with suggested amendments.

REQUESTED AMENDMENT: Uniting Qld Synod submission 0244 recommendation 10

Remove the wording "or revoke" from Section 141. Review the penalties for Section 141 as they are over-kill when compared with other offences in the criminal code.

REQUESTED AMENDMENT: Cherish Life

AMENDMENT 13 NO PENALTY (LEAST OF ALL 7 YEARS JAIL) FOR TRYING TO TALK SOMEONE OUT OF 'VAD'. Within reason, a loved-one should be able to help someone considering assisted suicide or euthanasia consider their ways. This includes a robust but respectful discussion if someone wants to access "VAD" and it is of a concern to a loved-one. Such discussions are not unique in close relationships at key life junctions. Discourse cannot be censored simply because it is a topic the Queensland Government obviously feels protective about.

OTHER ADVICE: Professors White and Willmott

With respect to the maximum penalty of 7 years imprisonment for breaching cl 141, Professors White and Willmott advised that they considered it was an appropriate maximum penalty because:

- a. The VAD Bill recognises in s 5(a) that 'human life is of fundamental importance', and in s 5(c) that 'a person's autonomy, including autonomy in relation to end of life choices, should be respected'.
- b. In its Report, the QLRC emphasised that the proposed maximum penalty of 7 years for both offences of inducing a person to access, and not to access, VAD 'reflects the seriousness of the conduct in undermining the autonomy and voluntary choice of the person'.
- c. The conduct giving rise to the offence is the same whether it applies to a circumstance where a person is inducing someone to access, or to not access VAD: in both cases the person's autonomy and voluntary choice is equally undermined. The law takes very seriously dishonestly inducing or coercively inducing people to change their mind about this significant decision. Therefore, we believe the QLRC's position is an appropriate one.
- d. However, we recognise that the consequences of a person being induced to access VAD are very significant and that harm (i.e. death) may be caused to a person who is induced to access VAD. Different harm (i.e. continued intolerable suffering) may result for a person who is induced not to access VAD. We believe that these differences in consequences would be appropriately addressed in sentencing. We refer to s 141 of the *Penalties and Sentences Act 1992* (Qld), which requires the Court in sentencing an offender to have regard to:
 - i. the nature of the offence and how serious the offence was, including any physical, mental or emotional harm done to a victim;
 - ii. damage, injury or loss caused by the offender;
 - iii. the presence of any aggravating or mitigating factor concerning the offender;
 - iv. any other relevant circumstance.

Penalties

It is extremely concerning that there are penalties in place for anyone who attempts to talk a person out of accessing VAD, - Part 9 141 (1) - with a maximum penalty of 7 years jail. This could have implications for a patient's family members in the area of freedom of speech and liberty of conscience. While the vulnerability of a patient can potentially be taken advantage of by a doctor or a nurse as they are able to raise the idea of assisted suicide in the context of discussing other end-of-life options.

Queensland Baptists. Submission No 1044. Page 2.

Mr MOLHOEK: Yesterday we heard from some of the church organisations. The Lutheran Church raised concerns about the provision in the bill that refers to inducing a person to revoke a request for voluntary assisted dying and the proposed penalties for being found guilty of having that. I would be interested in your response or reflection on that. There are many people who provide advice to people. There are counsellors, pastors, spiritual mentors and family members. In the context of perhaps the last year, where we have seen up to a 200 per cent increase in demand for counselling and support services around the nation, are you concerned that this requirement is perhaps a bit too broad?

Dr van Gend made the comment in his presentation that suffering is a part of life and people will typically seek all sorts of sources of advice and guidance in times of crisis. He went on to talk about how the brain chemistry significantly alters when people are under incredible stress. Are we at risk of introducing a law where we could see chaplains and pastors and qualified counsellors ending up in jail because perhaps they have been called on to support a family through a time of crisis and then they find they are actually being caught up by this provision?

Prof. White: Thank you for raising that. I think you are talking about clause 141 of the bill.

Mr MOLHOEK: Correct.

Prof. White: That provision requires, for criminal liability to arise, dishonesty or coercion. I cannot imagine chaplains engaging in dishonest or coercive behaviour to induce someone to not go down the path of voluntary assisted dying. That is the only instance in which that provision would apply.

