PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Thursday 26 August 2021

REVISED EDITION

Contents

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The President, **Mr Farrell**, took the Chair at 11.00 a.m., acknowledged the Traditional People and read Prayers.

QUESTIONS ON NOTICE

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - I seek leave to table an answer and have it incorporated into *Hansard* - question number (3) from the member for Launceston regarding the Calvary co-located hospital.

Ms Armitage - I do not see any tables or anything in the answer; I am just wondering the reason.

Mrs HISCUTT - I am happy to read it out if you like. It is just usually we table them.

Ms Armitage - Not necessarily. I would appreciate it even if it has got tables, if you could read it out, thank you, Mr President.

Mrs HISCUTT - I am most happy to read it out if that is what the member requires.

3. CALVARY CO-LOCATED HOSPITAL - LAUNCESTON

Ms ARMITAGE asked the Leader of the Government in the Legislative Council, Mrs Hiscutt -

With regard to the proposed Calvary co-located hospital slated for Launceston:

(1) Given that it has been three years since the unsolicited bid was made by Calvary Health Care, when will all stakeholders have an opportunity for an open and transparent conversation regarding what services Calvary Health Care intend to provide in order to cater for the future needs of the region's population?

(2) Does the Government acknowledge that, in order to achieve the best outcomes for the state's north, a significant and detailed consultation will be required?

(3) (a) How extensive will the public consultation process be; and

(b) will the Government ensure transparency during this process by allowing public submissions?

(4) Given that Calvary Health Care has already ruled out an accident and emergency department for this facility, does the Government believe that it is acceptable to forgo this service requirement as part of its proposal - noting that this service is provided by Calvary Health Care to patients in the state's south, and given the pressures that the Launceston General Hospital Emergency Department finds itself under?

(5) Can the Government give any indication about what services the proposed facility will offer, understanding that there is significant public demand for pregnancy, post-natal, mental health services, palliative care, pain management services and elective surgery capabilities?

(6) Can the Government guarantee this co-located hospital will not simply be a combination of both St Luke's and St Vincent's campuses on one site with no additional services?

ANSWER

Mrs HISCUTT - The answer is that it is important to understand this is not a co-investment for the Tasmanian Government but a privately funded development by Calvary that must be commercially viable to ensure its longevity in the provision of private health services to northern Tasmanians.

The Tasmanian Government's contribution to this project is the sale of land to Calvary at market value as determined by the Valuer-General and funding for the airbridge connection between the two buildings.

In that context I provide the following responses to the member for Hobart's questions.

Ms Armitage - Launceston, actually.

Mrs HISCUTT - Question 1 -

Members - Member for Launceston.

Mrs HISCUTT -

(1) Calvary presented its proposal, including concept drawings and a clinical services plan, to the Launceston General Hospital (LGH) executive on Wednesday 11 August 2021. Calvary has been in discussion with various stakeholder groups, including St Luke's.

The Department of Health project team will be facilitating further presentations by Calvary to key stakeholder groups.

(2) Consultation includes senior clinical staff at the LGH through the hospital executive, the AMA, the ANMF, private health insurers and the Northern Health Group (a group of local industry professionals). The Department of Health project team negotiating with Calvary will be seeking input from these key stakeholders.

(3) The Calvary proposal will be subject to broader community consultation through the planning authority development approval process. The Department of Health project team negotiating with Calvary will be seeking input from the key stakeholders mentioned above.

(4) It is an agreed principle that the co-location should not unnecessarily duplicate services, with a preference to have complementary services across the public and

private sector. While discussions are at an early stage, Calvary has identified several opportunities to relieve pressure on the LGH Emergency Department and these will be considered by a working group comprised of senior clinical representatives from the LGH.

(5) While still subject to negotiation, the Calvary proposal includes both overnight and same-day beds, with services including palliative care, mental health, post-natal services and elective surgery. The full detail of the service offering will be the subject of further discussions over the next few months.

(6) The Government's stated position to Calvary is clear in that the co-location must provide an enhanced level of service to northern Tasmanians.

Mr President, do I need to withdraw my motion or is that moot at this point?

Mr PRESIDENT - No, it was not moved. The honourable member settled before we put it to the vote.

JUSTICE MISCELLANEOUS (INCREASING JUDICIAL RETIREMENT AGE) BILL 2021 (No. 15)

Third Reading

[11.07 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

That the bill be read for the third time.

Bill read the third time.

GUARDIANSHIP AND ADMINISTRATION AMENDMENT (ADVANCE CARE DIRECTIVES) BILL 2021 (No. 14)

Second Reading

Continued from 25 August 2021 (Page 57).

Ms FORREST (Murchison) - Mr President, I have completed my contribution on the bill.

[11.08 a.m.]

Mr GAFFNEY (Mersey) - Mr President, I appreciate the comments made, and I appreciate the briefing. I thought it was really valuable, as were the comments made by the member for Murchison. Going from something interesting she discussed, there are a couple of things I would like to address before I start my speech.

The first is the situation of the doctor choosing a different direction to the directive, regarding the ventilator, member for Murchison. I think it was a great outcome but I wonder what the response would have been if the person had not recovered the way they did and they were then left on the ventilator for a number of -

Ms Forrest - They can still use the provision to withdraw treatment. It was a very clear clinical judgment of the medical practitioner that this patient would survive.

Mr GAFFNEY - That was a good outcome. I am wondering, in other situations, if it is not a good outcome, where does that place them?

The other point you raised was to let people know that the person has to have decision-making capacity in the End-of-Life Choices (Voluntary Assisted Dying) Act. It is interesting to note that in Canada at the moment they are doing good research and making good legislation regarding this very aspect and how to try and link the advance care directives, enduring guardianship, the bill of rights and medicinal assistance in dying and they have taken great inroads in that area. If you are interested in it, Professor Jocelyn Downie is the main legislator in Canada who would be able to help out.

Also, of interest, I remember reading some time ago about New South Wales when they were looking at advance care directives and the way they approached the voluntary assisted dying in their draft directives because they do not have VAD legislation in place. I thought there were some interesting aspects to their draft they put out for consultation, but have not had a chance to get back and have a look at that.

Mr President, I rise to speak on the Guardianship and Administration Amendment Bill relating to advance care directives. Everyone in this place recognises the need for this timely intervention in amending the Guardianship and Administration Act 1995 to formalise an essential update to an act that, whilst appropriate in its day, is now over 25 years old and can be considered to be a whole generation out of date.

The catalyst for this reform has been the Tasmania Law Reform Institute's review and the resultant report that amounts to nearly 500 pages, as the member mentioned yesterday.

The Government has taken the expedient move of extracting the recommendations relating to advance care directives and accepting them in their totality, and they are now delivered in the form of an amended bill to the act, the final consideration of which is the task before us and I thank the Government for doing that. I think it was a wise decision.

This could not have come at a better time as so much has changed in our community's expectations as we openly embrace new perspectives and legislation on end-of-life choices. This has been balanced with the need of engaging an inclusive culture that is at the core of our wider Tasmanian community.

Legislation must evolve and be improved upon to better reflect the ongoing expectation that we are an increasingly diverse society that has higher expectations of the services and choices available to us all; a society that must acknowledge and recognise a person's right to self-determination and, in the case of incapacity, that their predetermined range of treatment parameters and choices are defined in a form available to every medical practitioner who may be involved in their future care.

As we reflect on the ongoing challenges the COVID-19 pandemic is having, it has brought sharp focus on our vulnerabilities, both as individuals and that of our greater society. In order to address these concerns, there is often an impetus to deliver even more stringent regulations and safeguards that can be seen to address quite remote possibilities.

I would like to think we can examine this legislation with an open mind where we can focus on the intent behind a person's free choice in drafting an advance care directive that allows them a sense of control and dignity without undue intrusion or bureaucratic complication.

The seemingly onerous witnessing requirements are a case in point where the bill suggests that two witnesses must have a complete knowledge of the nature and effect of the provisions within an advance care directive and check those against the person's understanding of such. These may be something the person considering an advance care directive may wish to remain a personal and private matter between themselves and those with whom they choose to confide.

I raise this as one of the defining tenets of the bill: that in the absence of anything to do to the contrary, a person is rightly assumed to have decision-making capacity or ability at the time of establishing an advance care directive.

An advance care directive will be a defined device that gives authority to their choices at such a time when they may be incapacitated for whatever reason. As part of this defined decision-making capacity, it seems reasonable to assume a person by the very act of drafting such a document will be well aware of the impact of an advance care directive and be able to seek further advice or independent opinion if they feel it necessary.

It has been the case that traditionally one may witness a person's signature on a confidential document without needing to know the detail of its content. The requirement for two witnesses with intimate knowledge of the terms of the advance care directive, together with a forensic examination of the person's understanding of them, may be a safeguard too far. Perhaps an amendment witnessing protocol or an alternative mechanism for endorsing an advance care directive - such as a statutory declaration - would be appropriate for those who may hesitate due the currently drafted requirements.

I look forward to hearing the thoughts of others on these points.

One of the most notable improvements is the recognition that mature minors under the age of 18 may give an advance care directive. The needs and rights of people under the age of 18 have been a point of considered debate on a number of issues that have come before us. I applaud the Government in making this provision available for young people and their families that may be facing challenging decisions regarding their health care and treatment. This provision will hopefully give a certain amount of relief and clarity in impossible circumstances.

I note in this element, from an Australian perspective, that case law surrounding the original Gillick principle case has been applied to those under 18 years of age in this bill, whilst the original case relates to the health care decision autonomy of those under 16 years of age.

