



# ***HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE***

**Members present:**

Mr AD Harper MP (Chair)  
Mr MA Hunt MP  
Mr MF McArdle MP  
Mr BL O'Rourke MP  
Ms JE Pease MP

**Member in attendance:**

Mrs BL Lauga MP

**Staff present:**

Mr R Hansen (Committee Secretary)

## **PUBLIC HEARING—INQUIRY INTO AGED CARE, END-OF-LIFE AND PALLIATIVE CARE AND VOLUNTARY ASSISTED DYING**

### **TRANSCRIPT OF PROCEEDINGS**

**WEDNESDAY, 17 JULY 2019**

**Rockhampton**

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### **The committee met at 2.34 pm.**

**CHAIR:** I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I start by acknowledging the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. I am Aaron Harper, chair of the committee and member for Thuringowa. With us today are Mark McArdle, deputy chair and member for Caloundra; Marty Hunt, member for Nicklin; and Joan Pease, member for Lytton. I pause on announcing the local member for Rockhampton, Barry O'Rourke, because I would like him also to welcome you.

**Mr O'ROURKE:** It is absolutely wonderful to see a good crowd here. It is such an important issue we are discussing and listening to people about. Depending on location, the difference in some of the services provided in far western areas or remote areas compared to some of our largest service centres is quite amazing. This is a great opportunity for you to provide information to this group so that we are able to make recommendations to ministers. It is great that we are in a position where we can travel around and do a lot of consultation. In the last couple of days we have been to Bundaberg and Hervey Bay. As well, we have visited Mount Isa, Longreach, Townsville and a few places in the south-east corner. It has been really good. Thank you for taking the time. This is a great opportunity.

**CHAIR:** Thank you very much. As our road trip continues, the one thing I have noted is that there is a lot of roadworks going on. There is plenty of work happening. Our committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a nonpartisan approach to its inquiries. The inquiry into aged care, end-of-life and palliative care and voluntary assisted dying was referred to our committee on 14 November 2018. The committee is required to report its findings by 30 November 2019. Today we are here to hear the views of people from Rockhampton and the surrounding area on those issues. We are very keen to understand what care people can access now, what care people need but possibly cannot get and what this means for people's comfort and dignity. The issues we will be discussing affect everyone in the room. This is arguably one of the most important inquiries the Queensland parliament has ever undertaken. In fact, the issue of voluntary assisted dying has never before been put to the Queensland parliament, so it is historical and significant and we value your input very much.

Some of you may share experiences and insights today that are very personal and might be painful to talk about. I ask that everyone respects the rights of others in expressing their views on these sensitive subjects. The hearing will start with a panel of local experts who will paint a picture for us of what aged-care services, palliative care services and end-of-life services in this part of Central Queensland look like. We will then hear from people who have provided written submissions to our inquiries. If there are others who want to speak today, I invite you to see Rob Hansen, our committee secretary, who will give you a form to fill out to register you to speak. This is your opportunity to have your voice placed in the history books of Queensland parliament. We have Hansard here, and we thank Bonnie Phillips for sticking with us in our travels over the past few days. Literally, that is what it is. Given that Hansard is recording, the views and points that you want to express will stay in the history books of the Queensland parliament forever.

We do want this hearing to be as informal and relaxed as possible, but it is still a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I must remind you that intentionally misleading the committee is a serious offence. The public hearing is being recorded by Hansard staff. If you speak, make sure you give us your details so we can send you a copy of the transcript to check. All of those appearing this afternoon have been provided with a copy of instructions for witnesses, so we will take those as read.

Importantly, the proceedings are covered by parliamentary privilege, which means that speakers are protected from legal action in respect of evidence they give to the committee. If they give evidence today that reflects adversely on an individual or organisation, it should not be taken as proof of the allegations being made. The committee may choose to receive but not publish that evidence. We will have media present. You may well be photographed. I remind members of the public that they may be admitted to or excluded from the hearing at the committee's discretion.

**HIRNING, Ms Debra, Director of Nursing, Aged Care Clinical and Rehabilitation, Central Queensland Hospital and Health Service**

**WILLIAMSON, Mr Steve, Health Service Chief Executive, Central Queensland Hospital and Health Service; Adjunct Professor, CQ University**

**CHAIR:** Welcome. We would like to hear in an opening statement what it looks like in the aged-care sector that you work with. What is available now in terms of facilities? We have a growing and ageing population that does and will impact on our public hospital system. We visited the Bethany nursing facility this morning. We talk about wait times. Potentially, there are people sitting in hospitals waiting to access a bed. What palliative care services are available? We will hear any other points or views that you might have. I ask you to make an opening statement.

**Mr Williamson:** Thank you, Chair, and thank you, committee, for coming to Rockhampton in Central Queensland and for the invitation to be a witness at the committee today. I start by acknowledging the traditional owners of the land, the Darumbal people, and pay my respects to elders past, present and emerging.

I am the health service chief executive for the Central Queensland Hospital and Health Service. The Central Queensland Hospital and Health Service is an independent statutory body. We are overseen by a local hospital and health board and have responsibility for providing public hospital and public health services which include medical, surgical, emergency, obstetrics, paediatrics, outpatients, mental health, critical care and emergency care, and we also have responsibility for providing some residential aged-care services. We are responsible for the direct management of 12 hospitals and multipurpose health services across the Central Queensland region. That encompasses the Capricorn Coast, Rockhampton, Gladstone, Banana, Central Highlands and Woorabinda shire. That is about 110,000 square kilometres. We also provide mental health support to areas out to the central west, which is clearly a larger area again. We are also responsible for providing two dedicated residential aged-care facilities in Rockhampton and one residential facility that provides 24-hour individualised care to people with high and complex support needs. That is our Birribi service here at Rockhampton.

Residential aged-care services provided by our hospital and health service in Rockhampton are provided from two aged-care facilities. The first one is Eventide Home and the second is the North Rockhampton Nursing Centre. For information, Eventide has 80 beds to provide residential aged-care for general high-care residents and other residents including those with dementia. North Rockhampton Nursing Centre comprises 120 beds, of which 100 are Commonwealth funded beds and the remaining 20 are state funded beds used for interim care. Again, that facility provides residential aged-care for general high-care residents and residents experiencing dementia and also offers interim care.

I said that we are responsible for the direct management of 12 hospitals and multipurpose health services. That also means that we provide residential aged-care services across the region: Baralaba, where we have five residential care places; Blackwater, where we have four; Mount Morgan, where we have 12 residential places and three community places; Springsure, where we have 12 residential care places; Theodore; and Woorabinda. You can see that we have a range of services. They range from very large facilities at Eventide and North Rockhampton to services based in hospital settings like Baralaba which are much smaller in terms of providing those services.

Regardless of their size, those services are essential to local people and they are essential to their families. We constantly have exceptional feedback about the importance of those services to local communities, wherever we go across Central Queensland. Very positively, and additionally, the Commonwealth Department of Health recently approved one high-care residential place at Moura Community Hospital, with provisionally a further seven places to be allocated in the coming years. That will be very well received and has been very well received by the Moura residents.

The residential aged-care services provided by the Central Queensland Hospital and Health Service are regularly assessed and monitored against the aged-care quality standards by the Australian government. That is one of the key mechanisms by which we as an organisation and our board are assured of the safety, the quality and the experience of those services. Recent assessment contacts were conducted at both Eventide and North Rockhampton Nursing Centre by auditors from the Aged Care Quality and Safety Commission. They have resulted in services and care being assessed as meeting all expected outcomes against those national accreditation standards. Certainly in aged care, palliative care and other areas, the rest of our hospital and health service information is

assessed for its quality through our national standards accreditation. Our most recent accreditation of about one month ago assessed the entire HHS as delivering all standards in accordance with the set criteria.

We are focused on providing contemporary aged-care services to residents right across our region and that is highly valued by local people. What we see, as you set out at the start, Chair, is that the population is ageing. That is happening across Australia and it is happening across Queensland. It is also happening here in Central Queensland. The population of those people who are over 65 is forecast to increase by nearly 70 per cent in this region by 2026. Therefore, we see a growing population, but particularly we see a growth in those who are over 65 and also a proportional growth in those who are over 75.

We seek where we can to invest in our facilities. We have recently completed a refurbishment of the oldest wing of the North Rockhampton Nursing Centre to improve the facility, the environment and the experience for those residents. We have also completed an upgrade of the kitchen facilities there, so that we can continue to improve the quality of the living experience and also the quality of the food for our residents in the region. That has been about an \$8½ million upgrade, which was completed and opened earlier this year.

Recently at the Eventide Home we have invested about half a million dollars in this 12 months to improve the environment. Those things are really important, alongside the appropriate staffing levels, the experience, the entertainment, the environment and the actual infrastructure—the flooring, the furniture. They are core parts of the requirements. We just concluded about a \$525,000 improvement and investment in Eventide.

**CHAIR:** Would the HHS be able to table—and you might take this on notice—the staffing arrangements? For the benefit of the audience, aged care is just as important as any other part of this inquiry, especially when we look to what has happened on the Gold Coast recently where vulnerable people were left to fend for themselves. As a committee, we have a remit to make sure that each residential aged-care facility has the appropriate staffing available, whether it is public or private. We would very much appreciate getting a view on that. You may need to take that on notice or you may have the numbers there, but we would certainly like to get an idea of the nurse-to-patient ratio or the staff-to-patient ratio in terms of professional care workers. I will let you continue.

**Mr Williamson:** We can certainly provide that information from a hospital and health service perspective. We can provide the nurse-to-patient ratio in respect of Eventide and the North Rockhampton Nursing Centre. We can provide the ratios in our multipurpose health service centres, but they would be in a separate reporting mechanism. We would not be in a position to speculate on the ratios in the private sector, but certainly we can definitively and factually provide the information in respect of this position. In a moment I will chat with my colleague about whether we can provide that information during the session or whether we will provide it on notice. I will confirm that as we go forward.

I want to set out the services we provide in terms of specialist palliative care services. There are a range of specialist palliative care services available within Queensland. That can range from advice and information, through to referral and outpatient and inpatient care, depending on the setting. Some of the services are accessible by family and carers, as well as by the individual concerned.

As committee members will know, palliative care can be delivered in the home, in the community or in a hospital setting. To further complicate this, providers of palliative care can be general practitioners or GPs, they can be public hospitals, they can be private hospitals, hospices, non-government organisations and private sector organisations. We certainly see a complexity of palliative care services provided.

The Central Queensland Hospital and Health Service does provide specialist palliative care services. That includes inpatient, outpatient and outreach specialist palliative care advice, support and services. At Gladstone Hospital we have four palliative care beds. At Emerald Hospital we have one palliative care bed. At Capricorn Coast we have two palliative care beds. At Biloela Hospital there are two palliative care beds. At Springsure there is one palliative care bed. At Rockhampton Hospital, which is our base hospital for the region, palliative care is incorporated into the 11-bed cancer inpatient unit. We provide access to palliative care inpatient services in the Central Highlands, in Capricorn Coast, in Banana, in Gladstone and in Rockhampton. The new 11-bed cancer inpatient unit also provides medical oncology, haematology, radiation oncology and specialist palliative care services.

We also have a seven day a week palliative care outreach service to provide both in-home and phone follow-up to patients, particularly those who are discharged from the specialist palliative care service or are under the ongoing care of specialist palliative care services. That is primarily for patients who have a diagnosis of a life-limiting and malignant illness.

Palliative care funding is provided for home support on some occasions, but that is usually defined around those who were assessed as being in the last three months of life. That funding covers the hire of equipment. It covers some domiciliary nursing support. Each case is assessed on a case-by-case basis. Every one of those cases is individual and unique and dependent upon the patient, their family and care and support.

**CHAIR:** Which body does that funding come from?

**Mr Williamson:** Funding is from a range of sources. In terms of funding within the state, we have activity based funding for palliative care services which totals about \$2.2 million per year. If I break that down, that would be about \$1.8 million of activity based funding for admitted patients. For those of you who are interested in the particular detail, that is funded through Queensland rated activity units and that would equate to about 370 of those. From an outpatient perspective, the funding is about \$400,000. Those two together would total \$2.2 million approximately in terms of funding for those things.

We see a number of challenges in terms of palliative care. I mentioned that palliative care was provided by a whole range of providers, but the whole health system has a role to play in palliative care. It is unfortunate that the PHN is not able to be here today, as they may have been able to give a definitive position. However, we understand that some of the challenges include the funding mechanism for GP consultations, which is not necessarily aligned to the time taken for a home visit and a home consultation. I relay that as an observation; it is not something that I can really comment on.

**CHAIR:** Certainly that is something that we have heard everywhere we have gone. Whether you are in a residential aged-care facility or at home receiving palliative care, GPs are saying that it is certainly at a Commonwealth level for the funding of services, for them to go and access and treat patients. Certainly we have got the message from the GPs on that one.

