



## **HEALTH AND ENVIRONMENT COMMITTEE**

**Members present:**

Mr AD Harper MP—Chair  
Mr SSJ Andrew MP  
Ms AB King MP  
Mr R Molhoek MP  
Ms JE Pease MP  
Dr MA Robinson MP

**Staff present:**

Dr J Dewar—Committee Secretary  
Ms A Groth—Assistant Committee Secretary

### **PUBLIC BRIEFING—INQUIRY INTO THE VOLUNTARY ASSISTED DYING BILL 2021**

#### **TRANSCRIPT OF PROCEEDINGS**

**MONDAY, 14 JUNE 2021**

**Brisbane**

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**The committee met at 10.39 am.**

**CHAIR:** I declare open this public briefing of the Health and Environment Committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We are very fortunate to live in a country with two of the world's oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share.

I would like to introduce the members of the committee. I am Aaron Harper, member for Thuringowa and chair of the committee. Mr Rob Molhoek, member for Southport, is our deputy chair. The other committee members are Stephen Andrew, member for Mirani; Ms Ali King, member for Pumicestone; Ms Joan Pease, member for Lytton; and Dr Mark Robinson, member for Oodgeroo.

The purpose of today's briefing is to assist the committee with its inquiry into the Voluntary Assisted Dying Bill 2021. Before we begin, I remind everyone that this briefing today is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I ask that mobile phones be turned off or switched to silent. Hansard will record the proceedings and you will be provided with a copy of the transcript. The hearing is being recorded and broadcast live on the parliament's website.

**CHANDLER, Ms Kim, Director, Strategic Policy and Legal Services, Department of Justice and Attorney-General**

**GIBSON, Ms Eve, Manager, Social Policy and Legislation Branch, Department of Health**

**HARMER, Mr David, Senior Director, Social Policy and Legislation Branch, Department of Health**

**MATTHIAS, Ms Tricia, Director, Social Policy and Legislation Branch, Department of Health**

**McNEIL, Professor Keith, Acting Deputy Director-General and Chief Medical Officer, Chief Clinical Information Officer, Prevention Division, Department of Health**

**ROBERTSON, Mrs Leanne, Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General**

**CHAIR:** Good morning, everyone. Thank you very much for coming in. I am sure this will be hugely beneficial for the committee. I might ask if you would like to make some opening statements before we move to questions on the bill.

**Prof. McNeil:** Thank you, Chair. My name is Professor Keith McNeil. I am Acting Deputy Director-General for Prevention Division, Chief Medical Officer and Chief Clinical Information Officer for Queensland Health, and it is my privilege to be leading these discussions on behalf of the department.

Thank you for the opportunity to brief the committee about the Voluntary Assisted Dying Bill. I am joined by my colleagues from the department and from the Department of Justice and Attorney-General. The bill is large and complex and I will be relying on them for some of the detailed content as we move through, depending of course on the questions. As officers of the department, we will not be able to answer questions about the merits of policy. We will be able to answer questions about the bill and how it will operate if passed by the Legislative Assembly.

Before I go further, I also acknowledge the traditional owners of our lands across Queensland and let the committee know that, throughout the proceedings that we will go through in terms of discussions and any enactment or implementation, the issue of equity of access in Queensland with our diverse geography and our devolved population will always be front of mind for us. That is never more so an issue than with our First Nations people.

In terms of the bill, the bill provides a legal framework for people who are both suffering and dying and enables them to choose the manner and the timing of their death. It is based on recommendations of the Queensland Law Reform Commission and its draft legislation. The QLRC was extremely thorough in considering a substantial number of complex issues and examining comparable schemes in other jurisdictions. This is evidenced by the extensive and detailed nature of their report.

The report contained 197 recommendations for a legislative framework for voluntary assisted dying in Queensland and the effective implementation of such a scheme. The QLRC considered Queensland's unique conditions and recommended a bill that in its view best serves the whole of the Queensland community.

In terms of eligibility criteria, I will now provide a brief overview of the key features of the bill. A person will only be eligible to access voluntary assisted dying if they have been diagnosed with a disease, an illness or a medical condition that is advanced, is progressive and will cause death. That condition must be expected to cause death within 12 months and cause the person what is termed 'intolerable suffering'. The person must have decision-making capability and capacity in relation to voluntary assisted dying and be acting voluntarily and without coercion. They will have to be 18 years of age or above and fulfil both Australian and Queensland residency requirements. The person will have to meet all of the elements of the eligibility criteria to be eligible to access voluntary assisted dying.

The bill has a number of safeguards to ensure that only eligible people can access the scheme. These safeguards also serve to protect vulnerable people from coercion and exploitation. A person will have to make three separate requests for access to voluntary assisted dying. The second request must be in writing and signed in front of two witnesses. A person can change their mind at any stage and decide not to proceed further. The person must observe a waiting period of at least nine days between their first and last requests, although exemptions may apply in defined and limited circumstances.

The bill requires that two medical practitioners complete independent assessments of the person's eligibility against the criteria. If the person is assessed as eligible, the two medical practitioners must provide the person with key information, including: treatment options for the underlying condition and palliative care and further treatment options in that respect; and details of the voluntary assisted dying process and information stating that the person may withdraw their request for voluntary assisted dying at any point in the process.

Registered health practitioners and speech pathologists may conscientiously object to participating in the process; however, they must take certain steps to ensure that a person's access to the scheme is not impeded. An entity may choose not to provide certain services at a facility it operates. Entities include, for example, residential aged-care services, private hospitals and hospices. Decisions about the services that an entity offers may be based on the entity's policy, financial considerations or available resources.

An entity may also refuse to provide a service on the basis of what is sometimes known as an 'institutional conscientious objection'. The QLRC considered non-participation by entities to be one of the most complex issues it was required to consider. It concluded, however, that the complexity of the issue is not a reason to avoid regulation of processes for entities, otherwise processes will be uncertain. The bill sets out requirements for nonparticipating entities at each stage of the voluntary assisted dying process to ensure that a person's access to the scheme is not hindered.