I am not sure we in Tasmania are quite ready to consider this point in general terms, but it is notable to be aware that other jurisdictions outside of Australia have done so on the basis

of the mature minor's capacity to fully understand the consequence of their decisions at a younger age threshold.

It would be instructive to reflect on Lord Scarman's observation in relation to the original case from over 35 years ago. He said:

> … as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed.

There are additional requirements - dare I say safeguards - relating to inform minors that requires that a registered health practitioner is a witness to the advance care directive and bears the responsibility to attest to the minor's capacity to fully understand what is proposed.

There is an additional point of Australian law that may yet relate to this bill in terms of what is commonly known as Marion's Case, an incredibly difficult case that went before the High Court nearly 30 years ago in 1992. The outcome of the case of an incompetent child was that parents were ruled to have decision-making capacity in medical treatments that must only be in the best interest of such a child. If there was any doubt, it was left to the Family Court to rule on what might be considered as such, and as a child's best interest. We may have to consider if this has bearing on a dispute resolution process, revocation or variance of an advance care directive, one that may arise in a disputed advance care directive by the interested parties in the care of the minor that may have lost decision-making capacity.

In my community consultation and dialogue with stakeholders surrounding what is now the End-of-Life Choices (Voluntary Assisted Dying) Act 2021, one of the greatest causes of concern is dementia and how its victims are robbed of their cognitive abilities, together with their impact on the relationships with loved ones and life partners. At this stage, for many people and legislators the contemplation of including dementia within the eligibility criteria for VAD is a step too far. Despite this, it is my hope this bill can offer solace to those that might wish to retain some control over what may or may not happen to them if they happen to befall the ravages of this vicious disease.

There has been learned debate that a dementia patient, despite no longer being able to recall or demonstrate any of their past life or familiar relationships, can still live in a contented state. However, it is not our place to contradict the person's wishes on their health care choices that were properly made and registered when they were of sound mind and with full decision-making capacity.

I would like to think whilst any possible review or revocation process of an advance care directive may be initiated with the best of intentions, the person's wish must prevail with rigorous safeguards to ensure this is indeed the case.

I also acknowledge the significant emphasis on safeguards that will inhibit improper influence on a person's choice on establishing an advance care directive, as is right and proper. It is pertinent to observe this from another perspective, as an advance care directive can give a person comfort that they will relieve a loved one or life partner of having to make destressing decisions on that person's behalf.

There can be a worry a person may be unduly influenced not to be an unnecessary burden. However, in saying that, I am sure there are many of us who hold that concern close to our hearts and it is not an unreasonable wish. The opportunity to draft an effective and enforceable advance care directive can provide a particular comfort to all involved, knowing that a person's directions in the circumstance of unforeseen events can be followed in good faith, and that their express wishes relating to their treatment and health care have been properly enacted. In doing this, any condition that renders a person unable to have decision-making capacity will not shift a decision or responsibility onto someone else at a time of extreme distress.

Mr President, we have seen in recent years increasing community expectations in greater autonomy for a person's control over the interventions that may or may not be made to their wellbeing, health care and treatment. That need has never been more relevant in the light of expanding health care services, capabilities, and the ability to maintain life in challenging circumstances that may well be against the person's wishes.

I shall be closely observing the passage of this bill to ensure that a person's right to self-determination is fully supported and their rights are not eroded by the compounding effect of bureaucratic and legislative niceties. It has to be workable and it has to be appropriate. In this place, and the other place, many poignant issues that have a direct impact on our community's sense of personal identity, compassion and integrity have been debated at length and with dignity and respect.

It would be beneficial for members and those listening for the Leader, in her closing remarks, to indicate the Government's intentions to inform all Tasmanians and health practitioners about the amended and altered advance care processes. I look forward to hearing the considered thoughts of my fellow members on this bill. The bill has the potential to deliver significant advancements and I will be supporting it.

Recognition of Visitors

Mr PRESIDENT - Members, I welcome to the Chamber a group of two families today from the home education community. They are here to observe the proceedings of the Legislative Council. We are debating a second reading speech and this is for the Guardianship and Administration Amendment Bill.

In the second reading members of the Chamber put their points forward and then, after that, we go into another stage of the bill and it either passes through the parliament or is amended or it does not pass. Each member has an opportunity to speak on the bill. I am sure other members will join me in welcoming you to the Legislative Council Chamber today.

Members - Hear, hear.

[11.22 a.m.]

Ms ARMITAGE (Launceston) - Mr President, this important debate touches many people and will hopefully produce positive results for those making informed decisions about their health care and wellbeing.

The modernisation of the framework around advance care directives is perhaps overdue, but welcome all the same. Investigating the processes people must go through to make their

advance care directives has been quite a journey. To be frank, the previous frameworks have been rather disorganised and difficult to navigate.

Having codified law around these directives is, therefore, a very welcome development. It gives effect to the recommendations of the 2017 House of Assembly Inquiry into Palliative Care and the Tasmania Law Reform Institute's Review of the Guardianship and Administration Act 1995. This bill signals an overall modernisation of attitudes towards end-of-life care, and it is undeniable that the voluntary assisted dying bill brought forward by the member for Mersey has played a significant role into bringing this important discussion to the fore.

As the Leader mentioned in her second reading speech, this bill will bring Tasmania into line with other Australian jurisdictions which have legislation governing the use of advance care directives. We are showing that we take a serious view of the ability of people to make their own informed decisions about their future health care. It is important to have these discussions with our loved ones, as we never really know when advance care directives may need to be used.

In the past, we have seen drawn-out, emotive and highly-publicised cases where disputes have arisen about what health care should be provided to people who cannot make decisions for themselves. The bill also recognises that adults are presumed to have decision-making ability in the absence of any circumstances to the contrary. Ensuring that legislation like this is guided by self-determination and individual agency means that power to make decisions like these stays, as far as possible, in the hands of those it directly involves. The framework created by the bill also provides certainty to medical practitioners, who in practice, action the directives a person has provided in advance. It releases them from liability for any action taken or not taken, as long as it is done in good faith and without negligence.

Each of us has different priorities and circumstances. We are informed by our lived experiences, our faiths and our preferences, as we were during the discussion of voluntary assisted dying. I recall a few years ago when my mother went into the emergency department. She was asked by a nurse about resuscitation and we had not discussed advance care directives. When I went back into her room she said to me, I have talked to the nurse and I have told the nurse I do not want to be resuscitated. We had not discussed this, and it was quite frightening. We did not want the thought of our mother not being resuscitated. I mentioned it to my sister - a person of great faith - and she also thought, how could Mum do this without discussing it with us?

It is very important to have a bill like this, where people do make the time to have their advance care directives laid out, rather than all of a sudden being faced with the situation in the emergency department when someone is asked by a nurse, do you want to be resuscitated? They say no, but have had no chance to discuss it with family. It was mentioned by the member for McIntyre that at the moment, COVID-19 means you cannot go into the emergency department with a loved one. You have no time to speak with them about these decisions.

This bill gives effect to the universally recognised principles that adults should have the ability to make their own informed decisions about their health care; that these decisions are informed by a person's will, preferences and rights; and that adequate support should be given to a person to effectively communicate these decisions from preferences. This bill does all of these things whilst also providing a number of safeguards for people who are perhaps not

demonstrating adequate decision-making abilities due to impairment, coercion or other reasons.

This bill and the framework it creates provides an important pathway people can take at any time to make advance decisions about their own health and wellbeing. Unless we have reason to believe a person was not acting of their own volition in making decisions such as these, we have no right to treat them as they do not wish to be treated or tell them they do not have the right to make these decisions. As mentioned, it is often difficult for families to accept these decisions. We are not entitled to play God with decisions like these, and if we can provide more certainty, safety and regulation through this legislation then it should be universally supported. I support the bill.

[11.28 a.m.]

Ms LOVELL (Rumney) -This is important legislation and has been broadly welcomed among stakeholders, across the community and through the parliament.

Advance care directives are an important tool that can provide a great deal of comfort to individuals who might put their own advance care directive in place and, as the member for Mersey and others have pointed out, to the loved ones of that person. None of us wants to be have to make critical decisions on behalf of someone, if we are not quite sure whether we are making the right decisions for that person. Advance care directives can provide a great deal of reassurance and comfort to everyone.

I acknowledge the work of Palliative Care Tasmania, who I know have long advocated for advance care directives to be brought in and to be legislated. It is important to have legislation to outline how these operate, how they are registered and maintained. I know this is something Palliative Care Tasmania have done a great deal of work on.

I have always believed in, and strongly support, the right to live a life of dignity, and that extends to people's end of life. It is probably more important at a time when, without something like an advance care directive in place, that choice and that autonomy might be taken away from people.

This is a comprehensive and well-consulted bill. I am pleased to see inclusions such as a comprehensive and clear list of characteristics that do not constitute lack of decision-making capacity.

We are reforming the way things are done in terms of advance care directives, and we have also seen it done through the End-of-Life Choices (Voluntary Assisted Dying) Bill. That was an issue that was debated at length. We are starting to have a different set of expectations of people who are working in these fields and it is really important that we provide that additional guidance so I was pleased to see that included in this bill.

I thank the department officials for the briefing we had on this bill yesterday, particularly Bruce and Lisa for taking the time to explain at length the answers to our questions. Some of that took a bit of back and forth sometimes.

These are complex issues that we are dealing with so it is really important that we can be absolutely confident that we fully understand it and we get it right. After having that briefing

and having some of those conversations I am really comfortable with this bill so I am really happy to support this bill.

[11.30 a.m.]