**Mr Williamson:** That is really helpful. As a hospital and health service, we would certainly support any mechanism that enabled the whole health system to provide greater access to palliative care. I mentioned that the population in this region is forecast to grow quite significantly. The aged element of that population is also forecast to grow. There is also evidence to suggest that the demand for palliative care is forecast to grow at a similar sort of rate over the next 10 years. Therefore, we see those services as being critically important, but we also see the demand for those services growing in line with that ageing population. I think there is some information that suggests that some parts of regional Queensland are seeing that growth in demand, particularly.

Whether that correlates with some of the health inequities in regional Queensland is perhaps difficult to judge, but it is the case that in Central Queensland we have in our population very high rates of smoking. We have high rates of lung disease, diabetes and type 2 diabetes. I think the latest Chief Health Officer report showed that there was a one-to-two-year life expectancy gap for Central Queenslanders compared to the Queensland average, primarily I think driven by those sorts of health inequality factors. I am sure they have a bearing on palliative care as well, where there is an increasing number of people with a range of comorbidities and challenges that they will face.

**CHAIR:** One of our key features is to make recommendations in the aged-care and palliative care space. The data we have seen says there will be 800,000 more Queenslanders aged 65 in seven years' time. That is a significant burden. We are a population of only five million. It goes out by the millions each decade after that. Therefore, we need to get this right in terms of making sure that our palliative care services and aged-care services are adequately funded and staffed. Those are the things that we would like to articulate in our report at the end of the year. We are working with Queensland Health. They have briefed us on their palliative care review. We will make recommendations going forward in terms of that. For each HHS, it does not matter where you live. As local member Barry O'Rourke said, from Far North Queensland to Central Queensland, no matter where you live, people deserve access to good specialist palliative care.

You were talking about Rocky being a tertiary level hospital with 11 beds. You have talked about specialist palliative care. Do you have a palliative care specialist working at the hospital?

**Mr Williamson:** Yes, we do. I will provide the breakdown of the whole of the workforce that we have. We do have a specialist palliative care doctor working in Rockhampton. That doctor is supported by the inpatient team at the Rockhampton cancer and specialist palliative care unit, which Rockhampton

I described. In addition to that doctor, we have a nurse unit manager, a clinical facilitator, four specialist clinical nurses and four registered nurses, as well as an advanced practice and enrolled nurse.

Our outreach services are supported by 1½ full-time equivalent clinical nurses. I mentioned our palliative care consultant. That is a 0.5 full-time equivalent, so half a post. We also have an allied health team, with a social worker and access to physiotherapy and pharmacy support and, on a referral basis, access to a dietician and occupational therapy support. Also in our palliative care clinic we have some additional nursing support.

With the report you refer to, from a Queensland perspective, one of things that it identifies is when we look at the forecast workforce, both from a medical workforce and administrative workforce perspective. With the age of that workforce, the expected and anticipated retirements and the increase in demand, there is the projection of a workforce challenge going forward over that same period. That is particularly from a medical workforce perspective and, to some extent, from an administrative workforce perspective.

**CHAIR:** How do you attract and retain people, particularly in western areas such as Mount Isa and Longreach, as we have heard? Do you have a strategy to keep staff coming through? Is there succession planning? Aged-care nursing staff have an average age of 50 years and they will exit at some point. How do we get people working in this space?

**Mr Williamson:** We do. It is very challenging in regional Queensland, not just in this area of aged care and palliative care but right across the workforce. One of the challenges we see in this region is a difficulty historically in attracting doctors to come and train here and to work here. We as a HHS have worked very closely with the University of Queensland and Central Queensland University—ourselves and our neighbouring hospital and health service. That concluded with an announcement that we made earlier this year to establish a full medical program, effectively a medical school, in this region from 2022. We think that is one of the things that will be transformational in attracting doctors to this region, both training doctors but also experienced doctors who would like to teach and to research. It has been very positive to have the support of both of our local universities, and that includes the reallocation of 120 Commonwealth supported medical placements from Brisbane to Central Queensland and a further 120 to Wide Bay, which is the other region that we are working with.

That means that each year we expect 30 Commonwealth supported placement medical students over a four-year program—that is, 30 a year increasing to 120. We will be working particularly for that medical pipeline to be for local people. It is an innovative scheme to provide a pathway for Central Queenslanders to become the doctors of the future, and it is our belief that if you train in this region and you put down your roots and you make connections in this region then that will translate to you staying in this region. We also believe that will have an impact in terms of helping to attract allied health, nursing and other professions to this region because of the instability that we have had in the past from a medical workforce perspective. That by itself will not address all of the challenges that we face, but it is a strategic step forward and we think it will be transformational. That will include the palliative care areas as well as the other areas.

The medical program itself will be a regional one, so it will allow doctors to train in Rockhampton, in Gladstone, in Emerald and potentially on the Capricorn Coast in the likes of Woorabinda. It is a real beach-to-bush training program. On that beach-to-bush theme, we are also looking to reinvigorate a nursing beach-to-bush program to have a pipeline of training but also professional development going forward. I mentioned the MPHSs and the opportunity for nursing staff to work in an MPHS environment, where they might work across aged care and in an emergency department, which provides for a broader range of skills. The opportunity for them to exchange with larger centres like Rockhampton and Gladstone potentially presents an opportunity to address the kind of recruitment and retention challenges that you talked about.

We have seen, alongside that, some real changes in our rural generalist medical workforce model. If you go back about 4½ years, the majority of the medical workforce at Emerald Hospital were locums. Now the majority of that medical workforce are substantive, permanently employed doctors, many of whom have a local background. We are implementing that approach in Biloela and we are commencing work in the Capricorn Coast perspective. That more stable medical workforce allows consideration of a broader range of services in our local regions and will be a part potentially of how we could develop the understanding and awareness of palliative care across a broader range of practitioners. Although we only have a 0.5 palliative care consultant, the opportunity to influence the practice of the whole medical workforce is a really important one. As I said, palliative care is potentially

the business of the whole health system rather than just the professionals. That said, I think it is important for us to continue to see how we can expand that specialist resource as well and to do that innovatively so that we can increase the availability of expertise.

One area we have worked very hard on is telehealth medicine. Central Queensland Hospital and Health Service is one of proportionally the biggest users of telehealth in Queensland. Telehealth has an opportunity in palliative care as well as it does in other areas. We have had significant success in other areas, and at the moment we are focused on what we can do to broaden the use of telehealth in a palliative care setting as well. In a region like ours, which spans about 110,000 square kilometres, those things are really important. If it is possible for us to provide care in the Gemfields through an outpatient clinic, rather than people having to travel to Rockhampton, that can make a huge difference not only in terms of experience but also in terms of outcomes. That travel time can be a bar and a barrier to people choosing to access care as well.

**CHAIR:** Thank you very much. For the benefit of the audience, I come from North Queensland. I am from Townsville. We have a similar set-up there in terms of telehealth. I worked in the health profession for nearly 30 years. It is remarkable to see the advances in telehealth going out to smaller communities. We welcome that. Debra, being the director of nursing, did you want to add anything before we move to questions?

**Ms Hirning:** No, thank you, Mr Chair.

**CHAIR:** I raise two points in relation to nurse practitioners. In the palliative care space, in the state budget \$17 million was allocated to improve regional and remote access to palliative care. That is because obviously the minister is watching what we are doing in the public space. This is a year-long inquiry and there has been overwhelming feedback, particularly in regional Queensland, to increase funding. That is a step forward. Hervey Bay received \$7 million—we had a hearing there two days ago—to build a palliative care facility in the community. Can either of you comment on any funding that was given to Central at this stage or has there been application to access any more?

**Mr Williamson:** Our HHS received significant investment in nurse navigator funding. That nurse navigator funding has formed a part of our aged-care navigation, access and improvement and also has the opportunity to support palliative care. That significant investment in nurse practitioners has delivered a significant increase in nurse practitioners across this region at Rockhampton, at Gladstone and across regional Central Queensland. That was a really significant increase in resourcing to our HHS as a result of that Queensland government investment. We have seen other significant investments separate to this area: investment in maternity and other areas. These things are really important and make a huge difference to local communities and are always very highly valued. As you know, our health system is very complex. It is complex for us as health professionals, never mind for those who are seeking to navigate the system. Those investments are really important.

**CHAIR:** That is excellent. We have heard about the good role that nurse practitioners and nurse navigators play in delivering palliative care and that is good to hear.

**Mr HUNT:** How long have you had the position of palliative care specialist and how long has the current person been in that position?

**Mr Williamson:** I do not have that information to hand. I would be prepared to take that on notice and provide that information.

**Mr HUNT:** I am more looking in general. Is it a new position or has it been there for quite a while?

**Mr Williamson:** The position has there been there for some time. We are undergoing a change at the moment. A longstanding palliative care specialist is in the process of stepping back from that role. That person has provided services in Central Queensland, Wide Bay and other areas. Our 0.5 specialist doctor has been in post for a period of time, so that is not a new role. It has been there for some time.

**Mr HUNT:** That is a 0.5 role?

**Mr Williamson:** That is a 0.5 role—half a full-time role. Whilst that is an important role and it provides direct care, it also has a role to provide advice and guidance across the rest of the workforce. Palliative care is an area where we are considering what we can do to expand that investment. Particularly when you think about the demand that the chair talked about earlier—and I would certainly recognise—even if we are able to maximise the use of telehealth and maximise the use of other services, there may still be a need for further investment in medical and palliative care going forward. Is that enough to answer your question?

**Mr HUNT:** Yes, that is enough without taking it on notice. Are seven-day outreach services for palliative care under the supervision of that specialist? How does that work? Say somebody wants palliative care on a Saturday. How do they go about it getting that outreach to them and what does that look like?

**Mr Williamson:** That service can be accessed as a telephone follow-up. It is overseen through the cancer and palliative care inpatient units. Patients going into that unit or under that care or coming out have access to that seven-day-a-week outreach service. That can be provided in home, but clearly there are constraints in terms of a region like ours across that 110,000 square kilometres. There is an in-home opportunity there. There is phone follow-up and it is under the medical governance of the specialist palliative care service at Rockhampton Hospital. From a governance perspective, it is overseen by that specialist palliative inpatient service with the governance that sits with that. As you would expect as a palliative care service, one of the things associated with that is diagnosis of a life-limiting malignant illness.

**Mr HUNT:** In terms of the facility itself with 11 beds, is there capacity for family to stay with the person? What is the capacity for family to be around?

**Mr Williamson:** There is accommodation available via the Red Cross adjacent to the site of the hospital. There are times when that is not available. It is full. There have been one or two occasions where it has temporarily not been able to provide that service. It is separate to the hospital and health service. We have limited arrangements within the hospital to provide other family accommodation. The facility itself is a fantastic facility. We had a significant investment in the cancer care centre unit part of the hospital a number of years ago, so the environment itself is fantastic for staff and for patients.

One of the challenges we face in a number of services across Central Queensland is the ability to always support families who will travel. In the region that we service that can be a challenge for families. For that reason, and for others as well, we have a determination, where we can, to provide care close to home. We are determined, where it is safe and where it is sustainable, to provide services in the Gemfields. Just as an example, we recently—it is not a palliative care example—introduced eye clinics and then subsequently eye surgery in the Central Highlands region, very strongly supported by local regions. I mentioned that we highly value the aged-care services provided through the MPHSs. If you were to have your committee hearing in Springsure, Baralaba or elsewhere, you would find very strong support for those services. Where we can, we seek to use innovative mechanisms to deliver care close to home.

**Mr O'ROURKE:** In relation to telehealth services, Central Queensland Hospital and Health Service is one of the leaders, or the leader, in the state. Linking that to residents of Central Queensland has saved people in excess of one million kilometres in travel, so well done. It has been really good. What improvements could be made to ensure access to appropriate palliative care for residents in Central Queensland? Are there any key areas that we need to be aware of?

**Mr Williamson:** I think there is a range of areas. Thank you very much for the question and thank you for the comments about telehealth. If I start with a personal view that palliative care is the remit and responsibility of the entire health service, ensuring that every element of that service is able to provide palliative care support would lead to the question: what actions can we take to ensure the provision and access to GP services is equitable wherever in Queensland you might be? We see challenges perhaps related to the medical workforce challenges that hospitals face as well with access to GP services in regional Queensland.

There is potentially a question around, from a point-of-care perspective, the payment mechanism or the remuneration for those kinds of services from a general practitioner perspective. Whilst I mentioned that before, it is not an area that I will be able to speak to with a great degree of knowledge. I do understand that that is an obstacle in some areas from a primary care perspective.

In terms of other areas, the appropriate provision of the right nursing workforce to navigate through that system is significantly important. We have regular feedback from patients receiving palliative care that the right nursing experience, the right nursing insight, the right nursing navigation through that very complex system, can be instrumental in helping them and their families and can be transformational in terms of compassionate care as well. Continuing the ability to invest in and access the funding for those sorts of services that allow the appropriate navigation of these services would be of significance.