The bill includes further safeguards and governance, including: setting eligibility requirements for practitioners who wish to participate in the scheme; record-keeping and reporting requirements; and provisions to ensure the safe management of the voluntary assisted dying substance. The Voluntary Assisted Dying Review Board will provide oversight of the scheme. The board will monitor the operation of the act and will retrospectively review each completed request for voluntary assisted dying. The bill also contains offence provisions for noncompliance with the scheme.

The QLRC undertook extensive consultation when developing the report and the bill—this was in addition to the former parliamentary committee's inquiry, which considered thousands of submissions on the matter—in recommending that the Queensland government introduce a voluntary assisted dying scheme. Chair, thank you for the opportunity to briefly address the committee about significant reforms contained in the bill. My colleagues and I will, of course, will be very happy to take further questions.

**CHAIR:** Thank you very much, Professor McNeil. Would the Department of Justice and Attorney-General also like to make a contribution?

**Mrs Robertson:** Thank you, Chair, for the opportunity to provide a brief opening statement. As noted by Professor McNeil, the bill takes care to provide wideranging safeguards to protect vulnerable people from coercion and exploitation. The bill does propose amendments to, or intersects with, a range of legislation within the justice portfolio. The bill represents the approach recommended by the QLRC, which is to provide for specific offences for specific conduct arising out of the particular features of the scheme. Those offences will operate alongside existing offences in the Criminal Code and other legislation. As the QLRC itself acknowledged, a different approach is taken in other jurisdictions such as the Netherlands, Belgium and Luxembourg, where voluntary assisted dying is treated as an exception to existing criminal offences that prohibit assisting suicide or euthanasia.

With respect to other Australian jurisdictions, the bill contains similar offences to those found in voluntary assisted dying legislation in both Victoria and Western Australia. The key difference to note is how the offence for the unauthorised administration of a substance is dealt with. In Queensland, under clause 140 of the bill the maximum penalty is set at 14 years imprisonment. In contrast, in Victoria and Western Australia the maximum penalty for administering a voluntary assisted dying substance when not authorised to do so is life imprisonment. The QLRC justified this difference on the basis of the possible range of circumstances in which conduct may fall outside what is actually authorised by the scheme. For example, it may involve inadvertent breaches by a family member or carer who provides assistance in administering the substance through to circumstances where a person knowingly operates recklessly outside the scheme.

The QLRC itself noted that it is expected that the most serious cases would be dealt with under the code. The bill does not amend the Criminal Code; however, it does introduce significant changes that impact the operation of the current law. Firstly, the bill, if passed, will authorise certain conduct that would otherwise be unlawful under the Criminal Code; that is, conduct that would otherwise be unlawful killing or aiding suicide. For conduct that falls outside the voluntary assisted dying scheme under the bill, the offences in the Criminal Code will continue to apply.

Secondly, part 10 of the bill itself makes it clear that a person who does an act or makes an omission in the specific circumstances covered by these protections does not commit an offence against the relevant sections of the Criminal Code, in particular the offences in sections 300; 302; 303; 305 and 310, murder and manslaughter; 306, attempt to murder; 307, accessory after the fact to murder; 309, conspiring to murder; and 311, aiding suicide.

I also want to talk briefly about the interface with guardianship legislation. Care has been taken to ensure that the voluntary assisted dying scheme proposed by the bill is situated outside of Queensland's guardianship legislative framework. An important eligibility criterion for access to voluntary assisted dying is that a person must have decision-making capacity in relation to voluntary assisted dying at each stage of the process. Therefore, the bill itself amends the Guardianship Administration Act 200 and the Powers of Attorney Act 1998 to declare that voluntary assisted dying is not a matter to which those acts apply. A similar approach has been taken in both Victoria and Western Australia.

The bill also outlines how a death through access to voluntary assisted dying should be recorded and notified through the Registrar of Births, Deaths and Marriages and also the legislation's interface with the coronial jurisdiction. The bill amends the Coroners Act 2003 to exclude the death of a person by self-administration or administration of a voluntary assisted dying substance under the bill as a reportable death. The bill also provides that a medical practitioner must state on the death certificate that the cause of death was the disease, illness or medical condition that made the person eligible to access voluntary assisted dying. However, in the interests of accurate reporting, each death accessed through voluntary assisted dying will be recorded through notification to the Voluntary Assisted Dying Review Board.

The Queensland Civil and Administrative Tribunal has review jurisdiction for certain matters under the scheme. These reviewable decisions relate to certain eligibility criteria, including residency requirements, a decision about capacity to access voluntary assisted dying, and whether or not the person seeking access is acting voluntarily and without coercion.

Finally, I thought I should mention concerns identified by the QLRC in relation to the operation of the Commonwealth Criminal Code carriage service provisions. Sections 474.29A and 474.29B of the Commonwealth Criminal Code prohibit the use of a carriage service to counsel or incite suicide or attempted suicide or promote or provide instructions on a particular method of committing suicide. The bill provides that a person who dies as a result of the self-administration or administration of a voluntary assisted dying substance in accordance with the bill is not suicide. However, the QLRC identified that the application of offences under Commonwealth law relating to using a carriage service to counsel or incite suicide or to provide instruction on a particular method of committing suicide

suicide creates uncertainty. This will particularly affect individuals who are suffering and dying in remote and regional areas in Queensland. The Premier and Minister for Trade has written to the Prime Minister requesting the federal government urgently amend the Commonwealth Criminal Code so it does not impede the operation and availability of Queensland's proposed voluntary assisted dying scheme.

**CHAIR:** Thank you very much for your introduction. You touched on the carriage service. I think it is important to get clarity. Just to put it in context, the former committee, which the member for Lytton was also part of, heard from people in rural, western and outback communities. I am glad that you began your contribution too, Professor McNeil, with the issue of equity. A lot of people told us that, in a very practical sense, they did not want to leave their communities and they wanted access to medical procedures. I think it is important to note that the QLRC went to great lengths to separate what is a medical procedure from assisted suicide. Going on your point, I think we need to get some advice as to what the committee can do to address the carriage service issue that faces the committee in relation to this aspect of this bill. I do not know if anyone can speak to that. It is a bit complex. Just from a practical point of view, what we heard is that people want access. Do you have any recommendations as to what the committee may consider going forward?

