PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Tuesday 13 October 2020

REVISED EDITION

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

TABLED PAPERS

Government Response - Petition - National Driver Licence Facial Recognition Solution

[11.03 a.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) (by leave) - Mr President, I have the honour to provide the Government's response to the member for Nelson's petition regarding the transfer of driver licence photographs to the National Driver Licence Facial Recognition Solution.

Parliamentary Standing Committee of Public Accounts - Tasmanian Government Fiscal Sustainability Report 2016 - Report

Mr Dean presented the report of the Joint Parliamentary Standing Committee of Public Accounts in relation to an inquiry into the Tasmanian Government Fiscal Sustainability Report 2016.

Report received and printed.

STATEMENT BY PRESIDENT

COVID-19 - Chamber Seating

[11.10 a.m.]
Mr PRESIDENT - Honourable members, before we commence our special interest bills we have endeavoured to return our Chamber slightly back to normal with seating, as was the original plan before COVID-19 took hold. Bit by bit we will endeavour to move those in the far reaches of the Chamber back in. I remind members to keep practising hand sanitising, social distancing and time out of the Chamber when you can until we get to the point where we can all sit comfortably close together.

SPECIAL INTEREST MATTERS

Break O'Day Mental Health Action Group - Achievements

[11.11 a.m.]
Ms RATTRAY (McIntyre) - Mr President, October is Mental Health Month and I take this opportunity to talk about the Break O'Day Mental Health Action Group. The group has been involved in suicide prevention since the day it was established in 2016, and it has achieved an impressive amount of outputs and outcomes.

As a result of the group's work, it was approached by Public Health Services Tasmania in late 2017 for the Break O'Day area to become one of three Tasmanian trial sites for the LifeSpan National Suicide Prevention Trial. A number of members of the Break O'Day Mental Health Action Group are on the Suicide Prevention Working Group. The action group operates with the objective of spending 20 per cent of its time on planning and 80 per cent on action. The group meets only when actions from previous meetings are completed. It is a group that gets things done, resulting in an impressive amount of outputs and outcomes achieved over the two years it has been active.

Its key achievements and activities are far too extensive to name them all up here - some 23 in total - so I will share with members just a few to show the extensive, positive impact achieved by the Break O'Day Mental Health Action Group.

The group provided extensive input into the Rethink Mental Health consultation paper, an extensive community consultation to develop a suicide prevention community action plan. The group supported a two-day mental health first aid workshop for 10 attendees and provided community workshops on understanding and talking about suicide to 15 attendees. It provided mini-mindfulness and meditation weekly sessions throughout the year, undertook community and service providers' consultation in relation to mental health service provisions to identify service gaps, and developed the Mental Health Services Directory for the Break O'Day region, which is updated quarterly and is now up to version 9. The group provides access to free counselling, with no referral required, and provides individual support to families. The group also successfully conducted a lobbying campaign for youth mental health work support from Headspace and established the Community Champions program and provided training to 22 community champions.

A lot of really good work there; as I said, there were 23 initiatives but I have just picked out some I felt members may be interested in.

The effect of the above contributions is anecdotal evidence that the community is better connected. The workshops, awareness-raising events and radio sessions have resulted in a reduction of stigma in the community. People are openly talking about suicide and are better engaged in support. There has been an increase in the uptake of mental health and counselling services. The mental health services directory is well used by general practitioners and other health professionals.

Lessons learned are put into practice. The Mental Health Action Group has become well known in other regions of Tasmania, recently providing mentoring and peer support to the action group in Sorell. The group has been successful in lobbying for better service provision in the region, resulting in an increase in local services. Another measurement of its success is the number of community champions active in the community, reducing social isolation and improving community connections.

With the establishment of the local committee comprising senior personnel from a wide cross-section of the community - local people known to many - to oversee a coordinated response in the event of future loss to suicide, the Break O'Day community can feel supported and comforted that this arrangement is in place in their community. Thank you, on behalf of our communities, to those who are part of this committee. We wish you all the best over the course of the trial.

Post the trial, the committee intends to remain in place, and it is envisaged it will become a critical community support following a suicide, which I genuinely hope will not be needed.

As with all discussions around mental health and suicide, I remind honourable members, staff and those who may be watching this broadcast of the importance of reaching out when you or someone you know needs to seek support. The Lifeline number is 13 11 14.

Country Women's Association in Tasmania

[11.17 a.m.]

Ms PALMER (Rosevears) - Mr President, in our communities, one of my favourite things to do is to find hidden gems. Sometimes, the gems we have are actually in plain view, but do not always attract the attention that perhaps they deserve. I was delighted to receive an invitation to open the annual general meeting of the Country Women's Association in Tasmania on Saturday, 26 September. When I arrived, as expected, I was greeted with a cup of tea. It was hot, it was in a floral china cup, and it was very strong. Just as warm as the cup of tea was the hand of friendship extended to me as I arrived.

When I walked into the Ross Town Hall, the association had taken its COVID-19 safety plan very seriously. Every inch of the hall was actually used. The seats were spaced out, right into the back corners, so that everyone was separated by 1.5 metres. To be honest, these women needed it, because these women do not waste time. While they were there for the annual general meeting, they also had bags all around their feet filled with wool and different items of craft. They certainly needed the space for what they were doing. As I said, this was not a time they were going to waste.

To be honest, this is exactly how I thought the meeting might be, but that is where any stereotyping on my behalf ended. Over the hour, I sat there and listened to the work they had done over the past 12 months - and indeed, the work they would like to do in the coming 12 months. They have been heavily committed to a fundraising project, Orange Sky, which will be familiar to many in this place. It is a laundry and shower service that moves around communities, and is there for those who may find themselves homeless or unable to access laundry and shower facilities.

Their health focus for the year had been stroke - not only looking at the impacts of stroke on our community, but also how they could be better aware, as members, of the impacts it could have on their own lives, and also the telltale signs that would alert them that there may be trouble on the horizon.

Their food topic for the year was cheese. They had learned a lot about cheese, and how it is made. In particular, I am guessing there was a fair bit of sampling, because they had also discussed the quality that cheese can bring to one's diet.

They had also studied the Maldives, learning about the country's history, customs, government, food and agriculture - not because they were looking at next holiday options, but because they wanted to familiarise themselves with these people and their customs, and to always be learning more about our world and how they could impact that.

In the coming year we are going to bring back a scholarship program that sends a young Tasmanian girl in years 10 through to 12 to Canberra to get a better understanding of how our political system works. What a wonderful opportunity for a young woman in those formative years.

Ms Rattray - Are you really sure about that? I have seen some of those telecasts.

Ms PALMER -I think it is a good idea. What are they up to politically? The association is currently lobbying the Minister for State Growth to consider making it mandatory for vehicle headlights to be on at all times in order to improve safety on our roads.

They also want to raise the profile - not just among their members, but among the community - about advance care directives. We have spoken a lot about that over the last few months.

The environment was also clearly part of their focus. They are making a real effort to raise the awareness of Tasmanians about wet wipes - what I call 'wet ones' - and how detrimental they are to our environment when they are flushed. They are lobbying for warnings to be put on all packets so anyone who purchases them is aware of the impact they can have on our environment. All this comes on top of the normal roles we know so well the CWA plays in helping our communities through bushfires, drought and pandemics.

I was asked to speak at the meeting for about 15 minutes to offer some words of encouragement. However, the tables were turned and it was I who was encouraged. I was encouraged to see the power of like-minded women. I was encouraged to see their resilience. I was encouraged to see how the Country Women's Association had adapted so beautifully during this year and the fact that COVID-19 offered no excuse as to the extent of the role that they saw they would play in the coming year.

This Thursday is International Day of Rural Women. We owe this association a huge debt of gratitude. We owe these dynamic women who do things their own way a huge debt of gratitude. They go about their business quietly but they are always there for families and especially for women in regional areas across our state.

I acknowledge and thank the State President, Jenny Ivey, the executive and members of the Tasmanian Country Women's Association, for the dedication and the love they show for all Tasmanians, year in, year out, regardless of the circumstances. I wish them all the very best for 2020-21.

Cycling in Tasmania

[11.22 a.m.]

Dr SEIDEL (Huon) - Mr President, I appreciate the opportunity to talk about the cycling community in Tasmania and in particular the fabulous Franklin Velodrome in my electorate.

For a state boasting such road cycling household names as Amy Cure; the Huon's own Olympian and Cycling Australia Hall of Famer, Julie Speight; and, of course, the great Richie Porte, Tasmania has some of the worst rates of bicycle usage in the country.

Census figures show only 2.2 per cent of people in Hobart ride to work compared to 4.7 per cent in Melbourne and 3.6 per cent in Sydney. However, with the changes it has brought to our daily lives, COVID-19 has reinforced cycling as a fabulous sport and a very much viable commuting option. With a combination of vision, funding and community support, rural areas like Maydena, Derby and St Helens have been reinvigorated with world-class mountain biking venues embedded in the spectacular Tasmanian landscape.

A lot has been done in the north of our state, but the south - and in particular, my electorate, the Huon - has been missing out for years. It is a shame. As I have discovered during more than one close encounter riding on the Huon Highway, our roads and infrastructure in the Huon are anything but cycling friendly. Trucks passing at high speeds; back roads that have potholes resembling moon craters and bridges with cracks as wide as a full tyre-width are more indicative of a challenging obstacle course than an invitation to a healthy and relaxing commute to and from work.

Bicycle Network Tasmania's most recent survey indicates bike riding has now become disproportionately popular, with cycling accounting for 45 per cent of movement at surveyed sites that included Hobart, greater Kingsborough but not Huon Valley. There is genuine interest in cycling in the region; the Huon Valley is home to great cycling clubs such as the Southern Pedals and the Sister On A Roll - SOAR.

Small business owner and bicycle mechanic extraordinaire Damien English from Huon Bikes is an outstanding asset, and cycling events such as the Le Tour De Cygnet have brought many welcome visitors to the Huon. It is a good ride. Audax Tasmania has been holding regular long-distance events such as the Seven Hills Dash, a challenging ride starting from Sandy Bay via Ferntree to Lower Longley, Huonville, Port Huon, Cygnet over Woodbridge Hill to Middleton then to Pelverata back to Sandfly, then all the way back to Sandy Bay. Completing the over-200 kilometre ride is a fabulous accomplishment and I commend our dedicated community groups that continue to put bike riding on the map.

Huon Valley Council has correctly identified cycling as a priority. I very much welcome the initiation of the Huon Valley Mountain Bike Feasibility Study and the inquiry into the Huon River foreshore shared pathway which would connect Huonville to Franklin and provide the safe infrastructure walkers and cyclists appreciate. Sadly, neither projects will go ahead without a commitment from the state Government for funding as local councils just do not have the financial resources to realise cycling and recreation infrastructure that some feel are just not essential in advancing the Huon Valley.

It is not always about advancing new projects and building new infrastructure - sometimes it is about preserving and maintaining infrastructure that has been used by the community for decades. The historic Franklin Velodrome represents one venue that certainly deserves our attention. As the member for Rosevears mentioned earlier, it is really about finding those gems in the community.

In December 1930, 14 cyclists attended a meeting in Franklin to consider the formation of a cycling club. As reported in the *Huon Times* at the time, the meeting was called by Mr Garnet Pearce, who explained he had been asked by a number of cyclists to form a club so advantage could be taken to promote the sport in the district by making a racing track at the Franklin Recreation Ground, which was especially suitable for cycle racing.

Within a month, permission was granted by the Tasmanian Cycling Association to register a club in Franklin, and at the end of January 1931 racing started in earnest. The Wednesday twilight meetings were keenly contested and according to the local newspaper were generating a considerable amount of interest. Soon after improvements had to be made to the track thanks to the generosity and goodwill so typical of the Huon community. As was again reported in the *Huon Times*, one local motor lorry owner offered to place his lorry at the disposal of the cyclists for carting material on the track for levelling off uneven portions. The only payment he asked was the cost of petrol.

We could not find much on the Huon cycling scene in the National Archives of Australia from the mid-1930s to the mid-1940s. The war effort did not allow much reporting on recreation and sports. Soon after the war, people in the Huon rediscovered their passion for the sport on two wheels. In 1946, the Franklin Athletic Club was granted £200 to be matched pound for pound by the club to lay a Sheffield track and a turf cycling track around the oval. In 1951, the Latrobe Cycling Club granted permission for a consulting engineer to prepare plans identical with the Latrobe track, which was regarded as the safest and arguably the best track of its type in the Commonwealth. The track was completed a year later, just in time for the Easter Athletics Carnival. The Easter carnival was held annually until 1952 when the day was brought forward to Australia Day. Those carnivals continued to be held successfully until at least 1975. Throughout that time, the emphasis of the carnival changed with the changing popularity of various field events. When running declined in popularity, the emphasis changed to cycling, and the Franklin Wheel became the frontrunner of the carnival program.

By 1964, the velodrome was fully sealed. So many cyclists entered the events at the Franklin carnival that the lunchbreak and several minor competitions had to be cancelled in order to accommodate them all. In that year alone, well over 100 cyclists from all over Tasmania, including many professionals, raced on Franklin's now famous velodrome. Yet the 1980s introduced a period of decline and negligence. The interest in the velodrome as a sporting venue waned. Further deterioration of the surface made it increasingly unsuitable for competitions.

The concrete was spiked, and attempts to remove the surface resulted in a velodrome that represents a mere shadow of its former glory. It is a shame to leave it withering away, which is why I am so delighted in the renewed interest in this fantastic and historical community interest. The Friends of Franklin Velodrome - and in particular, local resident Shane Johnson - have done an outstanding job in raising awareness and gathering support to restore the venue. The group now has over 100 supporters, and meets on a regular basis at the historic sporting site.

Restoring the velodrome is a financial no-brainer. The venue cannot be left as it is. It is just not safe. Removing the concrete professionally would cost as much as it would cost to resurface it, yet resurfacing the velodrome would allow the track to be used again for young and old cyclists for decades to come. It would be a genuine return on investment over the years. If the state Government can easily find $20 million for a brand new sporting venue at Derwent Entertainment Centre in Hobart, surely it could find a fraction of that to restore a historic sporting venue to its former glory in the Huon Valley?

In fact, it would not be dissimilar to 1952, when the proposal for the new cycling track was presented to the responsible minister for Land and Works, Mr Reece. The minister put on public record that he was sure Cabinet would approve some financial aid, also acknowledging the necessity for distributing funds for recreational grounds throughout the state. It is a great example for the Minister for Sport and Recreation, who is in this Chamber today.

A small investment could kickstart the regular use by interested cyclists of all ages. Who knows - maybe the next Richie Porte might just come from Franklin, but we will only discover talent if we give our young community members the opportunity to shine.

The Franklin Velodrome may just be that opportunity for the great sport of cycling.

Youngtown ABCDE Learning Site

[11.33 a.m.]
Ms ARMITAGE (Launceston) - Mr President, at the heart of our communities are our people. For a long time, the effectiveness of people power has been overlooked as a driver for meaningful and long-lasting change. Initiatives that look to bring the everyday person into decision-making processes often seem like they will bring good results, but can fall by the wayside, become talkfests or fail to deliver tangible results.

I believe the cause for this is that there is often a focus on implementing ideas that are too unwieldy, too undefined, or do not have broad consensus. To my mind, the better and more meaningful approach is to leverage what assets already exist in the community, and make them the best they possibly can be.

This is where the City of Launceston's initiative of the ABCDE Learning Sites comes in as an innovative force. The acronym stands for 'Asset Based Community Driven Effort', and the program is all about focusing on what is strong, not what is wrong. It enables a community to identify its assets, build connections, and create change to benefit those living within the area.

The development of a learning site is a 12-month process. To help coordinate this, the City of Launceston provides a place-based community connector, who guides a group of community members through a self-led, flexible process. The Bank of Ideas has a methodology that comprises eight touchstones - the recruitment of a community team, hosting conversations to discover assets, engaging locals, building connections through social interaction, visioning and planning, implementing change, and fostering celebrations. This process is context-based and will vary in application from community to community. Considerations include the composition of the community, understanding age brackets, socio-economic status, levels of education, demographic data and taking stock of the available access to and opportunities for support. Again, the program focuses on what is strong, not what is wrong.

The challenge is for community members to move from being treated as customers, consumers, clients and patients in programs that are not their own and to start being treated as co-owners, co-producers and citizens in the design and implementation of actions that build their communities as healthy, caring and inclusive places and groups.

Right now, this program is being rolled out in the suburb of Youngtown in my electorate and has already started making great strides towards achieving milestones. The Youngtown Builder Time event was held in mid-September; it brought together people from right across the Youngtown community utilising an informal space with conversations being facilitated by the community connector, Sarah McCormack, who has been involved with previous ABCDE projects.

Sarah's role involves supporting, facilitating and mentoring communities as they develop their visions of plans to encourage the celebration of achievements and reflecting on what occurs. Everyone is welcome to attend the Builder Time events and it is an excellent way to get in touch with other locals who want to make their community the best it can be. In its reasonably early stages, the Youngtown ABCDE project already has some outstanding ideas to take stock about what they love about their community, to get creative, and how they will continue to use them in new and novel ways, bringing people together to try new and fun activities that will ultimately lead to happier, healthier Youngtown residents.

John Fahey AC - Tribute

[11.37 a.m.]

Ms HOWLETT (Prosser) - Mr President, I pay tribute to a dear friend and mentor of mine, the former Premier of New South Wales, the Honorable John Fahey AC, who sadly passed away in September at the age of 75 after losing his battle with leukaemia. John was born in Wellington, New Zealand in 1945, and his family migrated to Picton, New South Wales in 1956. He married his wife, Colleen, who is fondly known by many as 'Lady Col', in 1968 and they had three children - Matthew, Melanie and Tiffany.

In 1973 John became a naturalised Australian. He was educated in the Southern Highlands, New South Wales and later attended the University of Sydney, graduating in law. John was a very skilled rugby player and played 37 lower grade matches for the Canterbury-Bankstown Bulldogs between 1965 and 1966. He entered the New South Wales Parliament in 1984 and further served as minister for Industrial Relations and minister for Further Education, Training and Employment following the election of a Nick Greiner coalition government in 1988.

John was appointed premier in the New South Wales government in June 1992 after Mr Greiner was forced to resign due to being subjected to an ICAC investigation. This was a position John reluctantly accepted due to the circumstances and he described that moment as the saddest day of his life.

As premier, John oversaw the introduction of a number of important pieces of legislation, including the Disability Services Act, the New South Wales Seniors Card and the appointment of the first ever minister for the Status of Women.

It is poignant that 20 September 2020 marked the twentieth anniversary of the Sydney 2000 Summer Olympic Games because John played such a key role in this historic event in Australia. His most famous moment came in 1993 when viewers all across Australia and the world were glued to their television screens waiting for the announcement from Monte Carlo on which city had won the 2000 Summer Olympic Games. When the International Olympic Committee president announced, 'The winner is Sydney', John, as a member in the Australian delegation in Monte Carlo, leapt to his feet in excitement and dragged the chief of the bid team to the floor and grabbed him in a big hug. This footage was played over and over again on networks as John's excitement on hearing the announcement was felt by many Australians at the time. John is also remembered for an incident during Prince Charles' 1994 Australia Day speech at Darling Harbour. As Prince Charles was making his way to the podium, a man in the audience fired two blank shots from a starter pistol and charged on stage. John was one of several people who tackled him to the ground to make sure no harm was done to the prince.

In March 1995, the Fahey coalition government was narrowly defeated in the state election. A year later he resigned from the state parliament after successfully challenging for the federal seat of McArthur at the 1996 federal election. He served as minister for Finance and Administration from 1996-2001 in the Howard government. In February 2001, one of his lungs was removed due to cancer and he chose not recontest the seat in parliament due to ill health and family reasons.

He was profoundly affected by the sudden death of his daughter, Tiffany; at the age of 27, she was tragically killed in a car accident. John and his wife Colleen went on to raise Tiffany's two children, Amber and Campbell.

After politics, John became the director of the Bradman Foundation, and from 2007-13 he was president of the World Anti-Doping Agency. He received the Companion of the Order of Australia in 2002 for services to the Australian and New South Wales parliaments. He also became a director of the Royal Flying Doctor Service, Chancellor of the Australian Catholic University and chairman of both the Rugby League Development Board and Sydney Olympic Park Authority.

John was a devoted Catholic; he said his faith had allowed him and his family to get through a number of very difficult times, particularly his lung cancer and the tragic death of Tiffany.

I pass on my deepest condolences to Lady Col, his children - Will, my beautiful dear friend Mel, and Matthew - and grandchildren Amber and Campbell, and Bec in the United States. John was a kind and true gentleman; he was a dedicated husband, father and grandfather, a man who was respected by all sides of politics, a dear friend of mine and a dear friend to many. John's contributions to Australia will leave a long-lasting legacy and he will be dearly missed.

Emmerton Park

[11.42 a.m.]

Ms FORREST (Murchison) - Mr President, Emmerton Park is a community-based, not-for-profit organisation providing a range of quality aged care services and facilities, including residential care, community care and day respite care located in Smithton. It provides 66 independent living units in a village setting, and a 61-bed residential care facility delivering primary care for residents, all run by a highly dedicated and caring team under the leadership of CEO Ian Adams.

The construction of the current facility was supported by significant community fundraising and local support. When Gaylene De Jonge, an Emmerton Park worker and St Kilda Football Club fan, called the club recently to renew her membership, she began chatting to the club representative and mentioned two prominent figures around the facility and their love for the Saints football club and the community spirit that drives them to donate their time each week.

Chris Morris and Robert Palmer could be described as two of the most one-eyed, true-blue St Kilda fans you will ever meet.

Robert, or Bob as he is better known, has a quiet demeanour and has been described as being one of the nicest folks you could ever meet. Bob suffered a stroke in 1982 at the age of 37, having his movements severely impaired. He now relies on a mobility scooter and a leg crutch to help him get around. This has never kept him down, ever. Bob refuses to let his disability get the better of him and he still actively volunteers at Emmerton Park. He spends countless hours organising the footy tipping competition year in, year out. Over the past 13 years, he has managed to get as many residents as possible involved. He prints out and delivers the entry forms, collates the entries and hands out the ladder to everyone who participates, which is almost 80 people.

Chris Morris has also been involved in Emmerton Park as a volunteer for a number of years. After retirement, he became a presenter at Coast FM, the local radio station based in Wynyard, and developed a request program at Emmerton Park for the residents. This program has become much loved by the residents who tune in. It gives them something to look forward to each week. Of course, it is his job to read out the winners in the footy tipping, a task he loves. I believe he likes to wind up the listeners by sneaking in the Saints theme song from time to time, and he plays plenty of John Farnham to torment the CEO, who does not like it.

Today, around 1 p.m., Chris will broadcast his 500th show, I understand. Unfortunately, I cannot be there. I am here, rather than celebrating this magnificent milestone.

What a great achievement. No doubt it will be widely celebrated at Emmerton Park. The tenth anniversary program will be broadcast on 9 February next year, an event I actually plan to attend.

In 2017, Chris was diagnosed with cancer. This was a major blow, but again it did not deter him. He continued to travel an hour each way to host his show for Emmerton Park residents. The club representative that Gaylene had this conversation with was impressed to hear about the dedication of Bob and Chris, and said he would like to organise something special to thank them. From that conversation, a surprise Zoom call was arranged between the pair and none other than Dan Butler.

Chris' wife, Kathleen, was also invited, none of them having any idea about what was going to unfold, as they were told they were required at the clubhouse. I am informed that the look of delight on the faces of Chris and Bob was priceless, as they, along with Kathleen, chatted excitedly to their idol, and there was plenty of cheek to go around. They stirred Dan about missing opportunities against Brisbane in the previous match. Kathleen also advised him he would look better without a beard. He clearly took on the advice, because he got rid of it before the clash with the Demons the following weekend.

Bob and Chris were very grateful for the experience. Bob later said, 'I am still shaking.' Emmerton Park's CEO, Ian Adams, said from his point of view, the story was an example of staff going above and beyond to put out good news stories about aged care. In these troubled times, it seems like every time you tune into TV there is more bad news about aged care. This is a good news story. Ian also thanked the St Kilda Football Club for being so supportive and helping to arrange this special moment for Chris and Bob.

As I said, this is indeed a good news story for a wonderful aged care facility. I thank all the wonderful staff and management for their efforts and caring for the older residents of Circular Head. I wish to also personally thank Chris Morris and Bob Palmer for their dedication, through so much adversity, for making the lives of some of our more senior and highly valued members of our community brighter.

You are true legends, Chris and Bob, and much admired by all of us.

MOTION

Pharmacists - Role in Tasmanian Healthcare System

[11.48 a.m.]

Ms FORREST (Murchison) - Mr President, I move -

> That the Legislative Council notes:
>
> (1) The broad and vital role pharmacists have in the delivery of quality, evidenced based health care in Tasmania;
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> (2) The opportunity to utilise pharmacists to improve medicines safety and the quality use of medicines;
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> (3) The importance of medicine safety in all healthcare settings;
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> (4) The unacceptably high rate of medicine-related hospital admissions and presentations to emergency departments;
>
> (5) The impact on healthcare costs associated with these hospital admissions and presentations;
>
> (6) The unacceptably high levels of medicine-related problems in aged care; and
>
> (7) The Council of Australian Governments (COAG) Health Council Meeting in Perth on Friday, 31 October 2019 where Ministers agreed to make Medicines Safety and the Quality Use of Medicines the 10th National Health Priority Area.

Mr President, the week of 21 to 25 September was World Pharmacy Week. Friday, 25 September was World Pharmacists Day. I move this motion to recognise and note the vital role pharmacists play in health care across all healthcare settings. Pharmacists are somewhat unique in demographics, in that over two-thirds of the pharmacy profession are female, and overall, pharmacists are the youngest registered health professionals, with the majority aged under 35 - quite different from nurses, I might say, in terms of age, not gender.

I believe pharmacists are well placed to do more in our healthcare system and to fully support an integrated healthcare system. Pharmacists are willing and able to do more in the Tasmanian health system.

I will briefly address each point to the motion, then summarise the key points.

With regard to the broad and vital role pharmacists have in the delivery of quality evidence-based care in Tasmania, pharmacists support Tasmanians and work in various settings, including community pharmacies, hospitals, aged care and general practice, and in people's homes with home medicines reviews.

As five-year-trained, university-level health professionals with a commitment to lifelong learning, pharmacists are expert in the science of medicine, and how medicines work within the human body. The opportunity to utilise pharmacists to improve medicine safety and the quality use of medicines must also be recognised. The Pharmaceutical Society of Australia has called for the removal of barriers that prevent the pharmacists workforce - which numbers around 800 in Tasmania - to be fully used. When we see the health challenges we have in our health system, it makes sense to use all our health professionals to their full capacity, acknowledging there are scope limitations.

Barriers include limiting pharmacists from providing a full range of vaccinations. Current regulations preclude pharmacists from providing administration of injectable medicines; they can give you a flu vaccine but they cannot give other medications. Current legislation also prevents pharmacists who are the most highly trained health professionals when it comes to medicines from prescribing medicine. By saying that, I am not suggesting there should be carte blanche, but there are some medications they rightly could prescribe as we do with nurse practitioners, within their scope.

Commonwealth and state funding arrangements are also a major barrier to the full integration and utilisation of the pharmacists workforce in Tasmania. We need to support our pharmacists to do what they do best, and let them care for their patients without some of these limiting barriers.

The importance of medicine safety in all healthcare settings could not be more profound. I will refer to some of the statistics that indicate that so many of our hospital admissions relate to medication errors, and medication errors within hospitals themselves can lead to patient morbidity.

When used correctly medicines are a modern miracle, but they can cause problems if they are not used well, either through overuse, misuse and many other problems. Medicine harm can include anything from hospital admissions, minor side effects and, if severe, can cause death. When a decision is made to use a medicine there needs to be a medicine expert, a pharmacist, there for the safety of the person taking the medicine. That is why when you go to a pharmacy and get a script filled, particularly if it is a medication you have not been on, the pharmacist will nearly always come out and check with you that you know it is the right medicine, what the effect will be, what the doctor mentioned to you in prescribing it, all those sorts of things.

The unacceptably high rate of medicine-related hospital admissions and presentations to emergency departments should cause us all to pause for thought. In January 2019 the Pharmaceutical Society of Australia - the peak body representing pharmacists - released its *Medicine safety: Take Care* report. This report reveals some stark figures on the harms associated with medicine use in Australia. These figures show that 250 000 Australians are admitted to hospital each year because of problems related to their medicines. I am not suggesting we can prevent all of those but if we could prevent even half of them, imagine the impact that would have on our health system across Australia.

In addition, 400 000 Australians present to emergency departments again with problems relating to their medicines. According to this report, half of this harm is preventable. Nine out of 10 people have at least one medicine problem after leaving hospital; they leave hospital with their medications, and 9 in 10 will have some problem with that. Each year, more than 5000 Tasmanians go to hospital because of problems with their medicines and approximately 10 000 Tasmanians go to the emergency department each year because of problems with their medicines. Again, I am not saying we can prevent all of these but surely we can make some improvement in that?