Looking ahead, when we think about the ageing population and we think about the increasing demands on palliative care and ensuring that our health system has a mechanism by which it can manage and navigate through those areas, we could see something like a 40 per cent increase in



demand for palliative care services in this region over the next 10 years. That is an approximation but is broadly based on the Queensland Health report which has already been submitted to the committee. That presents huge challenges from the perspective of funding a health system. Ensuring we can work as seamlessly as possible to remove inefficiencies across the whole system will be really important.

From a palliative care perspective, if we look at aged residential environments in the Rockhampton and Gracemere region, there are about 620 residential beds. We provide 25 per cent of those beds. The rest are provided in the private setting. It is important that those organisations are supported, expected, required or enabled to play their part in providing palliative care in the home. For those residents of nursing residential homes, that would be their home.

From a hospital and health service perspective, we see times when private residential residents will enter an emergency department, not really because of an emergency department need but because of an inability to provide access to palliative care in those private nursing homes. We see that locally as a challenge in Rockhampton. We also see that—and we have that report back to us—there is a challenge in Gladstone. I think Gladstone has different challenges. Gladstone also has a challenge of a potential undercapacity in aged-care beds totally. That might not be an issue in Rockhampton. The ability to work with private nursing residential homes to ensure they are equipped to provide the appropriate environment in which palliative care can be provided, where that is appropriate and where that is necessary, is an area that I think could be improved.

**Ms PEASE:** Thank you so much for coming in today and thank you for that very comprehensive overview. I want to ask some more questions about palliative care. You mentioned the seven-day-a-week outreach service that you provide. Is that an after-hours service or is it only available during business hours?

**Mr Williamson:** It is available beyond business hours. I am not sure I could answer today the exact timing of that.

**Ms PEASE:** That would be fine to take on notice. In our hearings yesterday we heard of families who had access to a telephone number to call, but it was Monday to Friday and that made it quite difficult for families. We have also heard that people who are in hospital and looking to go back into the community or into an aged-care facility have delays because they are looking for their home care packages. Have you experienced or heard about that?

**Mr Williamson:** Yes, we have. That is certainly an issue and a challenge in the Central Queensland Hospital and Health Service. I understand that is a challenge that would be similar in other hospital and health services. We recently did an audit to give us some insight, some information in respect of that. That audit looked at a five-month period earlier this year and identified that patients who were in that situation waiting for a package of support or some other aspect waited on average 17 days. We had, I think, just over 100 patients over that five-month period who had that average wait.

Within that, though, there is quite a range. Some people will wait just one day. Other people will wait significantly longer. That audit was based on those who were in one of our wards who no longer needed hospital care and were ready for discharge from a health perspective but were not able to move into their preferred location or into their required package of care.

**Ms PEASE:** We have been hearing that some patients are waiting up to 12 months. One woman even waited up to four years to receive her package. Many had passed away before they got their package.

**Mr Williamson:** Those time lines happen. That is very unfortunate and incredibly traumatic for the person, the family and the nursing staff and ward staff who provide the care for those people who try, in my experience, everything they possibly can to enable and facilitate that person to go to their home and move out of the hospital. The audit that we ran was for one particular ward. We certainly have other evidence to say that sometimes patients can wait 12 months or longer for access to ACAT services.

**Ms PEASE:** Are you able to provide that information to the committee?

**Mr Williamson:** We can certainly provide that audit that I just referred to, which was from our SAGE ward, for that five-month period. I do not have it—

**Ms PEASE:** That is fine. If you could email it to the committee, that would be great.

**Mr Williamson:** I am very happy to do that.

**CHAIR:** We can place that on notice. That is a very good point. For the benefit of the audience, we are speaking about a Commonwealth home care package. People access levels 1 to 4. We are hearing of people passing away before they access it. The burden then goes back to the local HHS to care for this person, because they cannot get the funding. I think you should be applauded for doing the audit. Earlier you said that you had other evidence of people waiting. That is what I was keen to access. If you have other evidence of people waiting 12 months, we need to see that. We would like to get it from each HHS, because we know the impact of that on the public hospital system.

**Ms PEASE:** With regard to the 11 beds in the Rockhampton Hospital cancer and inpatient unit, do you take people who require palliative care who are not cancer sufferers?

**Mr Williamson:** Yes, we have.

**Ms PEASE:** Do they go into that same ward or are they just looked after within the wards themselves?

**Mr Williamson:** It would depend on the individual's circumstance. In the 11-bed cancer inpatient unit, we have and continue to take patients who are palliative patients and not through a cancer reason. We also recognise that Rockhampton is a base hospital for the whole region. Those other hospitals—Gladstone and along the Capricorn Coast, Biloela and Springsure—all have palliative care-specific designated beds as well. We seek to use those where we can. There are also occasions when people may have a palliative care aspect but they are elsewhere in the hospital for a range of reasons.

**Ms PEASE:** Do you think the area would benefit from having a palliative care hospice?

**Mr Williamson:** Yes would be my short answer, but I might say a little bit more about that, if that is okay. There have been some very successful stories of hospices elsewhere. The experience of the individual person, the patient and their family of having the environment which is not a hospital environment, which has facilities that make it very easy to allow family members to stay, that has an environment that is as close to home as it possibly can be, which is not clinical, I think is incredibly important. I believe that the potential for a hospice in this region would be greatly appreciated by those who work in palliative care and those who work across the health professions and it would be greatly appreciated by the local community as well. I would certainly support and advocate, if I were allowed to suggest to the committee, that that would be a very positive step forward.

**Mr McARDLE:** Thank you for coming today. Mr Williamson, that was a very comprehensive statement. The chair raised a question that is now on notice about the staff-patient ratio. Can I enlarge upon that slightly. You have 12 hospitals and MPHSs throughout the HHS. Can we look at a certain date—for example, today's date. With regard to those hospitals and MPHSs that provide aged care, as at today's date can you provide the data per shift of the staff-patient ratio, the mix of that staffing level—RN, PCW et cetera—and the number as well as the number of patients you are holding? That gives us the name of the facility, the number of beds, the number of patients and then the breakdown of the morning, afternoon and night staff-to-patient ratio and qualifications. Is that possible—not today, I accept that?

**Ms Hirning:** Absolutely.

**Mr McARDLE:** That would be great. What proportion of Queensland Health funding by way of the budget—not ABF—do you utilise in relation to palliative care? In 2018-19—and not ABF—what was the amount that you used from your budget from Queensland Health for palliative care?

**Mr Williamson:** The total income associated with the Central Queensland Hospital and Health Service from all sources—from state, Commonwealth and own-source revenue—would be a little bit over \$600 million.

**Mr McARDLE:** That is for this financial year?

**Mr Williamson:** For the year just gone.

**Mr McARDLE:** Right.

**Mr Williamson:** It would be a little over \$600 million. The total spend on palliative care would be a little over \$2 million. That percentage would be about a third of one per cent.

**Mr McARDLE:** About 0.35 per cent, is it not?

**Mr Williamson:** Yes. I am just giving range figures but, in terms of context, it would be about a third—

**Mr McARDLE:** Yet you made the comment that the population of people over 65 will skyrocket between now and 2026. That 0.35 per cent, based upon last year's figures and this year's budget of \$622.8 million, is a very small portion of funding allocated by this HHS to palliative care. Can you outline the plan over the next five years to increase that funding and what that funding increase will amount to each year?

**CHAIR:** That might be difficult.

**Mr McARDLE:** I am happy for you to take that on notice. I just wanted clarification. I want to put in context the \$2.2 million. If the budget was \$622 million, that is a small portion. Could you take that on notice? In the next five years, how are you going to increase that 0.35 per cent to something that caters for the growth that you have outlined? It is important for us to understand the dynamics.

**CHAIR:** We want to make sure that we land on the same thing. With respect to the deputy chair, we will be making recommendations per region, or however we land it, on what we think should be there, but we want to make sure that we get a shared view.

**Mr Williamson:** I understand the question and the perspective. I will just add, if it is okay, that a whole range of our services would be relevant to deliver support to those who are palliative care patients. Palliative care patients will, in addition to their palliative care condition, be receiving care for a whole range of other reasons. Because of that, it may be difficult. I understand and I will endeavour to see what information can be provided.

**Mr McARDLE:** Mr Williamson, with respect, you can give us a figure of \$2.2 million. You can tell us that now today, so you can calculate that out and that must be, based upon your own words, separate from other assistance given. We are ultimately asking you to provide what you are planning in the next two or three years in that quadrant, because you can give us the figure today for 2018-19.

**Mr Williamson:** I would just like to—and this is what I was seeking to do—clarify the answer I gave. Of the \$600 million income received by the HHS, just over \$2 million of that income relates directly specifically and explicitly to palliative care. I would need to be clear that our spend or our expenditure on patients who are palliative care patients would be—because those patients receive other access, other services, other issues or other support—most likely higher than that \$2 million.

**CHAIR:** To articulate that, that might be dialysis.

**Mr Williamson:** Yes.

**CHAIR:** That could be in cardiac or respiratory. There could be a range of things, so I understand it is very complex.

**Mr McARDLE:** If you can arrive at a figure of \$2.2 million, I think you can assist the committee by giving us an equivalent figure going forward, so I think we are at a simpatico in relation to that. You will do the best you can and get back to the committee. Thank you. With regard to the issue in relation to specialist palliative care, you have 11 beds in Rockhampton, four in Gladstone, one in Emerald, two in the Capricorn Coast, two in Biloela and one somewhere else and another as well. I ask you to provide the committee with a breakdown in relation to each of the facilities that do provide palliative care beds with regard to the number of specialist palliative care nurses who are employed in those facilities per facility—not today, but please take that on notice as well. You mentioned the seven-day outreach palliative care. You mentioned also the weekend palliative care services. Did I mishear you: is it only telephone on the weekend or is there physical attendance to a patient's residence to assist, or is it simply advice by telephone?

**Mr Williamson:** No. The service provides both in-home services at patients' homes and access to telephone support as well. As I said earlier on, with regard to the governance and oversight of the specialist palliative care service at Rockhampton, I undertook a little earlier at the chair's discretion to provide on notice a summary of the actual hours of operation of that service. I am not able to provide that today, but I will and have undertaken to provide clarity on the access to that seven-day-a-week outreach service.

**Mr McARDLE:** I am particularly focused on the weekend, Saturday and Sunday clearly. Is that manned by individuals or staffing levels that attend a patient's residence or is it merely telephone contact? That is all I want to understand.

**Mr Williamson:** It is a seven-day-a-week service with both in-home access and telephone support, but I am not able to provide today the details of the exact composition of that.

**Mr McARDLE:** Okay, but you will take it on notice?

**Mr Williamson:** I have undertaken to provide that to the committee.

**Mr McARDLE:** Can you also provide with that breakdown the qualifications of those who staff the service both each week day and on the weekend as well? Is that possible?

**Mr Williamson:** Yes.

**Mr McARDLE:** Thank you very much. You made comment, too, about the training places, and congratulations on that. I agree entirely with you: if you can get young people up here they settle in, as opposed to a mortgage back in Brisbane and they are locked into Brisbane, and they are likely to stay here. You said 120 places over four years will be developed. Is that year 1 and year 2 or are you starting at years 3 and 4? How does that scenario work?

**Mr Williamson:** That is the whole four years, so year 1, year 2, year 3 and year 4. At the moment some of that training is provided in this region, but the first two years are provided in Brisbane and not all of year 3 and year 4 is provided in this region. From 2022 the entire four-year program will be provided and the year 1 of that program will start in 2022. There will be 30 Commonwealth supported places in that year 1 and then in 2023 we will have a new year 1 and the previous year 1 moving up to year 2, so at that point we would have to accommodate having 60 and then it would build up to 90 and then to 120 Commonwealth supported places. Just for clarity, it is a similar number in Wide Bay. The agreement reached was for the two hospital and health services together to work with Central Queensland University and the University of Queensland to deliver that. It was our view that the scale across that wider region enabled this model of teaching and training to work and to work most effectively at that level of population and at that level of clinical opportunity.

The vast majority of training for Central Queenslanders would be in Central Queensland and similarly for Wide Bay. It may be as we progress that opportunity going forward—and we still have much work to do between now and 2022—for scenarios where we might end up with joint professorial appointments and in some areas there may be a Wide Bay and a Central Queensland one. I want to acknowledge particularly the support from the two universities but particularly from the University of Queensland. It is the University of Queensland which has the Commonwealth supported places which has agreed for those places to move from a Brisbane base to a Central Queensland and a Wide Bay base and I very much acknowledge that significant step forward to medical training in the region. That is exactly what we want to see in this region for the reasons that you talked about. That can be transformational. It is our belief that the quality of training that medical students will receive in this region will be as good, if not better, than the quality of training they would receive—

**Mr McARDLE:** No, you are wrong. They will be better. You cannot get a better training than out here in the regions.

**Mr Williamson:** If the committee would indulge me for 30 more seconds, the support we have had from some GPs for this program has been outstanding and I would acknowledge the likes of Dr Ewen McPhee, who has been a driving force behind this as well. I think we jointly have a view that this will transform general practitioner recruitment as well as it will transform hospital recruitment, so there is a great potential benefit for the whole community.