Ms RATTRAY (McIntyre) - Mr President, members who have already spoken have clearly articulated the parameters of the bill and the member for Rumney did an excellent summary in her contribution. The principle of this bill is to give greater legal certainty to the status of advance care directives and it certainly has had that extensive consultation. I also acknowledge the briefings that we had yesterday. They were clear, concise and all our questions that were presented were well answered and I know that some of those questions will be put on the public record through the Committee stage, and that is a right and proper process.

Also, I acknowledge the consultation process, as the member for Rumney and others have done. So often in this place we talk about consultation with the wider community, stakeholders and the like and this, to me, appears to be an excellent example of that thorough consultation. Well done to the Government and those who have been involved in that.

It is certainly a complex area because it is often a very emotional time for people, for family, for loved ones, who are involved in those life decisions. So to have an advance care directive or an ACD, as was used yesterday a number of times, in place so that everyone feels comfortable about the person's wishes, if you are that person who is part of that ACD process then you certainly have the right tools and have been through it. Another important aspect is the sharing of that information and as we heard yesterday it is important, as with organ donation and the like, to have those conversations with your family, with your friends, with your loved ones about what you would prefer to have, particularly when things are at an emotional time.

I had a couple of questions yesterday about the mediation process and I was very interested in that because, as we know, at those emotional times particularly families can be strained. I asked whether it was a formal or a compulsory mediation process and that will be something that I will be interested to hear in the response from the Leader. I think we need to make that is clear, whether that is through the Committee stage or whether it is in the second reading speech response. As I said, the mediation process will be an important aspect if there is an issue with an ACD.

I clearly remember when I first arrived in this place the former member for Mersey, Norma Jamieson, had a really key interest in this area. I know if she was here today - and she is possibly listening as I know the former member, as I said, has had a really strong interest in this area - I believe she would be exceptionally pleased with what is being presented today.

Mrs Hiscutt - If Ms Jamieson is listening in, I thank her for her email to me regarding this matter.

Ms RATTRAY - I have no doubt that the former member for Mersey would have had some input into this, because it was a key focus for when she was a member of parliament. From memory, we shared only two years together as members in this place, but I can assure you they were two very enlightening years for me. I greatly appreciated her friendship when I was a new member and did not really know how the place worked.

We heard yesterday that the bill refers to 'binding' and 'non-binding'. I asked a question about the non-binding aspect of the bill, regarding practical wishes. The answer to my question

was 'as practical as possible', and some examples were provided. I asked the question about my mum's situation. She has been very clear to her family - 'I want to stay at home. That is what I want to do.' How do we comply with an advance care directive when it gets to a stage where that is no longer practical? More information may be provided during the Committee stage.

I was interested to note from yesterday's briefing, that much of this legislation for our Tasmanian community was adopted from the South Australian model. We often use South Australia as a template, because they have some similarities with Tasmania as they are not one of the larger states and so possibly have some of the same challenges that we face.

With a nine-page second reading speech, there is not a lot more for an elected member to put on the public record. However, I noted from the second reading speech and our briefings that the advance care directive form is available on the Department of Health website. As the member for Mersey indicated to the Leader in his contribution, how is the Government intending to get that information out into the community?

That is a valid question and I also would appreciate an answer because as we know, not everyone has access to the Department of Health website.

Ms Forrest - There will probably be a new form.

Ms RATTRAY - I am sure there will be. There will be aspects that will need to be included. I expect that the new form will also be available on the website. As elected members we have access to that website, and I believe we will also be a useful resource for our communities to provide that information and to assist people. We will not be filling out their forms for them; that will be something that they will do with their family or whoever they choose to be the person who is part of their advance care directive.

This is a formal process and a highly complex area and certainly one for which we will need to be on the journey. A media release when this was first put out into the public arena indicated there would be a staged approach for the implementation of the TLRI report. As we saw yesterday, that was a voluminous report and I am interested in how much more reform the Government foresees and over what length of time. It is in the interest of the community to know what sort of time frame is planned for the implementation of the TLRI report, and where we are with this first piece of legislation.

I have no issue in supporting the bill into the Committee stage. I have appreciated the contributions that have been made so far; they have certainly helped me and it is useful information to have for our communities.

[11.41 a.m.]

Mr VALENTINE (Hobart) - Thank you Mr President, and thank you to all the members who have provided information on this bill. You have covered a lot of ground and I have found it most interesting. In a way, we were prepared in some ways for this bill, through the End-of-Life Choices (Voluntary Assisted Dying) Bill which addressed many aspects of trying to make sure people are granted the opportunity to have a say on how their last moments on this earth are to be. This is a similar circumstance - an opportunity for people to express those wishes in writing or orally before the event. This bill will ensure that people have the opportunity to express their wishes for their final months, weeks or moments on this earth.

Ms Rattray - When I was at the lectern, I neglected to refer to one of the main messages, through the end-of-life choices process and the community consultation: the great desire to have choice.

Mr VALENTINE - That is right. Many people thought the voluntary assisted dying approach was not the way to go; they wanted to see this in place. If this bill is passed, both circumstances are covered and people have the opportunity to express their wishes about how they want to be treated. The bill covers capacity to decide, which is very important. There are times when people do lose their capacity to say how they may wish to be dealt with; but hopefully, through this process, they will have a chance to be able to do that much earlier in their life.

The bill does not provide the capacity to appoint an enduring guardian. That is dealt with under a different area of legislation and it is clear there is no capacity for that in this bill. Gillick competence is provided for, as the member for Mersey mentioned, for those under 18, with safeguards there. I note there is no lower limit on that. I suppose Gillick competence takes care of that; not being a student of Gillick competence I do not quite understand how young a person might be able to be. The member for Mersey might have some information about how low that can go in terms of age. I am not sure how young a person might be to be at a point where they understand the seriousness of a decision they might make. It is all wrapped up in the measurement of what is called Gillick competence.

There is no mandate that medical or legal advice is required but it is encouraged to ensure the directive is clear and effective. You can understand when people write things down, quite often it can be ambiguous. It is important that when you are dealing with something that is going to be registered as your wishes for your last months on this earth, that it is clear and unambiguous for those dealing with your circumstances.

There is capacity to provide oral recording, and from that oral recording of an advance care directive a registration can be made. It could well be a new form but this bill, I believe, honourable Leader, is not a mandated form. It could be a form to similar effect, as a standard form that might be put into place. If somebody simply does not have access to the form for whatever reason, it does not stop them from being able to make an advance care directive. It is the content of whatever it is they write that is important and the registering of that directive requires certain things to be covered. That is good. You might clarify that is the case, I am pretty sure it is in here.

Mrs Hiscutt - Yes, that is the case.

Mr VALENTINE - It is. Another important point is that it was not signed under duress. The rights of the individual are being provided for here and it is important that people are expressing their wishes and not the wishes that someone else wishes them to have. Witnesses cannot be a close relative, carer or service deliverer. It is important to make sure that there is no opportunity for coercion when this advance care directive is being registered.

It provides the opportunity for health practitioners to have a conscientious objection. We know we provided for that in the VAD bill as well. All parties need to be treated with respect and it may well be that, for whatever reason, a health practitioner says they do not want to be a part of it. If that is the case, there is that opportunity for them to express their conscientious objection.

An advance care directive can be registered but it is not mandatory. It is interesting that a common law advance care directive can coexist with a registered advance care directive. It may be that the common law advance care directive deals with some components that are not in the registered advance care directive. I would like some clarification from the Leader as to whether there is an overlap and which takes precedence?

Mrs Hiscutt - I can answer that now. It is the date that takes precedence. It is like a will, the next one dated takes precedence.

Mr VALENTINE - Okay, so it is considered the final statement. If you have a more recent date then whatever is covered in that advance care directive is going to be complied with. If there is something in a common law advance care directive that is not dealt with in the more recent registered ACD then that will be complied with as well. However, if there is an overlap it is the most recent document that is followed.

Mrs Hiscutt - It is the more recent one.

Mr VALENTINE - Yes. I just needed to make sure that was clear to everybody.

There is a mediation process. Quite clearly sometimes things occur where there are disputes. It is important to have that mediation process. In talking about that mediation process, it is so important to make sure that the individual's wishes are the ones that are being complied with as far as possible.

I know that there are concerns that have been expressed by some. I think Advocacy Tasmania expressed some concerns and we have seen these sorts of concerns being played out where the Public Guardian process is a bit paternalistic.

I was encouraged in the briefings yesterday that the Government said that there is a work in progress to improve processes and procedures to make sure that some of that paternalism is addressed. It is important to ensure, whether people have a disability or where the Public Guardian steps in, that as far as possible the Public Guardian will be trying to respect the wishes of the individuals rather than making decisions for them. I believe that there is some work in progress in that regard. If the Leader wants to cover off on that I would appreciate having that placed on the record. That would be great.

Advance care directives can be changed. We all change our mind over time on all sorts of things. I have seen people change their mind in this Chamber.

Ms Rattray - Persuasive debate that is often called.

Mr VALENTINE - It can be. You might have expressed, 'I feel this particular way at the moment' but then somebody gets up and speaks and brings out a point that really drives home a particular issue. Then you think, 'I've got to change my mind on that'.

Ms Rattray - The former member for Nelson did that beautifully on a bill once, that the President will recall, and got the rest of the House to vote with him, and I lost.

Mr VALENTINE - Did he? You remember it well because you lost.

Ms Rattray - I am still in counselling for that.

Mr VALENTINE - Overall though, what this bill is trying to achieve - and why I will support this bill - is that people want control over their pathway of care when they are facing their final days on this planet. I am sure they want to retain their dignity with it. That is mostly what it is about. It is about providing people with the opportunity to express their wishes and to make sure that they are treated with dignity.