The impact on healthcare costs associated with these hospital admissions and presentations is not insignificant. The healthcare cost associated with these hospital admissions Australia-wide is $1.4 billion annually. The cost to the Tasmanian health system alone is $35 million per annum, not including the emergency department costs. These costs are actually potentially an underestimate because, as I said, these figures do not include the emergency department admissions or the healthcare costs of increased general practitioner visits or visits to the community pharmacy to try to sort out these problems. Often we do not know where people go to get help when they have a problem with their medicine.

The unacceptably high levels of medicine-related problems in aged care are also a major concern and we continue to see very concerning occurrences in our aged care system generally before COVID-19, but since COVID-19 it has been even more pronounced.

In January 2020, the Pharmaceutical Society of Australia released its follow-up report, *Medicine safety: Aged care*, and the data it contains are quite clear. The current system is failing and a new approach is needed to improve medicine use in aged care to make it safe for our elderly. The statistics in regard to medicine safety and aged care are alarming - 20 per cent of unplanned hospital admissions for aged care residents are as a result of inappropriate medications or medicines.

Unfortunately, our older Australians are paying the price with their lives or their quality of life. We have to do better. Nearly all aged care residents in Australia have at least one medication-related problem, 98 per cent and, starkly, most of them have three or more problems. This is related to their medicines, including dangerous and life-threatening drug interactions and medicine dosage problems, including overdosing. As people get older, their ability to excrete drugs from their system reduces.

Half of all aged care residents are taking medicines that cause sedation and confusion, 20 per cent are taking antipsychotics and more than half of these residents are taking medicines for far too long. This is a terrible indictment on the way we treat residents of aged care facilities - by sedating them with antipsychotic medication.

The report showed more than 95 per cent of residents in residential aged care facilities have at least one medicine-related problem and over 50 per cent are potentially prescribed inappropriate medicines.

The Council of Australian Governments Health Council is meeting in Perth on Friday, 31 October 2020 - I am not sure what is happening to COAG now. When they met in 2019, ministers agreed to make medicine safety and quality use of medicines the 10th National Health Priority Area.

The Pharmaceutical Society of Australia called for this to be the response to its *Medicine Safety: Take Care* report. At the same time, the interim report and the Royal Commission into Aged Care Quality and Safety recognised the magnitude of the problems we have with safe and quality use of medicines.

More needs to be done to address this issue. We need to support our pharmacists to be able to do more to support patients when they leave or enter hospital or aged care facilities. It is important pharmacists are part of this picture, working with doctors and with the aged care providers. This means ensuring our hospitals have enough hospital pharmacists to be able to hand over the care of patients to community pharmacists. If you do not have enough hospital-based pharmacists who can do the rounds seeing the patients prior to discharge, they will end up out in the community with potential problems. You also reduce the interaction with the community pharmacists because the hospital pharmacists cannot see all the patients before discharge.

This shortage also means better systems to measure and monitor medicine-related problems in hospitals and community pharmacy and aged care cannot be improved, because you cannot measure what you do not see or what you do not know.

I will now follow up with some of the key points raised, reiterating important details as they relate to Tasmania.

Over 5000 Tasmanians go to hospital each year because of problems related to their medicines. This is not a hospital presentation for a review. This is an admission to hospital because something has gone wrong with their medicine, something so severe it requires admission. Approximately 10 000 Tasmanians go to the emergency department each year because of problems with their medicines. We know the problems we have already in our hospital emergency departments, with long waiting times and overcrowding. If we could reduce even half of these, imagine the impact on our emergency departments. Hospital admissions alone cost the Tasmanian Health Service $35 million per annum. That is not including emergency presentations. These costs are an underestimate of the total cost. It is estimated 50 per cent of the harm resulting from these admissions and presentations are preventable.

The report shows the 95 per cent of residents in aged care facilities have at least one medicine-related problem, and over 50 per cent are prescribed potentially inappropriate medicines. I also understand three in five hospital discharge summaries, when not prepared in collaboration with the pharmacist, include at least one medication error. This can result in further harm with one in five patients requiring readmission. We do not have enough hospital pharmacists who can go through the discharge summaries and check them - it does not mean pharmacists never make errors either, we are all human, but you can certainly reduce the risk.

Evidence provided by the Pharmaceutical Society of Australia also notes that over 90 per cent of patients have at least one medication-related problem post-discharge. Many of these quite frightening statistics could be reversed if a pharmacist were involved in all hospital discharges.

In November 2018, the Society of Hospital Pharmacists of Australia released its report, *Reducing Opioid-Rated Harm,* which revealed some additional alarming statistics. More than 70 per cent of hospitals frequently supplied opioids for patients to take home, just in case, even when the patient did not require them in the 48 hours prior to discharge.

The reasons for this include patient expectation and pressure as well as cultural behaviour - 'we have always done this, so we will just keep doing it without questioning'. As a health professional, I say that. Clearly, these approaches need to be regularly reviewed and challenged as well as improving patient education. Less than 5 per cent of hospitals have formal opioids stewardship programs and the Tasmanian members of the Pharmaceutical Society of Australia are not aware that our hospitals have any formal opioids stewardship programs.

Perhaps the Leader may have some information about whether there are any opioids stewardship programs in our state, but if there are not, this is needed and should be considered as a matter of urgency. Almost 2 million Australian adults begin taking prescription opioids every year, with thousands becoming long-term users. This equates to about 50 000 Tasmanians - more than 10 per cent of our population - being commenced, including some on short-term treatment on an opioid.

We do not have to look too far over the water to see where opioid crises are causing major problems. Sadly, deaths involving opioids have doubled in the last 10 years in Australia, with major problems in Tasmania with accidental or inadvertent overdose often associated with the use of multiple medicines. This is not unique to Tasmania or Australia, but we can, and should, take effective action to address the challenge and take a preventive approach.

As I mentioned earlier, in January this year the Pharmaceutical Society of Australia released its follow-up report, *Medicine Safety: Aged Care*, and again the data is clear: while aged care falls predominantly under the responsibility of the Commonwealth Government, we all need to be aware of the challenge and be part of the solution. As the data I provided earlier demonstrates, the current aged care system in relation to medicine use and management is failing and new approaches are needed to improve medication use in aged care, with 20 per cent of unplanned admissions from aged care residents as a result of inappropriate medication use.

Half of all our aged care residents are taking medicine that causes sedation and confusion. As I said, 20 per cent are taking antipsychotics, and over half the residents are taking these medicines for far too long. They need them at some points, but they are continuing for too long. We must do better than this. The Pharmaceutical Society of Australia representatives who briefed us in our last sitting informed us that the role of the pharmacist within aged care is at a lower level than it should be.

Commonwealth programs to support pharmacists to deliver medication reviews and education programs are limited. For each aged care facility, the approximate funding available would allow a pharmacist to spend about six hours a week in an aged care facility, clearly not enough. A number of programs in other states are funded by primary health networks and state governments allow pharmacists to spend more time on the ground in aged care facilities, but I think it is time the federal government stepped up and funded this area properly.

Clearly, a collaborative approach is needed because costs associated with this are quite high in the human sense, as well as the financial sense where both state and federal health costs are negatively impacted. Again, it is a preventive health approach. A primary healthcare approach focused on prevention of harm is clearly needed, but needs to be supported at both levels of government, particularly by the Commonwealth Government because aged care is its responsibility.

As point (7) of the motion notes, at its meeting in 2019, the Council of Australian Governments Health Council agreed to make medicine safety and quality use of medicines a national health priority area. At the same time, the interim report on the Royal Commission into Aged Care Quality and Safety recognised the multitude of problems we have in regard to safe and quality use of medicines. In the interim report in the Royal Commission into Aged Care Quality and Safety tabled in the Australian Parliament on the 31 October 2019, the commissioner described an aged care system in urgent need of a fundamental overhaul in design, objectives, regulation and funding. This interim report highlighted the use of psychotropic medicines in residential aged care was not clearly justified in 90 per cent of cases in which they were prescribed. There is overwhelming evidence of a lack of knowledge about chemical restraints and their impacts, including alternatives to use, and the safe and appropriate management of the behavioural and psychological symptoms of dementia.

There is potential to improve transparency and increase accountability through the implementation of a system for the collection, publication and benchmarking of data on the use of psychotropic medication rates in residential aged care facilities. Residential medication management reviews should provide an effective mechanism for safe medication reviews. Current remuneration arrangements applying to the conduct of these reviews restricts people's access to them and fails to use the opportunities provided by the RMMR program. There is a need for a government-subsidised process to support pharmacists' involvement in case conferencing, monitoring the residents' response to recommendations and implementing of medication management plans.

All these issues highlight the need for pharmacists and the entire healthcare system to work to do better when it comes to medicine safety and the quality use of medicines. This will take a collaborative approach.

The role of pharmacists is also crucial at a community level. I think we would all be aware that pharmacies stayed open during the COVID-19 lockdown in the north-west. This required pharmacists to respond rapidly and to build perspex barriers to physically distance themselves and their staff from members of the public. That was done almost overnight in a number of pharmacies. I am sure other members from the north-west would have noticed this.

No doubt this would have directly and negatively impacted on their profitability and viability, because they still needed to staff their pharmacies and provide advice to consumers and customers, but with significant limitations on their stock and dispensing. As we all know, when we go to the pharmacy, the dispensing is at the back so you walk through all the other areas and purchase things as you come and go.

However, I am sure we are all aware that the need of the community during this period for advice and for supplies did not abate, and possibly grew during this time. I know in Wynyard the line in the street was quite long at times, with everyone standing 1.5 metres apart, at times not in the most pleasant of weather. The pharmacist's barrier was just inside the door and only two people could go in at once to different counters.

Pharmacists continue to play a key role and should not be seen solely through the supply and dispensing of medicine. They have an important role, not only in the community pharmacy, but also in healthcare settings such as general practice, aged care and mental health facilities. I know the member for Huon before joining us here was the first general practice in Tasmania to have a pharmacist as part of an interdisciplinary team delivering care to the patients who attended his practice. Congratulations to the member for Huon. A model such as this would provide significant benefit to all GP practices.

The Pharmaceutical Society of Australia released a report in February 2019, titled *Pharmacists in 2023*. This report has a stated aim to fully utilise the pharmacist workforce in Tasmania to help address the challenges of medicine safety and the quality use of medicines in Australia and Tasmania. The PSA contends that pharmacists need to be given greater responsibility and accountability for medicine safety, including the administering and prescribing of medicines in Tasmania.

I know this can cause concern for some doctors. However, this should be considered in context because pharmacists should be required to practise within their scope. As I said, pharmacists have to complete and pass a five-year university-level degree and are health professionals who provide frontline health care and advice. If you have any time to consider what pharmacists need to know - I know doctors need to know all this too - they need to know all the potential side effects, all the drug interactions and all the contraindications just as do the doctors who prescribe it.

We could not only improve the management of all Tasmanians, including aged care residents, by strategically using the pharmacists workforce in collaborative care models, including within general practice and in aged care, but it would be cost-effective. Creating a better and more coordinated link between general practice and the community pharmacies, especially to address the challenges we have in healthcare delivery in rural Tasmania, would enhance comprehensive care models and timely access to evidence-based medicines and appropriate medicinal products.

I understand the state Government has a commitment to address medicine safety and the quality use of medicines as a national health priority area through the COAG agreement. I ask the Leader: specifically what has been done to address this issue? Has it been progressed? The PSA suggests that as a state, we need a medicine safety and quality use of medicine strategy for Tasmania and we need to strategically better use the workforce of pharmacists we have in this state. There is no reason that the scope of practising pharmacists who can and should work in areas such as general practice and aged care should be limited, which is what we see today with certain restrictions. Pharmacists are experts in medicines and we should embrace that expertise.

I hope the Minister for Health will fully consider these recent reports and act to ensure we can utilise our highly valued health professionals as effectively and efficiently as we can to promote safe and effective use of medicines and quality care for all Tasmanians. We should also look for ways to provide evidence-based effective, efficient and timely access to health care. Recognising the skills and value of all health professionals working for the benefit of patients is key in this matter.

I welcome the contribution of other members on this important matter and hope to see credible action to progress these matters from both the state and federal governments in the near future.

[12.11 p.m.]
Ms RATTRAY (McIntyre) - Mr President, I am sure that my former boss, Stephen Love, and to some extent, Craig Walker prior to that, will be very disappointed if I did not stand up and make a contribution.

Ms Forrest - I was thinking of you as I wrote my contribution.

Ms RATTRAY - Mr President, I rise to support fully the member for Murchison's motion and also congratulate the Pharmaceutical Society of Australia, Tasmania Branch, for being so proactive during the recent World Pharmacists Week. I did not post a photograph. I should have done because I have some pretty good photographs of my pharmacy days, and lots of good memories about those days. I have often said I would not be in this place if it were not for the support that Stephen Love, the proprietor of Galloways Pharmacy, gave me to be able to attend local government council meetings and then to go on to be elected to the parliament. I have the greatest respect and thanks for the opportunity he gave me.

When I read the motion by the member for Murchison - and again I thank her for putting it forward - there was not one of those seven aspects of that motion that I did not agree with, and not just because I have a pharmacy background and know how valuable particularly community pharmacy is to our small communities. It made sense, and again when I listened also to the briefing session we had from the Pharmaceutical Society representatives from Tasmania who presented, not only collectively to Legislative Councillors, but also, I believe, individually to some of us. Again, all these aspects made perfect sense, particularly when we talked about pharmacists in aged care, and we know how difficult it can be for aged care.

We have seen that particularly during the pandemic, but we also know the matter around Aminya, the aged care hostel/home in Scottsdale in Dorset, that went through a terrible time because it was not viable. The 33 beds are not a viable facility. Now we have the James Scott Wing, which was the high care aspect of aged care in Dorset, and the Aminya Hostel - after a very expensive development, they are going to be joined together so that will make it a 60-something bed facility. That becomes a more viable option. You have 63 or 64 residents there, and I expect every one of those residents will have medications to some extent - some more than others. To have a pharmacist for some time at a facility like this, you would need those economies of scale to be able to afford that. We know that the one aged care facility that has a pharmacist onsite in the southern part of the state has something like 123 residents.

You need to have economies of scale to be able to have a pharmacist onsite - which is such a significant asset to any facility - otherwise you are relying very heavily on the people caring for those residents to be able to deliver medication. Also, they will not have the level of understanding a pharmacist has when it comes to tablets that often compete against each other.

I recall my pharmacy days when doctors - and with absolutely no disrespect to the medical doctor who is with us in the Chamber - from particular practices would ring the pharmacist just to check whether there were any competing interactions between medicines that might be prescribed for a patient, particularly if they had not had that medication before.

There would be quite an exchange between the pharmacist and the prescribing doctor about the interaction between medicines that might be happening.

I have also seen a pharmacist receive a prescription at the dispensary, look at it and then pick up the phone and speak to the doctor - particularly if it is a locum - about the possible conflict of a medicine that has been prescribed.

We now have a lot of locums in practices around the state, particularly in rural areas. I have talked about this in the House previously, where we have a real churn of doctors through practices. We are not getting them as much from the mainland at this point, due to COVID-19, but I am sure once COVID-19 leaves us, we will again see that particular practice in place again. Here we have this opportunity to have pharmacists, who are often long term in a community, being able to provide that support - and again it is a two-way interaction between the community pharmacist and the GPs looking after our patients.

When it comes to the broad and vital role pharmacists have in the delivery of quality, evidence-based health care in Tasmania, it is just a tick. They do such a fantastic job.

Moving on to the opportunity to utilise pharmacists to improve medicines safety in the quality and use of medicines, I have just given a couple of examples where that already takes place in our communities. That acknowledgment should be there already. I believe is really important to be able to use their skills at a heightened level.

The importance of medicines safety in all healthcare settings: I listened to the statistics shared by the member for Murchison, that 250 000 hospital admissions annually are a result of medicine-related problems. That is Australia-wide, but when you break that down into Tasmania as well, it would take a great deal of pressure off the healthcare system if we had those systems in place in our state.

There is an unacceptably high rate of medicine-related hospital admissions, as I have just talked about, so to be able to address that issue would be a very important aspect of having that pharmacist based around an aged care provider.

The unacceptably high levels of medicine-related problems in aged care: again, if that is the case, if it means putting particular designated hours into an aged care facility to address that, the cost of doing that, compared to the cost of having that person admitted to a hospital facility, would have to counter each other - and it keeps them in their environment, in which they feel safe and secure and supported, and also more accessible to family and friends, which is really important.

As we know, when people go into an aged care facility, it is then referred to as their 'home'. As I said, Aminya, in Dorset, is called Aminya Home, and even though they do not have all their bits and pieces around them, people certainly do have aspects of their life around them so that it feels like it is their home. That is exactly what a good aged care facility does for its residents.

I know the May Shaw complex at Swansea well. It has that same home environment, and Medea Park as well at St Helens, and the Deloraine facility.

We want to keep that home environment. As long as people can stay in that environment, rather than have to be part of a hospital admission, we need to do that as well.

The member for Murchison also talked about the fact that pharmacists already administer the flu vaccine. It has been suggested that having the opportunity to administer routine medicines such as insulin, vitamin B12 and injectable buprenorphine would improve Tasmanian patients' management of complex health conditions. We trust them with the flu vaccine, which is an injectable item. Why would we not trust them with something like insulin and vitamin B12, and that other injection?

Tasmanian law currently limits the medicines that can be administered in pharmacies, which would be the flu vaccine and adrenaline. Pharmacists in Victoria and the ACT are able to do so, and are already administering medicines by injection to patients. Amending the regulations to remove the barrier artificially preventing pharmacists to provide safe, convenient and timely health care to Tasmanians at no cost to the Tasmanian Government - I will repeat that, Mr President: no cost to the Tasmanian Government. It is a matter of changing the regulations. I heard the member for Murchison say some doctors are not necessarily in favour of moving towards this so I will be interested to hear from the member for Huon.

Ms Forrest - There are always turf wars. Every time you change the scope, there are always turf wars. It does not matter whether it is nurses, doctors, pharmacists, anyway there is always a turf war. Midwives do the same.

Ms RATTRAY - I am interested to hear the good doctor, the member for Huon's view on this. It is obviously something he has spoken about. My view is it would be a reasonable approach in supporting the pharmacists' view. If there is a contrary view, I am willing to listen to it. The member for Huon may be in full support; I do not know and that is why I will be interested to hear that.

I do not think I need to say anything else in regard to this, other than to reinforce the message that pharmacists are so valuable in our community, given that getting a GP appointment at various times can be a challenge in some of my rural communities. We often use the pharmacist for advice; I have done it many times myself. You go to the pharmacist and say, 'This is what I am experiencing; is there something I can buy over the counter or do you feel I need to see a GP?' They constantly give advice about whether they believe somebody should go. I am not asking for them to be dispensing willy-nilly, but absolutely within the scope of their knowledge and understanding.

When it comes to a number of these medications, that could take some pressure off the GP system, but also support our aged care system. I think it should be thoroughly considered and I urge the Government to do that in a timely manner. Sometimes we expect things to happen very quickly, but this is something that would need a change of policy to happen. The really important message is that it will not cost the Government one cent to do. Better health care for our communities, not at the cost of the Government on behalf of the Tasmanian communities. I support the motion, and I thank the member for Murchison for putting it on the Notice Paper and the opportunity to speak to it and relive a little bit of my pharmacy days, which I always like to do.

[12.28 p.m.]

Dr SEIDEL (Huon) - Mr President, that was not unexpected, was it? After hearing the member for Murchison and the member for McIntyre, we probably should go into business together after our parliamentary careers conclude. I did not expect to be put on the spot by the member so I will refer to her comments a little later.

I also commend the member for Murchison on her motion and her commitment and ongoing advocacy to and for all health practitioners. In order to get the best health outcomes, Tasmanian health practitioners are at their best when they overcome professional barriers and put patients' interests firmly at the centre. Nurses are good for their patients, doctors are good for their patients, pharmacists are good for their patients, but once we all work together, we can actually be great for our patients, and that should be our aspiration, particularly in Tasmania where the health system is struggling on a good day.

I acknowledge the great work the professional organisations representing the work pharmacists here in Tasmania do - in particular, the Pharmacy Guild, the Pharmaceutical Society and the Society of Hospital Pharmacists. They advocate for their members with professionalism and passion, not only in our state but increasingly nationwide. I must admit they punch above their weight on the national scene.

Our outstanding Tasmanian pharmacists are increasingly leading their profession nationally. Their talent and their drive are extraordinary. The School of Pharmacy and Pharmacology at the University of Tasmania is internationally renowned and the academics inform health policy by conducting innovative and relevant research that matters to the wider health sector. Their research outputs are remarkable.

However, my true everyday heroes are the pharmacists who serve our rural and remote communities. In rural and remote Tasmania, pharmacists are often the only health practitioners available for patients who seek health advice. Too often they are the only health practitioners who are available late at night and on weekends. In my community I have the deepest respect for Kim Hong and his team who run Australia's southernmost independent pharmacy in the small and remote community on Bruny Island, every day no matter what.

I also want to recognise Fredrik Hellqvist in Dover, Tasmanian Pharmacist of the Year 2019. No request is too difficult to for Fredrik and his team. There is nothing that cannot be prepared. It just needs to be prescribed.

Last but not least, I would like to acknowledge the work of Ian Magill in Geeveston. During the devastating bushfires in the Huon Valley last year, Ian's pharmacy stayed open. Ian slept in the pharmacy and somehow managed to provide emergency health advice, all the while dispensing essential medications and trying to fireproof his premises. Honourable members, that is dedication; that is putting patients first.

I support the motion of the member for Murchison; however, I do not think pharmacists are just vital. In my opinion pharmacists are far more than that. They are absolutely crucial and indispensable for keeping Tasmanians healthy. It is about working as a team and it is about meeting the needs of our communities. It is about making that phone call to ask about medication direction.

I am heartened to see that the new generation of medical practitioners, the new generation of doctors, does not want to work anymore without having a pharmacist available, particularly in rural areas. Their advice is absolutely indispensable. On a personal note I do not mind who gives the injection. It should be the person who can do it best, timely and appropriately, if it can be done safely. It is so much more than just giving a vaccination. It also makes sure that record keeping is up to date, privacy provisions are being made appropriately, standards are being set. Again, the Pharmaceutical Society of Australia is doing a good job in adopting the standards of the Royal Australian College of General Practitioners. There are precedents there. It can all be done.

Here in Tasmania it is about finding new ways of working together. I give you an example because the member for Murchison raised opioid use in Tasmania. A study was done in the Huon Valley where we tried to reduce the amount of opioids in patients with chronic pain. The clinicians involved were a pharmacist, a psychologist, and a nurse, with very little input from general practitioners or medical practitioners. It turns out that with a little effort, using collaborative models of care, they were able to reduce the prescribing and use of opioids by 30 per cent whilst otherwise maintaining the same level of functioning and reducing the amount of pain patients experienced. It is possible to do. It just has to be done.

Ms Forrest - Collaborative care.

Dr SEIDEL - It is bringing diverse groups together and being patient-centred and ensuring we are putting the patient at the centre of what we do, not our professional reputations nor other issues there.

Again, I commend the member for Murchison on her motion and I fully support it.

[12.34 p.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I thank the member for Murchison for bringing forward this motion.

With regards to point (1), the Tasmanian Government recognises the integral role community pharmacists play in delivering primary health care and ensuring the quality use of medicines in Tasmania. We know community pharmacies are ideally placed to help the Tasmanian Government deliver better health outcomes for Tasmanians.

This is why we have worked closely with our community pharmacists to deliver increased primary healthcare services where possible. This includes significant and regular engagement with key stakeholders including John Dowling and the Pharmacy Guild of Australia as well as Doctor Ella Van Tienen and the Pharmaceutical Society of Australia.

This engagement has proven to be particularly invaluable in communicating with the broader sector to develop, adapt and implement our response to the COVID-19 pandemic. Pharmacists work in a variety of settings across Tasmania, including public and private hospitals, community pharmacies, GP surgeries, aged care facilities and the Prison Service, and within the Department of Health and the University of Tasmania.

In each setting, the quality use of medicines and evidence-based health care are the key focus of pharmacists' activities, which include delivery of primary healthcare services such as individualised pharmaceutical care and advice, including healthy living and wellbeing advice, as well as emotional support to those in our communities feeling stress and isolation.

They also provide community education to ensure safe and correct medication use across the Tasmanian health system, delivery of vaccination programs, home medicine reviews and residential medication management reviews by authorised pharmacists in addition to everyday pharmaceutical dispensing services and medication advise.

Last month's World Pharmacists Day has shown that the role of pharmacists in the community has continued to change and grow. This day was a great opportunity for the community to thank and celebrate the important role pharmacists play in providing essential primary care services and improving patient health outcomes in our communities.

This is particularly evident this year as we know that our community pharmacists have been, and continue to be, an invaluable part of Tasmania's frontline health care as we continue to face challenges from the COVID-19 pandemic. As part of the national and state response to COVID-19, changes to the Pharmaceutical Benefits Scheme and related legislation changes have allowed pharmacists to continue to provide medicines to their patients during the pandemic. This has been an important measure to ensure continuity of care for patients. Where a medicine is required ongoing and reliable supply of that medicine is essential to the quality use of that medicine.

I will move on to point (2) - Tasmanian pharmacists have a strong focus on medicine safety and the quality use of medicines in their routine work. Through their many and diverse roles, pharmacists have the ability to improve medicine safety and the quality use of medicines through many mechanisms. Quality use of medicines is one of the four central objectives of Australia's National Medicines Policy.

Under this well-established National Medicines Policy, which is a partnership approach, it is recognised that the federal and state governments, health professionals and providers, consumers and their carers all have a shared responsibility in medication safety. Quality use of medicines strives to reduce preventable harm and improve health outcomes through selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively.

In Tasmania there are a number of ways pharmacists currently are working to improve medicine safety and the quality use of medicines. For example, pharmacists are working collaboratively with nurses and medical colleagues through the Safe Medication Practice Unit within the Tasmanian Health Service. This pharmacist-led unit was established in 2019 to identify and implement medicine safety initiatives within the THS and is leading work across Tasmania's acute hospitals to standardise dosing of high-risk medicines and adapt new practices throughout the health service.

The Partnered Pharmacist Medication Charting is a key THS medication safety initiative currently being piloted at the Royal Hobart Hospital as part of the Access Solutions Action Plan. Through home medicine reviews and residential medication management reviews, community pharmacists also continue to have an important impact for medicine safety and the quality use of medicines for individual patients outside of the hospitals.

Point (3) of the motion - medicines are the most commonly used treatment in health care and consequently are associated with a higher incidence of errors and adverse events than other healthcare interventions. Safe and appropriate use of medicines contributes to a substantial improvement in health, but medicines can also be associated with harms that can be costly in terms of morbidity, mortality and resources.

Harm from adverse medication events, which include prescription, non-prescription and complementary medicines can range from relatively minor irritations to more severe illnesses, disabilities and even death.

It is estimated up to 50 per cent of medicine safety incidents are potentially avoidable. The Government recognises that a collaborative approach between the prescribers, pharmacists and nurses is critical in identifying and minimising the risk of medicine-related harms. This can be achieved through thorough information gathering and clinical review of medicines, greater education and collaboration between health professionals as well as counselling and education of the consumer.

Points (4) and (5) of the motion - the THS advises the 2019 Pharmaceutical Society of Australia's report, *Medicine Safety: Take Care*, estimates 250 000 of all hospital admissions annually in Australia are due to medication-related problems. The annual cost of this is estimated at $1.4 billion nationally, as the member for Murchison mentioned in her contribution.

It is also estimated an additional 400 000 emergency department presentations across Australia each year are likely to be due to medication-related problems. With up to half of these medication-related problems being preventable, the THS and the Government recognise there is a significant opportunity to reduce the strain on health services through enhanced identification and intervention for patients at risk of medication-related problems. This is why the THS is continuing to develop and implement initiatives to improve medication safety and quality use of medicines through the Tasmanian health system.

Point (6) of the member's motion - on average, older Australians use the greatest volume of medicines. It is reported people aged 50 and over receive 75 per cent of Pharmaceutical Benefit Scheme medicines dispensed nationally.

The THS advises that the use of multiple medicines, also known as polypharmacy, is a known risk for medication error, drug interactions and other medicine-related harms. For this reason, tackling inappropriate polypharmacy is a key implement of Australia's response to the World Health Organization's third Global Patient Safety Challenge. This Global Patient Safety Challenge aims to improve each stage of the medication process, including prescribing, dispensing, administering, monitoring and use.

The THS has undertaken significant work to promote the quality use of medicines within aged care facilities and reduce the risk of harm posed by medicines. This work has centered on improving communications between acute care and community providers, including residential aged care facilities, through mechanisms such as increasing the rate and time lines of discharged summaries and forwarding these electronically to applicable community providers.

It is important to note community pharmacies are the primary providers for medicines for use within aged care facilities and also provide medicines management advice for prescribers and facility staff.

Through the Residential Medication Management Review, an accredited pharmacist can provide tailored medicines review for an individual permanent resident of an Australian government funded aged care facility. This important federally funded initiative provides valuable advice through the resident's GP, to optimise the resident's pharmaceutical care.