**Mr McARDLE:** With regard to the hospice, which I think is endorsed wholeheartedly by the community behind you and in fact yourself too—there is no doubt about that—where do you think that should be located? I know it is a very difficult question because you have to get flow numbers, credentialing et cetera. That is critical, so are we talking about Rockhampton proper? It is a very wide area. The population base is predominantly around Rockhampton and the immediate vicinity. Pushing it out further would create some real difficulties in recruitment, retention and credentialing as well. How do you tackle that? What would you suggest, even though I have put you on the spot?

**Mr Williamson:** I would start with a view that the numbers of people using our hospice service in a region like this are likely to indicate a single hospice rather than two hospices, and in a bigger region with a higher population that might be different. Our understanding for sustainability from a rostering and a support perspective is it would most likely be enabled with a single hospice. We have tested that. We have given that consideration, but I think we have arrived at a view that that would be the most likely operational way of delivering that and then wherever it goes there are challenges in terms of access across a region the size of ours. It would not need to be adjacent to a hospital, although some support from the hospital would be important, particularly from a medical workforce perspective, and there will be a need for a medical workforce.

Given the medical workforce link and given the cancer inpatient specialist service that we already have in the Rockhampton Hospital, there would be some advantages from a workforce perspective in it being somewhere in the Rockhampton region, and that is driven really by the location of the specialist palliative care services which are in this region. It is not impossible for it to be further afield so we would not discount that but, given the challenges of how these sorts of services are

funded, how they are viable and how they are sustainable, there are a number of advantages in a service like that being single site and being in a Rockhampton region but not necessarily on the base hospital footprint. It could be elsewhere. We do have a relatively large geographical footprint in the Rockhampton Hospital facility, so if we were fortunate enough to deliver and develop a hospice there are some opportunities for that to be adjacent to or on the hospital site if it was to be that.

There is also, though, a question about who is best placed to run a hospice, and that is not necessarily the hospital and health service. It could be, but there will be other organisations that would be very well able and equipped to do that. If it was not for an organisation, there would be opportunities, if it was useful, for partnership work to support, as an example, the medical workforce. There are a number of different ways in which a hospice could be enabled and when I advocate for a hospice I will declare that I am not necessarily advocating for the HHS to run that hospice, but I think first and foremost that would be a great service to have for the residents, community and families in Central Queensland.

**Mr McARDLE:** Are you part of the steering committee?

**Mr Williamson:** If I had an invitation, I would be delighted to be a fierce advocate for that and to—

**Mr McARDLE:** I give you your first nominee.

**CHAIR:** I think your local member would help champion that too.

**Mr McARDLE:** Thank you very much, Mr Chair and Mr Williamson.

**CHAIR:** I ask the audience to thank the excellent presentation given by your HHS and from the committee's perspective we want to thank every single nurse, doctor and allied health staff in your HHS for delivering good, quality care. You have informed us of what your vision is and we deeply appreciate that. It is a good practice for estimates as well. With that, we will adjourn for five minutes.

**Proceedings suspended from 3.40 pm to 3.49 pm.**

**ELLROTT, Ms Maria, Private capacity**

**SENICA, Mr Frank, Private capacity**

**van der WEL, Pastor Neil, Private capacity**

**WHYTE, Ms Lesley, Private capacity**

**CHAIR:** I welcome our next group of witnesses. We will ask each of you to make an opening statement of roughly three minutes—we have some other people to speak to—and then we will move on to questions. I welcome Maria to start first.

**Ms Ellrott:** Thank you. I am a registered nurse. I am a midwife. I have worked as a community nurse and I am also helping to look after my husband's mother in aged care, which I have already complained to the ACCC over because I feel there was gross negligence in care. That is to the point now where we take regular trips down to Emu Park to the nursing home involved because we feel that if we are not constantly on the ground there she is not totally cared for as well as we would like.

We are also doing this for all the other aged-care people out there in the community. It is probably worth noting that on Sunday I happened to be in the care facility. It is pretty apt at this point to mention that there was an assistance nurse, I think she was, who came in to Gran's room to put in her eye drops and she made a point of saying that she was the only person on that wing at that stage—that was roughly two o'clock in the afternoon—and the registered nurse was looking after the other care people. God help anybody if there was actually a multitude of things that went wrong, because the facility just would not cope.

**CHAIR:** How many people are in that facility?

**Ms Ellrott:** I knew you were going to ask that and I am not sure, but there are two floors and there are probably 20-odd or maybe 30-odd in each wing.

**CHAIR:** Okay, thank you. Please continue.

**Ms Ellrott:** Community wise, I feel palliative care is just deplorable. In the organisation that I used to work for I feel we tried our best as far as that was concerned. In terms of 24-hour care, I can vouch that we would give 24-hour care. There were several times where people may die on weekends or may die in the middle of the night and we all had our phones by our bedsides so we could go and support the families in their time of need. We can sign the death certificate because it is two registered nurses, so I think the families in those particular instances felt cared for, as far as we were concerned. However, it is grossly underfunded.

I notice that under-65s have not been mentioned. That issue is just massive in this area. As you say, there are a lot of registered nurses who are 50-plus. Again I say: God help the region when all of them start to retire, because there are not a lot of people who want to take over the responsibility. I can speak for myself and a few others who probably cared too much about our patients in that we liked our patients to experience the best of care to the very end of life. I do not think there are enough nurses on the ground these days in hospital situations to deliver all of this, and you hear it time and time again by so many people. We own a coffee shop here in Rockhampton, and a number of people come in and, not necessarily even knowing that I am a nurse, just spill all of their stories about things that are happening to them in the community.

**CHAIR:** Thank you very much.

**Ms Ellrott:** I have a whole heap of submissions here with stuff if you want to take the time to read them at a later date.

**CHAIR:** We have to procedurally table them, so is leave granted? Leave is granted. We will table those. Ms Whyte, I ask you to make an opening statement.

**Ms Whyte:** Thank you. I am a clinical nurse in palliative care with postgraduate qualifications in palliative care. I just wanted to draw to the committee's attention that—I do not work in the Rockhampton region but in the CQHHS; I work in Gladstone—each of the services functions quite differently because they are all structured a little differently. We do provide a 24-hour service. We carry a phone on evenings and weekends. I just felt it was important that the committee had an understanding of the capacity of the palliative care consultants, and Mr Williamson did allude to the fact that that is a 0.5 position. The 0.5 role cannot possibly sustain and cannot cover the region.

I think you also need to be aware that whilst the full-time clinician, who is at the moment on extended leave and going to retire, was funded from Rockhampton, that clinician did not work in Rockhampton. He was very much a fly-in fly-out, and that clinician provided support to Gladstone,

Hervey Bay, Maryborough, Biloela, the Gemfields, Baralaba, Winton and Bundaberg. I think we really need to have some clear indication when that position becomes available as to how that role is going to be funded and how it is going to provide support across the region.

**CHAIR:** Thank you very much, Ms Whyte. You were spot on time. Did you want to continue?

**Ms Whyte:** Yes. That has impacted on our clinical governance in that we contact the Prince Charles Hospital when we need advice and specialist palliative care input.

**CHAIR:** Thank you. We are working with Palliative Care Queensland. They have made a submission. They note that there are 48—do not quote me exactly—palliative care specialists in the state of Queensland. Our job is to make recommendations to try to improve the services, and their recommendation was to get that number up to almost double, at 92. With regard to how we go about attracting specialists to work in the area and retaining them, that is certainly something that the committee is hearing in every region where we travel. Thank you very much for articulating your views. It certainly helps us moving forward.

**Ms Ellrott:** If I could also just add on that point, we do not have anybody specifically in the palliative area who can make up a combination of drugs to assist somebody to live as normal a life as possible. There are a lot of people out there who have cancer and they are going to die, but there is no reason they cannot be on syringe drivers out in the community. Since we lost one guy years ago, we really have not had anybody to fill that role.

**CHAIR:** I am pretty sure that Mr Williamson said—and we hear it—that 80 per cent of people would like to pass away at home surrounded by loved ones. The reality is that around 14 per cent of the state do and the rest end up in a tertiary hospital. It is how we get those syringe drivers and how we get community palliative care delivered. Again, it helps us in our recommendations going forward, so thank you. Frank, I invite you to make an opening statement.

**Mr Senica:** My name is Fran Senica and I am 82 years of age. I come from Gladstone. I would like to thank the Queensland government for allowing me to speak here today. First of all, I want to table a brief summary of my ideas of euthanasia. They are in the papers.

**CHAIR:** Is leave granted? Leave is granted.

**Mr Senica:** Mine is a bit unusual because I am predated my death.

**CHAIR:** I see that in your submission.

**Mr Senica:** I think this would be welcome with the palliative care people before they get into that dilemma. For example with me, I am 82 years of age and I have leukaemia. My doctor says to me that leukaemia usually changes from good to bad between 80 and 90, and I am almost 83. I know I could be in trouble; I may not be in trouble. If I am not in trouble, with this predated I can advance this from 2024 to 2025 or 2026. If I am unlucky, I will die before 2024.

Three weeks ago I had this put in the local paper in Gladstone. I was amazed at how many people, not knowing me at all, came to me saying, 'Frank, aren't you the man in the paper? Gee, that's a good idea.' I have followed this since the Nitschke report 20 years ago and Kevin Andrews from Victoria 20 years ago—palliative care, how people get sick and how they die. I do not want to wait that long. I want to predate my death. It is as simple as that. I do not want palliative care.

**CHAIR:** We have been following with interest the Victorian legislation that was passed. It has a six-month period in relation to being diagnosed with a terminal illness. Western Australia's expert panel has just concluded and has recommended consideration of a bill containing provisions relating to 12 months. Do you have a view on that?

**Mr Senica:** No, I do not. In the Victorian system, two doctors need to say you can be euthanased. In my case, I do not need any doctors because I am predated my death. The only people who could help me are my specialists—my heart specialist or leukaemia specialist—and my local GP. I do not think it is necessary for two doctors to say if and when you can or cannot die, especially in my case. After listening to everybody speaking here, I think a lot of elderly people would be in favour of my predated euthanasia. Do not let yourself go that far. I am thinking about now. Now I am fine. I may not be fine in two years or less. I may be okay in five years. Who knows? But I am doing it both ways.

**CHAIR:** Thank you. We might pass over to Pastor van der Wel.

**Mr van der Wel:** Thank you for the opportunity to speak. I very much appreciate that. My name is Neil van der Wel. I am a Christian. I am a minister. I am the pastor of a local congregation, Reformation Presbyterian Church Rockhampton. I gather that I need not refer to my written submission, but I want to speak to it in a sense. In my submission I appealed directly to the Bible as Rockhampton

the word of God and as an authority not only for Christians but for all because God is the creator of all. When I say these things, yes, I am speaking in a sense for myself as a Christian, as one who has been set aside to say the things the Bible says, but I speak in a sense for those Christians who continue to hold the Bible to be their rule of life. I will not give any numbers; I think it is pretty hard to. In Queensland, there would be plenty of people for whom in this matter I would be speaking representatively.

When I appeal to the Bible as the word of God, God tells us in his word about life and death. The sixth commandment—many people would remember at least some of the commandments, even from their youth—is ‘thou shalt not kill’. The reality is—and this has been recognised for millennia and centuries—that whether it is called voluntary assisted dying, assisted suicide, euthanasia, mercy killing or whatever, it amounts to the same thing—that is, murder. I suggest that the current legislation in Queensland acknowledges that that is the situation. If someone helps someone else to die, however hygienic the circumstances and whatever the clinical setting then that is counted and could be prosecuted as murder, obviously leaving that to the courts. Some people will say, ‘Well, morality ought not be legislated,’ but that is not an option. The question is: which morality? Something has to be legislated. What will be the standard that is applied and upheld? The question is: will that be God’s standard or some other standard? Will it be that which has been recognised for millennia and centuries as true and a basis for the rule of a nation or will it be that which the present majority thinks is okay?

I suggest that we are safe and going in the right way when we adhere to the standard which has existed from the beginning and under which societies have prospered rather than what we see really as a slippery slope. We see that in other jurisdictions where this sort of legislation, in terms of voluntary assisted dying or whatever we call it, has been introduced. Perhaps at the beginning it is entirely voluntary but soon enough it is involuntary. I think recent history demonstrates this. I appreciate hearing things in terms of palliative care and aged care—I suppose I have pastoral experience in terms of these things—but I wanted to speak today with regard to voluntary assisted euthanasia.

**Mr HUNT:** Thanks, everyone, for sharing your views. Maria, you were a registered nurse in Bundaberg?

**Ms Ellrott:** No, Rockhampton.

**Mr HUNT:** You said that it is hard to attract new people to the regions to work. Do your colleagues tend to be locals or people who have come in?