I thank the Government for bringing it forward. I thank those who have put all the preliminary work and effort behind this particular bill and the inquiry that happened. The Tasmania Law Reform Institute, I thank them for their time and effort. We value the work they do and I am sure most members here would. I thank them publicly for that effort. We have a bill that is a synthesis of their work that is putting into play legislation that will improve the lot of people in our community as they are able to express their wishes with regard to advance care directives.

[11.55 a.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - I have numerous answers so I will work from the beginning. The member for Murchison was speaking on registering an ACD - how will the register work and who will have access to it?

Proposed new section 35X provides authority to the board to register an advance care directive and requires that the board keep or cause to be kept a register for this purpose. Flexibility in the form in which the register is kept is to account for any changes that may arise from national discussions to create a register for instruments.

At the same time, clause 25 amends section 89 of the principal act, Duty to keep register, to remove reference to the hours the register is open for inspection and to require that the register is made available for inspection by persons in accordance with the regulations. As we know, the regulations are still to be developed.

This one talks to the member for Mersey and the member for Murchison regarding implementation. Will the Government fund an education and awareness program to support the implementation of the bill? I think one other member also spoke about the education, the member for McIntyre.

The Government recognises there will be a need for a program of education and awareness-raising to coincide with the bill coming into effect. This will include a communications strategy targeted to health practitioners and other key stakeholders including hospitals, aged care facilities and other bodies providing healthcare services. This will also include the disability sector.

Health practitioners, particularly those working in a hospital context, have been working with common law advance care directives for some time. There will, however, be a need to ensure that health practitioners and other service providers are aware of the new statutory requirements. A communications strategy will be formulated prior to the commencement of the bill.

The Government is committed to educating the community on these changes and ensuring advance care directives are accessible to all Tasmanians. This will include with

stakeholders, including Palliative Care Tasmania, amongst others, to provide this information broadly to our community.

Another from the member for Murchison about additional resourcing. The proposed amendments to the Guardianship and Administration Act introduced significant changes to the functions of the Public Guardian, and the Guardianship and Administration Board. Resources will need to be allocated for this purpose, as is the case with all legislative implementation and processes.

Another one about the Gillick principle - will it be used to ascertain consent by children? Yes. Proposed new section 35D(4)(a) requires a child to be sufficiently mature to make health care decisions of that type covered by an ACD. The Gillick principle for establishing competency is the test to determine this capability which is a well known and established test used by medical practitioners.

The member for McIntyre about the mediation process - is mediation compulsory and please explain the process?

Under the bill, the Public Guardian may require for or arrange mediation between parties only where there is agreement to do so. That is proposed new section 35ZI(2) on page 64. Only where people are willing will they enter into mediation processes and they can withdraw at any time.

The member for McIntyre - what further work is coming?

Given the complex nature of this type of reform and the volumous nature of the Tasmania Law Reform Institute's final report- the blue brick - it was necessary to adopt a staged approach to the implementation to ensure all matters can be appropriately, thoroughly addressed and progressed in a timely manner.

There has been advice the Department of Justice commenced work on tranche 2 of the guardianship and administration reforms from the work of the TLRI. The second tranche will look toward entrenching further supports for vulnerable Tasmanians into the guardianship framework, including any outcomes from the recently announced independent Review of the Public Trustee. This report is due to Government by 30 November.

It is anticipated this next stage of reform will import into the principal act concepts that are now being given effect in this bill, including: the adoption of human rights principles as a framework for the way in which decisions under the act are to be made; a revised test of decision-making ability which recognises that all persons have decision-making ability as a common law right and that reasonableness of the decision is irrelevant to the assessment of the person’s ability to make a decision; the move away from a best interests approach to a will and preference approach, which requires substitute decision-makers to recognise the wishes of the person when making any decisions under the act; the removal of disability as a standalone test of decision-making ability. The approach adopted will ensure that key concepts in the principal act are contemporary and reflecting best practice.

Bill read the second time.

GUARDIANSHIP AND ADMINISTRATION AMENDMENT (ADVANCE CARE DIRECTIVES) BILL 2021 (No.14)

In Committee

[12.02 p.m.]

Clauses 1 to 13 agreed to.

Clause 14 -
Section 32 amended (Appointment of enduring guardian)

Ms FORREST - I want to pick up this point about the appointment of enduring guardians and the provisions that are changed in the principal act to require the effective reappointment of an enduring guardian if an advance care directive is made by a person, and the process for notifying people who have already appointed an enduring guardian or have some form of advance care directive already that may or may not be registered in any way but not made under this proposed bill, of course.

What will the process be for notifying people? We don't want to end up with enduring guardians who thought they knew a person's wishes that may have changed to ensure that they are contemporary, and the enduring guardian who is appointed has acknowledged and basically signed off on the current and registered advance care directive, or that the advance care directive that is made may not be registered by the person.

Mrs HISCUTT - I will seek some advice, Madam Deputy Chair.

As I thought was the fact, member for Murchison, this is a requirement at the time of the appointment, as you know. So, the bill provides a person making a new one to tell their guardian, but I think your question relates to what happens to the previous guardian if it has been changed.

Ms Forrest - How are people informed of this change?

Mrs HISCUTT - That is up to the individual who is making the advance care directive to inform them if they are changing their guardian. That is a matter between them because it might not be registered, it might not be known. So, it is up to the person making the new guardian to say, 'I am sorry for the previous one but I have changed my mind'.

Ms FORREST - I will reframe the question. Is there any plan to actually contact all those who have appointed an enduring guardian, or have registered an advance care directive previously, to notify them of this change in the legislation that requires their enduring guardian to be advised of any new appointments? The reason I ask this, if someone has changed - the appointment might have been made 10 or 20 years ago and people do not review their wills very regularly, sadly in some cases because that creates -

Mr Valentine - If they have them.

Ms FORREST - Yes, if they have them at all. But they might have appointed a power of attorney and enduring guardian some years ago and someone's wishes may have changed in that time. So, this new process comes in and they make an advance care directive but they

already have an enduring guardian. Now, I hear you say that it is that person's responsibility to notify them but how are they to know that? Is there going to be some information provided to people who have already appointed someone with the power of enduring guardian? That is the question I have.

Mrs HISCUTT - It appears that it is going to be part of the educative process that I read out in summing up. This will be part of it, to make sure that you update, make sure you inform the people who you are dealing with.

Clause 14 agreed to.

Madam DEPUTY CHAIR - As members will see, this is a large clause with a number of subclauses. The Deputy Clerk will read the clause divisions, in divisions and members can raise areas of debate under each division as we go through. Thank you.

Clause 15 -
Part 5A inserted
PART 5A - ADVANCE CARE DIRECTIVES
Division 1 - Objects and principles
Subclauses 35A and 35B

Ms FORREST - This is a matter I have raised in my contribution but also in the briefing and I would like a little bit more information on the record with relation t o the applying of the objects and principles. It does cover 35A and 35B.

Both of them are basically the same:

The objects of this Part include the following and I will go to subclause 35A(b):

> 35A(b) to enable persons with decision making ability to express their preferences and values in respect of their future health care, including by specifying outcomes or interventions they wish to avoid;

The same applies in the principles. It basically says in subclause 35B(b):

> The following principles must be taken into account in connection with the administration, operation and enforcement of this Part:
>
> …
>
> (b) a person with decision making ability can decide what constitutes quality of life for that person and express that in an advance care directive.

Some people have a lot of difficulty explaining what outcomes they make be seeking. Having talked to patients over many years about what they want, what they see as an acceptable outcome for them, and with all due respect they just say, 'I do not want to be a vegetable'. That is the response you get. You could write that on an advance care directive. I am not sure how that is to be interpreted though and this is the problem.

So what guidance will be given to people? People do not have to consult a medical practitioner; they do not have to consult a lawyer. They will be encouraged to, according to the information we have received during this process, but people do not have to. In the form itself with the information that is provided with it, bearing in mind the literacy levels of some people that I represent and others in this place represent, it is not easy to understand complex medical forms and terminology where there is a legal and medical overlay here.

How will people be supported or provided with guidance to understand what is the best mechanism for them to describe the outcomes they wish to achieve or what they perceive to be quality of life for that person and how they can express that? It is not an easy thing to describe when you do not have any medical knowledge. I know that many people will say, 'Well, if I get to point where I would have shot my cow I do not want to be like that'. That is the sort of thing we are talking about with farmers who see life in black and white terms: 'I would not let my dog suffer like that, I would have her put down'.

We need to understand that people have different ways of expressing what they see as quality of life and what they see as acceptable outcomes.

Mrs HISCUTT - I thank the member for her question. I am looking at the department's website now and there is an array of information there that can help. That will be updated as this comes online, so there is all that there to start with. Then the ACD form and supporting material will encourage people to explain their objectives in more detail in plain English.

The department will look at support mechanisms during the implementation so every effort will be made to ask people, to direct people, to give more information as it goes through and there will be supporting information for that.

Ms Forrest - Another question relating to this Part, if someone sought to register an advance care directive that was very vague, is there a process of someone assisting in the interaction with that?

Mrs HISCUTT - Do you mean once it has been lodged? Someone coming -

Ms Forrest - Once they put it in for registering.

Mrs HISCUTT - Right, okay. Section 35Z talks about the registration of advance care directives. The directive has to be clear and unambiguous and if a directive is lodged that is such, when the board gets it they may decide that they cannot work it out and ask for some more information.

Ms Forrest - So they go back to the person?

Mrs HISCUTT - If they see it as not being clear and unambiguous.