Point (7) of the motion - the National Health Priority Areas initiative is a collaborative effort involving the Commonwealth Government and state and territory governments. It seeks to focus public attention and health policy on areas considered to contribute significantly to the burden of disease in Australia and for which there is potential for health gain. The initiative also draws on relevant expertise in the non-government sector to support these outcomes. The addition of medicine safety and the quality use of medicines as the 10th National Health Priority Area is important recognition of the role medicines play in both health benefits and potential harms.

The member for Murchison asked the question about opioid stewardship programs. The Tasmanian Health Service is aware of the opioid stewardship programs being piloted in some hospitals in other jurisdictions. The THS is currently considering and investigating these approaches. The Government notes the motion.

[12.45 p.m.]
Mr VALENTINE (Hobart) - Mr President, I certainly thank the member for Murchison for bringing on the motion. I had the pleasure of meeting with people from the Pharmaceutical Society of Australia - Shane Jackson, Ella Van Tienen, presidents and Paquita Sutherland. It was quite an interesting meeting. They, of course, went over a lot of the ground the member for Murchison covered this morning.

Go into any town in Australia - it is the pharmacy that is an institution. We just expect there is going to be a pharmacy in that town; for the most part, in a town of any major size there is a pharmacist. They are there constantly delivering services for the people - medicines that many in our community need to be able to go about their daily lives with a degree of comfort, free from pain, or as much as possible. They are delivering what has become to be known as an essential service. All of us would agree with that.

For those of us who have elderly parents, it is a really important service for them, because they regularly have to deal with the taking of tablets and making sure they are done in the right way, at the right timing. The pharmacist is there to help sort out some of those problems. I remember, when my parents were about, having to go to the pharmacist on occasions to deal with my father's circumstances. It is such a valuable service and probably relatively unsung in our community.

Having the Pharmaceutical Society come and deliver a briefing to us, as the members obviously will recall, during the World Pharmacy Week, was eye-opening when you look at the facts and figures being quoted. I will go over a couple to reiterate the circumstances we have in our community: one-fifth of people living in aged care are on antipsychotics, and more than half use the medicine for too long; 50 per cent of people with dementia are taking medicines with anticholinergic properties that can worsen confusion and other symptoms of dementia; and over 95 per cent of people living in aged care facilities have at least one problem with their medicines detected at the time of the medicine's review - most have three problems.

These areas, particularly for older members of our community are very significant issues. It is important when we are looking at the delivery of these essential services that we as a community do what we can to improve that circumstance. Quite clearly worrying figures - one in four people has their medicines crushed or altered when they should not be. That is 25 per cent of people taking medicines in the aged care sector. One in five unplanned hospital admissions among people living in aged care facilities as a result of taking medicines generally considered inappropriate for older people. That is very significant and worrying.

A lot of the legislation regarding these sorts of things is in a different jurisdiction, but nevertheless we as a community need to do what we can to improve these sorts of figures. It really is worrying. I personally thank pharmacists doing their bit and trying their best to make sure the community is protected from the inadvertent use of medicines and the like.

The worrying figures in this executive summary provided to me - 250 000 hospital admissions annually are a result of medication-related problems. That is 250 000 admissions. An annual cost of $1.4 billion is the money being spent - sorry, this is money the community is having to bear as a result of incorrect administration of pharmaceutical products.

We really have to look at better ways of managing this. Of course, during our meeting we talked about the presence of pharmacists in aged care facilities. I was quite concerned when I heard we have 70 aged care facilities and only one has a pharmacist in residence. That is a significant problem.

I want to acknowledge the work our pharmacists do. I want to acknowledge they are an icon in our community - an unsung group of people who are essential service providers. We really have to reduce the pressure on our hospital system, those people going to emergency departments across our state and indeed across our nation unnecessarily - unnecessary admissions that are preventable.

Ms Forrest - Some of them.

Mr VALENTINE - I am not suggesting that life is perfect, but a lot of them are preventable. It is a matter of the community and government services to try to fix those figures. It is a lot of people - 400 000 additional presentations to emergency departments are likely to be due to medication-related problems - 400 000. That is a lot of people when you put them in a line.

Ms Forrest - We could not do it at the moment.

Mr VALENTINE - It would probably stretch halfway around our nation under COVID-19.

Nevertheless I congratulate pharmacists for the work they do. It is important that the various professional organisations work together to improve services that would see those sorts of presentation figures reduced and, of course, as a result the lives of a lot of people improved across our community. Thank you to our pharmacists. Thank you to those who work in pharmacies across Australia, who on a daily basis seek to improve people's lives and are very much valued by our general community.

[12.55 p.m.]

Ms FORREST (Murchison) - Mr President, I thank members for their contributions to this debate, and I will keep this fairly brief.

I note the important points made by the member for Huon that all our health care should be patient-focused and patient-centred. A collaborative approach to care with the relevant variety of healthcare professionals is always going to give a better outcome for many reasons. This is because everyone has different roles to play, but also it helps to mitigate against errors, because everyone is human, even health professionals. We would all accept that.

I also acknowledge the work that pharmacists in all our communities do. They support each other amazingly, too. Many of our small pharmacies - as the member for Huon referred to - and in my electorate - and I am sure the member for McIntyre's electorate - are single-pharmacist practices. When they have leave, a locum - usually from one of the other pharmacies, particularly during COVID - has to go to support that pharmacy to enable it to stay open, and they have stayed open through the most difficult of times - through bushfires and through COVID-19 outbreaks.

One thing I do during my trips around my electorate is go to a local pharmacy - because that is where you know what is going on - and catch up with my local pharmacist. They are not backward in coming forward, particularly those who work in single-pharmacist practices - which is a lot of them, in my area.

I acknowledge the work they do. What has been said during this whole debate, and the information we have been provided through the professional bodies that represent pharmacists, is the need for ongoing medication review. It is important that these things occur regularly, to try to prevent a lot of these problems. I know we cannot prevent every drug interaction, or every reaction to a drug a person may have - because people can react unexpectedly, even to a medication that is appropriate for them under normal circumstances.

I also acknowledge the work the Government is doing in our health services to try to improve the way this is worked. When I first started work, there was one hospital pharmacist in the Burnie Hospital; I think maybe two at the most. You never saw them on the ward. They lived in this little hole in the wall where you went to get your drugs, and that was it. You did not see them doing medication rounds, reviewing medications, doing discharge medication checks, and that sort of thing. It is a positive thing that we have seen those changes.

I appreciate the Government's consideration of the opioid stewardship program. I hope it is implemented because there is a need for it. We heard from the member for Huon - and the Government may like to take that model back - about that collaborative approach of using a psychologist, a nurse and pharmacist to work with individual patients to reduce their opioid use and dependency, in terms of their pain management. It can be done - 20 per cent reduction - which is a significant improvement. It is these collaborative approaches that we need in all areas of health care to make this work.

With the other members, I thank all our pharmacists. I know they are not backward in coming forward to talk to me about matters that relate to them and the challenges they have, some of which are matters for the federal government.

I will always do all I can to assist them to get the right point of support there. It is important that we acknowledge these real challenges. If we do not debate some of these things in the Chamber, they fly below the radar.

It is important for all of us to be aware of the very important role pharmacists have within the healthcare setting - not just within the community pharmacy, but within aged care, in medical health facilities, in hospitals, and in general practice.

It would be great to see the leap the member for Huon has taken in his practice before he left to join us to see more pharmacists based in practices - not necessarily full-time, but certainly there to assist.

I thank members for their support of the motion.

Motion agreed to.

Sitting suspended from 1.00 p.m. to 2.30 p.m.

QUESTIONS

Roadworks - Tasman Highway - Removal of Eucalypts

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

My question relates to the proposed roadworks on the Tasman Highway south of St Helens between Basin Creek and St Helens Point Road.

Could the minister provide a detailed assessment and supporting documentation for the final detailed design which includes the removal of a number of mature eucalypt trees which, if left standing along this scenic corridor, would promote the natural and scenic values of the Great Eastern Drive?

ANSWER

Mr President, I thank the member for McIntyre for her question.

As part of the upgrade of the Great Eastern Drive, the Department of State Growth is working on upgrading the section of the Tasman Highway between Dianas Basin and St Helens by constructing overtaking lanes in each direction and general road improvements, including widening of lanes and installing safety barriers and horizontal alignment improvements.

The proposed works will include -

- road widening for two existing lanes on the current alignment
- realignment of the road
- road widening and realignment for two overtaking lanes (one in each direction)
- reinstatement of existing access and creation of three new accesses.

The plan required to achieve these safety upgrades is an outcome of many options and is the best design possible that limits land acquisition and impacts to the surrounding environment. The planned roadworks will result in 25 trees being removed from a forest of many thousands of trees, which is necessary due to the road realignment required to achieve the overtaking lanes. Following completion of the roadworks, the existing road alignment and road corridor will be rehabilitated and replanted with trees and native vegetation. It is only a matter of 25 trees that will come out. I think that there may be some supporting documents coming later and when I get them, I will table them.

Launceston General Hospital - Emergency Department Attendees - Survey

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

Further to answer provided by the Leader on 23 September 2020 with regard to products and services utilised by the Tasmanian Health Service, would the Leader please advise -

(1) Why a Queensland firm has been utilised to conduct a survey on behalf of the Launceston General Hospital Emergency Department attendees?

(2) Can the Leader please advise the cost of this contract and its term?

ANSWER

Mr President, I thank the member for Launceston for her question.

(1) and (2)

The Launceston General Hospital Emergency Department conducts annual experience and engagement surveys as a mandatory requirement under the Australian National Safety and Quality Health Service Standards Action 1.13.

The National Safety and Quality Health Service Standards Action 1.13 stipulates the mandatory requirements -

- for health services to have processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care; and

- that health services use this information to improve safety and quality systems.

Benchmarking and comparison to other health services nationally is also a mandatory requirement under the NSQHS standards.

Sourced as part of a quotation process by the THS, the current provider is able to provide benchmarking with other healthcare services to ensure comparison of quality of care and identified specific areas of improvement for dedicated services such as emergency departments.

The minister is advised that if emergency department staff are required to attend to the distribution, collection, collation and reporting of any of these ED surveys, it is estimated it would cost approximately $30 000 to $40 000.

Presently, the emergency department survey cost component per annum is $12 911, excluding GST. This arrangement ensures the LGH ED staffing resources are focused on patient clinical care as much as possible.

Launceston General Hospital - Emergency Department Attendees - Survey

Ms ARMITAGE - Leader, I do not expect the emergency department staff to do the work themselves. I am wondering why a Queensland firm was engaged as opposed to a Tasmanian firm. I will put that further question in writing.

Inland Fisheries - Arthurs Lake - Trout Low Number

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

[2.26 p.m.]

My question relates to Arthurs Lake, which seems to be offering poor returns to those who have been fishing there for a long period.

(1) Is the Inland Fisheries Service aware of the low number of trout caught at Arthurs Lake?

(2) Why are fish still being transferred from Arthurs Lake when fishing, according to anglers, is so poor?

(3) What short- and long-term measures are planned to restock this lake's trout population?

(4) (a) What is the breakdown by year of the number of trout stock transferred to other lakes in 2017, 2018, 2019 and 2020?

(b) Could you itemise these figures by showing what lakes received how many?

(5) With regard to the fish deaths at the Salmon Ponds, will trout be removed from Arthurs Lake to cover for these losses?

(6) If applicable and if the Salmon Ponds receive additional trout from Arthurs Lake, how great will the impact be on restocking other lakes?

ANSWER

Mr President, I thank the member for Windermere for his question.

(1) The Inland Fisheries Service - IFS - is aware of the fishing performance of the Arthur Lake trout fishery. The fishing performance fell below long-term averages due to a decline in ecosystem productivity following very low lake levels during the Millennium Drought followed by rapid rise in 2009 as the drought broke.

Pleasingly, performance of the fishery is now showing signs of recovery based on catch estimates from the 2019-20 IFS angler postal survey.

(2) Given that Arthurs Lake is very large with a substantial naturally recruiting wild brown trout population, IFS is of the view that the fishery is able to sustain small transfers of fish without significantly impacting fishery performance or sustainability.

Consequently, small numbers of brown trout are transferred from Arthurs Lake to support small popular fisheries that have no natural recruitment of trout. A cautious approach to transfers is taken, with only small numbers taken and size limitations in place on fish transferred.

(3) The IFS advises that the Arthur Lake fishery does not require restocking in either the short or the long term.

The Arthurs Lake fishery is sustained by natural recruitment each year with several feeder streams that provide ideal spawning opportunities for brown trout.

(4) The answer to this question has a table with lot of dates and numbers and lakes so if you are happy, when I have finished the rest of the answers, I will table it.

Mr Dean - I am happy with that

Mrs HISCUTT - The answers continue

(5) No.

(6) Not applicable.

Mr President, I seek leave to table the answer to question (4).

Leave granted; answer to question (4) incorporated as follows -

The number of brown trout transferred from Arthurs Lake over the last four years, broken down by year, is 2017, 4507; 2018, 1416; 2019, 5; and 2020, 5.

The fish were transferred to the waters listed below -

Water	**Date**	**Number**
Bruisers Lagoon	2017	70
Penstock Lagoon	2017	770
Four Springs Lake	2017	1000
Lake Crescent	2017	741

Water	**Date**	**Number**
Tooms Lake	2017	1200
Craigbourne Dam	2017	81
Lake Dulverton	2017	45
Bradys Lake	2017	300
Pet Reservoir	2017	300
Penstock Lagoon	2018	1016
Blackmans Lagoon	2018	250
Curries River Reservoir	2018	150
Penstock Lagoon	2019	5
Lake Pedder	2020	2
Huntsman Lake	2020	3
Total		**5933**

Tasmanian Palliative Care Policy Framework

Dr SEIDEL question to DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[2.40 p.m.]
The Tasmanian Palliative Care Policy Framework 2017-21 was released by the former Health minister Mr Ferguson in May 2017. The first annual report was published in September 2018, but no subsequent annual report has been released in the last two years.

Does the Government intend to release the annual reports, and if so, when?

ANSWER

Mr President, I thank the member for Huon for his question.

The Tasmanian Palliative Care Policy Framework, Compassionate Communities, is a five-year plan for better access to palliative care in our community. In the time since the release of the plan, there have been many achievements, some of which are noted within the first progress report.

A second progress report covering 2018-20 is currently in the final stages of preparation and the Government looks forward to releasing it in the near future. As with the previous progress report, the latest report will also provide a summary of achievements to date.

In line with the priorities for action and to support the effective implementation of policy framework, the Department of Health has amended the reporting period of the report. This change reflects a pause in the commencement of some of the milestones and projects, owing to planning interdependencies with the implementation of national policy frameworks, as well as delays at the local level due to a focus on the COVID-19 response.

The implementation of the Tasmanian Palliative Care Policy Framework and the preparation of progress reports is undertaken by the Department of Health in conjunction with the Partners in Palliative Care Reference Group.

The reference group compromises representatives and palliative care stakeholders from across the state, including the peak body, Palliative Care Tasmania.

The minister would like to thank and acknowledge the ongoing work and commitment of the reference group in working with the Department of Health in implementing and reporting on the framework.

Co-Educational High Schools - Greater Hobart Area - Enrolment Demand

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

[2.42 p.m.]

With regard to a question without notice I asked the Leader on Tuesday,15 September -

(1) Subsequent to the answer provided, and given transport numbers cannot be known, can the Department of Education provide related information as to the number of students attending co-educational high schools in the Greater Hobart area who reside within the municipality of Hobart?

(2) (a) What is the enrolment demand at state, regional and cluster levels until 2036, as projected by Aurecon Australasia Limited through their education infrastructure planning framework modelling?

(b) From the same modelling, what is the enrolment demand, in particular for the Greater Hobart area?

I did ask earlier whether the Government, in the spirit of transparency, would release the full feasibility study report, but I did not receive an answer. That is just a heads-up. I would like some response to that as well. Thank you.

ANSWER

Mr President, I thank the member for Hobart for his question.

Addressing the member's last part first, the answer to that is still coming. We are aware of it and chasing it.

(1) The number of secondary students living in the Hobart LGA by school, attending in the Greater Hobart area is -

Bayview Secondary College	1
Clarence High School	4
Cosgrove High School	6
Kingston High School	6
Montrose Bay High School	7
New Town High School	121
Ogilvie High School	100
Rose Bay High School	7
Taroona High School	646

That is 898 in total.

As a footnote to those numbers, for this purpose Greater Hobart includes Kingborough, Hobart, Glenorchy and Clarence. This is based on Census 1 of 2020, students in years 7 to 10. A number of students may not have been geocoded, therefore have no LGA.

2 (a) The Department of Education engaged Aurecon to develop a preliminary education infrastructure planning framework, and apply it to scenarios developed by the department to test the feasibility, from the demographic perspective, of a new high school demand in the Greater Hobart area.

In 2017 Aurecon indicated that population growth in school-aged children to be low across Tasmania. Results indicated that there was excess capacity across the school portfolio in 2017, particularly for primary and secondary schools. This excess capacity would more than accommodate the forecast growth in primary and secondary students through to 2036.

This was also the case for the Greater Hobart area. Whilst there are a small number of schools at or near capacity, generally across the area it was reported that there was sufficient capacity to account for forecast changes in demographics.

It should be noted that this information is being considered as just one piece of a broader suite of research and evidence to inform a response to the complex issue of high school education provision in the Hobart LGA. It will be included with the findings from the Hobart City Partner Schools engagement work, the outcomes of which will be released later this year and will provide guidance on any potential infrastructure requirements.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020 (No. 30)

In Committee

Madam CHAIR (Ms Forrest) - Honourable members, before we start, I will give some information for the benefit of members, particularly those who may find this a little daunting in terms of having so many amendments.

I am happy to repeat aspects if we need to during the debate as well. Given the number of amendments circulated, the Deputy Clerk will call each clause separately and slowly to ensure we progress in an orderly manner through the Committee stage of this bill.

As members will note from the amendments that have been circulated, there may be several amendments to various clauses. Some may be amendments to amendments and others may conflict with each other.

Each member who proposes an amendment must do so on one of their three speaks to the question that the clause be agreed to.

All members will have three speaks on the question that the amendment be agreed to.

The member for Mersey as the member in charge of the bill has unlimited calls on each clause and any proposed amendments.

When a member speaks to their proposed amendment, they will read the amendment and then speak to provide rationale for the amendment.

These comments need to be confined to the purpose of and need for the amendment and not a re-prosecution of matters related to the principle of the bill.

Members will have three speaks on each question proposed from the Chair.

It is important to remember that when directing questions to a member proposing an amendment to do so in a manner that allows that member proposing a change an opportunity to respond to any issues raised in the debate without having exhausted all their calls.

Members with questions related to the intent or intended action of any of the amendments should propose these questions without waiting for the member moving the amendment to answer each question individually to facilitate it.

There will be occasion where there may be amendments to amendments and this will proceed as follows -

> The main amendment will be proposed by a member - the question before the Committee is that the amendment to the clause be agreed to.

At this point, another member may propose an amendment to the main proposed amendment. Then the question will be -

> That the amendment to the main proposed amendment be agreed.

Members opposing an amendment to amendment will have three speaks on the proposed amendment to the main amendment as will other members. Again, the member for Mersey has unlimited calls.

Once the question - that the amendment to the main proposed amendment has been agreed to - has been disposed of, either with a negative or an affirmative, the main proposed amendment, as amended or not, will be considered. The question will be either -

- the main proposed amendment, as amended, be agreed to

or that -

- the proposed amendment be agreed to.

Finally, followed by that question, either that -

- the cause as amended stand part of the bill

or that -

- the clause as read stand part of the bill.

There are many proposed amendments and the success or otherwise will mean that some clause 4 amendments are better dealt with at the conclusion of the consideration of later parts of the bill. The member for Mersey will be in charge of the bill and will seek to postpone this clause when we get to it. The Chair - either myself or the Deputy Chair - will keep a close tally of the number of calls on each question to ensure everyone has a fair opportunity to speak on the clauses and on the proposed amendments.

As I noted earlier, for clarity, amendments ought to be within the scope of the bill and in writing, and debates should be focused on prosecuting the case for an amendment or rebuttal of the arguments concerning the operation of the clause or proposed amendment. While some latitude may be extended on point, it is important members keep in mind this is not another opportunity to debate the broader policy issues or introduce things outside the scope of the bill or repeat arguments on questions before the Chair.

At times, I will move in and out of the Chair with the Deputy Chair with me in order to speak on clauses and propose amendments. If both of us happen to be out of the Chair at the time, we will then call to the member for Hobart as the next deputy, and it is the member for Launceston after that. Members may find this a little difficult but, obviously, it is important the three of us stay in the Chamber as much as possible to facilitate one person in the Chair.

If members wish to clarify any issues as we go along, please do not hesitate to do so by raising a point of clarification or a point of order.

So having said all of that, we will make a start.

Clause 1 -
Short title

Mr FARRELL - Madam Chair, I rise on clause 1 to represent the Derwent electorate in regard to the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020.

They say there are two certainties in life - death and taxes. Some they say cheat taxes, but nobody cheats death. The bill before us is not about life and death - it is about choice. Many things we do in everyday life revolve around choice. Our society is generally fortunate, so we decide when to eat, when to sleep, and when to do all the other things in the course of a day. We also choose whether to suffer pain. Most people would have medication with them to ease suffering from a number of sources - not many people choose to sit out a headache or put up with stomach pain if there is a way to dull the ache. Most of us choose to have anaesthetic when we are having our teeth filled to alleviate unnecessary pain. We use anaesthetics in our hospitals, so if you need an operation you do not have to bite on a rag while the procedure takes place. Childbirth can be assisted to an extent with methods of pain relief to make it safer for mother and child. The miracle of birth is not without pain and advancements over the years have lowered infant and mother death rates dramatically. Alternative birthing methods are more commonplace because they lower birth risks for mother and child. Indeed, even the choice whether to have a family is done through birth control methods. We are now a better society since the acceptance of birth control - now we are considering the case for death control.

Over the last few months, there has been much debate in the community about end-of-life choices and what choice an individual person should have over their fate when death is the only outcome. I respect people's right to their opinion on this subject and understand the religious-based groups' opposition to euthanasia, but I have been dismayed by some of the strong emotive terms used. I also respect the health professionals who are opposed to voluntary assisted dying and understand their wishes not to be involved in it.

The bill before us deals with facing a certain death and the individual's choice at the very end of their life - their life. I cannot even imagine what a person who is dying goes through. We are taught through our younger lives that we go to sleep and then ascend to the skies accompanied by a white-robed carer. Yes, some - and I would like to think many - simply pass away peacefully or do not wake up. This, however, is not the case for all. Through our briefings and based on personal experience, we know that it is not always the case. No-one knows how their life will end. I do not know what I would do if I had to make the decision of either having assisted dying or not, but I would like the choice.

Much of the correspondence we have received from those who have travelled the journey with loved ones tell of the difficulty and pain of watching a person slowly starve to death or suffocate on an increased morphine dosage. They see a person's dignity disappear because they have no control of their mind or body. Try telling those people going through this today, or in the past, that now is not the time to allow people to end their life in a dignified and peaceful manner.

Many have shared stories of their family members who, when diagnosed with a terminal illness, have attempted to end their lives through various means. These people should not have to go through this process. The fear of intolerable suffering is too much for many people and the only way to end their suffering is by their own hand as there is no other option. This causes a huge amount of grief for family members who often feel it was their lack of support and understanding or their feelings of hopelessness because they could do nothing legally or regulated to assist.

These deaths are recorded as suicides, although technically it is defined as taking your life intentionally. It does not expand in its definition to say that death is the only outcome. For people who do end their lives this way, this is the only choice they have to ensure they have the control over their inevitable death.

Recently, the Mental Health minister, Mr Rockliff, rightly expressed his concern with the suicide rate in Tasmania, and no doubt he will do all that he can to address this issue. It was unfortunate that this information was linked to the intent of this bill by those who oppose it. This bill deals with people who are actually dying. It is unfortunate this happened because it seeks to deliberately confuse two very serious matters. In the Derwent electorate, I have had discussions with many on this subject. Some people are totally opposed, either because of religious beliefs or because they fear the legislation is not strong enough to protect people from being forced to end their lives.

The majority of those who have engaged with me believe it is time that we develop an act to regulate the end-of-life choices. I have had conversations with friends who are very good Christians and who attend church every week. They believe this legislation should be supported because it allows a choice and does not prevent any member of the church from following the church's view. It is voluntary, not compulsory, and it does not take away a person's faith-based decision.

In conclusion, I commend the member for Mersey for bringing this bill forward and for the amount of time and effort he has invested in researching, developing and consulting for this bill, and the work Bonnie Phillips has done in coordinating the community forums held across the state. I also acknowledge the amount of work that Robyn Webb and the Office of Parliamentary Counsel have done in the considered drafting of this bill and all the proposed amendments.

I thank the many people who have contacted me and shared their thoughts on this very personal and complex issue, and the tireless campaigning Jacqui and Natalie Gray have done to bring this issue to the public arena in an effort to ensure others will not have to endure what they and their mother, Diane, endured at the end of her life. They are here not just because of the death but because of love.

Roscoe Pound, an American legal scholar and educator who considered law as a species of social engineering, attributed four major functions to law, namely: maintenance of law and order in society; to maintain the status quo in society; to ensure maximum freedom of individuals; and to satisfy the basic needs of people.

We now have a bill before us to consider in Committee. It has got this far because the majority of us believe in its intent. We now need to ensure it can be a robust piece of legislation. I know there are proposed amendments. I hope they are debated with respect, to get the best possible bill to send to the other place, so every elected member of the Tasmanian Parliament can have their views of their electorates considered.

Clause 1 agreed to.

Clause 2 -
Commencement

Mr GAFFNEY - Madam Deputy Chair, I move clause 2 be amended by -

First amendment -

Leave out 'the first anniversary of'.

Insert instead '18 months after'.

Madam Chair, voluntary assisted dying has to be person-centric with the needs of the person seeking the VAD process. I then ask: is the amendment a safeguard, or is it an unreasonable bureaucratic hurdle to fair and equal access?

Initially, in the bill I had a 12-month period from the anniversary of royal assent. Through discussions with people and trying to come to a compromise, I have changed it to 18 months, and I will come back to that.

Victoria was the first jurisdiction in Australia that achieved implementation in 18 months. Tasmania will have the benefit of training frameworks from two other states, input from voluntary assisted dying experts from Western Australia and Victoria, detailed feedback from the Victorian Voluntary Assisted Dying Review Board, and we have a smaller scale for implementation.

We have been relatively lucky in this state due to our geographic isolation, expert planning and government policy from our health professionals, along with the Department of Health. We have had significant time to plan and prepare infrastructure and resources to handle further outbreaks here, should they occur.

I think the hard work has been done. It is now a case of monitoring the situation, maintaining the preventive measures, and ensuring that emergency plans, should they be required, are always at the ready, which they are.

In any case, we should never accept arguments between one health and wellbeing issue against another, unless there are compelling, urgent and evidence-based reasons for delaying a bill or policy due to competing priorities. It is not good enough to suggest we cannot do more than one thing at a time. I have more faith in our Government, the Department of Health and our health professionals.

A response to members for Pembroke and Huon to their op-ed on Saturday, in which they wrote -

> Right now, terminally ill patients who do not find answers in current and contemporary care expect their parliamentarians to deliver.

I could not agree more. Another quote -

> We cannot afford implementation failure. Too many Tasmanians have suffered for far too long.

Indeed we cannot, and indeed they have - but why would we assume any more than an 18-month period would be required?

While the department secretary said she preferred a two-year implementation, this was not stipulated in the feedback received by the Premier from the departments four weeks ago on 3 September, which I shared with all members. The feedback stated that 'Twelve months may not be long enough time.'.

My amendment was drafted as a genuine compromise to the Government's feedback, like any other member in this place. If I were in the Government, I would want this legislation to succeed. However, Madam Chair, some of my strong supporters of this bill were a bit dismayed that I had actually lengthened or amended it from 12 months to 18 because they know within their municipalities and in their communities, there are people who want to be able to access this legislation more quickly than in a 12-month period.

I was not actually supported all the way through this, but in the end it became a compromise to what was asked by us from the Premier about what was and what could be good legislation, and an achievable framework.

I have full faith in the Government and our Health department that we need no longer than an 18-month implementation period and why is that not achievable. It is assumed, although it is difficult, that between 10 to 12 people would utilise the VAD process. A further delay in the implementation means that a number of Tasmanians in our community will suffer because of the extended time, if it went up to the two year.

I think 18 months is a fair compromise. I think a two-year implementation period is excessive and unnecessary. If you think about the populations and the geographical differences between the three states, in Tasmania we have, let us say, 540 000 people; in Victoria, there are about 6.7 million people; and in Western Australia, there are about 2.56 million people. As a small region - and if you compare sizes, we are about three-and-a-half times smaller than Victoria. Eleven Victorias will fit into Western Australia, so that means 33 Tasmanias will fit into Western Australia.