**Prof. McNeil:** There is no question that through COVID we have found that access to virtual care is going to be pivotal to the way we provide health services across Queensland in the years to come. We will need to work with the Commonwealth, which is certainly in that space open to conversations around how we can expand that capability. As to the legal aspects of it, that is beyond my remit. There are certainly going to have to be robust discussions had about whether or not that has changed, because as it currently stands, as my colleagues have said, there are things that head-butted together around the use of carriage services at this point in time.

**Mr MOLHOEK:** Mr Chair, can you just explain the term 'carriage service'?

**CHAIR:** Using telehealth, to give an example.

**Prof. McNeil:** I think it is anything to do with the telephone—electronic means of transmitting information.

**CHAIR:** Mrs Robertson, do you have anything further to add in that regard?

**Mrs Robertson:** The department cannot comment further. As I have noted, the Premier has written. It is open to the committee to recommend that those efforts be reiterated, but that is really a matter for the committee. I note that there are a number of other Australian jurisdictions faced with similar challenges.

**CHAIR:** Professor McNeil, can we get clarity from you: voluntary assisted dying, or the act of it, is deemed a medical procedure? Is that the best way of looking at this?

**Prof. McNeil:** That is an interesting proposition. Is it a medical procedure? It is certainly auspiced by medical procedures. There are two ways the voluntary assisted dying can be accessed. One is through self-administration—obviously there is prescription of the substance—and the other is with practitioner assistance. Depending on your definition of 'medical procedure', it could be drawn out that it is a medical procedure of sorts.

**CHAIR:** My question goes to that very point. We had people come before us who looked after loved ones with neurodegenerative diseases—motor neurone disease, for example. In your opening statement I think you said that the second request must be in writing. For those who cannot write, is there a need to address that point?

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

**Mr MOLHOEK:** Professor, I would like to better understand the current availability of palliative care services across the state as it is now. You talk about the need for equity of access, and it has been put to me on a number of occasions by people that perhaps palliative care is not all that equitably accessible either. In the context of the pressures the health system has been under, particularly over the last 12 months with COVID, how available are palliative care services now? What is the future of palliative care? Are we going to see that wound back or increased as an alternative to voluntary assisted dying? I suppose the extension of that is: how do we provide support for voluntary assisted dying in regional centres across the state, as you hinted at in your comment about equity of access? Some broader comment around that would be appreciated.

**Prof. McNeil:** I will pass to my colleague, David Harmer, for some of the detail. To your point that voluntary assisted dying should exist within a continuum, palliative care services are critical as part of that continuum. It is not an alternative to; it should be complementary to palliative care services, Brisbane

and that is made clear in the discussions. That is important. We do have issues across Queensland with equity of access and we are striving in the department to address that. A key pillar of our reform process is to address equity in all of its dimensions and wherever that may become an issue, palliative services being one. There have been substantial investments flagged for palliative care. I will pass on to Mr Harmer for the detail.

**Mr Harmer:** There are a couple of parts to the question, I think. If I have understood it correctly, I need to first identify what the current investment is and then outline what the proposed future investment is. In 2021 it is estimated that Queensland hospital and health services will spend approximately \$149 million on palliative care service provision. There are an estimated 134 dedicated palliative care beds across Queensland, but the committee should note that not all palliative care is provided in dedicated beds; it is provided in a range of different contexts, so it will be provided in many more beds than the 134 I have just identified.

In addition to the money that hospital and health services spend on palliative care each year, the Department of Health directly funds eight non-government organisations to provide palliative care in the community. It spends \$12.9 million per annum on that. Those non-government organisations are predominantly located in South-East Queensland and provide community based palliative care in a range of different ways, using hospice models or nursing support in the community, for example. In addition to that funding, the department jointly funds Hummingbird House, which is a children's hospice, together with the Commonwealth. In April 2021 there were 109 specialist palliative care clinicians in Queensland and 394 palliative care nurses.

That is probably a summary of the current position, but, as you have alluded to, the government has announced that it will invest a further \$171 million in palliative care funding in the five years starting next financial year. In the 2021-22 financial year it is estimated that the Queensland government will spend approximately \$176 million in total on palliative care, and that investment will grow to \$247 million by the 2025-26 financial year.

**Mr MOLHOEK:** Just to be clear on that, the extra \$171 million is over five years, not per year?

**Mr Harmer:** That is correct, yes.

**Ms KING:** Just to be clear, Mr Harmer, would you repeat that final figure?

**Mr Harmer:** It is approximately \$247 million in the 2025-26 financial year. It is a stepwise investment and the investment increases significantly towards the middle of the program. Initially the new investment is aimed at developing a new palliative care strategy for Queensland and a workforce plan. There will also be some initial investment in new community based palliative care focusing on regional Queensland, but as the investment rolls out there will be, once the workforce plan is developed, significant new investment in building the workforce over time. As I say, with reference to those earlier numbers, there is a stepwise investment so that the total recurrent investment annually by 2025-26 is approximately \$247 million.

In terms of that stepwise investment, we need to recognise that we start with the 109 specialist clinicians that I mentioned. The way you build the workforce in this space is for those who have expertise now to train and develop the skills of those who come after them. There is some time and effort involved in building the palliative care workforce. With your permission, I might pause there because I appreciate that that is a lot of information in a short time.

**Mr MOLHOEK:** It would be helpful to have some of that information in writing. You called it a stepwise program.

**Mr Harmer:** That is a term I just coined for it. I am happy to provide the detail.

**Mr MOLHOEK:** If we could have that detail in writing.

**Dr ROBINSON:** Is it possible to get that per HHS, to know across the state as opposed to only SEQ.

**Mr Harmer:** Yes, it is.

**Dr ROBINSON:** Can we have that on notice?

**CHAIR:** We can get that on notice.

**Ms KING:** Professor McNeil, you spoke about equity of access in particular. Could you please comment on how this bill attempts to address Queensland's unique conditions and particularly our large geographic area and our dispersed regional population?

**Prof. McNeil:** The bill notes that that is an issue for us without specifying how we might actually implement or instigate any particular issues which, of course, if the bill is passed into legislation, we will cover during the implementation process. The bill itself is clear on making voluntary assisted dying

available for the whole of the Queensland community, and we have to be very mindful of that in terms of how we go about implementing processes that enable that to happen. We have made reference to one of those, which is the carriage services which are going to be important in one way, shape or form moving forward. Largely, the answer to the question is on the implementation side of things as opposed to the bill specifying in detail how we would go about it from an operational sense.