**Ms Ellrott:** I think 90-plus per cent would all be local at some point. I was born in New South Wales but have lived in Queensland for nearly 40 years.

**Mr HUNT:** So people have grown up in the area. When we talk about attracting staff into the area, would it be better perhaps if we looked at better training facilities and keeping people, like people coming out of high school, in these areas to retain them?

**Ms Ellrott:** Somehow we have to manage that. I honestly do not have any cut-and-dried answers. Even with my kids, there are a couple who are willing to stay, I have one that will possibly move back overseas next year, and my son cannot wait to move to Brisbane. I do not know how we keep these young kids here in the area. A lot of people will probably shoot me down for saying this, but, even with nursing in general, I think a lot of skills that the old nurses learned in the hospital setting were better and better equipped the nurses for what they would face in the future. The young ones are very good with, say, drugs and such things—way better than I ever was with anything like that—but there are a lot of empathy skills and so on that I think people learn along the way. The doctors are finding the same in the area as well. They have great difficulty just getting people to come into the area. At the Mater, we have not had a paediatrician for some time. We have locums who come in all the time and, boy, is that hard.

**CHAIR:** I have a question for our two nurses. You both have nursed in palliative care?

**Ms Ellrott:** Yes.

**CHAIR:** We have received thousands of submissions. With the greatest of respect to Pastor Neil, who just made some comments—this is a sensitive area that has divergent views—we have had palliative care nurses and specialists sit at the table and the consistent theme we keep hearing is to provide people with choice and compassion at the end of life. In your experience when dealing with palliative care patients, have you had patients say, ‘I just want to end it all. Help.’ Can either of you comment on that in your practice?



**Ms Ellrott:** I have one strange case of a man with whom I still have regular contact. His family was all in for assisting him to pass away at home. We had syringe drivers set up. There was everything possible for him to pass away at home. He was spoken to by various ones: 'Is there anything you need that you still are hanging on for?' He said that he did not think so. As it turned out, they switched off the syringe drivers and a whole heap of stuff. He is still alive today. He is going to pass away at some point in the future, but I do think that, in the context that we are working with now, people will die when they are ready to go. They do need to be controlled pain-wise to keep them in a state where they can appreciate their family and have a nice way of dying without having to fight the whole way. It is hard to watch somebody die in pain. That is not fair.

**CHAIR:** We have heard, particularly in written submissions, about people lingering for days—this can go from hours to weeks or days—and about terminal sedation. One palliative care nurse in Bundaberg described it as 'euthanasia lite', because the end result is death. They just increased the titrate of the opiate or whatever they were using, but the result is the patient slips away and dies. I am just trying to get your views, Lesley.

**Ms Whyte:** I have been a registered nurse for about 46 years. I can count on one hand the number of patients who genuinely requested or pleaded to die. I agree with Maria. I often talk with families. It is the difficulty of witnessing this that distresses families. Very often you have not had the conversation with the patient. It is really not something that has arisen for them.

If we are talking about people with malignancies, with solid tumours, and if we then consider people with neurological conditions such as motor neurone disease, I think their wishes sometimes are expressed quite differently. Very frequently, my experience of patients with malignant solid tumour disease is that they go through a phase of acceptance of where they are. I think every person wakes up each morning with a degree of hope. We often just adjust what we are hoping for. The process for them is many times perhaps not as painful as it is for those families who have to witness. It is then in those last days and sometimes couple of weeks that families are so distressed with what they have to witness.

**Mr McARDLE:** Maria, I take on board your comment about nurse training and attitude today as opposed to some years ago. A couple of cheerleaders at the back agreed with you on that point. I have met many nurses who have retired who trained under the old matron scheme. They say to me that they were terrified of the matron because this particular person ruled the roost but 'by God, I learned how to be a nurse and I learned how to deal with patients and how to provide the care they needed'. I make that comment in that you are not alone. There are two nurses at the back who are with me. I think matrons, though terrifying, do provide a sound basis for training that may well not, on your comment, exist today.

Lesley, thank you for your commentary in regard to the palliative care position. A locum is certainly someone qualified, but there has always been debate around their understanding of the patient, their engagement with the patient and their continuity of care, because they do not see the patient on a regular basis. The fact it is 0.5 indicates to me that the holder of the position in this case is here on a regular basis. How often would that be the position in Rockhampton? Do you have any idea?

**Ms Whyte:** The 0.5 is permanently here, yes. The visiting specialist, as I say, was throughout that district and into the Wide Bay. One thing I would also comment about is we have spoken about telehealth, and telehealth is wonderful, but I have always said that there is no monetary value that could be placed on actually having the palliative care medicine specialist coming to visit you in your home, caravan, donga, whatever and actually sit with you side by side to discuss those issues that might be of concern to you and your family. There is no monetary value that can be placed on that.

**Mr McARDLE:** Where does the locum come from? Do you know where he lives?

**Ms Whyte:** He is not a locum, he was in a permanent position. My understanding is, and you could certainly clarify that with Steve, that it was a Rockhampton funded role, but he actually started his day at Prince Charles Hospital and I think he did one day perhaps at Prince Charles and the rest of his time was spent in the region. So he would then hop on a plane, visit us in Gladstone, fly out to Emerald or wherever he was going to and spend a day, a clinical day, with colleagues. The other component of that is that mentoring. You have actually got this very qualified person side by side with you training his nurses and clinicians with him.

**Mr McARDLE:** The replacement?

**Ms Whyte:** I do not know what that will be. I would suggest that that is something that the committee may like to have clearly defined.

**Mr McARDLE:** Do you have any concerns about palliative care nurses being able to consult with a physician on a regular basis living here as opposed to I think you said RBWH or Prince Charles?

**Ms Whyte:** Yes, I do. We actually refer to Prince Charles if we have a complex patient in the community. Our clinical governance in that instance would be a GP. We work very closely with the GPs, but very often symptom management is difficult. The drugs are used quite differently. The drugs are not what GPs are used to and the way that we use the medication is not always what GPs are used to. Having that specialist knowledge is crucial. At present we actually consult with Prince Charles over the phone.

**Mr McARDLE:** That would concern you as a palliative care nurse?

**Ms Whyte:** It does, yes.

**Mr McARDLE:** Maria as well?

**Ms Ellrott:** Yes, very much so.

**Ms Whyte:** That gentleman, just to add, was available to us—unless he was out of the country—24 hours a day.

**Mr McARDLE:** What an amazing man.

**Ms Whyte:** He is.

**Ms PEASE:** Lesley, I wanted to ask you, given that you work in the palliative sector and that is your substantive position, do you come across situations where people are waiting for a home care package?

**Ms Whyte:** Absolutely. That is another issue. Our main concern is also patients who are over 65 years of age. You would be familiar with the ACAT process. Currently we are being directed that we then have to register those patients, or their families have to register them, with the NDIS. That is a total waste of time and effort because those patients do not have a disability, they have a malignant, life-limiting illness. We go through that process. They get a reference number. That then may allow them to access some services. I think what frustrates myself and my colleagues is that we are clinical nurses. We are quite skilled at being able to assess. Invariably it may be that the care needs of that individual have exceeded the capacity of the family members to provide care so we are simply asking that if there was a bed available in an aged-care facility if we can have an accelerated ACAT, a process where that assessment can be done. At the moment that is taking weeks and weeks and weeks and, as you rightly identified, then the patient has died. We often have instances where we have patients get assessed and they die the next day. We might get them into an aged-care facility and in about two or three days they have died. That is hugely traumatic for them and their families.

**Ms PEASE:** Who is actually conducting your ACAT assessments up here? Are they done through the HHS?

**Ms Whyte:** Yes.

**Ms PEASE:** Are they conducting the ACAT assessments in a timely fashion or are there delays in getting those assessments?

**Ms Whyte:** They have a huge workload.

**CHAIR:** We saw that in Townsville. We were at the ACAT assessment area and they were getting requests for 10 a day.

**Ms Whyte:** It is often weeks, it could be two to three months.

**CHAIR:** I do not have any further questions, but if there are any closing remarks?

**Mr Senica:** Look, I am very dedicated to this idea of mine really. It has taken me quite a few years to come up with this. I think it is quite unique. I think it has merit because most people do not want to get into the palliative stage. I know I don't and I know damn well I am not going to because there must be another way besides that. I am dead against it. My lady partner, she is also against it. I hope this committee will look at it very thoroughly and try to understand it.

On the third page that you have I have a little drawing. That would be like a RACQ card except it would be a Queensland government card. It would have my name, or our name, and you apply for this card, like on 17 July, today, and this card would last for five years which would mean 17 July 2024. On the other side of the card it would be stated 'Queensland government'. It also would be predated euthanasiation. When you apply for this card, this card will be sent from Brisbane, from the government, and what I am talking about is predating it, it would start from that day, and after five years if you still feel fine you can advance it one year or two years at a time. Thank you very much for being understanding.

**CHAIR:** We thank the panellists, particularly the two nurses.

**GARDINER, Ms Linda, Private capacity**

**MORGAN, Ms Lyn, Private capacity**

**PARISH, Ms Helen, Private capacity**

**CHAIR:** Would you like to make an opening statement?

**Ms Morgan:** Thank you everybody. I am not here as a member of any medical discipline, I am just here as a person who has witnessed two people I care about passing. I have not made a formal submission, I am just up here on an ad hoc basis. In February this year a very close friend of mine was in the terminal stages of cancer. She had very good help. She was on morphine at home. When her pain levels were so bad that she could not manage it at home she went to live with her daughter who was a nurse. Not very long after she moved in with her daughter her pain levels were so bad that she was admitted to the Capricorn Coast Hospital. I must say here now that I cannot fault the staff down there. They were amazing. However, they were not able to assist her to keep her pain levels under control.

My friend was admitted on the Tuesday morning and by the Thursday afternoon she was begging, 'Please could you give me some pills. Just let me go. I am in so much pain.' Of course they could not. I am hoping after this inquiry that she would have had the chance. When she was told there was nothing they could do she asked, 'Well, how can I die?', and they only gave her the option of withdrawing food, water and medical treatment and my friend elected to do that. I sat with her for four days watching her cry out in pain and she literally starved and thirsted to death, which was the only way she could hasten her death. I put my pets to sleep because I love them and I only wish I could have done that for my friend. It was just cruel. I too am a Christian person, but I believe that my God is a merciful God and he would not want that for anybody. So please pass this so when it is my time I do not have to go through what my mother and friend did. Thank you.

**CHAIR:** Thank you very much. Before we go to Linda, I recognise the member for Keppel, Brittany Lauga, who has come in to join us. Ms Gardiner, thank you very much. Welcome.

**Ms Gardiner:** Thank you. My investment in palliative care and voluntary assisted dying comes from three different perspectives, and that includes under duress my need for aged care as well. My perspectives come from being a daughter and a sister, from being a mother and from being an individual. As a daughter and a sister, my mother and father both passed away from cancer. My brother, sister and I all have cancer. We have a 100 per cent hit rate.

My mother, who passed away five years ago, was what you would consider an atypical Scottish woman. She was not a particularly big woman, but she could cut steel with her tongue. She was strong, independent and had dignity and great pride in the person that she was. My father died when I was five. She brought up three young children in a foreign country and was very proud of her achievements.

My mother had three different types of cancer. She fought breast cancer and uterine cancer and eventually died of pancreatic cancer. Pancreatic cancer is one of the most evil diseases you are ever likely to experience. She went from being this incredibly proud, vivacious and interactive woman to being incontinent, drooling, demented and angry. In the moments of clarity that she had, she was angry. She hated us for allowing her to live. She hated the system for making her live. She hated God for making her go through it. She became bitter to the point where she would spend days not talking to us because we would not kill her. She would tell us, crying, that we did not understand the pain that she was experiencing. Unfortunately, from an individual perspective, it is something that I am going to learn in the very near future myself.

As a mother, I have a 29-year-old son who has a progressive neurological condition which is called primary angiitis of the central nervous system. Basically, he has a leaky brain. He has had six strokes. He has major cognitive impairment, physical impairment, speech impairment and, without fail, on every one of his strokes he has ended up in the Geriatric and Rehabilitation Services, or GARS, facility here in Rockhampton. I reckon he would be the only person in the facility aged under 60. By default, when he gets to the point where he is going to need full-time care, there is very little other care than aged care in Rockhampton for us to utilise for him. He is a 29-year-old man with a four-year-old daughter who ends up in aged-care facilities because there is nowhere else for him to go. That is not fair on the nurses, it is not fair on him and it is not fair on the other people in the facilities, either.