On that scale alone, both geographically and from a population base, I do not see why Tasmania would need six months longer than both Western Australia and Victoria to implement this legislation. I ask people to understand that we need to get this legislation passed. There is plenty of time for our departments to get it in order, as has been done. As I have found, and many people would have found, there is great support from the other states and other people involved to ensure that Tasmanian legislation will be strong. I see no concern about the implementation of it, so I encourage members to say we understand that 12 months is perhaps too short, but the 18-month time frame - as consistent with Western Australia and Victoria - should be plenty of time for us to have this legislation in place.

Amendment to first amendment -

Ms FORREST - Madam Deputy Chair, I move the following amendment to the member for Mersey's amendment to clause 2 of the bill -

Leave out '18 months after' and

Insert instead '2 years after'.

Including a provision like this in legislation is not usual. We have done it before but it is not usual because usually when bills come to us, they are brought in by the Government. The government departments have done all the work necessary to give effect to that legislation and essentially they are ready to go should the bill pass. There is often a delay to the actual enactment, particularly if complex regulations need to be drafted but it is not usual that we have a clause like this because the Government gets on and does it. It is their legislation and they have gone on and done it.

Here we have a private member's bill and we had a briefing from the government departmental officers that was arranged through the member for Mersey - and it was appreciated to have that with the consent and support of the Premier - to actually hear from some of the departments that will be directly impacted by this legislation.

When I first read through this bill some time ago, I looked at what was required for this bill to be put into place, and there is a lot of work to be done. There is significantly more regulation required under this bill than there was in Victoria. Victoria's regulations are quite narrow and all their forms, for example, are attached to their bill so they have already been done.

I am not saying that the forms will take months to produce; I am not saying that at all. I am just saying a lot of work needs to be done. As the departments have not been involved in the development of this bill, they have to start some of it from scratch, including the consultation necessary to make this work.

We had the letter signed by the Premier that reflected some of the feedback from the departments. We then had the briefing from the departmental officers, where they said two years would be necessary if things were more complicated than they believed, or we had another delay in implementing anything. It might be a COVID-19 outbreak, it might not be, but if it is, it is all hands to the deck. While the mechanism, as the member for Mersey refers to, is all there - yes, but we know how quickly these things can get out of hand. It puts them in the awkward position of trying to manage that because the very department that will be dealing with this will be dealing with the other measures.

It is also a maximum. If the consultation happens effectively and quickly - and that is up to them to do that - it may well be it is done in 12 months. Having that pressure on with such complex processes that do need to be established, the commissioner, or commission, depending on how this legislation goes, will need to be set up. There will need to be people appointed and a training program needs to be developed. Yes, you can look at models in Victoria for example, but this bill, regardless of how it ends up coming out of this place, is different from the Victorian legislation and the Western Australia legislation. You cannot just pick up one training program and put it into here. The training program is about how to operate under this bill. It is unique, it is different and has to be specific to the legal requirements that medical practitioners and people who are going to be using it will need to understand before they can participate in it.

If we do not give the departments adequate time to undertake all that work, we will find a situation - particularly if something else should occur that demands the attention of the Department of Health - it may just be that we they cannot do it and it just sits there with this time hanging over them. Let us be reasonable, listen to what the departmental officer said. It is a maximum. If this bill passes the parliament - it has to go to the other place as well - that is the decision of the parliament and they do have to implement it. Let us make it a reasonable time frame to enable all those other matters to be put in place.

I understand Western Australia is more than 18 months in the implementation. The member for Mersey said it was 18 months, but I think it has been longer than 18 months. Again, Western Australia has not had such a big outbreak as Victoria or we had, for example, but it has had challenges with COVID-19, as the whole of the country has.

For those reasons I encourage members to support the amendment to the amendment, which extends it to two years as a maximum. This is not as a requirement, but a maximum time frame, to give that bit of redundancy if things go a bit pear-shaped. To allow the government department to actually go about its work in making sure when it implements this that it is done with full consultation and support of the health practitioners and professions particularly, who, if we do not have their support, will not participate and it will not work for anybody.

Mrs HISCUTT - I would like to clarify that I will be talking today as the member for Montgomery. My colleagues may have a different opinion to myself; we will see how that goes when it comes to a vote.

I am going to support the member for Murchison's amendment to the amendment for a couple of reasons. Tasmania is a smaller jurisdiction and our resources are very limited. The Health department has been bombarded of late with COVID-19. Its resources are fairly tied up. That is not going to finish tomorrow; it will continue for a lot longer yet. I appreciate the member for Mersey coming to a compromise there; I think that is very good, but I cannot see why another six months will make a lot of difference. I can hear people saying there are people waiting, but we are doing this bill - we are getting it done and getting it here today.

Other states, as the member for Mersey said, are doing whatever they are doing, but they are bigger, have bigger resources and bigger amounts of money to spend on these things so I think that a two-year term is very relevant and applicable here in Tasmania.

Mr DEAN - Madam Deputy Chair, I rise to ask a couple of questions. First, if the amendment to the amendment is supported or the amendment is put forward for the 18 months, if those terms cannot be met - if the Government for instance, the department was not in a position to proceed at the end of the 18-month period or the two-year period - what actually will happen? Would the Government then need to bring this bill back to request a further amendment to extend the time period further? Would that be required? We would in fact have a bill in place that has gone through the parliament and approved by the parliament, agreed to by the parliament. I am wondering what situation would occur in that case?

Mr GAFFNEY - I cannot speak on behalf of the Government, but I can say that whenever we are in this place and time frames are put on legislation, there is an expectation that those time frames will be met. If there were something untoward where it could not, they would have to come back to the parliament to discuss it. I cannot give you another answer than that.

Mr VALENTINE - I wrestle with this a little as well. I weigh up the issue about the size of our state. Regardless of the size of the state, regulations will have to be put in place, whether the state is big or small - for instance if this were happening in another jurisdiction, the same amount of work would be needed for the regulations.

The resources that are available may be a question, something that a larger state might have, I suppose. That is probably more of an issue. Just because we are a small state does not mean to say there is less work. I think 18 months is a reasonable time frame. It indicates a degree of urgency to the Government that they should not be tardy in getting these things moving. Putting it out to two years, I think, well, might be seen as benefiting the bureaucracy. I appreciate that. The compromise has been made, though, going from 12 months to 18 months so I am inclined, and I will listen to any other offerings, not to support this amendment to the member for Mersey's amendment.

Ms FORREST - To follow on from what the member for Hobart said, when you look at the regulations in Victoria, they are very small in number. It is only a small regulation. Our bill requires a lot more regulation to be put in place, so there is more work in that regard but we also have fewer OPC staff and, as we know, they have a fairly heavy workload at the moment. OPC drafts up the regulations, same as it did with the bill. We are talking about a resourcing issue here, and the member is right to say that we are a smaller state and maybe we will have less resources. It is like most of these things - with Tasmania being a smaller state, we are still expected to do the same things as other states at times and legislation requires, mostly, regulations to sit below it and generally it is not done until after the principal act is passed because why would OPC take all that time to develop those if it is not a certainty?

The member himself made the point that he has argued for two years, in many respects because we are a smaller jurisdiction. We have less capacity in this state. I agree we can do more than one thing at once as a state, but should something else occur, yes, you could come back to parliament, or the Government could bring it back and request an extension. It would be almost impossible for us to deny that because they have said they cannot do the work. What are we going to do? Say, 'Well, you have to'?

I go back to the point. This is not, 'It will take two years to implement'. It is a maximum two years, to enable the redundancy to be there in a small jurisdiction. It still has to do the regulations, tick off and develop a training program, set up a commission - all those things need to occur in that time. One would hope they can be done in 12 months, but we heard from departmental officers that they believe two years is an appropriate time and is what they need, mainly because they did not have a chance to consult on this legislation in its lead-up.

They have to do that consultation now, or when this is passed, to actually start that process of drawing up regulations. It does not fall to the member for Mersey to do that. It falls to the Government to do, once this is dealt with. It is not a maximum. It is giving them that additional time, recognising the smallness of the state, and the potential for other things to get in the way. It might not be COVID-19; it might be something else.

It is providing a realistic time frame. It also sends a message that this is not going to happen overnight. We know it will not happen overnight. There are people who are suffering terminal illnesses now who support the principle, who would like to access it next week. They will not be able to.

It is about making it clear that it is really important to get the background work done properly, to get the regulatory framework right, and to make sure all the ducks are in a row, so that when it is implemented, it works. Doctors are happy to work within it. People will know how they can access it, how it works, what forms they will have to fill in with their medical practitioner.

It is about that time for communication. You have to let people know what the process is. It is quite a complex process, regardless of what we come out with at the end of the day. You need time for the medical professionals involved to get their heads around that, too, as they have to operate under the laws that we pass in this place, at the risk of losing their registration. It is no simple matter. If you are in breach of the Poisons Act, or in breach of this if it becomes law, if you are in breach of the nurses act if you a nurse, you could lose your livelihood. We need to make sure we have the right regulatory frameworks to facilitate that.

Hopefully it will not take that long, if this goes through, but I think we need to be reasonable and fair.

Dr SEIDEL - I agree with the member for Mersey. I want to see the bill implemented.

Tasmanians have been waiting far too long, over 10 years, but I must admit it is a very ambitious bill as well. The initial time frame of 12 months was ambitious indeed, and probably not possible if you consider you have to train or credential medical practitioners and nurses, because it is not legislation that is similar to the Victorian legislation, or the legislation passed in Western Australia.

Twenty-four months is a long time. I believe it is amazing what you can achieve when you put your heart to it, and I think it should be possible to get things done in 18 months. If Victorians can do it, if the good people in Western Australia can do it, Tasmanians can do it too.

It is so important to make sure we have a pragmatic approach, and have amendments so that we find the bill is actually implementable. That should be key. We cannot afford any further obstacles. Let us keep it to 18 months. I think it can be done.

Things can always happen that warrant a delay - hopefully not another COVID-19 wave - but 18 months is a pragmatic compromise.

Ms WEBB - This is an interesting one. In my first reading of the bill I immediately thought 12 months is really tight and that was not enough time. I was really happy to see the member for Mersey consider and then make some compromise in this area and propose an amendment to extend that time to 18 months. Extra time is needed because of complexity because it is a major new entry into our health care and social areas. The argument that we might have a resurgence of COVID or another unexpected delay is understandable because we have all experienced the disruption this year from things. I do not know we can accommodate or should actually accommodate the unknown and the unexpected in setting this time frame. So, when we are thinking about should it be 12, 18 or 24 months, the potential for unexpected events to arise - while we may have it there in our mind - should not be the determining factor on where we land. We should be keeping our attention on what is the most appropriate and possible time frame to get this task done.

If and when an unexpected event was to arise, we would then act and adjust things, just as we have this year when COVID arrived. We acted in this place to adjust all manner of things in current legislation, administrative processes and community processes and we did it in a way that was really responsive to what was needed at the time. It is not necessary for us to extend this time to anticipate the potential unexpected event. We can and will deal with that if it does arise. There is a clear community expectation we progress it if it passes both Chambers, that we progress implementation as promptly as possible. There will always be people who miss out. I have had awkward conversations too, with people asking me about what might be the most optimistic time frame this legislation might become available to them. I then had to interact with them about that fact that it will be too late for them. That is a really sad conversation to have. It does not matter where we set this for those realities, it will be there. There is a community expectation we progress as quickly as we can while undertaking the task appropriately.

To say two years is a maximum and it might be done quicker is probably not overly realistic. If you give a bureaucracy two years to do something, of course, it will take two years to do it. If we set an expectation that it will be only 18 months, I agree with the member for

Huon - we can set a clear expectation that may happen and it can happen. Lots of work can be done in a set time frame, even if it is a high aspiration to do it and it is an indication of community expectation and progress.

Again, in recognition that this is a complex matter and the things that will need to occur in that implementation time are really important aspects of this working well once it is in place, we also have to recognise the end of that implementation time, and when we actually make this process available will not be a point in which we are all done and dusted and everybody is utterly clear and the whole community and whole medical profession knows all about it and everyone is set to go. We will not be at that point at that time; we will be at that point when we get to the implementation time in 12, 18 or 24 months. We will still be at the beginning of something; we will be at the point we have built a system, a process, put appropriate documentation, training and all those things in place, and then we will begin transitioning as a community into utilising and making available that system and the ongoing education and the ongoing engagement with the broader community, with the medical community, that will continue and play out over years. That is what other jurisdictions are finding too.

Again, I do not think we need to feel that the extension of the implementation time needs to somehow arrive at a complete spot where absolutely everybody is informed and ready to go. I think we will have a spot where we have systems in place, we have some people ready to go so the systems can be operational, then we will begin a transition process more broadly in the community.

I am going to support the extension, the original amendment, which is the 18 months. I think it is important for us to send a message and to set an aspiration that we progress this as quickly as possible.

Mr WILLIE - My view is that 18 months is an aspiration that is probably reflective of where the community is at. I just have a question for clarification. If the Government took 20 months or 24 months, for instance, there is no consequence for that, is there? If we have 18 months in the bill and they take longer, there is no consequence?

Ms Forrest - You could argue you do not put any time frame in it then.

Mr WILLIE - That is probably a reasonable point to make in this debate. I am comfortable with 18 months if that is the case.

Ms LOVELL - Madam Deputy Chair, I am inclined not to support the extension to 24 months. It is difficult just by the nature of the fact that this is a private member's bill. It is difficult when we do not have the relevant departments here to advise us on how long it will take, but that is the nature of the bill. I know we have heard from them in some briefings an estimate of 24 months. I accept that 12 months is unrealistic.

I agree with the member for Mersey that we can learn from the work that has already been done in Victoria and Western Australia. On balance, this bill has had a different process to come to our parliament. We have not had the work done beforehand that would be part of that implementation work that will need to be done. I take the member for Murchison's point that there is a lot of work to be done, there are lots of different things that need to be done in this implementation, but not all of them involve the same department. There is quite an amount of that work can be done concurrently.

There is always the opportunity for the Government to come back and ask for an extension of time if there is a genuine reason why that work is not completed in the time. But it is important that we send a message to the Government that there is an expectation of the parliament that this work is done within the time frame that we believe is reasonable. On balance of all of that, I agree that 18 months is reasonable. I will not be supporting the amendment to the amendment. I think 18 months is a good compromise.

Mr DEAN - A short contribution is a good one, so I will keep it to that. I will be very surprised if the Government has not now looked at this bill. It has been around for a while. There has been a lot of talk, a lot of briefings on it. I think the Government would be in a fairly good position to know now just how long it might take it to get this legislation operational and up and running. I will be very surprised if, when this bill - I am fairly confident it will get there - gets into the other place, the Government will be in a very strong position to identify exactly the time, or roughly the time that it would need to get this bill in place and operational. Therefore, the Government will be in a position to move an appropriate amendment in that place if they feel that the 18 months is not long enough. They will have the evidence at that stage from the department to simply say, 'These are things we have to do, these are the things we have to put in place to make this work.' They will go into that in some depth. If they could put their argument in the right way and strongly, they will be successful in getting that extension if they need it.

I am of the position that this bill is here, the people strongly support it, there is no doubt about that. I do not think we should be procrastinating. My view is that I will be supporting the member for Mersey's amendment. I will not be supporting the amendment to the amendment at this time, unless I can be convinced otherwise.

Ms PALMER - I will be supporting the amendment to the amendment for the two-year period. I want to address a couple of things. I agree with the member for Nelson that if a second wave of COVID-19 came through we would adapt, as I certainly saw as a spectator when those other members in the Chamber had to do that over the past months. I have to say there is certainly community expectation that this bill will be passed but the community expectation is also that we are extraordinarily thorough. When we say that we do not know what the relevant department needs, we do not know how much time, well, we do because they told us in a briefing that the amount of time they needed was two years.

I feel like they have briefed us and they have said this is the reasonable amount of time that it will take to put this through. Based on the fact that I think we need to be really thorough, we need to be realistic and give the people who actually have to implement this the time that they are saying to us that they need, I will be supporting the amendment to the amendment. I think two years is reasonable and that is what is being asked of us by those relevant departments that have to actually make this work.

Mr GAFFNEY - I thank members for their comments and I thank the member for putting forward the amendment to the amendment.

A couple of points I would like to make: I think the member for Rumney said there is an expectation from the community that there is an urgency in this piece of legislation because of the impact it has on our community. Nobody in Tasmania wants to see people suffering longer than they have to in this situation.

As far as feedback from the Government, I do not think the Government actually thought the bill would get to this place. The only feedback I had from the Government was from the letter that we all received and it said, I was told, the implementation time frame of up to one year under current circumstances is insufficient. The other piece of information I was informed of and that we all received was that for the legislation to operate effectively consumers, family and health professionals and their employers would need to thoroughly understand it and be comfortable with its provisions. Twelve months may not be a long enough time in which to ensure this.

While they are saying 12 months may not be long enough, it could have been long enough. I thought we have one group saying that 12 months is not long enough and another saying, 'Well, it may not be long enough.'. I went to what I thought was a reasonable compromise of 18 months, as has been reflected in other legislation in this country. I will not repeat what we have said but we have that prior knowledge that the other places had and we can go straight there, as has been shown by some of the amendments that have been put forward. People have gone to those pieces of legislation and chosen what will fit and what will help.

I encourage members that we should go for 18 months. I think it is what our community expects because they see this as important. I do not think I have had any other legislation for a long time where somebody has said this is the most important piece of legislation they had seen in 15 or 17 years, so much more community engagement, than this one. If it is a priority for our community, it should be a priority to our Government and the government of the day should put whatever resources it needs to, to make sure that this is done and dusted and can be delivered to the people of Tasmania within 18 months.

I hope that members do not support the member for Murchison's amendment to my amendment, but support the 18 month one. I will not be voting for the two years.

Mr Dean - I think the way we are going, it will be 18 months getting there anyway.

Madam DEPUTY CHAIR - Before I call the member for Murchison, because it will be her last call, I will put the question -

> That the amendment to the main proposed amendment be agreed to -

so any other member can have an opportunity before the member for Murchison.

Ms FORREST - I make the point, if members remember, that in one or two of my amendments, I did have 18 months. When I first looked at the bill and saw the 12 months, again, going back to the point, it is not a usual provision to put in; it is because this is a private member's bill. The Government has not been involved in its development, for it to be there in the first place. There is no penalty as such for not doing it, as the member for Windermere and others rightly say, whether they come back or ignore it. The Government could do that. All you could do is put a motion to the Chamber calling for them to get on with it. You cannot make them. If there is not a process there, people cannot access it. You are relying on the goodwill of the Government regardless of whether we put anything in or not. I had 18 months as the first amendment I put up some weeks ago.

It was after we had the briefing from the Government that the member for Rosevears said they said two years. The letter from the Premier, which the member for Mersey read out, said it may not be long enough or it is not long enough. To me that was pretty clear. It would almost certainly take longer than that to do the work I have identified in the bill that needed to be done. After hearing that and hearing them say that and talk about the need for consultation from the departments to make it work and to ensure they could do all that, they would probably need two years, regardless of any other thing that might happen in the meantime, in which case you can do all sorts of things under emergency legislation as you know and as we have seen.

There is a community expectation this is dealt with one way or the other and I am not denying that. I am saying what we heard from the government departments is they would probably need that length of time. They might not need it. They may be able to get it done sooner. In many respects it does not matter whether there is no provision in there at all, or 18 months, or two years. If they decide to take five, then they will take five. What are you going to do except try and get public pressure to get them to act, but you can try. That is the reality. It does send a message and is important. After hearing from the government departments, two years was appropriate as an upper limit. If you said you might need two years, here you are, you have two years, get it done. Get it done in quicker than that if you can, but that is it, team. If they came back after two years and said we need more time and there has been no other major interruption to proceedings, you would really have to question their intent and it would be most unfortunate should a government ignore the will of the parliament to such a degree.

I will be sticking with my two years. It is because it is basically a request on a bill that has not been consulted by the government departments. They have to start that process from scratch. The government departments have to do all the work after this to put those regulations in place, to develop the paperwork necessary, to put together the commission or whatever it is we end up with and to do all that work. The community expects them to get on with it. They should get on with it and if they do not do it in two years, they might not do it in three or four either, but that is the cold harsh reality. It does send a clear intent there is an expectation they will not just sit on it and let it go nowhere, that they will do the work and we are being reasonable in listening to what they have said and giving them the time they have requested.

Mrs HISCUTT - In support of the two-year mark, also in the letter from the agencies, it says -

> Agencies would need sufficient time to consult with key stakeholders such as Primary Health Tasmanian, the Australian Health Practitioner Regulation Agency, the Australian Medical Association, the Royal College of Australian General Practitioners, and others. It will also be necessary to engage sufficiently with the broader Tasmanian community and with medical practitioners and other health professionals to determine the systems and processes that will need to be implemented within departments to support the Bill. It is not clear at this time what will be required for the pandemic response into the future.

The departments have a lot of work to do, especially the Health department that this will affect. If you read the actual clause, it says -

> This Act commences on a day to be proclaimed, but if this Act has not commenced before the first anniversary of the day on which is receives Royal Assent it commences on that first anniversary.

So, there is no limiting factor there by putting the second in. We talk about moving on and making it less and quicker for the comfort of those out there who might need it. I have received an email this afternoon and I will not mention the name, but it is someone the member for Murchison and I know, who is not in a good spot. His wife says he knows what he is likely to face in the next weeks and months and approved her contacting me essentially to say having a legal VAD framework in place would bring him immense peace of mind. A little footnote says he is aware it is unlikely to be ready for him, but these are his thoughts.

I do not see the need to come down to 18 months. There is nothing wrong with two years. It is a good space, and people who are in that position are relying on us to get it right.

It should not be - I do not want to say handballed - but it should not be up to this Chamber to pick up the things we are not sure of.

Mr Dean - We do it the other way.

Mrs HISCUTT - That is because we get it right. I urge members to stick to the two years, because it is not limiting. It is just a space in time, so I urge members to stick with the two years.

Mr VALENTINE - It has raised a question for me now, after re-reading this clause. Maybe I am reading this not in the right way -

> This Act commences on a day to be proclaimed, but if this Act has not commenced before 18 months after the day on which it receives Royal Assent it commences on that first anniversary.

It does not seem to me to make sense now. 'First' should be struck out for a start, and it should not be 'anniversary', it should be 'on that time' or '18 months' or something like that.

I think we need to postpone this clause and revisit it. I am sorry. If you put the member for Murchison's amendment in and read it

> … this Act has not commenced before two years after the day on which it receives the Royal Assent it commences on that first anniversary.

It does not make sense.

I am sorry I did not pick it up earlier, but it needs revisiting. Unless someone can explain to me - maybe the member for Mersey - I am inclined to -

Mr Dean - Everything after 'Assent' needs to come out.

Mr VALENTINE - … to say either the member for Mersey or the member for Murchison needs to revisit their amendment to fix that.

With respect, 'This Act commences on a day to be proclaimed'; 'This Act has not commenced before the two years after' - because we are dealing with the amendment of the amendment - 'it receives Royal Assent'. You have to have something else that follows. You cannot just have it finish there.

Ms Forrest - Can I just read it to you in context? 'The Act commences on a day' - I will use the member for Mersey's, just as an example -

> The Act commences on a day to be proclaimed, but if this Act has not commenced before 18 months, the day on which it receives Royal Assent commences on that first anniversary of the 18 months.

Mr VALENTINE - An anniversary does not mean 12 months; it means 18 months in this case. Is that what it is saying?

Ms Forrest - We need to check with the OPC. The OPC is very deliberate about how it does things.

Mr VALENTINE - Is it possible for me to move to -

Madam CHAIR - The member for Mersey was on his feet - or was attempting to while the member for Hobart was there. I will take the call from the member for Rumney while the member for Mersey gathers his thoughts.

Ms LOVELL - Member for Hobart, I have just had exactly the same conversation with the member for Huon as you rose to your feet. We picked up the same thing.

Having said that, respectfully, I would think we could vote on the amendment to the amendment, being the principle of whether it is two years or 18 months.

On the semantics of how it is worded, clearly we need some advice from the OPC, but in the interests of keeping things moving, and the amount of work we need to get through, I think we can vote on that question. That would then give us an indication of where members feel it should be, in terms of a time frame, which would then inform OPC in terms of the advice it gives on how that clause should be worded in its final version.

Mr GAFFNEY - I am not going to put words into OPC's mouth. I trust the experience of OPC. Both the member for Murchison and I went with amendments. I read this as saying, if we use the 18 months line, if it has not commenced by that, so if it does not commence at 15, 16 or 17 months, it has to commence at the 18 months, because that is when it is the anniversary. When they said they might be able to bring it earlier than the two years, what they are saying is yes, we could do it before the anniversary, which is the 18 months. If it does not happen before that, it has to happen on the 18 months.

The anniversary is the 18 months. It is the time frame put there. It can be a two-year or a five-year anniversary. It just says if it has not commenced by the 18 months, it has to commence on the 18 months. It says you can start early, but if it does not get there, you have to start at least by the 18-month mark we have put down. I think that if OPC were listening, it would say, 'Yes, Mr Gaffney, you have it right.'. That is how I read it.

The Committee divided -

AYES 7	**NOES 7**
Ms Armitage	Mr Dean
Ms Forrest	Mr Gaffney
Mrs Hiscutt (Teller)	Ms Lovell (Teller)
Ms Howlett	Dr Seidel
Ms Palmer	Ms Siejka
Ms Rattray	Ms Webb
Mr Valentine	Mr Willie

Amendment to first amendment negatived.

First amendment resumed -

Madam CHAIR - We are now back to the question on the member for Mersey's amendment, that the amendment moved by the member for Mersey be agreed to which is the 18-month time frame. The other point is that a question has been raised about the anniversary. There is a question before the Chair; we cannot postpone the call to get advice while there is a question before the Chair if the member for Mersey does not withdraw it, but the priority for that is that it is not clear the member can reintroduce the same amendment. I think I am right on that? There has been some advice from OPC that it does need to be corrected and it will require an amendment to the amendment you have just put.

Ms LOVELL - Point of clarification, this was something we discussed prior to the debate today. It was around that question of whether, if someone were to put an amendment and then decided to withdraw that for the purpose of seeking other advice, that same amendment could be put. I am unclear on whether we have an answer on that, not necessarily for this but for the remainder of the bill.

Madam CHAIR - With regard to that, if the member for Mersey does seek to withdraw it, the question can be put again. If it is the same question, though, members who have already spoken to that question cannot speak again. They can only speak to the number of speaks they have left. So it is a risk to do that, but it is possible.

As I said earlier, all amendments need to be in writing. If we could wait for a moment - it could be a slow and tedious process, as I said at the outset. We have to make sure we get it right and some information has come through that would allow it to be considered.

This matter will be addressed by a second amendment to this clause. The question before the Chair at the moment is the amendment as proposed by the member for Mersey, the first amendment to this clause - there is another about to be circulated which members will all get. If the member for Mersey when he gets up to speak again on his proposed amendment, there will be a second call on the amendment, he might like to indicate that he will have a second amendment and then that will make it clear for everybody, hopefully.

The question is that the proposed amendment 1 be agreed to.

Mr GAFFNEY - If the first amendment is agreed to, to help people understand, in the second amendment, you would leave out 'on that first anniversary' which is at the bottom of the original commencement, and you would put 'at the end of that 18-month period'. That would satisfy the member for Hobart. That would be the second amendment and then that would complete the clause.

First amendment agreed to.

Second amendment -

Mr GAFFNEY - I move that clause 2 be amended by -

Leave out 'on that first anniversary'.

Insert instead, 'at the end of that 18-month period'.

Second amendment agreed to.

Clause 2, as amended, agreed to.

Clause 3 agreed to.

Clause 4 -
Interpretation

Mr GAFFNEY - Madam Chair, I move -

That clause 4 be postponed.

Motion agreed to.

Clause 4 postponed.

Clause 5 -
Relevant medical condition

Ms FORREST - Madam Deputy Chair, I move that clause 5 be amended by -

First amendment

Clause 5(1), definition of **relevant medical condition** -

Leave out the definition

Insert instead the following definition:

'**relevant medical condition'**, in relation to a person, means a disease, illness, injury or medical condition, of the person that-

(a) is advanced, incurable and irreversible; and

(b) is expected to cause the death of the person; and

(c) except if the person is exempted from this requirement under subsection (3), is expected to cause the death of the person-

    (i) within 6 months; or

    (ii) if the disease is neurodegenerative - within 12 months.

In moving this amendment, I will refer to the second amendment to make it clear what that requires because it is referred to in this section. This amendment does put a prognostic time frame on the life expectancy of a person who is seeking to access voluntary assisted dying. The key reason I have worked on this amendment is it very strongly fits with community expectation. As we have heard many people in their second reading contributions talk about, this is two different deaths: a death at the administration of a substance as opposed to a death from the condition that was causing the death of the person at the time.