**Ms KING:** What can we extrapolate from the Victorian experience of the impact of the Commonwealth Criminal Code provisions on the likely Queensland experience if the legislation is passed without changes to those Criminal Code provisions in relation to the carriage service issues?

**Ms Matthias:** I think there is an inherent conflict between the Commonwealth legislation and the Queensland legislation. As Mrs Robertson has said, the Premier has written to the Prime Minister about it. If it is not changed, we will have to look at how we implement the scheme in Queensland with that inherent conflict. In Victoria there was a direction from their minister to not use carriage services—a blanket direction. They were actually caught out because they did not realise this was a problem until after their act had been enacted. We are in an advantageous situation, where we understand what that position is now. In other states they have looked at how to increase that equity of access. Western Australia and Victoria have financial schemes that enable practitioners to attend to patients and the reverse—patients who are able to attend to a practitioner. Given Queensland's unique geography and decentralisation, it will obviously be a challenge for us. That being said, we have a lot more metropolitan centres outside of Brisbane where there is access where there could be a hub-and-spoke model. In the bill itself there is the concept of the statewide care navigator service and a statewide pharmacy. They will enable access from a statewide perspective and we will need to look at how that model is developed.

In Western Australia and Victoria those models are out of a metropolitan tertiary hospital with links to other hospitals in other places. It is definitely an implementation issue if the law is not changed. There are degrees of information that will breach the Commonwealth legislation. General information may be okay, but actually telling a person how to administer a voluntary assisted dying substance may not be okay in that context. It is looking at the continuum of behaviour that has to happen and how it is delivered.

**Ms PEASE:** Thank you very much for coming in. What I wanted to find out about was with regard to palliative sedation, and we have heard about that. For remote and regional centres, how do they administer that? We have been to many residential aged-care facilities where they get calls from their GP to tell them what medication is required. What are the implications of that with regard to the use of a carriage service?

**Prof. McNeil:** That is a really good question. As you think about the continuum of things, the passage of an electronic prescription is done over a carriage service so you could include that or not. There is a lot that we will have to go through to unpick exactly what the detailed implications are from a legal perspective about what that means. For instance, does the electronic transmission of a form regarding voluntary assisted dying fall under that legal coverage? I do not know the answer to that, and I do not know if my Justice colleagues will either, because it has not been tested and it has not been asked as of yet. There is a lot that we have to do to unpick this, because the Commonwealth is moving to electronic prescribing. We all want to do that and so we are going to have to have those conversations as to what is in and what is out, but it is a very good point.

**Dr ROBINSON:** The document titled 'Members of parliament—call to action' by Palliative Care Queensland states—

While the Queensland government election pledge of \$171 million over six years—  
or five or six years—

which is \$28.5 million per year, for palliative care is welcome, it is well short of what the sector estimates is required to bring about system transformation.

They state that '\$385 million per year in dedicated funding' is what is needed. They are commenting, particularly in this document, on the gross underfunding of palliative care to date and going forward—that the government's additional funding falls well short. Why has the government allowed thousands of terminally ill Queenslanders to suffer and die without dignity when they could reduce end-of-life suffering with better palliative care?

**CHAIR:** Member for Oodgeroo, I take you back to the bill. Before you comment, I am getting some advice. Firstly, what document are you referring to?

**Dr ROBINSON:** It is called 'Members of parliament—call to action' by Palliative Care Queensland, the peak palliative care body in Queensland. This is the document sent to all members of parliament. I am happy to table it.

**CHAIR:** Just stand by for a moment, please

**Dr ROBINSON:** You asked about the document. I can table it if you want.

**CHAIR:** Member for Oodgeroo, let me get some advice.

**Dr ROBINSON:** I am just referring to a document that is out in the public domain. I am happy to table it.

**CHAIR:** I do not need it tabled. For those here providing advice, I point out that under schedule 8 of the code of practice for Public Service employees we cannot ask you to comment. That is within the standing orders. I would ask you to either rephrase the question or I will rule it out of order.

**Dr ROBINSON:** My question then is: given that peak bodies have made public comment on the fact that the funding going forward does not deal with the need across the state and there is the likelihood that that pushes people more towards assisted suicide, can you please comment on the adequacy of the funding to meet the need?

**CHAIR:** Member for Oodgeroo, please.

**Dr ROBINSON:** Chair, this is extraordinary to intervene—

**CHAIR:** Member for Oodgeroo!

**Dr ROBINSON:** This is extraordinary. Palliative care is part of end of life, and the gag around commenting on that is extraordinary.

**CHAIR:** You are close to being warned, member for Oodgeroo. You are questioning my ruling. Deputy Chair, would you like to caucus with your colleague? We will move to another question.

**Dr ROBINSON:** I am happy to move on to another question.

**CHAIR:** Thank you.

**Dr ROBINSON:** In terms of the provision of palliative care as a right—and that comment has been made and I think referred to here today already—how will the government provide that right to palliative care for terminally ill people when they need it and where they need it so that no terminally ill person will go without local, quality access in a timely way, particularly if it is grossly underfunded in the palliative care sector?

**CHAIR:** You are going back to making commentary, member for Oodgeroo.

**Dr ROBINSON:** I am asking about the strategy, Chair.

**CHAIR:** I will give you the chance to ask one last question without imputations or opinions. Please keep it concise. I will give you one last chance to rephrase that.

**Dr ROBINSON:** This is highly irregular, Chair, but I will take your guidance. How will the government provide the right to palliative care that is implicit in the legislation in terms of the current funding model that government has put forward in relation to the bill?

**CHAIR:** Thank you.

**Mr Harmer:** In some respects I think I have answered that. Palliative care is provided now and funded to a certain level. That affords Queenslanders who need palliative care care in a range of settings. The government has committed to significant new investment which will increase over time. By the end of the five-year period, Queensland's investment in palliative care per capita will be comparable to all other states and territories of Australia. It will afford people the opportunity to receive care in a range of settings, whether that is in a hospital or in the community, and there is a significant effort as part of the investment to strengthen Queensland's capability to provide care in home-like settings and in the community, particularly in rural and remote Queensland. I will probably stop there.