As an individual, a month after my mother passed away I was diagnosed with stage 3 invasive inductive carcinoma—breast cancer. Six months ago it returned. I am now stage 4. It has metastasised. The average life expectancy of someone with my stage of cancer is 2½ years. Like my

mother, I am a strong person. I am educated. I am a Christian. I have strong morals and strong values. I am a mother of two boys, a grandmother of two grandchildren and a wife. I want the right to choose my life journey. I do not believe that palliative care and the request for voluntary assisted dying are mutually exclusive. They can work together. There is no reason the two cannot support each other and I can have a good end to my life.

I remember my brother, sister and I running around doing mad dashes three or four times at one or two in the morning because we had had that phone call from the hospital saying, 'This is it. Get in here.' My brother took a job in Gladstone from the Northern Territory so that he could be close by. After three attempts, on the fourth attempt he did not make it. He lives with the guilt that he was not there for his mother. In terms of jobs, I had a large amount of time off work to run to my mother's side. It was only four weeks, but that is a substantial amount of time for any business to have to lose people at the drop of a hat, with no reason. In terms of travel, my sister came from Sydney and lived with my mother and looked after her. She left behind a daughter with a severely disabled child, therefore burdening the rest of the family. It is stressful. I do not want to put my family through that.

My main reasons for wanting the ability to choose this is not only for me. No, I am not stupid—I do not want to suffer like that—but I do not want my children watching me drool, moan and soil myself. Towards the end, my mother was asking for assistance to go to the bathroom. She was told, 'We are too busy. Just sit there and soil your nappy.' That was the last time she basically spoke to any of us. She just refused. She had lost all dignity and she just wanted to die.

Palliative care and even the choice to die is not just about our medical care, either. One of the biggest problems I have had with my son, my mother and even myself is disjointed services. Trying to get information from Royal Brisbane to Rockhampton to the GP to GARS—and then if anyone has had the pleasure of trying to jump the hoops through Centrelink to actually get any financial support. I have been trying for three years to get my son on disability. If you are impaired, whether it is for age or a medical condition, the expectation is that you have the capacity to jump through their hoops and do the paperwork they demand. My son is not mobile. He is not verbal. He is very severely cognitively impaired. He has to do a work capacity assessment next week.

Palliative care is not just about the hospital. It is holistic. If we do not take the other parts into consideration in this, then having a hospital facility is not going to help us. I want the right to choose when I die. It is inevitable. It is going to happen. I will be lucky to make 55. I want that right.

**CHAIR:** There is something that you have got from your mum and that is your strength and resilience. There is nothing more powerful than a personal journey experience. I thank you for sharing that with us. Helen Parish, welcome.

**Ms Parish:** Thank you for the chance to address this inquiry. Due to the obvious time constraints, I have some thoughts on assisted dying that I wanted to share, as well as on aged care. I will speak about voluntary assisted dying first, because I feel very strongly about that. I will read out what I have written. Before I go on, my background is in nursing and I have done a degree and worked with people who are disabled or were injured at work.

It is my belief that if someone of sound mind chooses to have someone assist them in their wish to end their life, they should be able to do so. I have nursed people in agony from terminal cancer, begging to die. I have listened to patients begging their spouses or other family members not to ask them to push on and continue to experience the pain they are suffering. I have assessed people with terrible disabilities. I have attended a Dr Philip Nitschke exit presentation. I believe that no other person has the right to dictate what I do with my end-of-life choices, regardless of their medical, legal, political or religious backgrounds or their ethical concerns. They are free to choose to suffer if they wish or to watch their relatives suffer. However, I choose not to do so and, provided I have stated this whilst of sound mind to my solicitor, the state should give me the right to die with dignity.

I should not have to consider moving interstate or internationally to die. I am entitled to die here with my family by my side. Not everyone has the money to spend on being brought back from overseas after their death so that they can be buried or cremated locally. Not everyone has the money to pay huge gap fees, which are ever increasing, for their medical treatment whilst lingering to appease the do-gooders in our society. Those are my thoughts on assisted dying.

In relation to aged care, over 10 years ago my sister, my mother and I suffered some real issues to do with aged care. My mother had a fall at home in 2006. She had an impacted hip fracture and, either during the surgery or the recovery period from that surgery, she had a massive stroke. A physician was called in and we were told that the stroke was so huge that it was incompatible with life. He said at the time that it might take an hour, a day or a couple of weeks for Mum to pass. However, that did not happen. Twelve months later she was still alive.

Around five weeks after the surgery, I got a phone call from one of the rudest women I have ever had the displeasure to have to speak to. She did not identify herself. She did not say where she was from. She did not say what her background was. It turned out that she was from the ACAT team. She was a psychologist, believe it or not. She was ringing to tell me that my mother could not stay in hospital one more day—she had been there for five weeks—and asking what I was going to do with her. I suggested she take her home for the weekend. I was working full-time. After some more unpleasantities with her, I went in to meet her. She literally threw a booklet on aged-care work at me and told me to sign it. I said, 'I'm not signing anything until I have read it.' I was very grudgingly shown into a room where I sat and read the document. I proceeded to fill it out after I had visited several homes in the area.

My sister and I are both trained nurses. At the time, we decided that we would be very careful about what we had to say about Mum's care, knowing that many nurses do not like to nurse other nurses and certainly do not like input from nurses who are now retired and doing something else.

Within a week of Mum being in the home, I went out to visit her and she had one tablet down the middle of her nightie, sitting on her chest. Another tablet was sitting on the front of the nightie. Her face looked like that of a painted clown. One of the tablets had dissolved and was sitting around her mouth so that she did look like a clown. I inquired about why she had been left like that, when one of the first things I was taught as a nurse was to make sure that patients swallowed their medication. I had also been promised that it had been put in her chart that her medication needed to be crushed and put in jam so she would not have any trouble swallowing it.

Eventually, after several issues like this, I complained to the director of nursing. I was told that I should not feel bad about having done so and that she would listen to what I had to say. I made a complaint and I was promised that things would get better. They did not.

On one occasion Mum had defecated into her continence aid. She scratched at herself and there was faeces on several pillows in her bed and the bedrail covers. I was not there at the time but visited later in the day. The bed and the continence aid had been changed, but several pillowcases and the covers over the bedrails—Mum used to try to get out through them—still had faeces on them. I was so angry that I took the affected pillows and the covers off and threw them on the floor. A staff member came in and asked why the pillows were on the floor. I told him in no uncertain terms why they were there. He told me that the covers could only be changed twice a week and it was not that day of the week. I said that if they were not changed immediately I would ring the Minister for Health at state level first thing Monday morning. Then they were changed.

On another occasion I asked the same gentleman if he could change my mum, as her dinner had come to her and she was dirty. When I found him and asked him to change her, he said, 'We've just been past her room and she was changed.' However, she had defecated afterwards. How dare she! Dinner came and he asked me, because he was busy, if I could feed her whilst she was dirty. I asked him if he would eat his dinner with his pants full of shit. He said no and came and changed her.

My main issue about some of these things is that understaffing is a major problem in aged care in this country. However, there is little empathy from some of the staff and some of them should know better. A lot of the nurses are enrolled nurses or assistants, and they certainly do not get the training that registered nurses do. One registered nurse that my mother had some dealings with told me on one occasion when I asked why the screens were pulled around my mother's bed that she had been throwing her legs around in an unladylike fashion. I said, 'So. Very few people visit out here except relatives and very few people are going to see my mum with her legs in the air.' She said that it was not ladylike and that people should not have to look at that. My mother hated being in that nursing home and this woman dared to confine her to a room covered by screens because she was offended by seeing my mother's continence aid.

The same woman also made a comment to me one day when I went out to visit that my mother was upset. I asked her what she was upset about, and she said that the lady down the corner was speaking in Japanese. My father was a prisoner of war of the Japanese for 3½ long years. My mother hated the Japanese. Surely the common sense thing to do would be to put my mother down the other end of that huge common room so she did not have to listen to the woman speak in Japanese. As I said, very little common sense was shown.

**CHAIR:** Ms Parish, I do not want to interrupt you because you are telling a dreadful story about your mum, but would you like to table the rest of that submission so that we have it on file? My second question is to ask whether you have taken that to the complaints commission and what was the outcome. Where are things at now?

**Ms Parish:** No. I complained to the director of nursing on several occasions and then mum passed away. I did put in a submission to the federal government inquiry.

**CHAIR:** I was going to ask you that question.

**Ms Parish:** But I have not heard anything back.

**CHAIR:** They do not report for two years. We report a year earlier. We would very much like to see your submission if you would like to table it.

**Ms Parish:** All right. Can I make one more comment?

**CHAIR:** Yes.

**Ms Parish:** There have been several stories on TV recently about the abuse of elders in homes. It is my very strong feeling that people who abuse elderly people while they are nursing them, particularly if it is caught on camera as it was in a couple of those stories, should be given a mandatory jail sentence.

**CHAIR:** Thank you very much, Ms Parish. Is leave granted to table that? Leave is granted. We thank you all very much for your contributions today. We very much appreciate it. We have a number of groups to go through.

**BOM, Mr Robert, Private capacity**

**LUMB, Mr Paul, Private capacity**

**ROSS, Ms Merle, Private capacity**

**WASS, Mr Rowan, Private capacity**

**CHAIR:** Welcome. We will start with Merle. Would you like to make an opening contribution and then we will proceed to questions?

**Ms Ross:** Good afternoon and thank you for the opportunity. Thank you for coming. I am just an ordinary person. I am not a nurse or any such thing. I have had experience of one of my loved ones saying they wanted to die and they gave all sorts of indications of how they wanted to die.

Did you receive my submission? I did not get any of the replies that some people seem to have got when they had submissions.

**CHAIR:** We will check with the secretariat.

**Ms Ross:** Because this flows on from that.

**CHAIR:** We will find it.

**Ms Ross:** I put that down to the tyranny of distance because there was no loved one living near her. We had to visit her, which was some hours away. I felt if there had been a good palliative care situation which incorporated all the different facets—not just the medical side but also visitors and comfort givers like that—it would have helped her a lot. She did go to another centre closer to my brother and that made a lot of difference. The tyranny of distance is a big thing, and I think palliative care can help in that respect because it would involve pastoral workers apart from the medical teams.

I was very pleased that the first speaker spoke about the budget for palliative care areas and that they realised it would need to be increased because the need for it will increase over the years quite dramatically. I was a bit worried—and this is a bit facetious I suppose—that maybe the voluntary assisted dying and those concepts that the government was proposing were a bit of a cost-cutting measure because of the cost of palliative care. I hope that is not going to eventuate because it is obviously cheaper to have a patient decide, 'This is the end and I don't want anymore,' rather than looking after them through a palliative care situation. Sorry about that.

By the same token, I do not know if they realise but motive is the big thing. When assistance is given, sometimes they do not realise there is a distinction between assisting to relieve the pain—so relieving the pain, killing the pain—but not a motive to kill the patient. There is quite a distinction. That leads on to needing to define all of the concepts. I have read different definitions of 'euthanasia', and some are on the positive side of things and some are on the negative side of things. To provide clarity to the population, the lawyers and the medical teams across-the-board, the terms need to be defined—define 'voluntary', define 'assistance', define 'dying', define 'euthanasia', define 'palliative care'. All associated words that are used in any draft law that could become law need to be defined. As I said, there is the tyranny of distance and having loved ones around.

To conclude, people are companion animals by nature and that is no more necessary than at times of crisis, one being the end of life where the patient is suffering. Palliative care is a multifaceted way to achieve that people interaction. As John Donne said at such a time in his life, no man is an island. My final comment is to ask you to remember that legislation is the baseline for the whole population. We must be careful that it just does not single out cases of deep emotion. There is a legal axiom that stands out in its wisdom: hard cases make bad law.

**CHAIR:** Thank you. I hope that the \$17 million already allocated to palliative care gives you some confidence that we are trying. That is what we are trying to do—make recommendations to provide the best care. At the same time, we have received thousands of submissions from people asking for choice. We need to take everything on balance in our considerations. Thank you very much for your contribution. Mr Bom, welcome.

**Mr Bom:** My experience with caring is looking after my wife for 10 years before she died. She died of Alzheimer's. I have been interested in care for life and respect for life ever since I was born. I cannot even kill an animal no matter how bad he is. I am drawn into this euthanasia debate—PAS or VE—virtually by experience. My birth country is Holland and I have some relatives there. When some came over last year, they said that they had been drawn into a community meeting to discuss someone's euthanasia and this particular person was a friend, so they had these meetings. When he was here, he got phone calls all the time as to the position as to what was happening. I said to him at Rockhampton

the time, 'Do you realise that euthanasia is not the answer? Palliative care is.' He said, 'But she's got a lot of pain.' I said, 'Pain can be overcome.' I have been assured that pain can be killed by drugs if it is available but it is not always available. He said that it was back problems. I said, 'A back problem is something that also can be cured in a lot of cases.' He said, 'But she's had a lot of operations and nothing works.' I said, 'Operations are not really the way to go, I am told.'