It is not that the person is not facing certain death at a time within six months or 12 months depending on their condition. When you speak to members of the community, they are very clear this is what they are talking about. They are talking about assisting a person die who is actively dying, not someone who may live two, three, four or five years hence. The exception that is referred to in the amendment to clause (c) referring to subsection (3), does provide the person with an opportunity to apply to the commissioner to have that requirement exempted, should they have a rare or unusual condition in which the commissioner would need to take medical advice on whether they should grant that exemption or not. I will prosecute that more at a later time, but it is relevant to this because I refer to it in this first amendment.

I might ask the Chair whether I should talk about it because we refer to it in this first amendment and it is hard to separate them.

Madam DEPUTY CHAIR - I suggest if it helps to make it clear.

Ms FORREST - It is two separate things. I will speak to it as well.

This amendment does not stop discussions occurring about voluntary assisted dying with anybody. Any patient who has been diagnosed with a terminal illness, or with an illness that is likely to become terminal, can have a discussion with any of their health professionals about this process if they wish to - if they want to raise it, they want to talk about it, and understand how this would apply for them.

The default position should be that the person is facing death. That is what we hear from the medical profession, the medical professionals who support the principle of this act and would be willing to work within it. This is what they are asking for. There may be the occasional one who is perhaps not, but all the ones I have spoken to - the ones who support the principle - have said they believe this is the appropriate process to have. This is the default position - that someone is facing imminent death, if you like. It should not be open-ended.

Some people talk about that being a barrier and making it too difficult for people, but when you have had a diagnosis of a condition that is terminal, that is incurable, that is likely to cause significant suffering, then obviously your doctor would have spoken to you about all the implications associated with that - what the normal course of events are, what the options for treatment are, what the effects of those treatments are likely to be, how they might affect you.

Everyone is different, and you cannot always predict, but doctors have a lot of experience in this. Doctors do this sort of prognostic assessment all the time. It is not unusual for them to do it.

I have had a few emails, but not a lot, from a few people saying this is just ridiculous, and people should be able to make their own decisions.

We are suggesting that people make their own decisions, absolutely we are, but the medical profession has made it clear to me - particularly the GPs who are most likely to be working at this point of the process - that they do not want to have these discussions with someone who is not likely to die in the near future.

I believe that is in line with community expectations. From the discussions I have had, that is what people say - members of the public, members of the medical profession. That is what they actually believe they support, when you actually ask them, 'Is this what you are supporting?'.

I said in second reading, some of them get confused between withdrawal of futile treatment and refusal of treatment, but when you say, 'Now what about voluntary assisted dying - actually helping somebody to die actively?', they say, 'Well, yes, they are already dying.'. That is the point I am making here.

The exception in the second amendment is where a person can apply to the commissioner - or depending on what changes happen later on, it may be the commission. I understand those changes may happen at vellum stage. There are further amendments to this bill proposed regarding a commission rather than a commissioner, so we may need to recommit this clause to change it to commission should they be considered - not to change the intent, just to change the word commissioner to commission. That is the second amendment.

Going back to the point, the person can apply to the commissioner or the commission - depending on what happens further on in the bill - to enable them to commence the formal process earlier.

It does not stop them having conversations earlier. It just means they can apply to start the formal process of the first request.

It does not remove any of the steps. It does not remove any of the points of contact with their doctor in terms of the first request, the second request, and the final request.

It does not change any of that. It just enables a person with a difficult-to-diagnose life expectancy condition, or a really rare condition where a person may lose certain capacities - not mental capacities, but others - to participate, and they can actually start the process of making that first request sooner than they might have been able to. That should not be the default, that should be the exception.

That is what the second amendment does. It creates an exception to allow the commissioner to be approached by the person to apply for that. Under that second amendment, the commissioner then needs to consult with the medical professionals with regard to that. You cannot expect the commissioner to have all the knowledge about that particular person's condition. The commissioner would not be making a medical determination at that point, they would be making a determination based on the advice from medical practitioners.

In the first instance - I will go back to the first amendment - this basically replicates the Victorian definition that requires the disease to be advanced, incurable and irreversible. It is not like it is saying it is going to get better. It is in the more advanced stages, not just at the early stage when there are possibly a range of treatments available that the person may wish to avail themselves of. They may have refused all treatment - that is their right - in which case they will probably progress down the path to a six-month life expectancy much more quickly. It is their right to do that, if they wish to refuse treatment. It is expected to cause the death of a person within six months, or within 12 months, if the disease is neurodegenerative.

In consultation with the health professionals, the college of GPs, members of the AMA - again, some of them are completely opposed, but those who support the principle and would be happy to participate in it, this is what they are telling me. I think we want this to work for the medical professionals; this is the way it should be. If it does not work for the medical professionals, it will not work for anybody. If you want people to be able to access it, you need to have medical professionals who are happy to work with it.

I urge members to support the first amendment. We will get to the second one, which I think is equally important, but the first one is about setting that prognostic time frame.

Ms HOWLETT - I thank the member for Murchison for putting this amendment forward. I must admit I had great concerns that this was not included in the legislation. I feel this amendment will certainly strengthen the bill. I urge all members to support this amendment.

Mr GAFFNEY - I thank the member for bringing this forward. It is something that I think needs to be debated and discussed so that everybody is aware of the situation.

First, I go back to when I first spoke. Is this a safeguard we are trying to introduce, or is it an additional hurdle for Tasmanians seeking fair and equal access for an option to voluntarily end their life, intolerable suffering, at a time of their choosing, from a condition that is already ending their life?

While the Victorian model and the Western Australian model have been based on the Oregon model of the six- and 12-month time frame, I think it is important for people to understand how that evolved.

The six-month time frame in Oregon started in 1997 and evolved because you can only access palliative care in the United States with six months left of your life. Therefore, it came down to more of an insurance thing. If they saw you were going to die within the six months or 12 months, you would be eligible for palliative care - so that became the time line in Oregon.

Now what happened here when Victoria introduced it is that the committee that looked into it did not actually come out with the six months. It was changed on the Floor of that place to become six months.

I do not think people actually realised that. This is why I sent out material early on about what happens in other places in the world. With 4 million people in Oregon and 6.6 million in Victoria, that is about 10 million people who would operate under the current guise; add the Western Australian one, that is about 12.65 million. In the Netherlands, 17 million people operate under legislation that does not have a six- and 12-month time frame. In Belgium, 11.4 million people operate under a system that does not have a six- and 12-month time frame. In Canada, 37 million people operate under legislation that does not have that constraint.

Have there been any cases in those countries where there have been signs of a slippery slope, where there have been signs of vulnerable people? No, there have not.

In fact, most people - 80 per cent of people - still end their life within the last two to three weeks of their death. So, in all those areas there have been no signs. I have also contacted the OAC GPs and nurses and doctors who have spoken to me and here are some of the comments that they have made regarding this. Dr Cam McLaren who operates in Victoria as a volunteer in that space said -

> [The Tasmanian legislation] removes the requirement for a short prognosis and instead focuses on the suffering of the individual. It seems cruel that we must tell some of our applicants in the most amount of suffering that unfortunately they haven't suffered enough and must wait …
>
> They have to wait until they have six months to go before they can actually access or start the first request.

Dr Chris Henderson, who is quite happy for me to quote this -

> My view is that, firstly, anyone in an untenable position of discomfort or pain, of sound mind, and with no prospect of relief, has the right to end their life. And we doctors should be legally allowed to make that event as easy as clinically possible, while you politicians should make it as easy as legally possible.

He goes on to say -

> Your introduction of a 2 year window of terminal illness is wise. The path to death in the final 6 months of a terminal illness is highly variable, and it is most unwise to think it runs a simple downhill course (as any experienced doctor will tell you). I'll give you 2 examples - some years ago the husband of a personal friend became terminally ill and was given 6-12 months to live. His wife told me of their plans to spend the time they had left together - but when I met him shortly afterwards I had to tell her that in my opinion the consultant was quite wrong, and that he had little time left - and so it proved, he died within weeks. Secondly my father had pancreatic cancer, was given a few months to live and in fact lasted a further 18 months, but

> recently another friend was fit and well until about a week before his death from the same disease. A doctor just can't predict it that accurately …

He goes on to say -

> I'm not sure why some will vote for the 'safe' option of 6 months - 'safe' from whose perspective? Is the parliament afraid they will sanction something that a patient will later regret having done(!)? Or that they will be held responsible for the unnecessary death of some patients?

Other material against the prognosis of six to 12 months - legalisation in Europe and Canada gives major consideration to the issue of suffering and allows choice of VAD as a means to end that suffering when there is no realistic option that it can otherwise be relieved adequately. In Canada, the Supreme Court said that natural death has become reasonably foreseeable, taking into account all their medical circumstances without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Studies have shown people who know that they are able to have, and are eligible for, voluntary assisted dying have better health outcomes because they know early what their condition is, how they can manage that and that they are eligible, and 70 per cent of people who are diagnosed or accepted as part of the voluntary assisted dying process go on to live quite long and do not ever access the substance. They learn to manage it. It is the comfort of knowing that they are eligible for it and are not going to suffer intolerably. I think that imposing a six-month restricted framework does not help the person at all, as studies have shown.

Victoria and Western Australia include the worst of both worlds and the message and outcome is you can access VAD but only when you have up to 6 months or 12 months when you are neurodegenerative, with more suffering left to endure - 'Yes, you can access voluntary assisted dying and you can start the process only when we think that it is a relatively good time or an appropriate time for you to have left. We think it is six months'. There are cases where people will take years and they would not qualify. One recent case was a firefighter from Australia who had to go to Switzerland to be able to take the substance because he would not be eligible under the Victorian law because of the time frame.

When people are not eligible because they know it is not within six months they will say, what other options do I have here? We know the options that some people take. Sorry, we do not think you are going to die within six months. But my condition is intolerable. I am suffering. Why do I have to wait to the six-month mark? If you cannot help me, what am I to do? What choices do I have if there is not a legal framework?

Why should this place dictate if somebody is suffering intolerably? We will put six months because that seems like a good time frame but in Europe and Canada they have not imposed that restriction. So with this safeguard that we are putting in, who is this safeguard for? I do not think it is for Mr Smith or Mrs Jones who are suffering intolerably. I think we put this safeguard in thinking, 'Well, if it is six months, that is not bad.'. What are we saying here? We are saying that the doctors, our medical practitioners, know. This doctor has just said it is really difficult. Some doctors will think, 'I do not think you will be eligible for six months and I am not going to make that decision because I am not quite sure whether you are going to live for eight months or nine months or 14 months so you are not eligible for this process.'.

However, that doctor knows you are dying. They are just not willing to commit at what time you will die so why cannot the person undergo the process? Why cannot they start their journey, have the first request? It does not matter if it is 15 months away if they are dying.

If they have satisfied the eligibility criteria, they do their second request and third request and in that last six months, as this doctor has said, it is impossible to predict whether it is going to be a slow pathway. It is not gradual. Sometimes it can go from six months to six weeks. Once it gets to six weeks, that person has six weeks to get all their affairs in order, first, second and third requests, and do all that work within six weeks. It does not make sense to me. Why are we putting this stricture, this framework in place? Why are we putting this in place, for whose benefit? I go back to my original where I said, the VAD process has to be person-centric. It has to be that.

Our legislation can be better than it is in Victoria and it can be better than it is in Western Australia because we do not have to play the politics in this place that they had to play in those places. That is the difference between this legislation coming from this place rather than downstairs where it has failed three times in a row. I know that we are going to get legislation through and I know it will be strong legislation. I hope it is the strongest legislation we can get for our community. I know the member for Murchison has the best intention with the six- and the 12-month time frame. I just cannot agree because 65 million people in other countries operate under a piece of legislation, a framework, that does not have that constraint.

Marshall Perron said, as most of you know, that it would be terrible if the Victorian and Western Australian legislation became the default position for Australian voluntary assisted dying legislation. He said that through his experience, the Tasmanian bill has better outcomes for people and is a better piece of legislation.

I encourage members not to accept the six- and 12-month constraint. I encourage you to let us show other states what we can do and let us be the leaders in this area and not the followers because that is what I think we are doing. I encourage members not to support the six- and 12-month constraint.

Dr SEIDEL - I thank the member for Mersey for his comments. I am a bit puzzled though, because the six- and 12-month prognosis actually are in your current bill and apply to a prognostic marker for patients who want to self-administer. It is already in your bill. From a logical point of view, to enhance the internal consistency of the bill, why do we have one way of definitions for people who want to self-administer but something completely different for the ones who are subject to practitioner administration? It did not make any sense from a logical point of view.

My second argument is that I am aware of the evidence from overseas. I have read it all, but we are not overseas - we are not Canada, Holland or Belgium: we are still Australia. I am mindful we do have legislation in Victoria that makes provisions for six and 12 months as a prognostic marker. This was adopted in the Western Australian model. If you want to go overseas, yes, in New Zealand draft stipulates six months and six months only. Why? Because it makes sense because this bill is about people dying, not necessarily suffering - suffering is not a good enough part to qualify for the bill, it has to be an active course of dying. That can be defined. Is it a barrier? No, it is not, because if you look at data from Victoria that was published on 2 September, we had over 314 patients who were eligible, 201 who got a permit for self-administration and 30 who got permission for practitioner administration. A substantial number of patients actually qualify under the provisions in Victoria. We are not failing patients. We are not failing patients if you put definitions in of six and 12 months; what we achieve is an increase in internal consistency, because it is already in the member for Mersey's bill. Six and 12 months is already in there for self-administration so it has enhanced the internal consistency and made it appropriate for all levels of administration. There should not be a need to distinguish one way or the other - it just does not make any sense from a logical point of view.

I do not want to aspire to have the most progressive bill in the world in one of the most underperforming health systems in the country. You still are living in Australia so if there is precedence in other states, we should look for consistency amongst other states. We cannot be too far out and the provision of six and 12 months as proposed by the member for Murchison would exactly achieve that.

Ms PALMER - This is end-of-life choices; one comment - I am sorry I cannot remember the member who said it - in the second reading debates was 'This is not a decision between life and death; it is decision between death and death'.

I wrote that down and I put it in my office. I keep referring back to it because this is death and death, it is end-of-life choices so how can we not have a prognosis of end of life? The community expectation, when I have been speaking to people, remembering I had to campaign on this issue, was, 'Yes, we want this option, but it is for when people are dying.'. What I have gathered, certainly in my electorate, is the assumption that people are making this is end of life. Putting a time frame where you know our medical profession, as best as they possibly can, can say 'Yes, we believe there is only six months left.'. The majority of the correspondence to my office from those who do not support this legislation has been anybody can apply for this. Well, no, they cannot. It specifically states 'a medical practitioner said you only have six months left to live', and they have used that as an argument against this legislation. I also think people are asking us to look after those who are vulnerable. This is another safety step, where the example is being used to me a number of times with aged care people, that an elderly person in a family could be coerced into thinking they are a burden on their family and this is an option for them.

Well, if their doctor is saying, 'Well, that is a load of rubbish, you could live for another 10 years', this is another safety thing. Isn't that what we are supposed to be doing? We want this legislation to go through, but there is certainly an expectation we put steps in place to ensure people are actually safe. It is another safety measure. We owe this to vulnerable people in our society - for me in particular, older people in our society - to have this step in the legislation.

Ms LOVELL - Madam Deputy Chair, I am inclined to support this amendment, I will be supporting this amendment, mainly for many of the reasons that have already been put by other members, that this is consistent with the provisions in the bill for self-administration. It is important to note that by adding this requirement for a prognosis for death within six months or 12 months for neurodegenerative conditions, that does not preclude the patient from starting the conversation earlier. It does not stop the doctor from discussing options with the patient, including VAD, much earlier than the six months prognosis starts.

For people who want to have this conversation, they may want to know what is happening, what their options are in the lead-up to their death, which may be 12 months, two years or a couple of months away. There are so many variables. Nothing stops that conversation from happening. The patient will know this will be an option to them once they reach the stage where they are dying, because that is what we are talking about.

The member for Rosevears and a number of members and I have raised the idea that many members of our community mentioned the idea that voluntary assisted dying is for me personally, and for many members of my community, about a choice between two deaths. I did the same as you, I heard that and wrote it down. That was actually Dr Cameron McLaren who said that. That is where I heard it. I wrote it down and referred back to it.

I understand the member for Mersey wants this bill to be patient-centred. I am not disagreeing with that as a concept, but I do not think it is wrong to address the concerns of the very workforce we will be relying on to implement this bill and to make this an option to members of our community. I do not think that is wrong. It might not be as closely aligned with a purely patient-centred bill as the member for Mersey would like it to be, but I do not think it is wrong. In fact, we are asking a workforce to implement this bill and to make this option available to members of our community. I actually would like to work with those people to make sure this is a model they are comfortable with. If it is not a model those members of that workforce are comfortable with, this bill will be no good to anyone if we do not have a workforce willing to participate. They have the option to conscientiously object, as they should.

The last thing I want to do is pass a piece of legislation that nobody wants to participate in, or that such limited numbers want to participate it limits access for people. The member for Mersey feels strongly about this. I heard his comments about playing politics on this and that we should not be playing politics. I do not think we are playing politics - what we are doing is working with the very professionals we will be relying on to make this option available to members of our community. I, too, am hopeful - in fact, I am optimistic - we will get a bill through the parliament. I am very optimistic about that, and for the fourth time lucky. We have to get it through this time. I do not want to put the community through this again.

But it has to be a bill supported by the health workforce, because if it is not, it will be no good to anyone. I will be supporting this amendment. I have some concerns about the second amendment but we will discuss that in terms of this particular amendment, including this prognosis time frame. I support it.

The other point I want to make is that in clause 5, not being amended, this will still apply, that -

> For the purposes of this Act, a disease, illness, injury, or medical condition, of a person is incurable and irreversible and is expected to cause the death of the person if there is no reasonably available treatment that -

This is the really important part for me -

> (a) is acceptable to the person ...

There are not many terminal medical conditions that left untreated would leave someone suffering for much longer than six months or 12 months. That to me is really important, that has to be there, that, if the patient says they do not want treatment, they do not want their condition to be treated, that is still going to be enshrined in this bill.

In terms of access for people, I am confident this will not impact greatly on people's access. The conversation can still start, people will still know that this is an option available to them. They can still make those decisions. The provisions in this bill for the formal request process to happen allow that to happen in a relatively short time compared to other pieces of legislation so once that time frame is reached, once that prognosis has been made, the process of getting the ball rolling and getting this underway is quite short. It can be done efficiently. I am supporting this amendment.

Ms ARMITAGE - Madam Deputy Chair, I will be supporting this amendment. I agree with the member for Huon and the other members who have spoken that it does bring consistency to the bill. When the iteration 13 came out, I went through and compared the bills in Victoria and Western Australia and the various differences. One of the things I noted, particularly with Western Australia, was the expert panel. We do not have an expert panel here; we have not had an inquiry or an expert panel come and put things together so I certainly agree with the last two speakers that it is consistent. It is also consistent with Victoria and Western Australia. I understand the member for Mersey and where he is coming from and I recall the doctor from Victoria stating that he preferred the bill before us because there was not the requirement for the six and 12 months in it.

Obviously, medical practitioners prefer this. I have spoken to many - some in favour, many against. The one thing that came out time and time again for those who were against this was 'If it goes through, we will accept it but we want it to be as safe and robust as it can be.'. I can accept that. I understand where the member for Mersey is coming from about the six months. There still is no reason, as was said by others, that they cannot start the discussion earlier, that they cannot start talking about it. Obviously, someone might think they have six months to live and they might have 12 months to live. How often do we hear that someone has only got a very limited time and then 18 months later you still see them and they are actually still quite well?

There are many vagaries with regard to times that people can have a terminal illness or the time that it might take for their passing. Most of it has been said by other members so I will not go on, but I certainly support it. It brings consistency. It is something the medical profession prefers and without the medical profession, we will not have a bill. We certainly need something that fits in quite well with its requirements. I support the member for Murchison's amendment.

Mr GAFFNEY - I will respond to some of the issues raised. First, we need to be careful saying that we will not have doctors being involved in this. On Friday, I sent a survey to RACGP and they forwarded it to all their doctors, and I came up with three scenarios: the six-month one, I put in a two-year one, if it was within two years, or an open-ended one. With the responses I had back, eight people said yes to six months; I had six people saying yes to two years; and I had three members saying yes to open-ended. Some of those actually said they would do all three. They would not mind if it was six months, two years or open-ended. Some said two years open-ended. Three said no to six months. They did not like that. Four said no to the 'no defined time frame'.

People might say there will be some doctors who will not operate in this space, If I take you back to Oregon, the first year that they started, in 1997, 22 doctors prescribed the voluntary assisted dying substance. Oregon has about 4.3 million people, which is eight times the size of our state. That would mean we would have to have four doctors who would be willing to undertake the training in this year. As we said before, we have 10 to 12 people who might do so. As far as doctors being involved, I do not think it is right to say that our doctors would not be involved. I think some will choose not to be but, as has been shown in Victoria, after the first six months of training, the numbers who have undertaken the training has grown to spread the load.

There was a good question from the member for Huon because I do have the six- and 12-months scenarios in the bill. This is what needs to be explained to people - why and how that came about. It came about because the 2013 and 2016 bills that came from Dying with Dignity Tasmania and went through the lower Chamber were focused more on the European model as a better way of operating than the Oregon model. In that they did not have a time frame so when it came to me when I was looking at this, and they said 'Will you carry the bill in the upper Chamber if it gets passed downstairs?', I was going to be carrying a bill that had no six months, 12 months to pass. When they realised that it possibly would not be passed down there because they did not have the numbers because of changing dynamics, they said, 'Would you table the bill?' When I tabled the bill, I said, 'If I table the bill, it has to be a bill that reflects me.'.

For the first iteration, if you think back to January 2020, I had only the European model on the Table. I did not have a six- and 12-month time frame and I did not have anybody privately self-administering either. You had to have a doctor present at the event. The Canadians call it an event. That is why I did that. Then I was quite taken aback by a lady in Devonport when I did one of my forums and she said, 'What right do you have to make me have somebody from the medical profession there when I take the substance? I do not want a doctor there. I do not want a doctor within 50 miles' - so either they had not had a good experience or they had just got their last bill.

What happened is that they did not want the doctor being involved and I thought, 'My bill is markedly different to the Victorian bill. My bill is markedly different to the Western Australian bill because I do not have a private self-administration clause in it so how can I mirror what is in Victoria and Western Australia and get this over the line? How can I come to a compromise?' My compromise was that once the person had done their third and final request, if within six months, or 12 months and they were degenerative, and were going to die, they could privately self-administer or it could be administered with a health professional with them. That mirrors the Victorian legislation.

However, how do we get somebody who might die, and here is a perfect case. A resident Bruce Yelle has a degenerative neurological condition that unfortunately for him does not fit easily into the parameters of the Oregon law. He has been diagnosed with a terminal illness but he could live for years with the illness, which will disqualify him from utilising the law to plan for the end of his life. He goes on to say he is also concerned that his illness will affect his judgment and this decline in his mental acuity will disqualify him from the law's requirement that he be mentally able to determine the time and manner of his death. What we have here is people who have asked their third request and yes, you have less than six months. You can either have a practitioner present or you can privately self-administer. But what about the person like Mr Yelle who will take years to die? How can we have access to those people who are suffering and those people who are dying but it will not be within the six months?

I introduced the concept that within that period yes, you can still go down the first second and third request, but at the time of taking the substance, you must have either a nurse or a doctor present. The reason is that it has to be voluntary; you have to have decision-making capacity. I did not want to have substances in the community that might not have been used. Someone dying within six months is going to have the substance. There is no issue with that because they are dying within the six months. Someone who might live for 15 months, but does not want to live that way - how do I ensure we do not have the substance out there? How do I ensure they are not being coerced? How do I ensure it gets done? I did that by introducing a medical practitioner - either a doctor or a nurse - being with them at the time of the event.

To me, this covers the Tasmanians who are dying, but they might be dying over a long time and they do not want to suffer. They might not die within six months. I took the best of what was in Victoria and Western Australia, and I put that here. I thought. 'How do we deal with the people who may die within two years? Why cannot they start the process down here - first request, yes, second request, so I am eligible - so I have some peace of mind, I can control what I am doing? Why are we saying you cannot start that? Yes, I can have a conversation, but I cannot start the first request. I can start the conversation, but I cannot start the paperwork. If I cannot start the paperwork and the disease ramps up, and I am left with eight weeks to live instead of six months, all the pressure is there.

There is no need for that. To me, it is not about dying within six months, it is about the quality of life and somebody dying over a certain period of time. The case of the 45-year-old nurse in Victoria who has a terrible skin condition which is going to kill her, but it is not going to kill her in five or 10 years. What will happen when her toes and fingers all fall off and she becomes wheelchair-bound? She has no quality of life, no independence and cannot qualify with Victorian legislation because of this six- to 12-month prognosis. That is why our legislation is a little bit different.

Ms WEBB - This is an interesting one, and I have given it a lot of thought. I took myself back to considering what this bill is fundamentally about. I regard it is fundamentally about a choice being made by a person about their life and their death. We are creating a framework within which we can be confident the choice can be made by somebody who we regard to be eligible and capable to make that choice and they can do it in a way that is safe and appropriate.

We can all probably quite readily imagine from what we have heard from our communities, what we read in the examples sent to us, and hear directly from people's personal anecdotes, is that people generally want to live as long as possible, with the best quality of life they can achieve, and have precious time with their families particularly. They want that to last as long as possible. There are very rare times when people would choose to cut that short, other than for absolutely extraordinary reasons - and typically those reasons are suffering.

Typically, the reason somebody would like to choose to bring their life to an end, within this context of already dying, but having the choice about when that occurs - that choice occurs when somebody, on the balance of things, feels that their suffering so far outweighs the value they place on their life, and their time with loved ones, that this is the right choice for them.

What we are doing is setting up a way for people to give exercise to that. We have established in the bill, as it stands right now, in this clause, that one of the things the person has to have is a relevant medical condition. Here, as it stands already, we have already clearly established that this relevant medical condition has to be advanced - not in the early stages, not in the mid stages. It has to be advanced, it has to be incurable, there is no hope of recovery. It has to be irreversible. We cannot take it back to an earlier stage and make them better. It has to be expected to cause the death of a person. It has to be terminal.

The bill establishes this really clearly in the definition that is there. There is absolutely no opportunity in this bill, as it stands, for any claims that, for example, anybody could apply.

If members of the public have come to members here with that concern - and I have had some come to me with that concern, that anyone could apply under this - I hope everybody else has done what I have done and explained very clearly to those people that this bill, as it stands, certainly does not allow for that.

This bill, as it stands here, under the definition of 'relevant medical condition', requires that the condition is advanced, incurable, irreversible and terminal. That is a given. The fact there is an articulation that there is a community expectation that people are dying, again that is here, it is in the bill. The bill expects that, too.

The bill gives expression to that community expectation, because it requires that the condition is advanced, it is incurable, it is irreversible and it is terminal.

We meet the community expectation with this bill, as it is drafted. We have captured it in the definition. It is not open-ended. The person is facing death quite clearly in that definition.

The fact there is not a time frame put on it is, I think, absolutely essential for keeping the person - each individual person - at the centre of this process.

What we do here - remembering that people will come to this process with their own unique circumstances, and fundamentally they will want to be availing themselves of this opportunity at the latest possible time for them in terms of the balance of those things I spoke about before. They will know, in their circumstances, when that balance point is reached.

If they meet the conditions we have already put there - advanced, incurable, irreversible, terminal - that point should be unique to them. That point should be a decision that sits with them, within the eligibility described in the bill.

There are multiple examples that the member for Mersey has already given - and we could come across and/or think up vast numbers more - where individual circumstances would be impacted and excluded by the inclusion of a prognostic time frame.

The member for Mersey gave us some examples of that already. The example of the fellow who may live some years, but will degenerate - and perhaps cognitively degenerate - before a time frame would kick in, and therefore never be able to access this choice that they clearly wish to access, is a compelling one.

It is an interesting argument to make that we are including a prognostic time frame here for the sake of the medical professionals. To me, that immediately invites us to surpass and displace the person at the centre of the process and the decision. I think statements like 'It has to work for the medical professionals' and 'If it does not work for the medical professionals it will not work for anyone' are not correct, and are misguided here as a rationale for this amendment.

I agree with the member for Mersey in the way he expressed this, and that is of course that there is a variety of views amongst the medical professionals right now. Some will never agree with this. Some will never participate in this. Some at the moment are probably a bit ambivalent, may hold some concerns, and they will wait and see. Some - and it may be quite a small number - but some may be ready to become involved, and to participate in this process if, and when, it comes into play in this state.

The reality is that we do not need every medical professional in this state to feel entirely comfortable with the process laid out here, because they never will. We will never get that.

What we do need is for this process to be appropriate and functional, legally sound, and keep the person at the centre of it. We can implement that after this period of implementation, when we develop all the things that sit around the bill. When we develop the training. When we develop the regulations. When we do the consulting and engaging with the professionals, with the community, and we get to the point of implementation, we will arrive there. I absolutely guarantee we will have medical professionals in this state at that time who would participate in implementing this process, or participate in this process, right then.