**CHAIR:** Do you want to continue Professor McNeil?

**Prof. McNeil:** If I could comment from a clinical point of view, palliative care is thought of in a particular speciality concept. End-of-life care and palliative care is provided across a range of settings, from general practice and community health through to just about every speciality. Certainly in my speciality of transplantation we engaged in our own services in that respect without relying on specific palliative care services.

What we are doing in the department and across Queensland Health is setting up services that enable, through the power of information—digital transmission of electronic health records et cetera—palliative care or end-of-life care to be delivered appropriately right across the state. That aligns with our electronic medical records initiative as well as our rural and remote digital health initiative. It is all-encompassing, and speciality palliative care is one part.

**CHAIR:** I will make comment that the former committee did consider palliative care and in its aged-care report made 77 recommends. I think we have now seen the commitment to continue to fund that. I think you have gone to great lengths to detail that.

**Mr ANDREW:** Is there a provision in the bill that a patient with a 12-month prognosis will be seen by a palliative care specialist?

**Prof. McNeill:** I will pass that on to Ms Matthias.

**Ms Matthias:** Could you repeat the question, please?

**Mr ANDREW:** Basically, if someone has a 12-month prognosis and they decide they want palliative care, will the bill provide that that person is seen by a palliative care specialist in that 12-month period?

**Ms Matthias:** Not necessarily a palliative care specialist. The person will be seen by two independent doctors and told about their palliative care options.

**Mr ANDREW:** Will that be a face-to-face consultation or will that be done via phone? When we are delivering that sort of sensitive information, will that be face to face?

**Prof. McNeil:** Assuming we can settle on the legal side of things, it would be whatever best suits the patient and the treating practitioners, so it is an either/or. We would not preclude either of those events, but it largely comes down to what is available and what is the most effective bandwidth in terms of being able to provide the information effectively. We would be as open as we can to providing as many options for people as we can in that respect that suit them in their particular circumstance.

**Mr ANDREW:** You spoke earlier about a retrospective look at things by the review board. Would the review board be looking at things in real time—the way the cases are determined and how it is done?

**Prof. McNeil:** We have not actually determined the timing of the flow of information, but the review board will be reviewing every case where a decision is made to access voluntary assisted dying. There is a flow of information to the review board at various stages through the process.

**Ms PEASE:** I want to talk a little more about participation by entities. I note that regulations are being discussed and are going to be put in place. I am interested to hear about the entities and whether there is a requirement on the entities to alert new residents or patients of their position and their policy with regard to voluntary assisted dying.

**Ms Matthias:** There is a provision in the bill that requires the entity to publish that in a format that is accessible to residents or patients. They have to inform the public, including persons who use the facility or may use the facility in the future, that it does not provide services associated with access to voluntary assisted dying such as access to the request and assessment process, access to the administration of a voluntary assisted dying substance or both at the facility and to do so in a way that is likely to be brought to the attention of consumers or potential consumers of the service—for example, on its website, in brochures and on signage at the facility.

**Ms PEASE:** How do you imagine this will be administered? I note that when you were discussing that you were saying it is a complex issue but not one that can be excluded. How will you make sure that entities fulfil those requirements?

**Prof. McNeil:** We will have a detailed implementation plan around that. Part of that implementation plan will be wide stakeholder engagement. We will embrace that issue during stakeholder engagement because of the complexities and differences at an institutional level but also at the individual facility level. That will be part of the implementation process. If the legislation is passed then we will be able to put the details around how that will happen.

**Ms PEASE:** This might be going a bit too far on, but, for example, if there are some residents already there and this is enacted and they did not know that voluntary assisted dying was not going to be available at their facility and so they have to be relocated from the facility, is their original facility required to find them an alternative provider or will it be up to them to source that?

**Prof. McNeil:** The details I will leave for Ms Gibson, but this has been addressed in the QLRC's recommendations regarding the responsibilities of entities to not impede access to voluntary assisted dying but also where there is a need for transfer how that would be auspiced.

**Ms Gibson:** Professor McNeil has touched on it, but the bill sets out detailed requirements for each stage of the process. It will depend on whether the person is a permanent resident within the facility and also which stage of the voluntary assisted dying process they are seeking to access.

Depending on the circumstances, the bill does set out what the entity would need to do at each stage—whether it is transferring the person's care or allowing reasonable access to the facility by other practitioners who are willing to assist.

**CHAIR:** I have a question in relation to accessing medications. Maybe you can inform the committee of the practicalities of that. If you have a terminal illness and are being looked after at home in a palliative care space, are family members able to collect medications from a pharmacy to provide pain relief? I am not sure of the schedule and whether or not it is an S8. Putting that into context, how will families be able to access medications for persons to utilise voluntary assisted dying? Does it come in a lock box or do you go to the pharmacy? How does it work?

**Prof. McNeil:** I will again pass on for the detail, but in principle the medications will be provided through a centralised pharmacy process, as yet to be determined. There will be a defined process at the institution of this. The medicine will be kept in a locked box so they are not readily accessible to family members and family members are actually not engaged in the process. It is either self-administration or practitioner administration.

**CHAIR:** Thank you for that clarification.

**Mr MOLHOEK:** I thought your notes said that there can be a nominated person.

**Ms Gibson:** I will follow on from what Professor McNeil has mentioned. If the person makes a practitioner administration decision, only the administering practitioner can be given the substance directly by the statewide pharmacy service and it is kept in their possession until the person actually goes through with administration. If they have made a self-administration decision, the substance can be given to either the person's nominated contact person or an agent or the person themselves. That is to deal with some of those regional and remote access issues and the fact that if the person is terminally ill they may not be able to travel to the statewide pharmacy service to collect the substance themselves. That is to enable family members to assist in that regard. As Professor McNeil said, the substance needs to be kept in accordance with the storage requirements, which will be that it is in a locked box and not easily accessible by other people.

**CHAIR:** Thank you for that clarification.

**Mr MOLHOEK:** Professor McNeil, I want to understand a little bit more about the actual process, if it is self-administered or practitioner administered. We talk about this substance, but what is it actually? Can you explain that to us in a little bit more detail?