He went over and it was our turn to go to Holland; it was my sister and me. We went over to Europe and we took in Holland also. He said, 'Robert, it's nice you're here. The woman has decided that she does want to go.' I said, 'Why didn't she go in the first place?' He said, 'Her faith kept her back.' I said, 'Well she should have stuck with that.' We saw her. The home was emptied by the husband. He was helping to make her die. She was lying on her back, still dressed, but she was full of life and loved a lot of attention and she needed a lot of love. You could see that. The husband was walking around as if he was terribly happy, and he was happy. In fact, he was the one who served the coffee and the tea. He was so happy that I thought, 'This bloke wants her to go.' The woman called out, 'He can't get rid of me quickly enough.' That is not a good way to die, is it?

It confirmed my suspicion that there is a lot going on in Holland. It has actually gone over the top. There is a person named Theo Boer. Theo was one of the founders of the legislation, but he the plot on it.' Back in 1983, Paul Keating said, 'Don't go there. Don't go to PAS. Don't go to VE'—that is, voluntary euthanasia. What we need is palliative care. More money has got to be spent. Start finding out what can kill the pain because this is something that is really necessary. Kill the pain but not the person.

**CHAIR:** Thank you. I welcome Mr Wass.

**Mr Wass:** Thank you for giving me a chance to speak. I am a private citizen who has some views on aged care. I am going to read from my notes. My first point is in relation to aged-care residents who have had no visits from relatives or friends for whatever reason. Residents who fall into that category need to be identified on a register that is independent from the nursing home. In other words, the nursing home would provide that information to an authoritative body that somebody has not been visited in six months. Then the process would kick in where that person is given an advocate from outside the nursing home to keep it autonomous. In that way, that person can get a visit and if they have any issues, follow-up, complaints or whatever they can be looked into. I am aware that there is an advocate service somewhere. The concern is that if it is done internally and the resident goes to the RN or the PC or even the administrator and makes complaints and those complaints do not go anywhere, and they go back three or four times and then give up in frustration, where does it go from there? It goes nowhere. That is my opinion. That is what I would like to see happen. The nursing home staff also get to know these residents and they know that some people do not receive visitors or relatives and they are pushed back. They might say, 'We won't worry about him. Mrs Smith who gets the regular visitor and gets regular complaints can be given the priority.' That is concern No. 1.

My next point is about chemical and physical restraints regarding dementia patients, and they can be very demanding. My concern with any inquiry such as this and with the federal government aged inquiry is that, with regard to the chemical restraint and physical restraint, your committees will push the pendulum too far the other way in the utilisation of those restraints. I see that in other inquiries. You see it on TV when the pendulum goes too far that way and it is brought back and swings too far the other way. That is a concern. People on any of the committees need to listen to the staff about the issues regarding chemical and physical restraint of residents because they are at the coalface and are dealing with them all the time. I do not think it would hurt for people like yourselves on these committees to go and spend a day in a dementia ward and see what they have to put up with. I do not mean that as a facetious comment; I am talking about observation. Just sitting around, watching, having a cup of coffee and seeing what the fantastic carers and PCs have to do would help in your decision and recommendations. Those people with dementia who go into the nursing home areas are there because they cannot be handled at home for whatever reason. They are a handful—some of them are; some are not.

The next point is about residents' meals in aged care, and it is to do with cost cutting. There should be a report given with regard to the types and the frequencies of meals per patient per week. I am referring to good nutrition, the tendency of cutting costs and reheated meals being delivered seven days a week. I know that it does go on in some nursing homes. I think there needs to be a balance between fresh fruit, sandwiches and properly cooked meals and also with the frequency of reheated meals.



**CHAIR:** Thank you. We are cognisant of time and we have another group to come through.

**Mr Wass:** The other thing is in relation to cutting costs. RNs and ENs must have patient ratios. I think it is a must for proper care. Where that cannot be done, such as in small towns, then perhaps there can be exemptions or training and recruitment of people from those areas. If you do not have that ratio, the attention of care to clients in all areas—hygiene, meals and social activities—starts to go down the gurgler. If that does go down due to cost cutting then you get overworked staff. They will leave the industry because it is too stressful for them to stay there and they will be hard to replace.

**CHAIR:** Thank you for your points. I will make a couple of comments before we move to Mr Lumb. The committee has spent considerable time visiting every centre—and we were at one this morning. At each residential aged-care facility we endeavour to spend some time, including in the dementia ward. I started my career as an AIN in the aged-care sector many years ago before the Ambulance Service.

We have an idea of the standard and levels of care. We are working with the royal commission. In terms of your points in relation to chemical and physical restraints, I think a new standard has been set after what has happened in other states. That is why the royal commission is taking a national snapshot. In just about every facility we have been to there is a change in attitude and making sure that safety, preventing falls—it is very difficult dealing with dementia patients—and good nutrition are key. Complaints should not go nowhere anymore. A new body was started, and that is the quality and safety commission who come with us. They now do snap audits right throughout Queensland. They are almost quadruple the amount that were done. There is a lot of focus on the aged-care sector. You have raised some good points today. Thank you for your contribution.

**Mr Lumb:** I recognise the difficulty of the job that you have chosen to undertake. I sincerely mention that. I would like to ask you to have a look at history briefly—however briefly. If we look at the issue of capital punishment, it was abolished by all jurisdictions in Australia by 1984. The last execution was in Victoria in 1967. Interestingly enough, Queensland abolished capital punishment in 1922, which I think we would consider a very humane action.

There were two platforms around that. One platform was that society no longer wanted to impose the death sentence on anybody irrespective of the crime committed, and that was a vote for life. Secondly, innocent people would be executed because our justice system is imperfect. That again was both a vote for life and a vote for safety. There is no jurisdiction in this world—and there are 16 of them currently, I understand—that has made the process of assisted dying or assisted suicide safe. It is impossible to legislate for the safety of taking life. No law can exclude misdiagnosis or error in prognosis. No law can reduce the burden of overt or, as we have heard from the lady on the end or the gentleman, subtle manipulation. Sadly, we have all been through experiences where death occasionally brings out the worst in human nature. Every jurisdiction is fatally flawed in the legislation that is brought to the marketplace.

I would like to move to pastoral care, and a lot has been said today which has been extremely helpful. I would encourage you please to firmly place pastoral care as an extension of palliative care. What we have heard today is the mechanics of palliative care. We have heard about budgets, patient ratios, hospital funding and access to services. What we have not heard today, except from one gentleman, concerns the spiritual needs of the patients. Please embed pastoral care in any recommendation you make regarding palliative care.

The other concern I have is that the staff will be required to participate in the implementation of decisions contrary to their beliefs and conscience. Sadly, I have to say that there is a nurse who has written to us. She resigned because she found herself in a clinic that was undertaking abortions. The job that she was given—and I do not mean to upset anybody here—was to reassemble the birth products in a tray to make sure that there was nothing left behind in the womb post abortion. That was the most traumatic thing that she has ever experienced. I would hazard a guess that in the conduct of moving forward in the area of assisted suicide, staff will be required to participate in matters which are contrary to their beliefs and their conscience.

I move on to the other jurisdictions. The other jurisdictions produce death certificates which in no way mention the element of euthanasia or suicide. There is no transparency; there is no governmental record of the true position of what may or may not be implemented in this state. If there is an implementation, if there is a journey down that route, in order to be completely transparent the true method of death needs to be recorded on the death certificates.

You might ask why I emphasise pastoral care. We have an expression quite clearly in the Christian faith that the promise of Jesus gives us eternal life. What we are talking about here is not the temporal life, not just the physical life; we are concerned with the spiritual destiny of not just those

who find themselves passing but also those who help people pass. We are not to bring a stumbling block into the lives of those people by making decisions which we then place upon other people. I say this quite truly: we can be either heaven-sent or hell-bent.

In my life experience I have been in welfare, mental health, drug addiction, general practice, prisons and courts. I can say the most overarching statement I could ever make is that man's reason, man's medicine and man's psychology is never enough. I will just close with a remark made by Russell Crowe in the film *Gladiator*. As he addressed the legions before the battle he said, 'Whatever you do on this battlefield today will echo into eternity.' Amen.

**CHAIR:** Thank you. You said you were with a Christian group. You referred to a nurse who 'wrote to us'. Are you representing—

**Mr Lumb:** I am a branch member of Cherish Life Queensland.

**CHAIR:** I just wanted to clarify. Thank you.

**Mr Wass:** I would like to table a DVD of the *7.30 Report* about cost cutting in aged care.

**CHAIR:** We already have a copy.

**Mr Wass:** Is it the one about Bundaberg? You are quite welcome to keep it.

**CHAIR:** Is leave granted? Leave is granted. I do not think there are any questions. I would like to thank each of you for your contribution today.

**CAMPBELL, Mr John, Private capacity**

**FORDAY, Ms Susan, Private capacity**

**McCULLOCH, Ms Raewyn, Private capacity**

**McINALLY, Mr Maurice, Private capacity**

**MURRAY, Ms Chi Chi, Private capacity**

**VAN GESTEL, Mr Peter, Private capacity**

**Mr van Gestel:** My name is Peter van Gestel. My wife told me to ‘go, sit down and shut up’, but that is not going to happen. I will attempt to be as brief as I can.

A year and a half ago I was diagnosed with frontotemporal deterioration. It is also known as early onset dementia. It is a horrible thing. I have an anticipated life expectancy of, on average, three and a half years. What I would like to speak to in particular is the difficulty of getting help for something that is not commonly known amongst the medical profession. I do not mean to be disrespectful, but many people that I have come across in the medical profession do not know what FTD is. I will give you a quick definition. Frontotemporal degeneration, which I prefer to call it, strikes in the prime of life, generally eroding an individual’s personality, their ability to speak, make sound decisions, control their movements, behave within social norms and relate to those they love. When I was first diagnosed I did start to change. My wife was the one who suffered. She tried to get help from Alzheimer’s Australia. We received a phone call and a few brochures. When we tried again we got a phone call and a few brochures. We spent a lot of time looking things up on the internet, and we did find a lot of information from the American AFTD association. They were quite helpful. I am under the care of two specialists.

At the moment my four little grandchildren—two aged six, one aged five and one aged four—love me because they think I am silly, which is fine. I am not silly yet in the true sense of the word, but I can still have good fun with my grandchildren. My brother died two years ago of another form of dementia. He was, very sadly, not treated. He was pretty much a vegetable for about 1½ years prior to his death. I am looking at the same thing, but in the meantime I have a personality change as well. I will be totally lacking in empathy, aggressive, quite nasty. I am not looking forward to that, neither is my wife, neither are my grandchildren. I would like you to think for a moment about the people you may have seen die. I bet you two bob the memory that comes to mind first is how you saw them just before they died or in their casket—not how they lived. I do not want my grandchildren to see me strapped to a bed not being able to recognise them, not being able to smile and not being able to throw them a kiss. That and not being able to recognise my wife sadden me the most, but a lot of people have been there.

The other thing that concerns me is I would like to have the choice, but not at the expense of professional medical people who do have to flick the switch, pump the pump—I acknowledge that difficulty—or have my wife risk going to jail. No, she does not deserve that. I simply want a choice and a mechanism; that is all I want.

**CHAIR:** You may want to respond to this. We have heard a number of people talk about advancing dementia, advance healthcare plans and advance healthcare directives. They have asked us as a committee to consider having that decision-making placed in an advance healthcare directive in relation to voluntary assisted dying before you lose the capacity to make a decision. Is that where you are going in terms of your thoughts?

**Mr van Gestel:** I think that would certainly be helpful. I think the tyranny of distance is a big issue. I know that last year my wife just wanted to talk to someone. I am in the hands of a clinical psychologist and a geriatrician—he has another title too but I cannot think of what it is—and they are in and out. They are only here once every two or three months. My wife just wants someone to talk to who knows about FTD and who knows what she is going through, and that is what she cannot find. But assistance building up to that, the approach, the discussion, yes, that is important.

**CHAIR:** Thank you very much, sir.

**Ms Murray:** I am coming from another aspect. We have recently had an election and I worked for the Australian Electoral Commission. I find it very, very distressing to have to go to nursing homes where people in all sorts of ill health are made to make a decision about who they wish to have in control. The first place I went to was Eventide. We were taken to the breakfast table and told, ‘These Rockhampton

people want to vote.’ One lady said to her companion, ‘What’s my name again?’ Come on! I assisted everybody to fill in their form because they were incapable. I filled in their election forms. There was a scrutineer, so I did not cheat. One gentleman nearly fell out of his wheelchair because he was throwing some type of fit. He just pointed to a picture and that was who he wished to vote for. Do we really have to take votes from people who have been put into nursing homes?

**CHAIR:** I do not know if this falls within the scope of our inquiry. I take your point on board. It may be a matter for the AEC to consider going forward. I understand what you are saying, particularly with regard to dementia wards.