There will be some who never will, and some who will wait and see. If we are likely to follow what has happened in other jurisdictions, we can look to them and see that beyond those initial - perhaps small - numbers who are ready to go straight off to bat, we will grow the numbers of medical professionals, because they will come to understand and see in practice that it is not necessary to have a prognostic time frame, because the very process itself delivers people coming to it at their latest individual unique point of their journey in their terminal illness. It is likely to be within the time frames that this amendment seeks to legally impose. It is likely to be - but by not imposing it in the legislation, we allow for the unique exceptions. We allow for those.

In allowing for that, what do we lose? Do we lose a safeguard? I do not think we lose a safeguard, because I do not think a prognostic time frame is a safeguard. I think it is a comfort measure for some medical professionals. It is not a comfort measure for all, because there will be some who do not need that comfort, who would be happy to operate, and understand operating within what is in the bill now.

I do not think it is a safeguard, because the people themselves who come to this process are already coming to it at the latest stage they feel the balance has been achieved, within the eligibility that is there. I think the legislation is actually more robust without a prognostic time frame. It allows for the unique situations that can and may arise. It is interesting to hear the member for Huon talk about the Victorian statistics and point to the fact the legislation in Victoria is being used, people are being supported to access VAD under it. That is true, we can see that in the statistics. But those statistics do not tell us who had to wait to get a prognosis of six months in order to access it and what was the impact of that waiting. It does not tell us that in the statistics.

The statistics also do not tell us about patients who would have liked to access this process to achieve the death they preferred, but were prevented from doing so because there was no opportunity for them to get a prognosis of six months. We do not know what impact this had on them and their families as it is missing from the statistics.

We do not know who has fallen through the cracks in Victoria or in Western Australia because of this legally-imposed requirement for the apparent comfort of medical professionals. That is a shame. We probably would never know that. Perhaps what we might be able to do in Tasmania, if we were to have this bill go through without a prognostic time frame, is we would be able to demonstrate back to those states an example of a bill that did not require prognostic time frames, and has achieved the same ends, has not delivered adverse outcomes and could encourage them to then advance and improve their legislation to then mirror ours. I do not think we need to go backwards to repeat what they are doing for consistency; we should do what is legally and humanly the right thing to do by not putting in this prognostic time frame. Inviting them to come and mirror us at a certain point down the track when we show them it works well that way, is more humane and as legally robust as it needs to be.

What does this preclude if we include it? What does it preclude for people? It does not preclude discussions, I agree with the member for Rumney. People can absolutely have discussions outside of a prognostic time frame of six months, but it certainly precludes any progress into and through the actual process. This is a multi-staged process. It is one people would prefer not to rush. It is one people would prefer not to have to do all of a sudden if they suddenly find their circumstances change, then have to get through the stages in a very short period in order to be able to access it before the time they may die, and die in what would likely be heightened suffering.

The fact the second part of clause 5, which talks about treatment being acceptable to the person, does not give people an appropriate out here if the implication is, if you are outside the six-month diagnostic time frame, get yourself into it by refusing treatment. This may be treatment that actually is essential to your quality of life to make the most of your last time, in order to advance your condition more quickly to access this is a really perverse thing to expect people might do.

I do not think we can sit back on the fact people could say, 'Well, treatments are no longer acceptable, I will advance my condition by withdrawing treatment so I can get a six-month prognosis so I can access voluntary assisted dying.'. That appears to me to be cruel and unnecessary. I do not support this amendment. It is a backward-looking, unnecessary inclusion into this bill. It does not provide a safeguard required beyond what is already contained. It is the tail wagging the dog. It is the medical workforce - some parts of the medical workforce perhaps - making a demand that is not reflective of the whole medical workforce, one that actively works to displace the person from the centre of this process. To me that is just simply wrong, so I will not be supporting the amendment.

Mrs HISCUTT - I just wanted to get on the record - and I will not be repetitious, but I will say the relevant medical condition as explained by the member for Nelson is absolutely correct the way it is put there. I do not think you need to put more time frames in. How many times have members heard that people have only been given six months to live and then they go on for two years or the opposite? It does not happen a lot, but you certainly hear of that happening so to put that onus on the medical profession is fairly daunting, I imagine.

Even among themselves, doctors cannot decide, or with the doctors spoken to by the member for Mersey, they could not settle on a good spot either. Amongst us and amongst them, we do have to settle on a spot somewhere so we are all trying to get the best bill we can. I was going to ask too about the conundrum between the time frames in this part of the bill and later in the bill. I think the member for Mersey covered that very well and he has satisfied me that the amendment, the clause as it is here, is satisfactory. So unfortunately, I will not be able to support the member for Murchison in this particular amendment.

Mr VALENTINE - I am actually fighting myself with this and I looked forward at some other amendments with regard to 'anticipation'. The one thing that concerns me about not supporting this is whether 'anticipation' still is there. The representations I have had focus on this business about 'anticipation' of suffering where people are concerned that people are going to be able to access it, and it needs to be. I actually mentioned in my second reading contribution that I think it is about two deaths and about choosing the more comfortable of two deaths, not between life and death.

If a person is going to anticipate their suffering, that needs tightening up. I think this tightens it up a little - correct me if I am wrong, member for Mersey - but I think this takes the anticipation out of it by tightening it up. I really appreciate listening to all the different opinions around here. This is what this Chamber is all about; it is about getting it right. I appreciate the erudite way people express their opinions on this particular matter. I am inclined to support the amendment because I think it moves closer to taking out the anticipation of suffering at the end of the day.

Mr DEAN - I have listened to the positions put forward in relation to this amendment and at this stage I am inclined to support it. The first question I want to ask of the member for Mersey is: of all those doctors you approached over the weekend, did all reply or just only some of them?

Mr Gaffney - I sent it through the Tasmanian branch of the RACGP and they put it out to their members. They had about 15 members and three doctors who were not part of that group also responded to me. That is where I got my numbers from. It was not an extensive survey. I had heard people saying that doctors were not going to support it, and so I put some options out there and that is the information I received from them.

Mr DEAN - From that, I take it that doctors are supportive and not supportive, probably more supportive of the time frame.

Ms Forrest - How many members in the RACGP are there? About 600?

Mr Gaffney - There are a lot. I made it clear when I sent it out and that is the response we got back. So when people were saying nobody would support it, that was not on the brief spot that I had with 15 or so of them responding. Several of them had commented, yes, they would support it, whether it was open-ended or whether it was a two year or a different time.

Mr DEAN - It would have been good to have known just how many it went out to because only that small number came back with a response. From that one might assume doctors are perhaps ambivalent. A lot of doctors will accept whatever the position is that might come forward; I do not know. I am not quite sure what I can accept from that but the fact that you only had the small number reply sends some message to me.

Whether we like it or not, there are many people out there - and I have had many, as all of you would have had - saying that an end-of-life choice is a form of suicide. Whether we like that angle or not, that is what a lot of people are thinking. When I take that into account, my view is that if a time frame is put in, perhaps it would strengthen the position that is not the case. I hear what the member for Rosevears says and whoever it was raised during the second reading debate about it is not a choice of life and death, it is a choice of death over death. I take that further, the way I see it, it is a choice of death with pain and no quality and a quicker death and removal of pain and intolerable suffering. That is the way I see that in this situation.

Of course, doctors get it wrong from time to time, as we all do. In all professions we get it wrong at times. I might say here that in situations involving my family where I have had a number of deaths unfortunately, doctors have got it right in almost all cases with the exception of one I can remember, where they were not quite right. Other than that, they gave a good indication of time left for my family members, and they did that because of their background, the history of the patient they were aware of, and of having been the doctor for that person for a long time. They were fairly accurate with their assessments in the circumstances. Doctors frequently put time frames around expected death time of a person, and they will give you a good idea. With my brother, they were very accurate with what they assessed would be the time he had left with us.

My other point is, and I will not be going on for a long period, that this bill has written into it a review period, and the first review period, I think, commences three years after the bill commences. If this amendment is supported and if it is not working and is creating and causing problems and doctors are finding it very difficult to work with and a lot of other issues that come out of it that do not support the time frame being an acceptable or good position to have in this bill, it can be changed. One would expect to get an amendment coming back on this bill at the end of that three-year period. That is what the review period is about. It is looking at how this bill will operate, how it is working, whether things can be changed to make it a better bill, a stronger bill and no doubt the medical profession would be listened to very closely in any review that is going to take place.

Having considered all of that and weighing it all up at this present time, I am inclined to support the amendment but I will listen to any other contributions that are being made.

Ms FORREST - I want to address a few of the points made during the debate. I thank the members for their comments and contribution on this. The reality is that we are dealing with a bill that is contentious. It raises significant and ethical questions, and we need to be alert to those and to community expectation. As the member Rosevears said, she had to campaign on this effectively and would have been asked at almost every door because it was one of the things, every time any of those candidates were asked for comment in the media leading up to the election.

Ms Webb - Same thing last year when we campaigned on it in my election and were asked about it constantly.

Ms FORREST - I am not disputing that it was very fresh in this last one. Not only that, I am not up for election yet but even my office, in the street and everywhere you get asked about it. Certainly, I have been asked by the media since the bill has been on the Table. The reality is when you talk to the broad community, people who support it in principle - including religious people who support it in principle - support the fact people are actually dying. As the member for Rosevears said, this is the voluntary assisted dying bill. People are dying when participating in this, and what we are talking about here is a prognostic time frame for them to actually start a formal process of access. It does not stop you from getting all the information a patient might need or a person might need. It does not stop them having multiple conversations with their doctor, their families - hopefully - and with any other health professional they come across. Obviously, when they have a terminal condition, they will be having conversations with a range of health professionals. It does not stop any of that; in fact, it will help them potentially be more prepared for that process.

What this does is put in place an expectation this person is likely to only live six months or 12 months, depending on the nature of their condition, before they can start the process of the first request, second request and final request. It is person-centric in that at that time, the person then knows they are on that pathway. It is the default position, which is what the community expects.

Ms Webb - That is a very sweeping statement because we have not asked the community on that.

Ms FORREST - Haven't you?

Ms Webb - No, of course I have, as you have, but you cannot make those sweeping statements about the whole general community.

Ms FORREST - I can about my community.

Ms Webb - Okay, that is fine.

Ms FORREST - That is whom I am talking about. This is what they tell me when someone is actively dying. I hate to go down this path, but I will talk about putting down animals. The member for Windermere talked quite emotionally about putting down his dog, but you do not put your dog down unless they are actively dying either. It is relieving that suffering at that point where the animal's life is too unbearable according to the assessment of the owners, and you know your animal better than anybody. This is what people in my community say to me, 'We do not let animals suffer at that point.'. This is what we are asking is for - a prognostic time frame to enable a person to formally start the process of access. Not the conversation, as that conversation can happen anytime and the reality is it will happen with the medical professions caring for these people. That will give the comfort of knowing that it is available for them to start on that process when they are facing their death. We are not debating the second amendment now, but there are the rare occasions, and my second amendment deals with those as the exception not the rule. Exceptions should be the exception. A default position should be what we would expect for the majority of people. If there are rare, unusual or really unique circumstances, there is a process in that second amendment whether it is supported or not. That is another matter for a later debate. This process is similar to the same process in the other states that have dealt with legislation.

There is some merit in having fairly consistent legislation across the country, but that is not the reason I am supporting it or proposing it. I am a little bit disappointed it was suggested it was playing politics, as was done in the other places, other states, because it was governments that brought in the legislation.

I pride myself on not playing politics in this Chamber. This is not a Chamber to play politics, and it should not be. This is about listening to the community, listening to the health professionals who will work with it and respecting their views, knowing there will always be people who disagree vehemently with what we do here in an ethically very difficult debate, and those who support a very open process. Somewhere in the middle is the acceptable solution, if you like.

As the member for Huon and others have mentioned, there is a six- and 12-month prognostic time frame in the bill for self-administration. For the member for Mersey to say it is too hard for the doctors, well, the doctors are going to have to do it then. They are going to have to do it if a person wants to self-administer.

What I also hear from the medical profession is that the default should be self-administration. You should be taking the medication substance yourself, unless you cannot, because that is what it is about. That is another debate for a later time as well.

Doctors will be required to make prognostic determinations. The comment by the member for Mersey that he does not want to see substances in the community that might not be used, well, that is the reality with the bill the way it is currently framed. The people who are seeking to self-administer, who have that six- and 12-month prognostic determination, will have the potential to have this substance in their home, appropriately stored, and it may not be used. They may die of their condition before they get to take it.

We saw in Victoria that something like 32 times the people did not take their medication, and it had to be returned to the pharmacy or pharmacist. There is a risk associated with having a lethal substance out in the community in someone's home. It is a risk we have to accept if we are going to allow people to self-administer under this framework. It is contradictory to say you should not have a prognostic time frame at the front end if you can have one in the self-administration phase, because the same assessments by the medical staff have to be made - so if they can do it at that point, they can do it at another point. The same doctors are making the same determinations.

Before the person actually starts the formal process - and if they did not have the six-month life expectancy, maybe 12 months - they can start the discussions and getting all the information they need. They can discuss it with their family, so everyone knows they wish to do that. The comfort is still there, knowing it would be possible and available, and if their condition does deteriorate quickly, the process within the bill as set out - and it does not interfere with that - can occur quite quickly. Say, it is going to take the six months to do it, well, no, it will not - not if that person's condition is deteriorating quickly. There are provisions in the bill for it to happen - I think the shortest time frame is about 48 hours, if it needs to happen that quickly. If someone's condition does deteriorate that quickly, or there is a risk they are going to lose decision-making capacity, it can be acted upon.

We need to be realistic about this. I hope the member for Montgomery might reconsider her position here. This is not making it a barrier. I do not necessarily think it is even making it safer. It is making it appropriate for the purpose of someone who is wishing to have assistance to die at a time when they are dying. They can get all that information ahead of that time. They can be prepared and understand when they can make their first request, how they progress to the second request, and what the process of the final request is. This does not change any of that. It means you do not start that formal process until that time is met - unless we get to the exceptions where there are unusual circumstances, such as the nurse with the skin condition.

We should not be making legislation around a particular case, and we are not. That should be the exception, and that is what my amendment seeks to do.

I urge members to support this amendment. It provides some clarity around the intent - that it is about actively dying, and support and assistance with dying. It is not a barrier. It is about enabling that process to occur in an appropriately timely fashion.

As we all know, later in the bill there are mechanisms to enable that process to be done quite quickly, should the need arise.

Mr GAFFNEY - I thank honourable members for their contributions. Just a couple of quick comments before I go to another space. I have to put this on the record. We spoke about this in the second reading debate, when the member for Windermere had the issue with his dying dog. I have to make it clear again, and everyone knows, that the difference here is that with a person, they make the choice themselves. It is not making it for them.

To go back to the member for Murchison's analogy, about you know the dog is dying - that is not always the case. I had a dog, a West Highland White Terrier, Hamish. He developed really bad feet. Every time he walked or ran somewhere, his feet would cause him to cry. But every time you walked through the gate, he would run to you. He could have lived for three or four years with that condition, because his heart was fine, his liver was fine, his lungs were fine, but his feet were suffering. So, we made the decision to have him put down, because he was suffering intolerably, but he could not stop his reaction. Every time you walked through the gate, his buddy would run up to us, so he would run, and he would be crying all the way there. He was not dying, but he was suffering. So, to use the animal analogy, what we did, we chose for him not to suffer.

But it is not the same with humans. It points out that you do not have to be dying to be suffering.

I probably did not make it clear enough but the reason for the private self-administration we have after the third request is that the person is dying - they go through a process, they have a contact person, they get the medication or the substance, they do all the appropriate things, and that is fine.

The difference down here is that a person has to be with an AHP - a medical practitioner, that is - at the time of taking the substance, the person has to have decision-making capacity and be acting voluntarily. That is why you do not give that person any substance, because they may not have to take it until way up here. At the time they choose to take the substance, that is when the AHP would deliver, be there while the event was taken, and if the person died before it, would take the substance back or whatever.

That is the difference between the two. Even at the AHP event, where a health practitioner, the nurse or the doctor is present, the person can still self-administer if they are able to. They can have it administered by the AHP. They can have it set up so they use it with the AHP, and the AHP can administer.

I am trying to cover all bases. This is where we have drawn from experience from Victoria. We have gone to the doctors who are in that space. Dr Nick Carr, who we have heard, and had briefings, he plays in that space. That is a really bad word, but he is in that space. None of the other Tasmanian doctors, as far as I know, are in there, because we have not had the legislation there.

But he says one of the advantages of the Tasmanian legislation is that there is no requirement for the patient to have a specified prognosis with their terminal illness -

> In Victoria, the need to provide a prognostic timeline has proven to be a significant stumbling block. In reality, almost no doctor can say how long a patient who is terminal has left to live. The requirement to provide a prognosis has paradoxically made some doctors hesitate, so that patients only become eligible for VAD care when it is in fact too late. The removal of this barrier would be likely to enable patients to begin the process at a more appropriate time.

This is a doctor who operates in that space.

I spoke earlier about the Tasmanian doctor, Dr Henderson. I mentioned Dr McLaren before, but for those listening, Dr McLaren has been involved in over 100 cases of application for VAD in Victoria. More than 50 of his patients have received VAD medication and more than 40 have chosen to take the medication. He has been present in support of patients and their families at over 30 administrations of VAD medication, including seven cases where practitioner intervention was required.

He says one of the advantages of the proposed Tasmanian bill is that it -

> removes the requirement for a short prognosis and instead focuses on the suffering of the individual. It seems cruel that we must tell some of our applicants in the most amount of suffering that unfortunately they have not suffered enough and must wait as their prognosis is unclear.

Here we have two doctors who work with the Victorian legislation and they say that the Tasmanian bill is better the way it is written. I am sensing in this place that we are not going to take any notice of what they have experienced, the people working in that place.

We are going to stay in the safe zone that was introduced 12 months or 15 months ago, and by the time it comes in here, it is going to be four or five years since the Victorian legislation and we have not moved on from this. That is what concerns me.

I thank the member for Nelson for her contribution, but I do not think I have convinced enough people and so this amendment from the member for Murchison will get up. She speaks very well. I understand that.

In light of that, I have an amendment to the amendment that I will circulate now. The reason I did not circulate this amendment before is I was really hoping I would have had the numbers not to and that we would have, the bill as it stood, but with the member for Murchison's six and 12 months I think that will get through so now is the right time for me to move an amendment -

Ms Forrest - It is a bit disappointing when we have been so up-front with all of ours but anyway -

Mr GAFFNEY - Thank you, member for Murchison, for that.

Ms Forrest - It is a bit disappointing when we have been up-front with amendments to amendments and things like that, that we just get it now. We have not had time to even fully consider it.

Mr GAFFNEY - Well, I have just explained the reason why. My first preference was as the bill stands. You put up an amendment, which is fine, and we now have the honourable member complaining -

Ms Forrest - I understand how that process works. I think I have put up ones that I necessarily will not move depending on how other ones go. It is just the point that I think it would have been helpful to know this beforehand. That is okay, but I just think it is a bit disrespectful of members.

Mr GAFFNEY - Point made. That is fine.

Madam DEPUTY CHAIR - When all honourable members have received their amendment, I will ask the honourable member for Mersey to proceed.

Amendments to first amendment -

Mr GAFFNEY - Madam Deputy Chair, I propose that the member for Murchison's amendment to clause 5(1), definition of relevant medical condition, at paragraph (c) be amended by -

First amendment -

After 'expected',

Insert, 'on the balance of probabilities'.

Second amendment -

Leave out all the words after 'death of'.

Insert instead 'the person within 2 years'.

I put on the record that I also support the member for Murchison's next amendment for people who may be outside that in exceptional circumstances. I have gone down this path because in the briefing the member for Huon raised a question about doctors being regularly asked to make a two-year or less diagnosis to enable terminally ill people to access their superannuation on medical grounds. I think Dr McLaren said that it was easier perhaps to have a prognosis of two years than it would be of six months.

I am also suggesting this because, as the member for Murchison said, somewhere in the middle we might have an acceptable solution. I think the two-year time frame is a reasonable assessment that will allow the person to start the process, get the first, second and third request and be diagnosed if we actually have it somewhere in law already in Tasmania.

The Asbestos Compensation Commissioner's annual report points of interest reported that 16 applications for assessment were made in 2018-19, and one of its criteria is that a life expectancy of less than two years is a key eligibility criterion. Already in our law with asbestos compensation, with the commissioner, they have that as a key criterion so they use that as an eligibility criterion. I would have preferred not to have any prognosis time frame, as you have heard and as we have debated. On the other hand, we had the amendment put forward by the member for Murchison on the six and 12 months. I am now saying that we should arrive at a two-year time frame period which to me is a compromise and would assist those people getting themselves organised, even though they know they may be dead within 12 months or 14 months.

They know their condition is terminal; it has to say that in the eligibility criteria. That is already in place so therefore I believe this is a fair and just compromise in the position from there to there, arriving here. I would hope that members in this place would say, we understand it could take away some of that rush that we might have. I will go back to the member for Nelson, humans inherently want to live. No-one would take out this process unless they absolutely have to and just because they start at two years does not mean they rush through the event. It is just the administration side of it which will give them some comfort, knowing that that are eligible.

It allows someone to get their affairs in order in a reasonable and a timely manner and fashion. I would like to think that those people in this place who were on the fence about this would think, that is not a bad compromise. In three years time when the report is done if there have been issues they can be picked up there. I would rather use that as a starting place than the Victorian or the Western Australian legislation, especially when doctors who have operated and played in that space and have done it a lot - because as we know, Dr Maclaren was only one of the medical oncologists, one of the few, who was willing to do that in that place. He has two young children. He has put himself out there. He is saying to us that our legislation is better.

I would have preferred that scenario, but now I think that if we can go back, the idea on the balance of probabilities means that with all the information and all the knowledge doctors can have and share and get together on - the balance of probabilities means that 'Yes, we think it might happen so you can start the process because you are eligible.'.

I think this is a step in the right direction. and it gets us away from the default model. Other people have said the Victorian and Western Australian legislation should not be the default model in this country. I have compromised on the understanding that I would not have got six and 12 months, but this is a fair and just position. I would like members to think seriously about this - I know you will - and please give this consideration as a good amendment to the amendment and vote for the two-year term.

Madam DEPUTY CHAIR - Before I call members for the question of the amendment to the main proposed amendment, I remind members you all have three speaks again.

Ms FORREST - I cannot support this amendment because there has not been any time for consultation. Had I known this was a potential amendment, I could have actually talked to the health professional I have been dealing with and others, even members of my community, about this. It makes it really hard to now say 'Well, okay, this is a fair compromise' when it has not been something I have had any time at all to consider. The balance of probabilities is not such an issue because it does not matter whether it is six months, 12 months or two years. But certainly I do not believe the second amendment is something we should just do on the run. I have not had any time to consider or consult on it.

This could be something that would be considered as part of the review, the first review being three years after it commences, as the member for Windermere referred to. The comment made by the member for Mersey - it gives you a bit more time to consider going through the process, but a person who might have two years to live potentially could have a rapid deterioration of their health. They might decide they just do not want to have any more treatment for their cancer, or whatever it is, and rapidly go downhill as a result.

All those same arguments that were put do not go away by doing this. It may be an appropriate measure, but without time to consult, and I have consulted quite deeply on my amendment, I believe it is not the right thing to do at the moment. I will not be supporting it.

Dr SEIDEL - I must admit I am actually disappointed by this. None of us have prepared amendments we put in the drawer to pull out just in case something does not work out. We have all put our amendments forward as soon as we really could so they would be made available to all members for their consideration.

Mr Dean - I have had some amendments in and out five and six times.

Dr SEIDEL -That is exactly right. That is how it is meant to be. I am really uncomfortable with that. We are now asked to make a decision within five minutes. But the reason I am really upset is because it is a really good example of how things are not being done. This is really how politics are being played. That is politics - I will tell you why: when I asked the expert witnesses specifically about the 24 months, I did this in the context of when they said doctors cannot give an accurate prognosis, and it has not been done.

I had two expert witnesses and both of them said doctors cannot give a prognosis accurately. I knew that actually is not true. If you look at international evidence, doctors certainly can. There is plenty of evidence out there. If you want to look it up, look at the surprise question, where doctors certainly are able to predict prognosis over six- and 12-month periods. Conclusive international evidence, actually very expert, how doctors can do it with the information they have been provided for two scenarios.

One scenario is: is the patient still going to be alive in 12 months time with medication and treatment, or is the patient still going to be alive in six or 12 months without treatment? It is actually possible to provide international evidence. The second reason I asked was because when you specifically look at scenarios for doctors who are asked to give a prognosis, doctors are doing this routinely, with regard to early access to superannuation for patients who have a terminal condition and a life expectancy of 24 months. Doctors do this. On average, it is 4000 times a year that it happens, so doctors actually can do that.

The point I wanted to make is doctors are well capable, that is number one, and they are actually doing this on a routine basis. But to be frank, access to superannuation is a completely different context compared to somebody who is actively dying. It is completely different. The premise of asking for early access to superannuation is to have a life as much as possible and have the financial means to actually enjoy that as much as possible. This is not about terminally ill patients who said, 'No, I need help in dying'. You are putting the question of prognosis in a completely different context. From a medical, academic and scientific view, we cannot support that and I stand by it. I am disappointed and think it is politics.

Mr DEAN - I am convinced a time frame ought to be in this part of the bill at this stage. This is a bit of a surprise, I must say - we have been talking about this for a long time. We are not going to get through a quarter of the amendments by midnight tonight so this matter is not going to be resolved today. Would the member for Mersey give support to this clause being postponed for the purposes of allowing members to have some time to give it more consideration in the circumstances? We can still proceed, we could simply postpone this clause and still proceed with the bill.

Madam DEPUTY CHAIR - We have two sets of amendments before the Chair at this point. We already have the member for Murchison's amendment; she would have to withdraw her amendment. We have the member for Mersey's amendment, which would also have to be withdrawn to be able to postpone the clause.

Mr DEAN - I am not sure where the members for Mersey or Murchison would sit in relation to that, but if we could get a better position in relation to the amendments currently before this place, I think that would be in the best interests of this bill rather than members having to decide this matter on the spur of the moment. I would certainly like some time to consider this. As I said, I am convinced at this time a time frame should be in there, because we have the review period coming up, three years later on after the bill is enacted. I am fairly convinced it will get through.

All of us received the information from the Queen's Counsel in Victoria yesterday where they are saying very clearly that there needs to be a time frame in this bill. They said that in relation to relevant medical conditions this definition is very vague, and they give an example as to how and why it is vague and their understanding. The example given is diabetes - it is incurable and irreversible, but it is still be able to be managed and treated satisfactorily. There is no time frame stated in relation to expected death, so is this degree of vagueness acceptable?

I am satisfied it needs to be in here, but I am just testing the Floor as to whether the appropriate courses of action could be taken to have this clause postponed.

Mr GAFFNEY - I am more than comfortable to postpone this clause. I make it clear that I would have preferred the bill to stay the way it was written. I have made it very clear that was my preference, and I wanted to argue about that to see if I could convince the Chamber to vote that way. The member for Murchison put up her amendment and at that time, I thought I was going to lose this. I then presented the other amendment with the two-year option, but did not want to put that on the Table to start with because people might have gone there to start with, before listening to what my preference would be. I am more than comfortable for people to have time, because we are not going to get through this bill today. We will be back in two weeks time on 27 October, and hopefully doing it. I am more than comfortable to allow people to have time to see whether they examine two years.

Madam DEPUTY CHAIR - In that case, the member might like to seek leave to withdraw his amendments. I will take some advice.

Mr GAFFNEY - I seek leave to withdraw my amendment to the main amendment.

Ms FORREST - Madam Deputy Chair, as I pointed out in my opening comments before we started this process, if the member for Mersey were to withdraw his, could you enlighten me as to how many calls I have had on my amendment?

Madam DEPUTY CHAIR - Two.

Ms FORREST - So I have only one call left. The risk is that I have one call left to re-put my amendment. I have extensively consulted on the proposal I put forward. This is something which, if necessary, can be reviewed as a three-year review. It creates an inconsistency with the six month- and 12-month provision for the self-administration already in the bill. It creates another time frame. I would not be happy to withdraw my amendment because I have already had two speaks and it has been well prosecuted. If the member wishes to withdraw his amendments, that is his business obviously, but I will not withdraw mine.

Mr GAFFNEY - If that is the case, Madam Deputy Chair, I will proceed with my amendment to the amendment because otherwise if I do not, it will not get a hearing. I would have been more than comfortable for members to have had some time to do the research on it. It is not a lot of difference. It is talking about the 18 months and the two years right at the beginning. This is whether you are going to agree with the two-year time frame. I am happy for the amendment to the amendment to be put to the members.

Madam DEPUTY CHAIR - Are you going to seek leave to withdraw yours?

Mr VALENTINE - Point of order. It says there is a motion before the Chair for the withdrawal of -

Madam DEPUTY CHAIR - The member will need to invite members not to support your seeking leave and to vote against it. We cannot just leave it.

Leave denied.

Mr GAFFNEY - I have nothing more to add now. Everyone has heard the case. They have seen where it is going and I am putting it to members. That is it.