**Prof. McNeil:** The substance is yet to be defined. It is my understanding that we do not publish what that substance will be. Obviously it will be of medicinal quality and be appropriate for the function that it is designed for.

**Mr MOLHOEK:** It is actually a drink?

**Prof. McNeil:** The detail around that is yet to be determined, but it could be.

**Mr MOLHOEK:** There is a perception in the community that it is administered via a lethal injection. There seems to be a lot of confusion around how this is undertaken in the final stages.

**Ms Gibson:** As Professor McNeil said, we will not be making publicly available the specific details of what the substance is, for obvious reasons, but the bill provides that it will be a schedule 4 or schedule 8 substance or a combination of those substances. Those are substances that are prescribed in the Commonwealth Poisons Standard. We will not be specifying what particular substances are used. Only the people accessing voluntary assisted dying and the practitioners who are involved will be given that specific information. The route of administration will depend on whether the person accesses practitioner administration or self-administration. Some people who access practitioner administration because they will be unable to self-administer would be likely to have it intravenously, but, as Professor McNeil said, that will be worked out during implementation.

**Mr MOLHOEK:** You could have it by injection or by drip or by ingesting? There are a variety of ways that the substance could be administered. Do I understand that correctly?

**Prof. McNeil:** That is correct, with the intent that we give people choice and we make sure that there is equity of access to the substance for people depending on their specific clinical condition.

**Dr ROBINSON:** Just to clarify, we are administering under S4 or S8, as it says in the bill, a poison to end a person's life—just to clarify the medical process here.

**CHAIR:** Let us get clarification; this is a medication.

**Dr ROBINSON:** But it is a poison; is it not? Is it a poison or not a poison?

**Ms Gibson:** It is defined under the Poisons Standard, but that is a Commonwealth document that defines a range of substances, therapeutic and non-therapeutic, in use.

**Dr ROBINSON:** But ultimately to take a person's life.

**Mr MOLHOEK:** If we can go back to my line of questioning, the reason I am asking is: I was under the impression from the briefing that we had from Justice Applegarth that the only option was via a drink. For clarity, there are a variety of ways that the substance can be administered and it will be determined by the practitioner or the individual, based on their ability at the time.

**Prof. McNeil:** Correct, and the process that we go through in determining what the implementation of the legislation will be.

**Mr MOLHOEK:** You have just added a slight bit of confusion for me. Are we saying that the current legislation as drafted does not specifically deal with that?

**Ms Gibson:** That is by design. As I said, we are not intending to publicly say what the specific substance is or detail. These are clinical matters. As Professor McNeil said, the person's particular condition would determine the route of administration that is appropriate for the particular person. That will be dealt with in clinical guidelines and the statewide pharmacy service will work closely with the practitioner to determine the appropriate substance on a case-by-case basis.

**Mr MOLHOEK:** In the case where someone chooses to self-administer and they are well enough to do that, my question is: what are the options they have? Would it only be via some sort of tablet or drink? I hate asking these questions because it seems a bit macabre.

**Ms Matthias:** I do not know that we are at the stage of knowing that information. Other states have gone through this process, but we are still at the stage of working out our implementation and how this will happen and learning from what other states have done. I do not think we actually have the answer for you at this point in time.

**Mr MOLHOEK:** If the other states have gone through the process, maybe we could have a briefing document to understand what other states are doing in practice. If we could have, on notice, how the other states are dealing with it.

**Ms KING:** I have a question to the health team. I and probably other members of parliament have been receiving a number of form letters, some in support and some against the legislation. One in particular makes a claim that under section 82(1) a person will be able to access VAD without ever seeing a specialist. I was hoping to hear your reflections on whether in clinical reality that is true or untrue. If this bill is implemented, is a person ever likely to go through the steps of accessing voluntary assisted dying without seeing a specialist in their illness?

**Prof. McNeil:** It would be unlikely for someone with a particular medical condition that reaches an end-of-life stage, where appropriate and where accessible, to have not seen a specialist; however, that may be as a single consultation at some point and ongoing care would be provided by their usual practitioner. What is clear, though, is that two independent medical opinions will be sought, and if there is a need for specialist medical opinion that information will be provided to the person at that time. That is a requirement of the process that we will go through during the conversations around voluntary assisted dying.

**Ms KING:** In the process of determining their eligibility, if there is any question about the terminal nature of their illness at that point in time they would be referred to a specialist, potentially.

**Prof. McNeil:** Potentially. The intent is to make sure that the person is fully aware of all of the options available to them in terms of their medical care, and part of that would be an assessment of what has led up to that point of them making a decision to access voluntary assisted dying.

**Dr ROBINSON:** In terms of the need or otherwise to see a specialist, because we are talking about life and death matters here, why not just mandate that there needs to be one specialist as part of the process? We have two doctors, general practitioners—we respect them highly, of course; they give great advice—however, because we are dealing with such a very serious situation here, life and death matters for people, why not mandate a specialist for assisted suicide?

**CHAIR:** Can we get clarification? The bill that we are looking at is voluntary assisted dying. I will ask the member to keep to the bill.

**Dr ROBINSON:** I am keeping to the bill, Chair. It is otherwise known as various things: euthanasia, assisted dying, assisted suicide. It is described in various ways. I am happy to put my question through another channel.

**CHAIR:** Member for Oodgeroo.

**Dr ROBINSON:** I do not know that you need to intervene in every question, Chair.

**CHAIR:** Member for Oodgeroo, I am asking you to stick within the title of the bill. Please respect my ruling.

**Dr ROBINSON:** I am sticking to the bill, thank you, Chair. I take your advice.

**CHAIR:** I do not need arguments.

**Ms Gibson:** I would note that the QLRC considered specifically whether one or both practitioners should be required to be a specialist, and they came to the view that there was a need to balance the person seeing two practitioners with regional and remote access issues. If we did mandate a requirement that one doctor be a specialist, that would likely cause issues in those regional and remote areas, given that specialists in some fields are largely based in South-East Queensland, and that would potentially cause access issues. They did consider that specifically and determined that the best approach was to not include such a requirement.