Professor Ben White. Professor of end-Of-Life Law and Regulation, Australian Centre for Health Law Research, Faculty of Business and Law, Queensland University of Technology

Clause 141 – Inducing a person to request, or revoke request for, voluntary assisted dying

This clause should be amended to specifically remove the reference to revoking a request. It should not be a criminal offence to encourage someone to live and there is no real risk of a person dishonestly inducing another person to revoke a request for voluntary assisted dying; indeed it is difficult to conceive of circumstances in which this could occur. It is certainly not a risk that warrants a maximum criminal penalty of 7 years.

Australian Christian Lobby. Submission No 1054. Page 12.

PART 11: Miscellaneous

N. Approved training

165 Approved training [Part 11, Section 165]

- (1) The chief executive must approve training for the purposes of sections 20, 31 and 83(b).
- (2) The approved training may provide for the following matters—
 - (a) the operation of this Act in relation to medical practitioners, nurse practitioners and nurses, including the functions of coordinating practitioners, consulting practitioners and administering practitioners;
 - (b) assessing whether or not a person meets the eligibility criteria;
 - (c) identifying and assessing risk factors for abuse or coercion;
 - (d) other matters relating to the operation of this Act.
- (3) The chief executive must publish the approval on the department’s website.

COMMENT: The bill is light on detail in respect of training requirements, how is it to be conducted, will it be proper professional development, face to face or delivered on-line. Training needs to be conducted like any other Advanced Skills Courses for Accreditation. It needs to be a substantive formalised program, rigorous, peer reviewed and recognised by a reputable college. It should encompass proper medical diagnosis measures and recognised standards. What does a GP do if the administration of a voluntary assisted dying substance doesn’t work.

O. Advanced Health Directives

Section 177 Amendment of Powers of Attorney Act 1998

Voluntary assisted dying under the *Voluntary Assisted Dying Act 2021* is not a matter to which Powers of Attorney Act 1998 applies.

COMMENT: No provision for Advanced Health Directives or Powers of Attorney

REQUESTED AMENDMENT: AMAQ Submission recommendation 6

Permit patients with Advanced Health Directives who have a request to access the proposed VAD scheme but subsequently loses their capacity, for their wishes to be followed.

Committee evidence:

Ms McNamee: There are two things I will end on, both of which are equally controversial. One is the issue of dementia. I understand that the committee and the QLRC last decided to sort of park that issue for now, and I totally understand why. We need to get this legislation in place, up and operating and see what the exact issues are in Queensland before we take on such a difficult issue to legislate. However, the loss of dignity and autonomy that dementia inevitably brings is one of the biggest causes of distress to people diagnosed with it. The use of a possible advance health directive with VAD built into I think would give people immense comfort. Even the AMAQ, who have not been overly supportive of the legislation until recently because I think they have seen the writing on the wall, have stated their support for the use of advance health directives for someone to say that 'in the event of my becoming completely incapacitated I wish to access VAD'.

Heather McNamee, Queensland State Convenor Group, Doctors for Assisted Dying Choice. GP for 25 years in Cairns, Torres Strait and Cape York. VAD in relation to rural and remote patients. Page 14 transcript Townsville

DWDQ wants specifically to bring to the attention of the Health and Environment Committee, a condition that is frequently brought to the attention of DWDQ by many of its members and supporters across Queensland, it is that of dementia which is of great concern and indeed fear for them.

Dementia is the second leading cause of death in Australia, and it is particularly devastating for families and their loved ones. Dementia is a terminal illness.

DWDQ recognises the disease specific difficulties in relation to Voluntary Assisted Dying that dementia poses. DWDQ supports those members' and supporters' future aspirations to have access to Voluntary Assisted Dying if they develop dementia resulting in unbearable suffering with no prospect of improvement. DWDQ recommends that in the future, the Queensland government take steps to develop a dementia specific Advance Health Directive, while people have decision-making capacity, and steps to foster community discussion about dementia related end-of-life choice.

Dying with Dignity Queensland Inc. Submission No 0278 p7