Madam DEPUTY CHAIR - The question is that the amendment to the main proposed amendment be agreed to.

The Committee divided -

AYES 4	**NOES 10**
Mr Dean	Ms Armitage
Mr Gaffney	Ms Forrest
Mrs Hiscutt	Ms Howlett
Ms Webb (Teller)	Ms Lovell
	Ms Palmer
	Ms Rattray

	Dr Seidel
	Ms Siejka
	Mr Valentine (Teller)
	Mr Willie

Amendments to first amendment negatived.

First amendment -

Mr GAFFNEY - I will vote against this, but I will be supporting the next one because I think that is a compromise as well. It will support some people who will be able access that. I thank you for the work you have done in that area.

The Committee divided -

AYES 11	**NOES 3**
Ms Armitage	Mr Gaffney
Mr Dean	Mrs Hiscutt (Teller)
Ms Forrest (Teller)	Ms Webb
Ms Howlett	
Ms Lovell	
Ms Palmer	
Ms Rattray	
Dr Seidel	
Ms Siejka	
Mr Valentine	
Mr Willie	

First amendment agreed to.

Clause 5, as amended -

Ms FORREST - Madam Deputy Chair, I move -

> That the clause, as amended, be postponed.

With the indulgence of the Chamber, I ask that we postpone the amended clause to deal with the second amendment after clause 7 or later because clause 7 deals with the 'commission' versus 'commissioner' approach. Rather than recommit the clause, we will just come back to it later on and debate it than. The advice of the Clerk is that this might be the tidiest way to manage that.

Mrs HISCUTT - I have a question on the substantive amendment; this might be the time to do it. To the member for Mersey, I just want to get it in *Hansard* and clarified that this 'relevant medical condition' does not include depression as a standalone illness.

Mr GAFFNEY - That is correct.

Clause 5, as amended, postponed.

Clause 6 -
Relevant information about eligibility

Mrs HISCUTT - Clause 6(e) -

> whether the person is suffering intolerably in relation to a relevant medical condition.

Can the member put on the record how 'intolerable' is measured? In my second reading speech, I said that some of my nieces wear 'intolerable' shoes - which is totally irrelevant to this conversation - so how is this measured to be 'intolerable' in this context? Do the doctors do it on a 1 to 10 scale? How is 'intolerable' measured?

Mr GAFFNEY - In various legislations in other countries, they use the word 'intolerable suffering' as an expression of what the doctor would assume from the medical condition they have, and their details and their backgrounds, and on their notes on the medical history, whether it is reasonable to assume that the person is suffering intolerably.

Therefore, your nieces being upset about their dresses would not pass the test. It is on their background, their medical history, the diagnosis of that condition, on past experiences, on the pain and suffering of the person. It is undertaken on a whole range of indicators, whether they are going to suffer, or whether they are suffering.

Ms WEBB - It is an interesting one. People may recall I spoke about this in my second reading contribution. I would potentially dispute what you said about your bill, member for Mersey, because if you refer to clause 13, it is actually all about this.

Clause 13 of the bill is titled 'When person is suffering intolerably in relation to relevant medical condition'. Clause 13(b) talks about what constitutes intolerable suffering in relation to the relevant medical condition and says 'persistent suffering that is' - and here is the important part - 'in the opinion of the person'.

The only person who has to assess the suffering in this bill, in terms of its tolerability, is the person themselves. When you look at clause 13(b)(i), (ii) and (iii), they are required to consider that it is in relation to the relevant medical condition. That is what the person who is assessing eligibility is meant to assess, but the person who is assessing eligibility does not have to make any assessment as to the level, the intensity, the tolerability, any of those things - except what the person themselves identifies.

Perhaps the member for Mersey could clarify that this is the case?

Mr GAFFNEY - Yes, member for Nelson, that is perfectly correct, and also it is quite lengthy in clause 13. I am sorry I did not -

Mrs HISCUTT - I still would like the first explanation, because as I said, my nieces find their shoes intolerable at times, and intolerability comes at a different level to different people for different circumstances - and for someone to go in to a doctor and say, 'I am suffering intolerably', I want more than that person to say that. I want that doctor to assess that.

That will be what will happen in the end, but I need to put that on *Hansard* because, as I just said, the example of a person's tolerability to a level of pain is different for everybody, so what is intolerable?

Thank you very much for answering that on behalf of the member for Mersey.

Dr SEIDEL - There are different ways of doing this. In clinical practice, you have subjective measures, as the member for Murchison mentioned, but you also have objective measures, and there are validated internationally used scales that we are using to assess that. The Palliative Care Outcomes Collaboration that is based in Wollongong actually has done the scale for the Australian context, and it is now used increasingly internationally. This is what medical practitioners use to assess and document subjective and objective levels of distress for patients who are nearing the end of life.

Ms WEBB - Can I just clarify again - though perhaps the member for Mersey can clarify for me specifically, irregardless of the existence of that subjective and objective assessment of suffering in other medical circumstances. I accept that happens and there are scales for it.

This bill does not require any objective measurement of the suffering in terms of level of suffering, or tolerability of suffering. It is not legally required in this bill under clause 13.

Clause 13(b) simply says for -

> persistent suffering that is, in the opinion of the person, intolerable is being caused to the person by any one or more of the following -

Then there is a list of the following, which is about the cause of the suffering. It is not about its level, or its level of tolerability. There is no objective assessment, only subjective assessment, in this bill in relation to this eligibility criteria - which is why I made the point that it is legally meaningless to have it there.

Mr GAFFNEY - If we go to clause 13(a), the person has a 'relevant medical condition', and we go to the 'relevant medical condition', which now 'in relation to a person, means a disease, illness, injury or medical condition, of the person that is advanced, incurable and irreversible and is expected to cause the death of the person'.

So you are right in that it depends on the person's perception, but it also highlights that it is a disease, an injury, an illness, a condition that is irreparable and irreversible - and hence the person says that they do not want to live anymore because they are suffering.

Mr VALENTINE - I just want to reiterate what the member for Nelson was saying. Quite clearly, it says 'for the purposes of this Act'. No other definition required, because it is actually in this, and whenever it is used in this act, for the purpose of this act, a person is suffering intolerably in relation to a relevant medical condition - and rightly so, because this is all about a person who is accessing voluntary assisted dying. They are the ones who are suffering, and it has got to be intolerable suffering for them.

I agree with you in regard to the fact that it is not a legal test, and I do not think it could be, but it is definitely the case that - wherever it is used in this act - clause 13 makes it according to what clause 13 says.

Clause 6 agreed to.

Clause 7 -
Relevant facts in relation to accessing voluntary assisting dying

Ms LOVELL - By way of explanation for members, this comes after seeking some advice from the Deputy Clerk on our amendment around the establishment of a commission, as opposed to a commissioner and deputy commissioner.

As members will have seen from our amendments, the substantive amendment is much later in the bill, but if that were to be passed, there are a large number of consequential amendments that would be required through the bill.

In the interests of not having to recommit every clause after the debate is finished on the later clause, we thought it would be more streamlined if we had some leeway, and were essentially able to debate the principle on this clause and on this amendment.

So, while this amendment might not seem like it is about establishing a commission, that is the argument I will put and is what we will be asking people to debate at this point. When the question is put, that will be an indication as to whether or not we need to move the rest of the amendments or not, depending on the will of the Chamber.

Madam CHAIR - To clarify, we will have a standing debate on whether we should establish a commission as opposed to having a commissioner and deputy commissioner. As to the debate now, even though it is only on a small part of that, you need to prosecute the whole case.

Ms LOVELL - Yes, correct. Madam Chair, I move -

First amendment

Leave out 'in a form approved by the Commissioner',

Insert instead 'in an approved form.'

Second amendment

Paragraph (c) -

Leave out 'Commissioner' (twice occurring)

Insert instead 'Commission'.

The reason for these amendments is that, as has been discussed on a number of occasions, one of the really fundamental principles with voluntary assisted dying legislation is how important it is to have the appropriate oversight and reporting mechanism. The commissioner, or in what I would propose should be a commission, will play a very important role in terms of oversight of the operation of the bill and eligible cases where people have accessed voluntary assisted dying. They also have a role in providing guidance to medical professionals. It is a critical role they are playing.

By expanding to a commission, as I will propose later in the debate, what this will do will allow for a broader range of knowledge and expertise to be part of the roles and functions of the commission, which will enhance its function. I do not believe this needs to be a significant impact in any budgetary sense, as these would not be full-time roles I am envisaging. It would be a five-person commission, including an executive commissioner and deputy executive commissioner. I am not anticipating there would be any large budgetary impact of this. What it would do is provide appropriate level of scrutiny and oversight.

The model proposed by my amendment is a five-person commission, as I mentioned, with an executive commissioner, a deputy executive commissioner and three other members. In terms of the make-up of the commission, this would consist of a person who is an Australian lawyer of not less than seven years standing as an Australian legal practitioner, and who is to be the chairperson of the commission and the executive commissioner, and a person who is to be the deputy executive commissioner; and at least three other members, as may be necessary for the proper functioning of the commission. That would allow for other members of the commission to be appointed from a medical background, an ethical background, perhaps more from a legal background, so broadening that range of expertise to enhance the functions of the commission.

My understanding when reading the bill is that the Victorian legislation has a voluntary assisted dying review board consisting of a chairperson, deputy chairperson and members, with no limit on the number of members. The Western Australian legislation provides for a voluntary assisted dying board consisting of five members. That is essentially what we are debating at this point, as to whether or not members support the principle of expanding to a five-person commission as opposed to just having a commissioner and deputy commissioner. I would ask members to support that amendment.

Ms RATTRAY - Madam Chair, I am somewhat supportive of the member's proposition of expanding the role of the commissioner to a commission. Why were five chosen? In my second reading contribution, I talked about a panel of three. Is the member expecting all five would sit at the one time? Or is it interchangeable, given there might need to be some expertise in a particular condition when you are looking at medical expertise. I am looking for some more information around that. I am not necessarily opposed to five; I am interested in how you believe that might work, whether it is the whole five that would sit when there was an assessment to be made or whether you have just three members with bringing in the appropriate expertise. I am looking for some clarification, but I certainly support the intent of the amendment.

Mrs HISCUTT - This is not something I am really in favour of. At the minute there are two - the commissioner and the deputy commissioner. The member is looking for a five-person panel. I am not sure whether maybe that is going to more inhibit access to this, having five people that you have to run past conditions and what have you. Has the member looked at the costing of this? I note in the substantive debate that there is a cost for each member of this panel.

I suppose you have to consider money - in 2014 when the Government came in, we saved $7 million just by trying to reduce committees and boards. I do not think I can lean towards a commission because I do not think it is necessary. I think two people are quite capable after having the three requests already and then the commission to have a look at it. I think the safeguards are already in place and this might be - I was about to say 'overkill', but that is not the right word to use - over the top. I wonder: did the member for Rumney actually look at the costing for this? Have you looked at that and considered how that would work?

At this point I am not inclined to vote for a commission because I think the commissioner and his deputy is two; here we are debating about numbers again. I think the bill has it right with who is there at the moment. I think the commissioner and their deputy would be quite capable of making these decisions without going to a five-member commission. I will err on not voting for this amendment.

Ms HOWLETT - Madam Chair, I support the principle of this amendment. I think it allows for a broader scope of expertise. I was wondering if the member for Rumney could explain to me what comprised the 'expert panel', was it two medical? I must have missed that bit when I went out.

Ms WEBB - I will add a couple more questions for the member for Rumney to deal with in one go. I am also along similar lines not particularly inclined to support this. I believe that what is in the bill with the commissioner and deputy commissioner is sufficient and workable in regard to the role being played under the legislation. I would like to hear more about how you would see a five-person commission undertaking specifically the role laid out here differently to the model already there in the bill.

Within that, perhaps you can identify what benefits you have identified there in substituting a commission for a commissioner in regard specifically to the way the role would be undertaken? What potential downsides do you see from it or are balanced, when you believed their benefits may have outweighed those downsides? What specific risks are you seeking to guard against? In terms of good governance, why we should contemplate a commission rather than a commissioner and a deputy commissioner - specifically in terms of governance and the undertaking of the role, what risks are you looking to guard against?

Mr GAFFNEY - I will not be supporting this amendment. I will give some reasons why that is the case. When I first started I said, 'Is this a necessary safeguard or is it an unreasonable bureaucratic hurdle to fair and equal access?'. I have had some comments passed to me by quite a number of people that I think I should read in because it is very important to this.

In principle, any independent, effective oversight, monitoring, reporting, follow-up action, are essentially accountability and transparency safeguards for the VAD legislation. I think the single commissioner is a much more efficient, effective and suitable approach providing these safeguards in the Tasmanian circumstances compared to the proposed commission. If you look at the data and evidence which needs to be taken into account for 'reasonable perspective', jurisdictions with VAD legislation have significantly different approaches to providing these safeguards which must be suited to local conditions and demographics and public monitoring models and practices. For example, in Tasmania we have the Anti-Discrimination Commissioner appointed by the minister, a five-year term, and codicils on any terms and conditions that the minister determines.

We have the Commissioner for Children and Young People, appointed by the Governor on the recommendation of the minister for a five-year term. We have the Asbestos Compensation Commissioner, the minister, three-year term, no codicils. We have the Executive Commissioner of the Tasmanian Planning Commission, the minister, chairperson and executive commissioner, a full-time appointment, member for five-years. We have the

Chief Commissioner of the Integrity Commission, and that was the only one that has to have persons not eligible to appointed as Chief Commissioner unless they are an Australian legal practitioner of not less than seven years standing. I suppose that relates to what we have here.

In the context of this bill, it is unnecessary and offers no improvements to its functionality, given the expected low numbers of cases in the Tasmanian context. If we go to the Asbestos Compensation Commissioner, it provides an appropriate example which shows the commissioner for VAD would be a fit-for-scale choice. There is one commissioner, one staff member, 16 case applications in 2018-19; 158 applications over eight years. It manages up to $20 million in assets, it maintains a medical practitioner register, and the Tasmanian Government - I think the member for Launceston sometimes mentions about board structures and the Tasmanian Government itself in one of its platform policies has moved away from board structures and this has proven to be effective and safe.

Commissioner for Children and Young People, they look after over 100 000 young Tasmanians and I have to say here I think that the commissioner and the deputy commissioner have the right to pull together any other members that they wish, fit for purpose, while they are getting this in place. The commission in Victoria or the board they had in Victoria, has specific additional requirements for the VAD review board that include regular reviews with additional formal reporting requirements and oversight of individual cases.

There is a series of formal review panel processes in this act which means that the commissioner has those reviews done by independent people. I would have thought that in a situation where you are starting an organisation and when you look at our numbers compared to the Victorian population and the Western Australian situation, 540 000 is about the size of Geelong so do you want a commission of *x* amount of people running that sort of thing or do you want a commissioner who has all the roles and functions?

If you go to clause 111, Officers of Commissioner -

> The Minister may appoint such officers as the Minister considers to be necessary to assist the Commissioner in the performance of his or her functions.

That is saying that you have the commissioner of voluntary assisted dying and a deputy commissioner, and they may appoint staff as they see fit to work with different departments getting this structure into place. The functions and powers of the commissioner are in clause 112, and the commissioner may delegate any of their 'functions or powers under this Act, other than this power of delegation', which is in clause 113.

I do not see the need for a larger body, when the voluntary assisted dying commissioner has all those powers at his fingertips. I do not really care how much it costs, but in the situation here we must ensure it is an effective way of getting this legislation up and running. I do not think the commission has any advantages and I would seek that members stay with the intent of this. The question should be asked what problems are you trying to solve with a commission, what safeguards to you think this provides that a commissioner does not? With our Anti-Discrimination Commissioner and the Commissioner for Children and Young People, who are equally playing in such important areas, we have never thought to think 'Well, we should put a commission there because we do not think they can do the job.'. We trusted that the right person would be put in place and would have the right abilities and capacities to be able to afford the role and get this legislation up and running. If they need help or assistance in certain areas, they have the powers to call on groups of people to help them out.

In my experience it is good to have someone overseeing and being responsible for that, more so than the commission. The feedback we have had from doctors in Victoria welcomed the fact we are looking at a commission instead of a board. The proposed Tasmanian bill utilised the commission instead of a board. Our cases are only viewed when the board meets. Granted, this is several times a week, but having a commissioner will allow for faster turnaround times for applications.

Again, it goes back to the person and their role. The voluntary assisted dying commissioner is to quickly assess and decide. In some situations, if you go to the bill, there is sometimes an exceptional circumstance where the PMP might apply to the commissioner and within 48 hours, because the person needs the capacity very quickly to undertake a certain step in the process. In this situation would they then have to wait for the commission to be convened, to have three out of five members pass that? Why do we need that? It is not in the best interest of the person and so I would urge members not to support the commission.

Ms ARMITAGE - I am inclined to support the commission. I always believe there should be an uneven number - either three or five. Obviously, if the member could clarify that five would be therefore three to be chosen from the five. To clear up the comment by the member for Mersey about my issue with boards: my issue with boards with the state Government is not about the amount of boards or the number of people on boards, it is the representation across the state with the boards - the fact that most of the board members come from interstate and the south rather than the north and north-west. I am inclined to support the amendment before me.

Dr SEIDEL - It is really important not to compare apples with oranges here because although it is the board in Victoria and the board or tribunal in Western Australia and the commission or commissioner here, the functions are actually very different. For example, in Victoria where we do have a 14 member board currently, the main procedural matters are being dealt with by the secretary of the department of health for applications and so forth. The function of the board in Victoria is strictly that of a review board. They are not really involved with procedural issues anyway so they provide oversight and reporting so every six months they are providing a report. Western Australia's is very similar, but they also have a tribunal so it is again a heavy way of providing that oversight.

It is interesting the member for Mersey quotes medical practitioners as expert witnesses because the expert witnesses we also had presenting were professors Wilmott and White who were drafting the Queensland VAD bill. Clearly, in their draft bill they recommend setting up a board structure very similar to what the Victorian and Western Australian jurisdictions have done. They are not the medical experts but they are the legal experts drafting the bill who make direct reference to existing structures. Again if you look at precedents, this is what other jurisdictions are doing.

Strictly speaking, from a procedural and medical point of view, there is not even a need for us to have a commissioner in Tasmania. The work that is outlined in the bill can easily be done by the Department of Health secretary and a delegate. Yet this bill appreciates that there has to be a certain level of oversight somehow but it is the commissioner who is dealing with procedural matters but then is also doing the oversight and then is doing the reporting to external stakeholders and parliament. So you have three quite different roles combined in a commissioner and a deputy commissioner and, yes, that might be possible but is this really the intention of what review boards are meant to be doing? My argument would be no, it is not.

The model that the member for Rumney is proposing is very much based on the model that we have for the Guardianship and Administration Board that we have in Tasmania, which functions very effectively and actually is dealing with applications and procedural matters and oversight on a daily basis whereas the Integrity Commission and so forth would not be dealing with this. The children's commissioner would not be doing this, it is a completely different function although it is called commissioner.

So again let us not compare apples with oranges here. There is an argument for establishing a small but defined review board. Again, with regard to cost I appreciate that typically in those compositions you would have sessional fees that need to be paid to board members but certainly with regard to the commissioner and deputy commissioner that is already a cost that is part of the member for Mersey's bill anyway. Potentially we are looking at casual positions as a board that would meet four times a year for three members and they will attract sitting fees that would be very standard across the sector.

Mr VALENTINE - A commission versus a commissioner - it is happening now. In effect people are being ushered over the threshold without a board being in place. Let us face it - it is unregulated but it does happen.

Quite a low number of people are likely to go down this path, one expects, given the overall numbers in our population of about 515 000. It is a voluntary assisted dying bill; it is not something that a board should be involved in. It is about the person's wishes. If in three or eight years time - the first review is in three years time, the next one after that will be eight if this gets up - we can look at that and see how it has operated and whether there is a problem or issues that have raised their heads.

I hear the argument about the Guardianship and Administration Board that the member for Huon raised, but that is dealing with people who do not have capacity. This is about people who do have capacity - and in fact they cannot access this unless they do have the capacity to make a decision so I am not convinced. I will listen to other members' opinions and offerings, but at this point in time I am not really convinced a board is necessary.

Commissioners exist for a number of other things and as serious as this may be, this is about voluntary assisted dying. It is not about whether a board should be involved.

Ms PALMER - I am really a bit conflicted with this, and I keep swinging from one side to the other, so I am listening with intent to the debate. I am all for as many safeguards as possible with this legislation. That is a commitment I made to my electorate and I feel a weight of responsibility in this place to look at that. However, the member for Mersey made a point, which is actually a question I wrote down for the member for Rumney to comment on. It was with regard to instances where a really quick decision and a really quick look at a situation are needed.

We have already talked about the fact that someone can only start the process when there is a prognosis of six months so there are going to be times when in some circumstances there is going to have to be quite a quick turnaround. I guess I am looking at this thinking 'Is it far more efficient for one overriding commissioner with the assistance of a deputy to make good decisions there? How much more time is going to be added if you have an actual commission?'

I am leaning towards supporting this, but I would like clarification on that. I am probably a little like the member for Hobart - I am really intently listening to this debate because I do not feel comfortable with my position as yet.

When you stand could you add that to your list of many questions?

Ms LOVELL - I will start by addressing some of those questions that have been raised and I understand the member for Huon has also got some more contribution to make as well and as members would be aware, we have been working closely on this amendment.

In relation to the member for McIntyre, why five and the member for Huon touched on that already. We have modelled this on the Guardianship and Administration Board that is essentially similar in terms of looking at the functions of the commissioner as we would propose a commission, as opposed to the other commissioner roles that we have in the state like the Anti-Discrimination Commissioner and the Integrity Commissioner. I would see that this should operate more closely to an operation like the Guardianship and Administration Board than those other commissioner models.

In terms of all five sitting at one time or being interchangeable, the five would be appointed but in terms of the mechanics of meetings and sittings there would only be three required to make up a quorum for a meeting. It would allow the minister to appoint people with a range of expertise in different aspects of the things that the commission will be overseeing.

The member for Montgomery talked about having a delay in assessing applications or people being able to access voluntary assisted dying by the establishment of a commission as opposed to a commissioner. I do not believe that this would happen because - and again the member for Huon touched on this as well - in terms of how it does operate in other states and how boards of this nature operate that would not be a concern.

Regarding the cost, yes, we have done some, and again it is estimated costs because we do not have access to the departments that would be able to do these types of costings, but looking at a board of this nature and bearing in mind that with the executive commissioner and deputy executive commissioner that cost is already present in the bill. It would be an additional cost you would estimate at around about $1000 a day per person, bearing in mind they will probably only be required to sit maybe four times a year, something of that nature.

Mr Dean - How many times a year?

Ms LOVELL - You would estimate around four based on other models in other states and how they are operating.

Ms Webb - They are modelled differently then?

Ms LOVELL - For the meetings of the whole commission that is what our model would propose.

In regard to the questions that have been raised around what this amendment is attempting to resolve, or what problem or how is it better, what is the benefit? The role of the commission or the commissioner and deputy commissioner as it stands does require oversight. They do play a role in the operation of the bill. A commissioner and an executive commissioner are essentially overseeing themselves so by expanding that to a commission that does provide an extra level of oversight to enable the commission to have that appropriate level of scrutiny and conduct the functions that it is being asked to conduct under the bill.

The member for Hobart talked about whether or not there was a need to expand it given the expected low numbers of people who will be accessing voluntary assisted dying in Tasmania. We are not expecting big numbers, but there are other roles the commission would play, or the commissioner, in the bill. Approving training courses, input around the approval of the substance that would be decided upon, maintaining a list of practitioners who are participating in voluntary assisted dying, reporting and potentially investigating suspected contraventions of the bill. There are other roles the commission would undertake.

In relation to the member for Rosevears' question, I do know the member for Huon has further to say on that, so I will leave that to him. Really, in summary, what my amendment is attempting to do is provide an added level of oversight, an extra range of expertise to be part of the implementation and operation of the act, and providing an appropriate level of oversight and operation of the bill, and the role of the commissioner and the deputy commissioner as well.

Dr SEIDEL - Specifically, for the member for Rosevears, again the function of the executive commissioner and the deputy commissioner literally really would be to ensure the day-to-day running of the VAD program and the scheme. With regard to the oversight, that would be the function board members would use. In terms of delay, would the board members really be involved in the day-to-day running - no, of course not. We are anticipating to meet four times a year for oversight and for reporting purposes. That is no different to other boards in the community and business world.

Again, the day-to-day running of the scheme should be enabled and supported by the executive commissioner, then the deputy, but with regard to delivering that oversight and reporting. This is why we believe similar jurisdictions - in Western Australia, in Victoria, and potentially in Queensland - believe there should be another level of oversight put in place. Otherwise we would have a deputy commissioner and executive commissioner controlling each other, which cannot be in the interest of the VAD bill and process.

Ms Palmer - I want to be really clear, so the day-to-day decisions are not part of the board, the five-member function?

Dr SEIDEL - No, that was not the intent and would be not necessary. Again, the day-to-day business would be conducted by the executive commissioner and the deputy. With regard to oversight of what the executive commissioner and the deputy does, that is the board's function and reporting function, and you would hope the board members are going to be involved.

Mr GAFFNEY - A commissioner, a deputy commissioner and a staff is effectively a micro-commission anyway. The staff would be doing a lot of those functions. The commissioner has the capacity to call on other people to feed into the organisation in a fluid way of working through the issues they might have. We do not have an oversight commission for the Anti-Discrimination Commissioner, or for the Commissioner for Children and Young People, and for the asbestos compensation, so why would we need a commission in this situation, which is really a function clearly outlined?

I do not believe this is necessary. It is just another layer of bureaucracy we think of as a safeguard. Again, I go back to the question, what problem are you trying to solve in this? The numbers of people accessing the funding for this would be less than what we have with the asbestos commissioner, and he has a $20 million budget. I do not understand the need to put another layer of bureaucracy on top of what can just be a function. Look, as I have heard before, in three years, if the review period comes up and the commissioner says, 'Look, we could do with a board now, or we could do with a commission in this area', let that be one of the outcomes of that.

Why impose something like this just because it happens elsewhere in another piece of legislation, when we have not gone down this path in a number of the commissions we have in this state? They work very effectively. We have never had any questions about how they have performed, and there has been no commission available, so why are we choosing this pathway for this role? I do not think it is necessary.

Ms WEBB - I agree with the member for Mersey. I am going to add a couple of things to what he just said. To reiterate quite clearly, in the bill as it currently stands, we have the commissioner and deputy commissioner. The minister may appoint officers to assist those roles. There are also delegation powers, so the commissioner may delegate any of his or her functions or powers under the act, other than the power of delegation - so that is another way to draw in other resources, or share roles in that sense.

We have an annual report that is provided by the commissioner to the minister, who then also has to lay it on the Table in parliament - so in terms of oversight and accountability, they are not overseeing themselves. They are quite clearly being overseen to some extent, because they are having to report to, and be accountable to, the minister, and then also ultimately to parliament. On top of that, we also have built in already the idea that there will be a review of this act, and my understanding is that the review of the act will be done by independent persons, whenever that is determined to occur. That review is not being done by the commissioner. Perhaps the member for Mersey can indicate that will be an independent review.

What we essentially have there, for the purposes that are described through the legislation, is a very comprehensive way to go about the day-to-day tasks that are spelt out here, and the oversight tasks, with multiple layers of oversight then on top of the commission.

The member for Huon, I think, was making a distinction between particular tasks the commission would do at an executive level, and then as a broader commission. It is not clear to me, from the way you described it, what the distinction is between those particular tasks here in the bill, and therefore in terms of a quorum of three being required - and presumably, if there is a quorum of three, you would need two to carry a decision - what decisions are those in terms of these functions and tasks? What might be decided by the executive members outside of having to convene a meeting and have a quorum?

I think it is over-complicating this. I would like to understand a bit more on how that might specifically look in terms of this, rather than that there are broad reporting and administrative tasks, and there are oversight tasks. Please tell me more about that, and the functioning of the five-person commission.

Mrs HISCUTT - For clarity, I am hearing that the bill before us provides for a maximum of three people - the commissioner and the deputy, and one other, if called upon -

Mr Gaffney - No, that is not correct. There is a commissioner, a deputy commissioner, and the minister may appoint officers at the request of the commissioner or deputy commissioner. They can be appointed at any time to help out in whatever aspect of the role they want.

Mrs HISCUTT - So this current bill provides for there to be a minimum of two, or a maximum of whatever they deem is necessary. Is that correct?

Mr Gaffney - Yes.

Mrs HISCUTT - So we have established that with the current bill before us, there is a minimum of two and a maximum of whatever is deemed necessary. So, the member for Rumney's amendment is going to give us a minimum of three and a maximum of five, and -

Ms Lovell - No, minimum of three.

Mrs HISCUTT - sorry, that need to meet at one time to form a quorum. So, you can have up to three members in your proposal to make a decision?

I can see that what we currently have in this bill is providing for - a few people, dare I say - two plus more, whatever is deemed necessary, whereas the amendment from the member for Rumney is having a minimum of three for a quorum, plus whatever up to five, whatever is necessary. So, I cannot see a difference.