**Ms Murray:** Yes, and palliative care. You take their vote today and they have died tomorrow.

**CHAIR:** People may still wish to express their opinion. I do not know if this falls within the scope of our inquiry.

**Ms Murray:** On the other side, we lack in the area of disability. There is a very, very big gap for disabled people. I am with access and equity. It took me four years to get a toilet put at the causeway for a disabled person. When I threatened Livingstone Shire Council that I personally would sue them for discrimination, I got two toilets. The headline was: ‘Chi Chi wins two toilets’. There is a big gap for the disabled and I would like to see something done in this area as well. I know we are talking about euthanasia and everything else, but by heavens there are a lot of people out there in wheelchairs and they need a lot of help too.

**CHAIR:** Raewyn McCulloch, welcome.

**Ms McCulloch:** A friend of mine said, ‘Come along and have a say.’ I am quite nervous about this. I work for a non-profit organisation as a nurse out in the community, and I have been very passionate about the lack of services available here. I mainly work in Yeppoon, and over my 10 years in this job the palliative service has deteriorated quite substantially here. It is really sad, because I find that one of the most rewarding parts of being a community nurse because I deal with aged care as well. The 0.5 palliative care doctor is really limited. We do have a nurse practitioner with Queensland Health who has been quite helpful.

We have increasingly found that we are usually called in when clients are in crisis. They have been referred to us either by their GP or they are awaiting a review by Queensland Health and their family is trying to look after them. They want to fulfil their last wish of being at home. We are finding families in crisis, with mismanaged pain and carers at maximum stress level. Often these clients are unable to leave their home. Some of the GPs are great at doing home visits. To access the public system they are usually required to have an initial review in Rockhampton, which is just not feasible, and often then to attend telehealth. They are in Yeppoon and the specialist is in Rockhampton, so that is unachievable too. We have found that intervention by the nurse practitioner very helpful in conjunction with the GP for end-of-life care so it is being delivered with a dignified, positive-centred approach; however, access to equipment has been a major stumbling block.

**CHAIR:** Is that things like hoists and—

**Ms McCulloch:** Hoists, beds, shower chairs et cetera—all that equipment. Often they end up in an acute hospital for management rather than remaining at home. Some of the clients buy or hire the equipment themselves because they just cannot wait. Access to allied health for these clients is also limited. We have had tongue cancer patients who require quite extensive specialist lymphedema treatment. It is very hard to even get the allied health team from Rockhampton to Yeppoon, and they want to do a telehealth review. I think it is a bit extreme when someone has lymphedema that you can see through telehealth. That has happened quite often. Some of these people are on level 4 packages, but it does not meet their requirements or needs by any means.

**CHAIR:** Does that include nursing?

**Ms McCulloch:** That includes nursing.

**CHAIR:** I have heard the same things. It is disgraceful.

**Ms McCulloch:** And often some of these people have had to pay quite substantial amounts out of pocket. Sometimes you can substitute the nurse with a care worker for personal care, but there are specialist areas where they need that so they definitely do not. Under 65 is just a nightmare. There are very limited services for them. If you have money you can manage, but apart from that you cannot. Also, dieticians and all of the allied health services are sent to Yeppoon once a week and for some time they did not have a lot of those services, so it is hit and miss as to whether you get them down there or not. In fact, I think some of their rehab programs down on the coast have stopped so they have to come up here. Transport is a major issue for a lot of the elderly. They do not get there.

Particularly complex cases do not get up there. They get abused—not abused but kind of labelled as noncompliant. Look at the system. They can be seeing four specialists and you are wanting them to go up there and they have no family, so transport is a major thing. They are offered it as part of Centacare but it is a cost of \$20 a trip. It is quite expensive. Access for a lot of the elderly on the coast is quite difficult, I think.

From my point of view, My Aged Care has been a bit of a disaster. Before, your service provider would get a referral, you would go straight in there, you would assess the situation and refer on. Now you have to register with My Aged Care. We assist some clients with that. They have a lot of difficulty because they are talking to someone on the phone who does not know them. One lady was trying to sign up her husband and requested to be a spokesperson for him and was told, not until the end of a 30-minute rather frustrating conversation, that she could do that. That is quite able to be done. Now we go in and sit with them and ask for that to occur straightaway. There are a lot of things that they are not aware of regarding My Aged Care.

The other thing is that before they would come to us and we would refer on. Now they go to My Aged Care, they get asked all these assessment questions, then the regional assessment team come and they do the same set of questions. Then they get referred to whatever agency that may pick them up. Then they go and do the same set of questions. They are finding that frustrating, plus the fact that they may end up with multiple service providers going in there. There is no continuity. When the regional assessment team do their assessment and put it up into the portal you could have four different services required and four different services take that on. That is very confusing for a lot of elderly people.

NDIS is a nightmare. The only thing I would like to say in regard to voluntary assisted dying is that I have a lot of clients who are not even palliative, well into their 90s, who are often asking me that question. It is not just necessarily a palliative. They have varying levels of health and cognition. Some of them are quite active and have asked if they could have the right to choose how and when they complete their journey.

**Ms Forday:** I worked at the base hospital as a registered nurse for 35 years. I had to give up 10 years ago due to ill health. I looked after a lot of people who would benefit from just a little bit of assistance with ending their life. Continuing on from that, there is a lady here who gave me a pamphlet that I found very exciting so I wanted to mention it. It is called Dying With Dignity Queensland and it is an organisation trying to get a lot of people in different areas to join. It is 'My Life, My Choice'. Basically, voluntary assisted dying can be either the doctor providing a script that is filled and the patient self-administers or the doctor administering the medication to the patient. Participation by doctors is voluntary. This is taken from the Victorian principle.

In terms of public opinion, multiple polls by reputable polling companies over the last 10 years have consistently shown overwhelming public support for voluntary assisted dying. Why do we need it? Despite great advances in medical knowledge and treatment—and sometimes because of these—what should be the natural and dignified end of life is far too often a prolonged, painful and distressing experience. Palliative care does not always alleviate a terminally ill patient's suffering.

**CHAIR:** Dying With Dignity made a submission so we have that on record. I would like your experience as a nurse over 35 years.

**Ms Forday:** I worked with the first lot of chemotherapy that we had at Rockhampton Base Hospital and I got burnout because there were a couple of people who did not have visitors. Just three years ago I went through chemotherapy for breast cancer. The wonderful care up at the new unit is lovely. I have not been to the new palliative care, but I have worked in the old palliative care and the nursing staff need a medal, I think, because of the amount of stress they cope with and how wonderful they treat the relatives.

**CHAIR:** In your experience working in palliative care, did you have people asking to end it?

**Ms Forday:** Yes, in a few different wards, yes, I have had a few people. Now I have my mother, who is 88, asking questions. I came along to see what everyone else had to say because that is going to be a very sad time. My father passed away.

**CHAIR:** Thank you for sharing your experiences.

**Mr Campbell:** There is much to say about the proposal for euthanasia and its consequences. It is a sad day for me to be trying to defend moral integrity instead of channelling my energies into empowering life. I want to speak about the problem of pain, the spirit of death, the role of government, consequences and Viktor Frankl. I have three fingers that are giving me pain. Pain tells me that something is not right. Too much pain motivates me to seek help. We need each other. We need the

skilled help of others. Every heart has its own sorrow and no-one can share its joy. King Solomon said that. We all have experienced pain in life and there is no joy in sharing it. Some of that pain is self-inflicted. We have all done wrong things purposefully.

In terms of spirit of death, there seems to be a philosophy or spirit of death driving the Western World. We have legalised death at the beginning of life and are now bringing in death before the end of life. What is the next step? Bringing back capital punishment?

In terms of the role of government, the mandate of government is to empower its citizens for good. Therefore, its agents need to be on the lookout for a higher moral code of conduct to bless and empower its citizens. The taking of life is not empowering or blessing the people. Murder has universally always been accepted as wrong, yet we are trying to legalise it. What happens after death? When someone dies it is sad because they are no more. Death starts around the age of 30. It is called atrophy. My body is dying. How do we value a human being? Is Nick Vujicic of no value because he has no arms or legs?

In terms of consequences, as soon as we endorse murder as lawful we open the floodgates of wideranging legal and moral ramifications. Civilisations have come and gone. The best way to self-implode ours is to justify murder. Every human being has a moral code of conduct. We cannot have rights with no responsibilities and thus avoid the consequences: accident scene, severely injured, provide no assistance, give a lethal injection; elderly, giving grief, inconvenience, useless eaters, remove. No celebration, no mourning, no empathy. We have a duty of care to ourselves and to others. We are to love our neighbours as ourselves.

For those facing difficult life circumstances, Viktor Frankl, a survivor of various Nazi concentration camps, details his experiences in his book. Nevertheless, say yes to life. Even within the narrow boundaries of the concentration camps he found only two races of men to exist: decent ones and unprincipled ones. These were to be found in all classes, ethnicities and groups. In terms of the importance of finding meaning in all forms of existence, even the most brutal ones and thus a reason to continue living, after enduring the suffering of these camps Viktor concluded that even in the most absurd, painful and dehumanised situation life has potential and meaning and that, therefore, even suffering is meaningful. What is to give light must endure burning. People without meaning in their life are exposed to aggression, depression and addiction. The statute of liberty must be accompanied with the statute of responsibility. Thank you.

**CHAIR:** Thank you. Mr McNally?

**Mr McNally:** Gentlemen and lady, dear people, I thank you for being here in Rockhampton. I know that you have been everywhere and you have done a lot of kilometres. It is a responsibility that you have been endowed with. I did not expect to be here today but I am very grateful to be here with all these other dear people from Rockhampton. I applaud a lot of people for the things they have said. I know that a lot of things they said were said in sorrow, because sorrow is something that begins with life. The first thing we hear is a baby cry. A lot of people think it is sad—the baby is crying—so we try to stop the baby crying, but it is good in a way to hear the baby crying because you know there is life. Isn't that right, Barry? Did you cry when you were born? I think I cried too much.

My point is that I am 70 this year. I am a dad and a husband. I have seven children, all born here in Rockhampton in the Mater Hospital. I myself was born in the Mater Hospital. I have 14 grandchildren. I have a lot of wonderful friends in this city of Rockhampton. I have friends in every city of this state and of Australia. One thing I have learned is that we need each other. People need each other. Government is a wonderful place because it is designed to care for people, but there is no greater care than the care that begins in the home. I know that a lot of homes do not necessarily have things working smoothly so that that care can prevail. It would be a lot easier for you guys in your jobs if that happened, wouldn't you agree?

In the last 15 years my wife and I were called to go to various nursing homes in this city, not just because of parents but because of friends—not always aged friends. It was something that we both dreaded, but we had a wonderful experience. We met some beautiful nurses and those nurses were always encouraging us: 'Please, if you have a spare moment come and spend some time with these dear people.' I am not a very good singer but I used to enjoy singing and I find that the older people love singing. It lifts your heart. It lifts you out of the dung of this world to seat you in a heavenly place.

My joy was to bury a dear friend two years ago. She was paralysed from a stroke. Half her body would work and the other half would not. She also had a very debilitating disease called arthritis. I think she had several forms of it. She persevered and she loved those people in the nursing home

and she would always say to me, 'Can we sing a song?' Not everybody liked to hear me sing, but there were some who did and some would join in because they would remember a song and that would cheer their hearts.

My point is that care is an important thing with everyone. Giving someone care—and everyone was talking about loving somebody—is so important. You would not be here if you did not love people. That is your position as members of parliament. I believe that is why you have taken it up. A lot of people think you get into politics just to get power. That is not true. You are there to represent people and you do, and you do a very good job. I can tell today by seeing each of your faces that you are very caring and very genuinely interested in everything that is happening. I am very grateful for that. I cannot thank you enough and I cannot thank enough the other people like yourselves who give up their time. I do not know how many hours a week you all work, but it is a very thankless thing.

As a lot of people have said, everybody needs relief. We get that relief from the loved ones who are around us. My wife and I are available to help people. We cannot force people to want help, but we often ask people, 'What can we do to help?' We try to visit our neighbours who are all elderly, older than us, to share with them the joys of grandchildren and friendship, and that encourages everyone and brings them out. They do not want to die. They want to live longer now. The husband of the lady across the road from us passed away and she was thinking she wanted to go the following day or the following week, but now she realises that there is a lot more to live for in this beautiful state of Queensland, in this beautiful place Australia.

**CHAIR:** Well said!

**Mr McNally:** God bless you all and uphold you all. We need you and we need each other.

**CHAIR:** What a great way to finish. Thank you very much, Maurice. Before I thank each of you, I want to thank the rest of the committee who have travelled the last few days. I do not know how many kilometres we have done from Brisbane up. We have visited many places, in particular Hervey Bay, Bundaberg and Rockhampton. We are grateful for the contribution that everyone has made. I put on the record our thanks to Bonnie Phillips from Hansard, who has travelled with us, and to our committee secretary, Mr Rob Hansen. It is a huge body of work that we are undertaking in looking at aged care, end-of-life and palliative care and voluntary assisted dying. With that I thank the last panel and I declare this public hearing closed.

**The committee adjourned at 5.47 pm.**