Ms FORREST - This is still on the same subclause 35B(i). This is still about the principles to be considered:

> subject to this Part, in determining the preferences and values of a person who has given an advance care directive containing a direction that is unclear, consideration may be given to -

(i) any past preferences and values expressed by the person in relation to the matter; and

We spoke about this in the briefing, but I seek some further clarity about in what form those values and other preferences may have been expressed, and what could be taken into consideration. We are talking about a situation where the advance care directive is, perhaps, not clear.

Mrs HISCUTT - It could be a conversation over a dinner table about what you hope to do in the future. It can include anything, and that is why there is a mediation process. If someone says, 'oh but Aunt said A and I think you want B', that is when the mediation process would come into it.

Ms Forrest - It can be verbal?

Mrs HISCUTT - Yes, it can be verbal.

Mr VALENTINE - I would like some clarity. Clause 5 states that an advance care directive 'means an advance care directive under Part 5A that is in force'. Is a common law advance care directive considered to be a directive that is in force, or is this only dealing with those that are registered? It is not essential that they be registered.

I seek clarity about the advance care directive that is referred to here. Is it registered advance care directives or common law advance care directives? They do not have to be registered; the person may well have followed the process of filling out a form, but the directive is not registered. What is their standing?

Mrs HISCUTT - The principles introduced under Part 5A apply to the advance care directives made under Part 5A or common law advance care directives that are registered. Common law advance care directives can still be valid and in force, even if they are not registered, hence mediation.

Subclauses 35A and 35B agreed to.

Division 2 - Preliminary
Subclauses 35C, 35D, 35E and 35F -

Ms FORREST - My question relates to clause 35D, subclause (4) where it says:

> For the purposes of this Part, a child is taken to have decision making ability in respect of a health care decision only if a registered health practitioner considering that ability under this Act is satisfied that -
>
> (a) the child is sufficiently mature to make the decision;

I want to clarify that is any registered health practitioner. We did discuss this in the briefing, and my recollection is that it does not have to be a doctor or any particular health professional.

Ms Siejka - Can I add, whether it is a nationally registered health practitioner?

Madam DEPUTY CHAIR - We will wait until the Leader responds, thank you.

Mrs HISCUTT - What the member for Murchison has indicated is correct - it can be any health practitioner.

Ms SIEJKA - In relation to the same section, about a registered health practitioner - I want to clarify for the record that it is a nationally registered health practitioner.

Mrs HISCUTT - I refer the member to page 19 - clause 35C - describing a health practitioner. It says:

health practitioner means the following:

(a) a health practitioner within the meaning of the Health Practitioner Regulation National Law (Tasmania) (other than a student);

(b) any other professional that is prescribed for the purposes of this definition;

Subclauses 35C, 35D, 35E and 35F agreed to.

Division 3 - Advance care directives
Subclauses 35G, 35H, 35I, 35J, 35K and 35L

Mr GAFFNEY - Subclause 35I(5)(e) and (f) require some clarification for me. Subclause 35I(5)(e) states 'if the person has a pecuniary interest in the estate of the person giving the advance care directive;'.

If the person has a pecuniary interest in the estate of the person giving the advance care directive, I can see the situation where a person may not know that there is any pecuniary relationship or interest until after the event. Then the person comes out and says, 'You have been bequeathed X amount of dollars.' If there is any argument from one of the family members who says, 'So and so got $100 000. He or she is on the advance care directive and they are not allowed because of a pecuniary interest' - I am interested to know how that would be adjudicated or mediated. I will stand here and wait.

Madam DEPUTY CHAIR - Do you want to finish your questions?

Mr GAFFNEY - For the next one as well?

Madam DEPUTY CHAIR - Either that or you will have to take your seat. You have three speaks. If you ask all your questions you would only use one call. The Leader or somebody very close by will be making a note of them. Second question?

Mr GAFFNEY - My second question is to 35I(5)(f). One question will be can doctors sign the advance care directives, and I think we have been told that, yes, they can. However, 'if the person occupies a position of authority in a hospital, hospice, nursing home or other facility at which the person giving the advance care directive resides' - so, a doctor signs the form, the person moves into the home where the doctor is in a position of authority and works in that care. I am interested in the relationship. Are they still able to be on the advance care directive as a signatory because they would have been a person of authority? I am interested in the term 'occupies a position of authority'. If you have three gardeners in a venue and one is

chief gardener, that chief gardener occupies a position of authority. That chief gardener could be an acquaintance of the person who is doing the advance care directive. In that case, that person would not be able to be involved in that advance care directive - even though it has nothing to do with it. They could be a cook or whoever has a position of authority.

I am interested to know what is the definition of 'position of authority' in a hospital or hospice. I think I know what they are intending to mean, but it could fan out into other areas depending on your definition of 'position of authority'.

Madam DEPUTY CHAIR - Does the member have any other questions on 35G through to L?

Mr GAFFNEY - No, I do not.

Mrs HISCUTT - With regards to position of authority -

Mr Gaffney - Could you start with the first one?

Mrs HISCUTT - With regards to the first one, paragraph (e) says 'if the person has a pecuniary interest in the estate of the person giving the advance care directive', if you were not part of that and happened to inherit and you did not know, what you have done is in good faith. If anyone was to challenge that, then that is another issue. There are no offence provisions in this bill. Sorry, there are, but not just for this section. If you did that in good faith, you have done it in good faith, and if someone challenges it, that is another issue.

With regards to the other one. The 'position of authority' is designed to be a position of authority over the facility, not within the facility. My advisers are telling me they might just have a closer look at that one to make sure it is correct and it might be addressed in regulations. They were happy with it, but it is the overall facility person.

Mr GAFFNEY - I am pleased -

Madam DEPUTY CHAIR - It is not the chief gardener?

Mr GAFFNEY - No, I do not think that is very clear in the legislation. That it is to be the administrative, or the people who actually have responsibility for the facility or the venue. It just says a person who occupies a position of authority. I am not comfortable with the response I have received.

Ms Forrest - You could say, 'over' rather than 'in' hospital -

Mr GAFFNEY - Yes. The one about pecuniary interest I understand. The one about the doctor - if the doctor was one of the witnesses on the advance care directive and the person then moves in, because the doctor who visits would be a person of authority, that would be an issue. Obviously, a doctor is an authoritive figure within that place. Does that mean the person would have to get another witness then to the advance care directive that the doctor might have signed when they were living at home, because then the doctor might hold a position of authority within that hospice?

Mrs HISCUTT - I will just take some advice.

Subclause (5) reads:

A person must not witness an advance care directive given under this Part -

(a) if the …

So, if you get through to (f), if the person occupies a position of authority in the hospital, they can't. That person must not. Therefore, they would have to change if that doctor had been. They would have to readdress who was witnessing, at a point of time. This would exclude, in your example, the head gardener, because that person cannot. Subsection (5) says, 'A person must not witness an advance...' Especially, if they are in a position to unduly influence.

Madam DEPUTY CHAIR - The member for Mersey, third call.

Mr GAFFNEY - What I am hearing here is you have got a small town and a gardener that works at the place. The gardener is a friend of a person down the road who has never been in a hospice. That person becomes the administrative ACD of that person. The person moves into the hospice and then that person cannot then be on the advance care. I would have thought it would have been simpler to have included the word, 'administrative authority' in (f) because it is to do with the administration of a venue so there is no implication of any undue financial, or anything like that. This is more so than the general person in a small town, who might work in that venue where the person ends up. It is broad and I am not overly satisfied with the response received.

Madam DEPUTY CHAIR - So is the member considering to ask for an amendment to be drawn?

Mr GAFFNEY - I would if the Leader felt that would make this paragraph (f) clearer. I would not have a problem, but yes, okay, thank you.

Mrs HISCUTT - My advisers are quite satisfied that this is correct. It is a matter of a point in time. If, in your example, the head gardener was to sign the advance care directive and then the person moves into the aged care facility, the point of time that the chief gardener signed the advance care directive, the person was not in the aged care facility.

Having said that, Madam Deputy Chair, if the member is still not happy with that, can we set aside that particular clause and we will get some clarification from OPC which might be more helpful?

Madam DEPUTY CHAIR - I do have another member waiting to speak, so we will do that first.

Ms FORREST - I wanted to ask the Leader, what is the intent of (5)(f)? Is it intended that people who must not witness an advance care directive for a person who occupies or is living in a hospice, nursing home or, rather, facility in which the person giving the advance care directive resides - whatever facility they are living in - what is the intention of the clause? Is it that the people who have the financial management responsibilities of that facility, where there could be some sort of financial interest, rather than the gardener, the head chef, the person who runs the occupational therapy programs or whatever it is?

When I first read this, my mind went to - that is who we are talking about - we are talking about the CEO of the aged care facility, we are talking about the owners of the hospice, we are talking about those people.

I agree with the member for Mersey, that is not what this says. I think it does need clarity. I would be quite happy to move that this division be postponed in order to have a discussion with OPC about whether that should be amended to make it clear. We are talking about the people who have financial or management oversight of the facility where that person resides, or is receiving care in the case of the hospice or the hospital. They are not going to live in the hospital.

Whilst that discussion is happening, I would also encourage OPC to pick up the point that the member for Mersey made in paragraph (e). You can act in good faith, and I hope people do. But if the person has a known pecuniary interest in the estate - for example, if I knew that the member for Windermere, even though we are not related and we do not fit any of these other criteria, was going to make me a beneficiary in his estate, then I would know that and be immediately excluded. But if he did not tell me and out of the goodness of his heart, decided I should be a beneficiary - which I am sure is not likely to happen - I could then sign it for him.

There needs to be a little more clarity around that for people to act in good faith, to do it in a way that if I had no knowledge that I had a pecuniary interest in an estate, then I would feel quite comfortable signing that. But if someone came to me who I had known for a period of time, who I had helped in the past, that is why they came to me and asked me to be their witness, then this, without some known pecuniary interest in that provision, it may make me reluctant to sign because I do not know.