**Dr ROBINSON:** Given that eligibility requirements in section 82 for coordinating and consulting practitioners do not include any requirement for specialist qualifications, experience or knowledge in either the relevant condition or palliative care, how will non-specialist medical practitioners and nursing practitioners be able to properly and fully inform the person of the matters required, such as the person's diagnosis and prognosis, the treatment options available to the person and the likely outcome of those treatments and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment? How will non-specialist medical practitioners and nursing practitioners, who often do not have specific specialist training in those areas, be able to provide that information? Again, we are talking about life and death matters here.

**Prof. McNeil:** As part of the process for being involved in voluntary assisted dying at that level, there is specific training that is going to be required for those individuals. That will be covered off in the training—

**Dr ROBINSON:** Just to clarify, is that the five-minute video or is it further training mandated in the bill?

**CHAIR:** Member, you have asked the question. Allow the professor to answer. We do not need the continued commentary. Perhaps it might be beneficial to talk about the Victorian experience of the two years to train medical practitioners who wanted to participate in this.

**Ms Matthias:** Both Victoria and Western Australia have a similar provision in their act, the minimum requirements for the coordinating practitioner or consulting practitioner. In addition, they have to go through a training process. QUT has developed the training package for both Western Australia and Victoria. It is an online training process that they have to go through that will look at how to determine capacity issues, how to determine eligibility issues and also whether a person is being coerced or undertaking the process voluntarily. It has been a well-worn path through those other two states.

**Dr ROBINSON:** What is the level of training or time frame? If I missed that, I apologise. In one case in one state jurisdiction there was a five-minute specific training video. Is that the type of training that we are talking about in this very specialised area?

**Ms Matthias:** It is an online training program. I have not seen it so I cannot comment specifically, only from what I have read. It will take the practitioners through all the steps and the stages of the process, depending on whether they are the coordinating practitioner, the consulting practitioner, the pharmacist or the nurse practitioner. Each one of those will have a very specific training package about the steps and what they are required to do. Obviously it has to be quite detailed because the bill is detailed around their roles in that regard. Then at the end of that process they will have met one of their eligibility requirements to be that practitioner under the act.

**Mr ANDREW:** If the federal government does not change section 474.29A or 474.29B, how will that affect the bill going forward?

**CHAIR:** Do you want to repeat the question?

**Mr ANDREW:** We are waiting on a change of legislation from the federal government in relation to the carriage situation that we have at the moment. If that legislative change does not get made, how will that affect the bill as it stands?

**Mrs Robertson:** As has been mentioned, both Western Australia and more particularly Victoria, which has commenced its legislation, have their operations. My colleague from Health has indicated how Victoria and the Victorian health minister address that situation there. Obviously a change to Commonwealth law is a matter for the Commonwealth. I probably should also mention that, just like all prosecution decisions, a Commonwealth decision to prosecute is the exercise of what we call prosecutorial discretion. That would be a matter for the Commonwealth DPP. How they exercise their discretion in particular situations would be a matter for them. We of course at a state level cannot bind that in any shape or form.

As I said when we mooted this discussion at the outset, the Premier has written—the challenge is not unique to Queensland. It exists in both Western Australia and Victoria. Victoria has taken, as my colleague from Health has indicated, an operational approach to it. The bill makes it clear that it is not suicide in that sense. The legal issue is of course how that impacts on the Commonwealth legislation and the troublesome nature of the Commonwealth provision. As a state, we obviously cannot legislate for the Commonwealth in that respect. To some extent, it is an issue of the Commonwealth government choosing to respond to the representations that have been made to date and may continue to be made.

**Mr ANDREW:** Will there be transparency in reporting on death certificates in regard to VAD? Will people know how many Queenslanders opt for VAD so that we can understand how it has hit the mark?

**Prof. McNeil:** The short answer is that VAD will not be mentioned on the death certificate. The underlying disease that has led to the decision to access VAD will be written on the death certificate. I pass to my legal colleagues if they have anything further to add.

**Ms Chandler:** Yes, that is correct. Further to that, where a medical practitioner can attribute a cause of death, they need to complete a cause-of-death certificate when a person dies and they give that to the Registry of Births, Deaths and Marriages. The bill provides that that cause-of-death certificate must not mention VAD, voluntary assisted dying, as the cause of death but rather the underlying illness or disease that made the person eligible for the scheme.

Similarly, all deaths in Queensland have to be registered with the Registry of Births, Deaths and Marriages. Again, that registration will say the underlying illness or disease as the cause of death and not voluntary assisted dying. Similarly, the death certificate that someone gets when they apply—certain people can apply to the registry for a death certificate—again, will not mention voluntary assisted dying. It will mention the underlying illness or disease. The way voluntary assisted dying is recorded is by notifications from the medical practitioner to the voluntary assisted dying board. They will keep the data and the information on the number of voluntary assisted deaths.

**Mr MOLHOEK:** It will be like the births, deaths and marriage register, which just says what the underlying cause is. Then there will be a separate register maintained by the board for people who have applied—

**Prof. McNeil:** That is correct.

**CHAIR:** The Victorian board publishes data. If this legislation is passed, I would imagine the Queensland board would do similar.

**Ms Matthias:** There is also a requirement under the bill for an annual report of the board which will include numbers of completed requests for voluntary assisted dying the board has received, the number of referrals the board has made to other entities such as Ahpra or the Coroner, any recommendations the board wishes to make and a summary of de-identified information that will be required by the regulation.

**Ms KING:** These are very personal matters for families who have dealt with end-of-life issues. Privacy clearly becomes an issue when it comes to what is recorded on death certificates. I wanted to inquire whether there might also be concerns about recording of voluntary assisted dying on a death certificate from the point of view of insurance—whether, hypothetically, a notation of voluntary assisted dying might lead to concerns about people receiving their life insurance payouts.

**Mrs Robertson:** Chair, we might have to take that on notice. I do note that the QLRC in its report does discuss the insurance issue and does acknowledge the challenges in that space. I would hesitate to give an answer at this point in time.

**Ms Matthias:** I can add to that if you would like, Mrs Robertson. Clause 8 of the bill provides that voluntary assisted dying is not suicide. For the purposes of a contract, deed or other instrument entered into in the state or governed by the law of the state, they are not considered to have died as a result of VAD or by suicide but they are considered to have died from the disease, illness or medical condition from which that person suffered. That was to address the issue of insurance contracts. Clearly insurance contracts are a contractual relationship between a person and a corporation, but that was the QLRC's position and other states have that position as well.