I would support reporting progress here, or postponing this subdivision, in the interest of getting some further clarity around those particular subclauses.

Madam DEPUTY CHAIR - We would need to postpone the clause.

Ms FORREST - We are not going to tick off the whole clause until the very end of it. So, if we could go through the rest of the subclauses, we could do it at that point and come back to it, if the Deputy Chair could calrify that.

Mrs HISCUTT - I am happy.

Madam DEPUTY CHAIR - I have been advised that as long as we do not finish the clause we can come back.

I see an honourable member waiting to get to his feet. I will take the call on that and then I will explain where we can move to progress the clause and postpone the part of the division.

Mr VALENTINE - My query is along similar lines in the sense of pecuniary interest. When I read in the second reading speech that the witness cannot be anyone who delivers services to the individual making the advance care directive, I think to myself, it says here under paragraph (4) page 37:

An advance care directive given by means other than in writing must be witnessed -

(a) by 2 persons (one of whom is a registered health practitioner) …

Ms Forrest - That is for a child.

Mr VALENTINE - That is only for a child? So, a health practitioner cannot sign an ACD for a general person wishing to make one?

Ms Forrest - Yes, but one of them has to be a health practitioner if it is a child.

Mr VALENTINE - Yes, for the child, but what about normally? What about a person - if you want to make one - is a health practitioner allowed to sign yours?

Ms Forrest - Yes.

Mr VALENTINE - Right, so the question I have, if that person is providing services to the individual, be it the member for Murchison -

Mrs Hiscutt - I beg your pardon. Do you mean just to sign something? Are you saying that is a service?

Mr VALENTINE - Yes signing the ACD. Witnessing the ACD.

Mrs Hiscutt - So you are saying that witnessing the ACD is also a service?

Mr VALENTINE - No. A health practitioner can witness an ACD.

Mrs Hiscutt - Yes, correct.

Mr VALENTINE - Okay. Your second reading speech says that no-one who provides services to the individual can be a witness. I am just trying to point out here that the health practitioner who witnesses the ACD - whether it be a child or whether it be an adult - it has to be a separate health practitioner to someone who is providing services to that individual. That is the question.

Ms Forrest - If you read the services bit, does it not say if the person is a carer for the person giving it?

Mr VALENTINE - Yes, that says it is a carer.

Ms Forrest - For the services provided.

Mr VALENTINE - Well, when you read the second reading speech it says 'providing services'. I am wondering whether there are other clauses in here that actually prevent anyone who provides a service to an individual who is making an ACD from witnessing an ACD?

If the health practitioner is providing a service to a person making out an ACD, they should not be allowed - I would expect - to be a witness to that ACD. It needs to be another health practitioner.

Mrs Hiscutt - Yes.

Mr VALENTINE - I raise it now because you are talking about going back and getting advice from the OPC and that needs to be considered at the same time.

Whether it is a child or whether it is an adult making up an ACD, a health practitioner can sign. That health practitioner should not be a person who is providing services. Part of the ACD might be, 'I want Dr such and such to look after me for the rest of my days'.

Mrs HISCUTT - This is a provision that is putting in place protections against undue influence and coercion. Service in this context is not delivery of medical care. I could be someone coming in doing your housework for you, a podiatrist or someone like that.

Mr VALENTINE - I understand that when I read about 'carer' and 'services'; however, it is still a service to be somebody's GP. Therefore, should that GP be allowed to sign someone's advance care directive registration? They are providing a service; they have a pecuniary interest. It might be an advance care directive, and you would not know that it was coercion; you would hope it would not be. It might be that person is the one who is saying the person has the capacity to make a decision, and they have persuaded them to make sure that Dr "X is going to be their carer for the rest of their days and is going to make money out of it.

Mrs HISCUTT - The act, in section 5, makes it clear that if a person is a carer - a doctor is not classified as a carer. They are classified as a 'professional'

Mr Valentine - I appreciate that. They still have a pecuniary interest though.

Mrs HISCUTT - There is an offence provision further in the bill at 35G(5) that states: 'A person must not require another person to give an advance care directive, or include a provision in an advance care directive, as a precondition to providing a service'.

There are penalties if that happens.

Mr Valentine - Okay, I will take that.

Madam DEPUTY CHAIR - Member for Murchison, would you like to ask your initial question again?

Ms FORREST - The Leader did not respond to my question about what is the intent of 35I(5)(f)? If you could address your mind to that. What is it intended to include? Then we can determine whether we need an amendment.

Mrs HISCUTT - As we said before, it is a protection. It is to ensure the people in these positions are not in a position to cause undue influence and coercion.

Ms Forrest - You are not understanding my question. The question is, what is the intent of paragraph (f), in terms of the person who occupies the position of authority. Is the intent to only capture people who have oversight of the facility, such as the CEO?

Mrs HISCUTT - Yes, that is the intent.

Ms Forrest - Right. I suggest we do need an amendment; that is my view, so we would have the opportunity for that.

Madam DEPUTY CHAIR - Leader, in light of that, you might like to propose that we postpone Division 3, subclauses 35G through to 35L to allow an amendment to be drawn.

Subclauses 35G to 35L postponed.

Division 4 - Operation of advance care directives
Subclauses 35M to 35P

Ms FORREST - I want to further explore the binding and non-binding provision here, particularly in light of the questions that the member for Mersey was asking during his contribution on the second reading. The member referred to my contribution, about a person who had an advance care directive stating that the person did not want to be resuscitated, or put on a ventilator; the doctor then made a judgment call that the patient had a very high chance of a full recovery, which he did have.

The member for Mersey asked, what if the patient did not have a good outcome? Clearly, the health practitioner in that case made a clinical judgment. The patient had said he did not want to be resuscitated, and he did not want to be put on a ventilator. That would have been a binding provision. It was his request, which was unambiguous and clear. However, the doctor held the view that the only way to treat him to ensure a full recovery, was to sedate, ventilate and treat - which he did and the patient fully recovered.

Madam DEPUTY CHAIR - And thanked him.

Ms FORREST - Yes. However, in circumstances where the best clinical judgment is made, and something else happens and the patient does not make a full recovery, is there still protection for the medical practitioner? I believe there is, but it should be on the record - that this is the best clinical judgment, as long as the reasons for those decisions are all documented.

I do not want people or medical and health professionals to feel that they will not be protected by this bill when acting in good faith and without negligence.

Mrs HISCUTT - Proposed section 35U discusses a circumstance where a health practitioner may not comply with an advance care directive. It talks about what a health practitioner must or must not do before they refuse to comply, or comply, and keeping notes on everything, and they have to make a reasonable effort. I think that is the part which it will help protect.

Subclauses 35M to 35P agreed to.

Division 5 - Consent to health care when advance care directive in effect
Subclauses 35Q to 35W

Ms FORREST - The Leader gave a very brief assurance of the protection for medical professionals so I will take a bit of time here with proposed sections 35T and 35U to ensure it is clear to medical practitioners that make decisions based on the application of their expertise and knowledge, that they are protected should an outcome not be as they would have expected for a person.

Clause 35T says:

Health practitioners to give effect to advance care directives.

(1) Subject to this Part. a health practitioner who is providing, or is to provide, health care to a person who has given an advance care directive and who has impaired decision making ability in respect of a health care decision -

(a) must comply with a binding provision of the advance care directive; and

That is clear; they must.

(b) is to comply, as far as is reasonably practicable, with a non-binding provision of the advance care directive; and

(c) must seek, as far as is reasonably practicable, to avoid any outcome or intervention that the person who gave the advance care directive would wish to be avoided (whether such wish is expressed or implied); and

This is the case the member for Mersey was referring to because a person has not wanted to be adversely impacted by the treatment when all endeavours were made to ensure that would not be the case:

(d) must endeavour to provide the health care in a manner that is consistent with the principles set out in section 35B.

Which go to complying with a person's wishes even though they may seem a bit strange to some of us. It goes on in subclause (2):

(2) Despite subsection (1), a health practitioner who is providing, or is to provide, health care to a person who has given an advance care directive, must, in providing that health care, act in accordance with the following:

(a) any agreement reached in relation to the advance care directive at a mediation under section 35ZI;

Which is the process under which the board would undertake - sorry, it is the Public Guardian's part there. Obviously, that can be referred to the board should a resolution not be able to be reached under a mediation, or

> (b) any direction of the board given in relation to the advanced care directive.

So it is pretty clear that the medical practitioner is to abide by particularly binding wishes. Then we go to proposed section 35U, which is what the Leader just referred to.

35U. Circumstances where health practitioners may not comply with advance care directive

> (1) A health practitioner may refuse to comply with a provision of an advance care directive if the health practitioner believes on reasonable grounds that -
>
> > (a) the person who gave the advance care directive did not intend the provision to apply in the particular circumstances; or

This is again a judgment call because the health care professional there is making a judgment that even though the person said, 'Do not put me on a ventilator,' they believe that did not apply now, and it is obviously always open to interpretation:

> > (b) the provision is ambiguous or does not appear to reflect the current wishes of the person …

It is a bit hard to determine that when they are unconscious. But this example I used was not ambiguous. It was quite clear. Going on to subclause (2):

> (2) A health practitioner must, before refusing to comply with a provision of an advance care directive under subsection (1), make reasonable efforts to consult with the authorised decision maker for the person who gave the advanced care directive.

The authorised decision maker in the case of the person I describe - that is his wife - would have said, 'No way, you are not to put him on a ventilator.' The health practitioner consulted and she said, 'No way, you can read what he has written there'. So

> (3) A health practitioner who refuses to comply with a binding provision of an advance care directive must, in the clinical records of the person who gave the advance care directive, make a written record of the refusal and the reasons for refusal.

The next step, this particular doctor would have had to -

Sitting suspended from 1 p.m. to 2.30 p.m.

STATEMENT BY PRESIDENT

Budget Speech - Attendance by Members

[2.31 p.m.]

Mr PRESIDENT - Before I call on Question Time, a reminder of the procedure for today. Members of the Legislative Council will assemble outside the Long Room at 2.55 p.m. and the attendants will assist us to get into the House of Assembly. After the Assembly resumes and the Budget is introduced, the Sergeant-at-Arms will then allow us entrance into the Chamber.

We will withdraw after the speech has been delivered. For the members who do not wish to be seated on the Floor, the Speaker's Reserve can be used and accessed at any time. Members, your budget paper packages, which include the speech, will be placed on your seat here in the Chamber while we are in the other place.

QUESTIONS

Tasmanian Schools - Back on Track Pilot Program

Mr WILLIE question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.33 p.m.]

The Back on Track pilot at Hellyer and Claremont colleges supports young people identified by the department's youth participation database, who are not enrolled with an approved education or training provider. It aims to locate, support and re-engage students in years 11 and 12 or equivalent.

(1) How many students have been re-engaged through the program?

(2) How is the Department of Education evaluating the program?

(3) Are there plans to expand the pilot?

ANSWER

I thank the member for his questions.

(1) The data provided is from the pilot conducted from September 2020 to March 2021.

The numbers below provide an approximate indication only of those young people participating in the pilot: 154 young people had interactions with Back on Track during the pilot; 74 young people were being case-managed at the conclusion of the pilot; 15 were successfully re-engaged with education or training providers. A further 65 young people were identified as meeting their requirements under the Education Act 2016, so they did not require further assistance through the pilot.

(2) A full evaluation was undertaken in March 2021. The evaluation was undertaken by the Child and Student Wellbeing unit in the Department of Education. The evaluation involved examining quantitative data in relation to cases managed and the collection of stakeholder feedback through interviews and surveys.

(3) The Back on Track program is no longer considered to be a pilot program, but an explicit intervention within student support.

Currently, two teams provide support to students in the north-west region of the Learning Services Northern Region based in Burnie and the Learning Services Southern Region based in Hobart.

A new northern region Back on Track team is to be based in Launceston and will commence in 2022.

Ambulance Response Times

Ms FORREST question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.35 p.m.]

My question is to the Honourable Leader. With regard to ambulance response times in the Circular Head region over the last five years:

(1) What is the average response time taken for an ambulance to reach a call-out for each year?

(2) What is the longest response time each year; and
(a) what is the reason for this long response time in each case?

(3) How many times has the Smithton Ambulance Station not had an on-site paramedic overnight during this period per year?

(b) What arrangements have been put in place to cover these times?

(c) How does the Government ensure the urgent/emergency health and safety of people in Circular Head when the station does not have a paramedic on site?

ANSWER

Mr President, I thank the member for her question.

(1) The emergency response times for the Circular Head area have been relatively stable since 2016-17 to 2020-21. There is a table saying that and I will seek leave shortly to table that table and have it incorporated in *Hansard*.

(2) Specific case information cannot be provided. However, the length of an emergency response time is influenced by several factors. This includes the

demand for emergency ambulance responses at the particular point in time, location of resources and resource availability. The ongoing stability of the patient can be monitored by call-backs from the State Operations Centre which receives triple zero calls and manages emergency ambulance deployment.

(3) This information is not available. The Government is committed to maintaining ambulance service delivery to communities across Tasmania at all times. Where shift vacancies do arise, arrangements are made to backfill these shifts.

Mr President, I seek leave to table this table and have it incorporated into *Hansard*.

Leave granted; see Appendix 1 for incorporated document (page 38).

Ms FORREST - Mr President, in terms of those answers, or lack thereof in some cases. The second question was, 'What is the longest response time each year?' The Leader says she cannot answer that. Surely you would know what the response times are and what the longest time would be. I find it staggering if that is the case, that that data is not collected.

I also find it staggering that we do not know how often the ambulance station does not have a paramedic on-site at night. I am staggered that this information is not collected. I would ask the Leader to actually verify that is the case. How are the people of Circular Head to have any confidence in their emergency services when they do not even know when the station is manned?

Tasmanian Schools - Sports Coordinators

Mr WILLIE question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.38 p.m.]

(1) The three regional sports coordinators employed by the Department of Education lead and coordinate participation in sport. How is their impact being measured and evaluated by the department?

(2) Can the Government please provide the Department of Education sports infrastructure audit?

ANSWER

Mr President, I thank the member for his question.

(1) The Regional Sports Coordinators, the RSC, provide support directly to schools and sporting bodies and associations to increase sport and physical activity participation for Tasmanian public school students. Their impacts be will evaluated through the usual performance management processes of the Department of Education.

(2) The Department of Education undertakes regular school building condition audits as part of its asset management system. These audits include the general condition

of sporting facilities. Specific data on conditions of sporting facilities is not able to be provided.

Tasmanian Travel Vouchers

Ms ARMITAGE question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.39 p.m.]

Regarding the recent round of Tasmanian travel vouchers:

(1) Can the Leader please confirm that in order to claim the voucher funds recipients must have booked and paid up-front?

(2) In the event of a lockdown scenario, what will happen regarding voucher payments should a recipient's booking need to be cancelled?

(3) In the event of a lockdown, does the Government have a plan to support travel voucher recipients if they are unable to get a refund for travel bookings or activities if they are unable to actually undertake them?

(4) Would the Government consider extending the window during which a travel voucher can be redeemed if a lockdown should occur?

ANSWER

I thank the member for her question.

(1) Scheme terms and conditions state that for the voucher holder to redeem their voucher they are required to book, pay and complete their travel and/or experience between 2 August and 24 September (inclusive) and then lodge their proof of purchase documents to ensure processing of their claim. However, for round 3, voucher holders who have pre-booked for valid travel prior to 2 August 2021, but are intending to complete their travel within the 2 August to 24 September time frame are also eligible.

(2) If the travel activity can be rescheduled within the current scheme period, the voucher holder may reschedule their booking (subject to the relevant terms and conditions of the operator). Should a lockdown event take place for an extended period or continue outside the current scheme time frame, the Government will consider extending the timeframe for completing travel beyond the current 24 September deadline.

(3) Should a lockdown event take place for an extended period or continue outside the current scheme time frame, the Government will consider extending the time frame for completing travel beyond the current 24 September deadline.

(4) Yes.

Future Potential Production Forest Land

Ms RATTRAY question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.41 p.m.]

I have a rather lengthy question and, unless anyone else is getting up, I will use the opportunity to read it out. Leader, Future Potential Production Forest land outside the Tasmanian Wilderness World Heritage Area comprises some 356 000 hectares and environmental groups repeatedly call all this area high conservation value forest.

A recent national advertising campaign by the Wilderness Society states the area in question is all 'ancient forests'. According to the Facebook Ad Library, this ad has been run in various forms across Facebook and other platforms recently and has had a target audience of hundreds of thousands of people.

A review of LISTmap data shows the FPPF land is not all ancient forest, but a mix of old growth, regrowth, and tens of thousands of hectares of non-forested areas such as button grass, sedge land and moorland.

My information indicates the FPPF land outside the TWWHA consists, as I said, of 365 000 hectares of land so my questions are:

(1) Is the minister aware of this advertising campaign?

(a) If yes, has the minister challenged this statement?

(2) Can the minister please advise how much of the FPPF land (in hectares) is -

(a) forested land;

(b) old growth forest as defined by the RFA;

(c) regrowth forest;

(d) moorland, sedge land and rush land (as per TASVEG 4.0 Groups);

(e) highland and treeless vegetation (as per TASVEG 4.0 Groups);

(f) native grassland (as per TASVEG 4.0 Groups);

(g) scrub, heathland and coastal complexes (as per TASVEG 4.0 Groups); and

(h) saltmarsh and wetland (as per the TASVEG 4.0 Groups).

ANSWER

Mr President, I thank the member for her question.

(1) The minister is aware of many activist group campaigns and claims.

(a) The minister constantly challenges false claims by radical activists continually in his capacity as the Minister for Resources.

(2) The total area of FPPFL lying outside of the TWWHA is approximately 356 800 hectares. The total area of vegetation, according to TASVEG 4.0 - forest and non-forest communities - is approximately 329 500 hectares. The remainder of the area of FPPFL outside of the TWWHA is approximately 27 300 hectares. It consists of water bodies, naturally bare ground and modified land. Modified land would be agricultural land, roads, easements, quarries and the like.

Down to your assessment of vegetation types, because you have them listed there I might just go from (a) and give the response.

(a) forested land - 288 240 hectares.

(b) old growth as defined - 114 520 hectares.

(c) regrowth - 58 090 hectares.

(d) moorland, sedge land, and rush land - 23 380 hectares

(e) highland and treeless vegetation - 690 hectares

(f) native grasslands - 290 hectares

(g) scrub, heathland and coastal complexes - 16 700 hectares

(h) saltmarsh and wetlands - 200 hectares

Mr President, I seek leave to table this information so that it is clear in *Hansard.*

Leave granted; see Appendix 2 for incorporated document (page 40).

Electric Vehicles

Mr VALENTINE question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.46 p.m.]

This is the completion of the question that I asked the other day with regard to electric vehicles Part (5):

(5) The number, type and location of battery-charging installations across the state -

(a) directly related to the Government's grants for that purpose;

(b) others that have been privately installed and registered for public use outside the grants process?