**Ms KING:** Given that people are at the end of life anyway, it is certainly the last thing that this legislation would want to see—families being deprived of an insurance payout.

**Ms PEASE:** I know there has been much discussion—and you have touched on it today—with regard to capacity and being able to make those end-of-life choices. Could you elaborate on how capacity will be tested and how people will be protected from potential coercion with regard to voluntary assisted dying?

**Prof. McNeil:** There are definitions of capacity, both clinically and legally. They will be applied through the guardianship act and will align with what already is in place to ensure that people have capacity as currently defined through our other existing legislation.

**Ms PEASE:** What my question is leading to is: if someone makes a request, who will undertake that test? Who gets the ball rolling? Is it their practitioner who would get that capacity testing done? Would there have to be legal people involved in that capacity testing?

**Ms Gibson:** As part of the two eligibility assessments by the two practitioners, they would have to undertake their own clinical assessment of whether the person has decision-making capacity for voluntary assisted dying. That is one of the limbs of the eligibility criteria in clause 10 of the bill. It would be the practitioner making that assessment. There is an ability to refer a person if the doctor is unable to make a determination about capacity. They can make a referral to a registered health practitioner with the skills and experience to make a determination and they can then adopt that determination as part of their eligibility assessment.

**Ms PEASE:** Taking that further, what safeguards are there to make sure that person is not being coerced or encouraged to make those requests? Are there any tests in place there?

**Ms Gibson:** A separate limb of eligibility criteria is that the person has been assessed as making the request voluntarily and without coercion. Tricia mentioned that the practitioners will be required to undergo training, and one of the things that training is likely to cover is the practitioner's ability to identify and assess the risk around any coercion or abuse. There are a range of other safeguards around ensuring that the person is accessing the scheme voluntarily and without coercion. That is why there is a staged request and assessment process. They obviously have to make three separate requests. One has to be in writing and witnessed by two eligible witnesses. The scheme, taken as a whole, is there to safeguard against any coercion or abuse.

**Ms PEASE:** My final question goes back to the medication. If someone has made a request for voluntary assisted dying and they are eligible, what will happen if the medication is not utilised? For example, the person might pass away before they get to use it.

**Ms Gibson:** The scheme includes a range of provisions around managing the substance to ensure there is a chain of responsibility for the substance at all times. Once it has been supplied by the statewide pharmacy service, if it is practitioner administration and it is in the practitioner's possession, if the person revoked their administration decision or they died before they were able to access it then the practitioner would return the substance to the statewide pharmacy service for disposal. There is also a provision for that practitioner to dispose of the substance themselves, and that is to address those rural and regional access issues.

For self-administration, once it is in the person's possession, again, if they either revoke their decision, decide not to go ahead with it or die before they self-administer the substance, then there are provisions requiring their contact person to return the substance to the statewide pharmacy service. That needs to be done as soon as possible and within 14 days to make sure that it is not just left lying around the person's house. It needs to be returned for disposal within that 14 days, and there is a penalty on the contact person for not complying with that.

**Ms Chandler:** Just on the issue of capacity, as a further safeguard, whether a person has capacity to access voluntary assisted dying and whether they are being subject to coercion are both reviewable decisions to QCAT.

**Ms PEASE:** So if a family member was unhappy about that decision, they could get it reviewed?

**Ms Chandler:** Yes, that is right.

**Dr ROBINSON:** In terms of the issue of conscientious objection of institutions or non-government organisations in terms of aged-care facilities and hospitals, there is the requirement for every aged-care facility and hospital to allow VAD to take place on their premises in certain circumstances should that be seen as necessary. How is that compatible with the right to freedom of religion? For example, what would happen in a Catholic Health or UnitingCare aged-care home where the person cannot be transferred and Catholic Health or UnitingCare have a commitment, for freedom of religion values, to not have that happen on their premises itself? Can you guarantee that that will never be the case under the legislation?

**CHAIR:** You cannot ask for guarantees.

**Dr ROBINSON:** Can you comment in terms of the likelihood of that happening?

**Prof. McNeil:** I will pass on for the detail. The bill does go into that detail in terms of what conscientious objection at an institutional level constitutes and what the options are, balancing the rights of the entity and balancing the rights of the person seeking voluntary assisted dying. Of course there is a complex amalgam of scenarios that you could draw here. I might pass on to my colleague for further detail.

**Ms Matthias:** As a starting point, the Human Rights Act has certain rights that apply to individuals rather than to entities. Under the bill, an individual can conscientiously object—so the individuals within that organisation. The right under the Human Rights Act does not apply to an entity. As Professor McNeil said, if an institution objects as a policy or religious matter, there are other detailed provisions around how that will play out within their institution. That is a balance between the rights of everyone involved.

**Dr ROBINSON:** Just to clarify, are you saying that it is possible within the bill that organisations that provide aged-care or hospital services may have to provide for VAD on their premises against their own sense of religious freedom and their own values?

**Ms Matthias:** They will not be providing it themselves, because each individual can conscientiously object, but they must not hinder access to that person's medical practitioner or for that person themselves accessing voluntary assisted dying.

**Dr ROBINSON:** They would have to let it happen, then? Is that what the bill says?

**Ms Matthias:** They would have to not hinder. They would have to facilitate someone else coming in.

**Dr ROBINSON:** Against the state—

**CHAIR:** Within the bill, I think you have answered that. We have one final question.

**Ms Gibson:** As I mentioned earlier, it depends as well on the stage of the process and whether the person is a permanent resident in the facility or not. If they are not a permanent resident and they want to go through with administering the substance in the facility, the entity would have a first right of transferring their care to a different facility, unless that transfer is not reasonable, using criteria set out in the bill about ensuring the person does not suffer unnecessarily and it does not cause them harm.

**CHAIR:** Thank you very much to the representatives from both the Department of Health and the Department of Justice and Attorney-General for being here today and better informing all of us on the bill before us. Can we have responses to any questions on notice back by 21 June? I now declare this public briefing closed.

**The committee adjourned at 12.00 pm.**