ANSWER

I thank the member for his patience. This is the last answer to your series of questions:

(5)(a) The Government's first ChargeSmart Grants Program provided $600 000 in grants towards the installation of fast, destination and workplace charging stations. This resulted in the installation of 14 fast charging stations, and 23 destination and workplace charging stations, and stimulated a total spend of $2.5 million on charging infrastructure in Tasmania.

The second ChargeSmart Grants Program is currently open for applications for funding towards the installation of fast and destination-charging stations, with a focus on regional areas and tourism hotspots. A total of $600 000 has been allocated with grants of up to $50 000 for fast charging and grants of up to $2500 for destination charging.

(5)(b) The Government does not have an estimate on the total number of charging stations that have been installed in Tasmania that are available for public use, outside of those installed through the ChargeSmart Grants Program. Owners of charging stations can register their stations for public use on websites such as, PlugShare, so that electric vehicle owners can plan trips accordingly. The Australian Government has also recently announced funding towards the installation of an additional 10 fast charging stations in Tasmania as part of the first round of its Future Fuels Fund. These stations will be installed across the greater Hobart region.

Mr VALENTINE - A supplementary question, Mr President. I asked for the type and location of the charging facilities as well, but the type and location haven't been provided. I'm happy for it to be compiled and tabled at some point, but that was part of the question.

Ms Forrest - They are all going to be in Hobart.

Mrs HISCUTT - These stations will be installed in the greater Hobart region.

Ms Forrest - Don't worry about the regions.

Mr VALENTINE - I was of the impression that there were some in the north as well, but if the Leader can provide the information that would be appreciated.

Mrs HISCUTT - Thank you. We will send you the information, and you may decide you need further details.

Mr Valentine - I asked for location as in address - not location as in region.

Mrs HISCUTT - Okay.

SUSPENSION OF SITTING

Mrs HISCUTT - Mr President, I move that the sitting be suspended until the ringing of the division bells to enable members to attend the other place to listen to the Treasurer deliver the Budget speech**.**

Motion agreed to.

Sitting suspended from 2.48 p.m. to 3.56 p.m.

TABLED PAPERS

Budget Papers 2021-22

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) (by leave) - Mr President, I lay upon the table of the Council budget papers for 2021-22 entitled Budget Speech; The Tasmanian Budget, Budget Paper (No. 1): Government Services, Budget Paper (No. 2), Volumes 1 and 2; Appropriation Bill (No. 1) 2021 and Appropriation Bill (No. 2)2021.

MOTION

Government Business - Precedence

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) (by leave)- Mr President, I move -

> That Government Business have precedence on the next two sitting Tuesdays, being Tuesday 31 August and Tuesday 21 September 2021.

Motion agreed.

MOTION

Budget Papers - Noting

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) (by leave) - Mr President, I move -

> That the Budget papers and the Appropriation Bills (No 1) and (No 2) of 2021 be noted.

Mr President I look forward to poring through the Budget papers and giving my report as I am sure all members will next week.

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - I move -

> That the debate stands adjourned.

Motion agreed.

ADJOURNMENT

Mrs HISCUTT - Mr President, I move -

That at its rising the Council adjourn until 11 a.m. on Tuesday 31 August 2021.

Motion agreed.

Mrs HISCUTT - Mr President, I move -

That the Council does now adjourn.

Quarantine Arrangements
Budget Papers - Availablility to Members of the Legislative Council

[3.59 p.m.]

Ms FORREST (Murchison) - Mr President, I rise on adjournment to raise two questions. I have been informed that the hotel quarantine facilities have been utilised this weekend for AFL footballers and their support crews. This means, according to my information, that there is no room at the inn for Tasmanians seeking to return - including some who have providing the health effort. I will be horrified if that is true and I ask the Leader to find out the response to that as a matter of urgency. I hope it is not true, that Tasmanians cannot return to our state because AFL footballers are taking up the room in our hotel quarantine.

The second matter, I note in the House of Assembly today, some members who are not Government members had access to the Budget papers, including all papers prior to the delivery of the Budget speech.

They were then provided with an additional package of Budget papers. I want to know, why that is possible and that we too, as members of this parliament cannot have access to them. I also want to know particularly, if other members of the other place get a second set of Budget papers free of charge because we have to pay $150 each for a second set of Budget papers to do our job.

Some of us may feel we only need one set, but I have people work with me on working through the Budget papers to do my job well and I have to pay that extra money. I want to know if we, at this House, are being treated equitably in this approach. I was not aware this was happening before. Maybe it was not but it was clearly happening today, because I saw it, so do not deny it has happened. It has happened.

I want to know if they pay and how they managed to get access to these Budget papers before they are tabled in the House of Assembly.

The Council adjourned at 4.00 p.m.

Appendix 1

tabled and incorporated into Hansard
L. Hiscutt (Leader)
26 August 2021

Questions without Notice

written reply clerk.

Name: **Hon Ruth Forrest MLC**

Questions:

With regard to Ambulance response times in the Circular Head region over the last five years;

1 What is the average response time taken for an ambulance to reach a call out for each year;

2 What is the longest response time each year; and

2.1 What was the reason for this long response time in each case;

3 How many times has the Smithton Ambulance station not had an on-site paramedic overnight during this period per year;

3.1 What arrangements have been put in place to cover these times and;

3.2 How does the government ensure the urgent/emergency health and safety of people in Circular Head when the station does not have a paramedic on-site?

Answered by: Hon Leonie Hiscutt MLC
Leader of Government

Answers:

1 The emergency response times for the Circular Head area have been relatively stable from 2016-17 to 2020-21. Please see the table below.

Table – Emergency Response Times in the Circular Head Area

Year	Priority 0 and 1 (life threatening cases)	Median Emergency Response Time (minutes)
2016/17	44	22.6
2017/18	26	21.8
2018/19	29	23.1
2019/20	27	21.7
2020/21	25	22.8

2 Specific case information cannot be provided, however the length of an emergency response time is influenced by several factors. This includes the demand for emergency ambulance responses at the particular point in time, location of resources and resource availability.

The ongoing stability of the patient can be monitored via call-backs from the State Operations Centre, which receives Triple Zero call and manages emergency ambulance deployment.

3 This information is not available. The Government is committed to maintaining ambulance service delivery to communities across Tasmania at all times. Where shift vacancies do arise, arrangements are made to backfill these shifts.

Jeremy Rockliff MP
Minister for Health

Appendix 2

QUESTION WITHOUT NOTICE

Legislative Council

added and incorporated into Harsard L. Hiscutt (Leader) 26 August 2021

ASKED BY: Hon Tania Rattray MLC, Member for McIntyre

ANSWERED BY: Hon Leonie Hiscutt MLC, Leader of the Government in the Legislative Council

Future Potential Production Forest (FPPF) land outside the Tasmanian Wilderness World Heritage Area (TWWHA) comprises some 356,000 ha. Environment Groups and the Greens repeatedly refer to all of this area high conservation value forests.

A recent national advertising campaign by The Wilderness Society states that the area in question is all "ancient forests". According to the Facebook Ad Library, this ad has been run in various forms across Facebook and other platforms recently and has had a target audience of hundreds of thousands of people.

A review of List Map data shows that the FPPF land is not all "ancient forest" but a mix of old-growth, re-growth and tens of thousands of hectares of non-forested areas such as button grass, sedge land and moorland.

My information indicates the FPPF land outside the TWWHA consists of *365,000ha of land.

QUESTION 1:

Is the Minister aware of this advertising campaign?

ANSWER 1:

The Minister is aware of many activist group campaigns and claims.

CA

QUESTION 2:

If yes, has the Minister challenged this statement?

ANSWER 2:

The Minister challenges false claims by radical activists continually in his capacity as the Minister for Resources.

QUESTION 3:

Can the Minister please advise how much of the FPPF land (in hectares) is:

a. *Forested land*
b. *Old Growth Forest as defined by the RFA*
c. *Regrowth Forest*
d. *Moorland, sedgeland and rushland (as per TASVEG 4.0 Groups)*
e. *Highland and treeless vegetation (as per TASVEG 4.0 Groups)*
f. *Native Grassland (as per TASVEG 4.0 Groups)*
g. *Scrub, heathland and coastal complexes (as per TASVEG 4.0 Groups)*
h *Saltmarsh and wetland (as per TASVEG 4.0 Groups)*

ANSWER 3:

The total area of Future Potential Production Forest Land (FPPFL) lying outside of the TWWHA is approximately 356,800 ha.

The total area of vegetation (TASVEG 4.0 forest and non-forest communities) is approximately 329,500 ha.

The remainder of the area of FPPFL outside of the TWWHA (approx. 27,300 ha) consists of water bodies, naturally bare ground, and modified land (e.g. agricultural land, roads, easements, quarries etc.).

PTO

	Vegetation type	*Area (Ha)
a.	Forested Land (total of TASVEG 4.0 'forest' communities)	288,240
b.	Old Growth Forest as defined by the RFA (subset of forest communities – calculated from Sustainable Timbers Tasmania dataset)	114,520
c.	Regrowth Forest (subset of Forested Land – calculated from Sustainable Timbers Tasmania dataset)	58,090
d.	Moorland, Sedgeland and Rushland (TASVEG 4.0)	23,380
e.	Highland and treeless vegetation (TASVEG 4.0)	690
f.	Native Grassland (TASVEG 4.0)	290
g.	Scrub, heathland and coastal complexes (TASVEG 4.0)	16,700
h.	Saltmarsh and wetland (TASVEG 4.0)	200

APPROVED/NOT APPROVED

Guy Barnett MP

Minister for Resources

Date: 26 August 2021