Mr Gaffney - The difference is that they would still need all the staff that they would have to do to undertake functions of work of the office.

Ms Lovell - I am saying what I currently see in the bill as it is drafted is quite adequate.

Mr VALENTINE - I am encouraged by the member for Huon saying that the commissioner and the deputy would be doing the day to day decision-making, but again I agree with the member for Nelson. I was about to get up and say the same thing.

The description of exactly what is the area that the commissioner is supposed to cover is not here. I have just been looking through the amendments, and I cannot see described exactly what the commission would be responsible for.

There is a bit about the modus operandi - how it operates and all those sorts of things - but it is missing a vital part, and that is describing exactly what the commission does, to my mind, as I read through the amendments here. I am thinking, 'Are they somehow tied to what the commissioner has to do, and I am missing something?', but I do not think I am.

I think there is a distinct role for the commissioner, and at various times things are referred to the commissioner for a decision. I am not sure which components referred to the commissioner would, under your model, be handled by the commission. It is not clear to me, so I do not know that I can support it as it currently stands.

Ms LOVELL - Just to address some of those further comments that have been made. The arguments around the current model, the bill as it stands, allowing for staff and officers and what the member for Mersey has described as like a micro-commission.

The key difference with the model currently in the bill and the model I am proposing is around that oversight, so officers and staff would not have that role of oversight of the decisions and the role of the commissioner and the executive commissioner.

The comparison with the Anti-Discrimination Commissioner, the Ombudsman and other commissioner roles where we do not have that level of oversight: my view on that - and everyone has their own opinion about this, so this is essentially an opinion that people will base their decision on - is that there is a different level of expectation of the oversight provided by this bill, by the commission, the community and the people who will be operating under this bill. In the community, generally speaking, there is an expectation that there will be a very rigorous level of oversight of the operation of this bill, particularly in its first iteration.

So, with the comments about the three-year review, and we could always expand the commission if there is a requirement to do that, I would argue that we actually should look at it the other way around. There is a three-year review. We can always reduce the number of people required in the first iteration of this bill, in the first implementation period when people are accessing this for the first time in Tasmania. That is when, in my view, it is even more important to have the most rigorous oversight we can of this process, because that is what the community expects, and that is what our community wants to see. If, after three years, we decide maybe that is not required, that is fine. We can look at amending it at that stage and reducing the number of people.

In terms of annual report and reporting mechanisms to parliament and the minister - yes, the commissioner would be required to submit an annual report, but again that comes back to the question of whether that is enough. Is that the level of oversight and scrutiny that people expect and want this bill and this process to have, when that would only be a once per year annual report? I would argue that it is not enough, particularly in these early stages.

The member for Montgomery, in relation to your question, the commission itself would consist of five members. Three would be required for a quorum, so any meetings would be a minimum of three, as is normal process, but there would be five members of the commission appointed at any time.

Mrs Hiscutt - Those three can make a decision?

Ms LOVELL - Yes. Five members including the executive commissioner and deputy executive commissioner. What I am proposing is three additional members to what is currently in the bill. For me, it comes down to that level of oversight particularly in the early stages of the implementation of this bill. My view is there is an expectation we should have the most rigorous oversight we can of this bill, of the operation of the bill and the scheme as it operates in the community. If a decision is made to reduce at a point later down the track, I would absolutely be willing to consider that, but at this time the added level of scrutiny is required.

Ms WEBB - I will pick up on a couple of those things, because we are still being asked to contemplate this as a concept and a structure that is opaque and does not have clarity within the context of the bill in the way the commissioner role and what is described around that in the bill currently are quite clear. It has established clarity and, forgive me if I am wrong, but I do not think anyone is arguing that is not a part of this bill that has credibility and clarity.

If oversight is the key reason for us to contemplate a commission, because we have dealt with the other main thing that extra expertise could be provided - we have dealt with that, because we have identified quite clearly the commissioner as it stands can bring in extra expertise as required quite readily in this bill. Oversight is the central rational to contemplate a commission. We have just had it asserted an annual report by the commissioner to the minister, which then must be laid on the Table in parliament, is not sufficient oversight or would perhaps not be regarded as such in the eyes of the community.

Why not? That is the level of oversight regarded as supreme - parliamentary oversight, ultimately and accountability to have something laid on the Table of parliament and then potentially be dealt with in a parliamentary context is a significant level of oversight. If that is not, from a community expectation point of view, a sufficient level of oversight, what does a five-person commission provide by way of oversight beyond that? Let us just think that through. It literally means there are potentially more pairs of eyes on the activities and the responsibilities in the functions of the commission.

As a community, if we are thinking of ourselves as citizens assessing an acceptable amount of oversight or level of oversight, we say, 'Oh, well, there are five pairs of eyes on it, rather than two; that must be better', just making that assumption. Those five pairs of eyes from what I can see in the proposed amendments are not required to do anything further in the way of public release of information, public reporting or accountability. We are citizens looking into that area; other than knowing there are five pairs of eyes on it, we have no idea whether there is more accountability, more appropriate behaviour, better undertaking of the role - we just know there is more of them.

I do not believe the simple fact of having five pairs of eyes on it rather than two pairs of eyes provides us with an enormously increased level of public confidence about accountability. It might do in situations where we may be given to expect people might behave mischievously or abuse powers or act inappropriately. There might be situations, governance situations, where we may want to know there are more eyes in the room because of opportunities for financial gain, for benefit of some sort or taking advantage of the matters being dealt with by that governance group. In those sorts of situations, in some senses we say more eyes in the room are good because there would be more likely to be whistleblowers if there were bad things that are going on. I do not think that is the kind of situation we are talking about here, because the commissioner and the deputy commissioner are being appointed quite purposefully and, I would imagine, with an enormous level of care under this bill.

I do not think we would ever expect that with whoever may come to be appointed commissioner and deputy commissioner under this bill, we could ever have an expectation that they may be likely to behave inappropriately.

I do not believe that extra pairs of eyes benefit. Without any additional reporting, public visibility, public release of information, any of those extra things, that is not really indicated here in any realistic way in terms of delivering us a better level of oversight, if that is what this is all about.

Examine simplistic assumptions about 'more is better', 'more people equals more oversight'. If the structures are not there actually to deliver that public accountability in some way and actually give effect to a function of oversight, then we are actually comforting ourselves with the idea that five sets of eyes are better than two. It is not actually tangibly, legally delivering us a substantially different level of accountability and oversight that we see here.

I encourage people to err on the side of supporting, when it comes to this role of commissioner and deputy commissioner that is existing here in this bill, the way it is laid out with the roles and functions, the way it is laid out with the responsibilities, the accountabilities, the reporting, the clarity that is there. I invite people to support the robust clarity that is there, knowing that we will be reviewing it in a timely fashion, rather than support this amendment which will be shoe-horning in a different and not well thought through adapted model to fit into this in the way we are trying to with this amendment.

I suggest to you very strongly, it does not deliver a required outcome that is being asserted in terms of oversight which is already there.

Dr SEIDEL - If you look at the legislation for Victoria and Western Australia, the way the board function is defined is actually very plain because it is clear in the context of what the function of the board actually is.

Again, it is about providing oversight of programs, overseeing management, developing and maintaining a competent board, ensuring legal integrity and so forth. It is a given. It is what boards do. It is a generic function of oversight.

Mr Valentine - Is it in their legislation is the question?

Dr SEIDEL - It is not in their legislation either. You could argue whether this should be in the regulations. By all means it could be, but again, there could be an argument for it.

As the member for Mersey said, the Integrity Commissioner is just an integrity commissioner - yes, but he also has a three-member board.

Mr Dean - They also have the Integrity Committee which overlooks as well.

Dr SEIDEL - Yes, so it is not unprecedented for a commission and a commissioner to be supported by a board. I am somewhat surprised at the question about what is the function of a board because it is actually very clear, with regard to precedence, when we look at what the Integrity Commissioner does with a three-member board.

Mr GAFFNEY - Thank you for the comments. A couple of quick questions. We have dealt with this quite a lot.

I am assuming that a commission and a board are the same thing. I would have thought there were distinct differences between a board and a commission; I am not quite certain it was explained to us. You might have to explain to me now where that has gone.

I have to put on the record that oversight in clause 141 which says there is a six-month review that is in the legislation, a six-month review of the operation which has to be presented within 10 months. That is another oversight; that is 141. Then there are yearly reports from the minister on clause 118, and presumably the three-yearly review of the act with the independent panel appointed by the Governor would also examine the commissioner's role. I am not sure what other oversights of other commissions and commissioners should occur, or what they think should occur. In the bill as it is written a lot of oversight, a lot of thought, has gone into that, particularly in light of Tasmania's scale compared to Queensland or Western Australia, which is a huge expanse with lots of different areas.

We have tried to streamline this for effective implementation, effective organisation, which I do not think the commissioner or the board as described is going to have any bearing on. I go back to the member for Nelson - and followed by the member for Hobart - who eloquently spoke about how in Tasmania we have been very good at putting the right people in the right places to do the right job. I am not always certain that the person who has the most compassion in those areas should actually have a seven-year law degree, either. To me, the voluntary assisted dying commissioner would pull in those resources when they need them, at the time when the issue arose. I do not support a commission. I am very pleased with some of the responses from some of the members. Thank you.

Ms FORREST - I want to make a contribution on an amendment that I think I need to put on the record whether I support it or not. I actually do support this amendment. I believe that the roles, if you go through all the amendments and we are only dealing with one very tiny microcosm of the amendments here, but when you actually look at the role of what would be the commission if this was supported, all the roles and functions that are currently assigned to the commissioner under this would be picked up by all those 44 pages of amendments, or however many it is, to insert 'commission' rather than 'commissioner'.

The new clause - I cannot remember what number it is - that would be added regarding the commission talks about the five-member commission, with three being a quorum, with the meetings and other aspects of their operation. But all the other processes are not removed from the bill. All the other aspects of the role and function of what is currently the commissioner are picked up by the board. They would approve the training program, the commission would do that. They would assess the patients who come to them if the other amendment that I am putting up in relation to an exemption to the six-month, 12-month prognostic time frame succeeds, the commission rather than the commissioner would assess that.

But as the member for Rumney - I think it was - said, it does not have to be a full commission that would assess that. The application would go and be assessed and dealt with by the commissioner and the staff who support them. To me, the amendment names up - not this amendment, but further on the new clause - a legal practitioner of five years experience -

Mrs Hiscutt - Seven.

Ms FORREST - Sorry, seven years experience, as occurs with other commissions. My way of seeing this is that you would put on the commission skills-based people to actually assess the matters coming before them. A lot of them are health-related matters obviously. You would have health expertise on there - that would be, dare I say a no-brainer - and other skills that would be helpful in undertaking the roles and functions of the commission, which are no different to the roles and functions of the commissioner currently, as the bill stands.

We come back to the point, is this better to have a commissioner and a deputy commissioner doing all these roles, or is it better to have a commission of five people appointed, requiring three to actually undertake the role? Someone please correct me if I am wrong in this - they would do the same work as a commissioner and/or deputy commissioner would by delegation.

Ms Webb - While you are on your feet, because most of us have used up our speaks and the members for Rumney and Huon might have used up their speaks too, and not yet having it answered, there is lack of clarity. We all understand the amendments as they are proposed replace throughout the bill - 'Commissioner' with 'Commission'.

Ms FORREST - Yes.

Ms Webb - But the discussion has been around the fact that some elements and roles will be done by the executive, some would be done by the full commission, but it is not clear anywhere what that distinction might be and it is not clear which particular aspects of the different roles and functions are administrative and which are oversight. We are told again in the contributions that the executive would deal with the administrative and the whole commission would deal with the oversight Those questions remained unanswered and I have run out of speaks so I cannot re-answer them.

The members may have run out of speaks and have not provided answers so, if that is insight you can provide because of discussions, that would be really useful, because it is not clear.

Ms FORREST - I cannot just speak directly to the intent of that, obviously, but every function in the bill now if done by the commissioner will be done by the commission, and they would use the powers the commission has to determine how to do their work. Commissions do work like this all the time. I do not know whether the member for Rumney wants to interject.

Ms Lovell - Thank you, member for Murchison. I have used up all my speaks but if people want to liken this to something similar, the Integrity Commission Board, in the legislation there are about three sentences. It is very broad. It is not normal practice for a bill to be very prescriptive about what the role of the board, or the commission, or the commissioner or the executive would be.

That is determined by the commission and the deputy commissioner in the functions of their role, including delegation of some of those roles. So, to try to give members some context, using the Integrity Commission Board as an example, that piece of legislation is actually very broad and it is left to that board and the commissioner to determine that themselves.

Ms FORREST - So they would determine the best way of actually undertaking that?

Ms Lovell - That is right.

Ms FORREST - If we need more clarity, you can put it in regulations - you would not prescribe everything here because you would create a problem by having overly prescriptive principal acts. We know what problems that causes. There is certainly a regulation-making power to address this if it needs to be addressed, but it is not the sort of thing that needs to be clarified to the nth degree other than the responsibilities in the bill that already exist that would be taken over by the commission.

I just want to express my support for the establishment of the commission, because I believe it provides a skills-based approach in a very important ethical area of operation. It is not the same as some of the other single-person commissions. It is a different role and we do not need, as the member for Huon said, to compare apples with olives or something -

Madam DEPUTY CHAIR - Oranges.

Ms FORREST - Or whatever he suggested. It is important to look at this in context of the work being laid down in the bill for the role of the commissioner, which is quite extensive. There are quite a number of roles, hence the number of amendments to change from 'Commissioner' to 'Commission' and that is picked up by the commission, which is then done with administrative support as the commissioner would be seeking administrative support as provided for in the bill.

You could argue there is not a lot of difference, but there is a significant difference in a commission with that skills-base aboard or a commission with five people to make those decisions, particularly on matters that are ethically difficult at times. It also removes some of the risk of having - this is, again, a later amendment I was proposing as well as being in, I think, the member for Rumney's amendments - a joint appointment made by the Minister for Health and the Attorney-General. This is particularly important because you could have an ultra-conservative minister who wants to appoint a commissioner who would be ultra-conservative and might make it difficult for people to actually go through the process.

Now, we do not want that to occur, so this provides not only for that joint appointment but the commissioners are appointed through joint appointment by the Minister for Health and the Attorney-General. I think it actually provides for a robust assessment process of the operations of this bill. It is an important piece of legislation. It is a critical piece of legislation in terms of what it is dealing with. It is a highly ethical area and I think this provides a much more robust structure around the various assessments and the processes in it, including some of the considerations that need to be made under that role. I think it is better performed by a commission than a commissioner.

Mr DEAN - Point of order, Madam Deputy Chair. I would like to know what we are doing for the dinner break tonight.

Madam DEPUTY CHAIR - I cannot deal with it until we finish this amendment.

Mr DEAN - This amendment is going to be going on for a lot longer. What time does the dining room close?. We cannot work through until 11 o'clock at night without some break.

Madam DEPUTY CHAIR - I had a discussion during that debate with the member for Mersey who is in charge of the bill and as soon as we have dealt with this amendment, we will be having a break for dinner and the member will move to report progress.

Mr DEAN - As long as the dining room is open.

Mr GAFFNEY - Just a couple of points that might help. I am not sure if comparing what we are looking at here with the Integrity Commissioner and that board is as good a fit as it would be with the Asbestos Compensation Commissioner because of the nature of the material dealt with by the asbestos compensation material, which is to do with people who are dying. So how do they deal with that there?

Its annual report says clearly that it is able to support workers, members and family; collect data; it can get a medical practitioner register; and it can introduce a medical panel where they can do that assessment process. That structure which is already set up is, I believe, closer to the commissioner of voluntary assisted dying than the Integrity Commission because of this person's work in that space, and one of the guidelines, as I mentioned before, is that if the person is dying, within two years they are able to access superannuation. The Asbestos Compensation Commissioner provides a model for that, one which is working and working well.

One matter was raised - people said the Government had commented on it but nowhere in the Government's papers that came to us was there a mention of the Government not being happy with a voluntary assisted dying commissioner. When the heads of agencies came back and the Premier sent those four pages with 33 points, it was not raised. It was not an issue when we met with them in briefings. Therefore, if it is not an issue for the government of the day, which is satisfied with the process it is involved in with the commissioner, the Anti-Discrimination Commissioner, the Commissioner for Children and Young People and the Asbestos Compensation Commissioner's annual report, and is quite happy with the level of scrutiny and security there so -

Ms Lovell - I certainly did not raise that as part of my argument. I do not recall anyone raising that the Government had raised this as part of -

Mr GAFFNEY - No, I am saying the Government has not raised it.

Ms Lovell - You said someone had said that they had. I do not recall anyone saying that as part of the debate.

Mr GAFFNEY - I just said that the Government has not raised it here, and it was not raised in the briefings that we have had so therefore -

Ms Lovell - I misinterpreted what you said; I thought you said that we suggested that.

Mr GAFFNEY - No. I am saying that the Government has not raised this as an issue. It was not raised in the briefings. We have models here that work - the Asbestos Compensation Commissioner - and so why are we again looking to outside and introducing something that is not necessary when the bill clearly covers all of that element?

I think this is a layer of bureaucracy that we do not need and it is not necessary.

The Committee divided -

AYES 9	NOES 5
Ms Armitage	Mr Dean

Ms Forrest
Ms Howlett (Teller)
Ms Lovell
Ms Palmer
Ms Rattray
Dr Seidel
Ms Siejka
Mr Willie

Mr Gaffney
Mrs Hiscutt
Mr Valentine (Teller)
Ms Webb

Amendments agreed to.

Mrs HISCUTT - I have one quick question on the amendment. I am sure that the answer will be to keep the language consistent. I noticed in version 13 that you had 'relative facts in relation to receiving assistance to die' whereas now you have 'relevant facts in relation to accessing voluntary assisted dying'. I presume that was just to keep your language the same or is there a reason for that change?

Mr Gaffney - Where are you talking about?

Mrs HISCUTT - Clause 7, the clause we are on, says -

> For the purpose of this Act, the relevant facts in relation to accessing voluntary assisted dying …

In version 13 you had 'for the purposes of this act the relative facts in relation to receiving assistance to die' et cetera. There was a change in your language there. Was there a reason other than consistency of language throughout the bill?

Mr GAFFNEY - There was a change because it had to reflect the title of clause 7 and it did not. It is a consistency issue which the OPC picked up.

Clause 7, as amended, agreed to.

Mr GAFFNEY - Madam Chair, I seek leave to report progress.

Leave granted; progress reported.

TABLED PAPER

Question - Tasmanian Highway - Removal of Eucalypts

[7.34 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, during question time today I undertook to provide further documentation regarding the roadwork on the Great Eastern Drive south of St Helens for a question asked by the member for McIntyre. I seek leave to table this document; I will not ask to have it incorporated in *Hansard* because it is so extensive. The bulldog clip was not big enough for all the documents so we have separated it into two.

Leave granted.

Sitting suspended from 7.36 p.m. to 8.38 p.m.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020 (No. 30)

In Committee

Resumed from above.

Clause 8 -
Authorised medical practitioners

Dr SEIDEL - Madam Chair, I move that clause 8 be amended by -

First amendment -

Clause 8(a) -

Leave *out* 'a medical practitioner with at least 5 years' experience as a medical practitioner after being'.

Second amendment -

After paragraph (a) -

Insert the following paragraphs -

(ba) the person -

(i) is a vocationally registered general practitioner; or

(ii) holds a fellowship with a specialist medical college; and

(bb) the person has relevant experience in treating or managing the medical condition expected to cause the death of the person; and

Third amendment -

Clause 8(b) -

Leave out 'within the 5-year period immediately'.

Fourth amendment -

Clause 8(d) -

> *Leave out* all the words after 'indirectly,'
>
> *Insert instead* 'benefit from, or directly or indirectly receive a financial benefit as a result of, the death of the person, other than by receiving reasonable fees for the provision of services as the PMP, CMP, or AHP of the person.'

Honourable members, the intent of the proposed amendment is to ensure the most qualified and appropriate medical practitioner is credentialled to support and advise patients in the VAD process. It is absolutely essential to specify that not any medical practitioner can be credentialled. The proposed amendments specify that the medical practitioner must have demonstrated competence in treating and managing the condition expected to cause death. The current wording of the legislation does not specify that at all. The current legislation only specifies that the medical practitioner needs to be registered and experienced. Experience is defined as being registered for five years.

Medical practitioners should be qualified, and should have demonstrated competence in the condition relevant to the condition expected to cause death. Under the proposed legislation, medical practitioners would not need to demonstrate competence. They would just need to pass a moratorium five years after graduating from university. It is also not clear what class of registration medical practitioners are required to have, because there are quite a few of them, so it gets very complicated.

I would like to comment on comments made earlier by the member for Nelson, for example. We can be be quite specific with regard to the legislation, and the more information we put in, the better it is going to be. In the current form of the bill -

Ms Webb - To clarify, I have not at any point suggested we put more detail in, just that the changes suggested were aligned and consistent with the detail that is in the bill.

Dr SEIDEL - With regard to the class of registration for medical practitioners, there are four different classes. They are very different for each and every class. For example, there is limited registration, and that is available to medical practitioners whose medical qualifications are for medical schools outside Australia or New Zealand. Applicants must be able to demonstrate that they have completed a medical curriculum, leading to an entitlement to registration in the country issuing the degree to practise clinical medicine. Again, within the limited registration, there are four subtypes. There are four types of limited registration granted for different purposes, which allow internationally qualified medical practitioners to provide medical service under supervision.

Applicants who are eligible for the competent authority pathway, or who hold the AMC certificate, apply for provisional registration. That is, again, a different class of registration. Within that, there is registration for hospital training, there is specific registration for area of need, and there is registration for public interest. There is registration for teaching or research. Then there is provisional registration that applies to people who are qualified for general registration, and who are also required to complete a period of approved supervised practice in Australia before becoming eligible for a general registration.

There is general registration, and then there is also specialist registration, and by now you understand it is very complicated.

In order to improve the integrity of the bill, we need to specify what registration we actually want. We need to be very clear who the medical practitioners actually are who are guiding a patient through the VAD process. I believe that is absolutely essential.

The core to my amendment is to enhance provisions that describe the competence of the practitioner who is involved - not necessarily experienced just because they have been registered in one of those various categories of registration for some time.

We heard earlier that there are obvious barriers to access VAD, particularly in Victoria, and some members propose that the definition and the provision with regard to the prognosis is a limiting factor. However, when we speak to practitioners on the ground, when we read the reports - for example, on the Victorian process - one of the limitations is how they define medical practitioners who are meant to be involved in the VAD process. For example, you need to have a five-year moratorium or 10-year moratorium, depending on the subclass of medical practitioners, before you can actually engage in the VAD process. If you have a neurological condition, then you need to be a medical sub-specialist - for example a neurologist.

In the Victorian context, that may be appropriate. In the context of Western Australia that may be appropriate too, because in particular, in Western Australia there are many medical practitioners who do not have what we call 'vocational registration'.

Vocational registration would qualify them to be a general practitioner, and they can call themselves general practitioners, but only if they work in a particular area of need or after hours under certain circumstances. Again, the point I would like to make is it gets really complicated and I do not think that is appropriate for the Tasmanian context.

It is not appropriate for the Tasmanian context, because the vast majority of GPs are medical practitioners who we want to be involved in the VAD process - they are actually specialist medical practitioners and specialist GPs; they are specifically defined and we have many of them in Tasmania.

We currently have way over 500 specialist general practitioners. They are medical practitioners who are vocationally registered and who had specific postgraduate training in the specialty of general practice. They are specialists in their own right, the same as a specialist physician would be, for example, a specialist oncologist or a specialist neurologist. It is no different under the law.

We do not have the non-vocationally registered medical practitioners that jurisdictions such as in Victoria or Western Australia have. In fact, it is estimated that 98 per cent of all general practitioners here, in Tasmania are vocationally registered. Therefore, we can actually rely on our specialised workforce. The medical colleges have done a fantastic job in ensuring our GPs are not only experienced but also competent, and that is reflected in my amendments.

I propose that we certainly would have a ready workforce that is able to engage in the VAD process and does not need to be subject to any form of moratorium. It is completely unnecessary. The only thing that should be demonstrated is competence. Competence is defined - you are either a specialist general practitioner and therefore on the vocational register of general practitioners, or you are a medical specialist and you have competence in the area that is relevant to the medical condition. Typically, that would be an oncologist, to be fair.

Madam CHAIR - If I might, member for Huon, you have spoken to the first and second amendments; the third and fourth amendments are slightly different. I am wondering whether we should deal with the first and second amendments which are linked. The third and fourth amendments are separate matters, which you have not spoken about.

I suggest you move that the first and second amendment be agreed as that is all you have spoken to at this stage.

Dr SEIDEL - Okay. I move -

> That the first and second amendments be agreed.

Ms WEBB - I have a couple of questions ready for clarity. I thank the member for the detailed explanation, which I appreciated. In terms of the first amendment, being to leave out that part of clause 8(a), the part that says -

> a medical practitioner with at least 5 years' experience as a medical practitioner after being

That removes any length of time being registered prior to being able to be regarded as an authorised medical practitioner. I am making sure that is the case and therefore somebody could participate as an authorised medical practitioner immediately after registration. That is one point of clarity and whether there is contemplation that concerns may be voiced about this.

Personally, I am not voicing any concern about it, but concerns could be voiced. I would not mind hearing some thinking about why that might not be of concern.

In relation to the second amendment, I am looking at the proposed insertion of paragraph (bb), which says -

> the person has relevant experience in treating or managing the medical condition expected to cause the death of the person.

Perhaps you could provide some clarification around what we could regard as relevant experience in treating or managing to encompass that and what might not be captured by that? Where somebody might be deemed to be not able to be authorised as a medical practitioner because they were deemed to not have that relevant experience in treating or managing.

They are my two questions on that for clarity.

Mrs HISCUTT - I talked to my own doctor about this, not during a medical consultation but as a phone consultation about the bill. She seemed to think that the five years experience that is already in the bill was quite adequate. But after listening to the member for Huon - we have a doctor in the House, don't we? - the experience you are relaying across to us makes an awful lot of sense to me. I am not sure where I am going to go with this. I look forward to hearing a response from the member for Mersey before we go to a vote on this. What you were saying, member for Huon, made absolute sense.

Mr GAFFNEY - Madam Chair, a couple of things. First of all, I do not have any issue with the first or second amendments as tabled. I think that was clear.

I would just like to say though since the member's discussion prior to our break I have had some feedback from other doctors questioning some of the statements made by the member. Whilst we do have a doctor in the House I wanted to make certain that there are doctors out there who may have a different opinion about some of the aspects raised. That is like any of us. I want to put that on the record.

While I am on the record, I am not sure I can do this now but I am going to, I made an incorrect statement beforehand that I want to correct.

Madam CHAIR - Deal with it when we do not have an amendment before the Chair.

Mr GAFFNEY - I do not have a problem with this. I have made the point about, yes, we have a doctor in the House but the doctor in the House does not speak for all doctors in this place.

Mrs Hiscutt - While the member is on his feet, it was the factual part of the doctors' rankings that I was talking about.

Mr GAFFNEY - That is fine and we were given some factual information before but I have had other doctors sending me information saying that they felt that that was an incorrect assessment of that. I just want to put that on the Floor of the House.

Mr Dean - But you are supporting the amendment?

Mr GAFFNEY - I am supporting the amendment, yes.

Ms RATTRAY - A question to the member whose amendment we are looking at. Can I get some clarification on the second amendment? I understand leaving out the five years experience. In (ba)(i) and (ii) and (bb), does that mean if this is supported that you can have just one year of experience and meet those requirements in (ba)(i) and (ii) and (bb)? I want to have it clearly clarified that somebody with just one year of experience can be vocationally registered as a general practitioner or hold a fellowship with a specialist medical college and that person has relevant experience in treating. I really want some clarification on that.

Mrs HISCUTT - On my second speak while the member for Huon is thinking about that, (bb) 'the person has relevant experience in treating or managing the medical condition expected to cause the death of the person', is that referring to what I see as a specialist or is that covered by the vocational registered general practitioner?

Dr SEIDEL - Thank you very much. I may start by addressing the question from the member for Nelson with regard to training time and experience. That is actually the scope of practice we are dealing with, and the scope of practice is defined for general practitioners as well as for specialists in their field. It is not defined for medical practitioners who are not specialists in their field. It is not defined for medical practitioners who are not specialists or non-VAD GPs. It gets a bit complicated, but there is no definition there. However, within the VAD GPs who are specialist GPs and specialists in other areas, the scope of practice is defined. For example, a specialist who would not qualify to participate in the VAD process would be a cosmetic surgeon because I would not anticipate a cosmetic surgeon necessarily to have demonstrated expertise in a terminal medical condition.

With regard to the member for Montgomery's question on whether five years experience is adequate. Again, five years experience alone is not considered to be adequate anymore in medical training; medical regulations are moving away from defined experience towards demonstrating competence. That is why a moratorium would be considered redundant in this particular context and again it is the scope of practice that is important for this particular amendment as well.

With regard to the member for Mersey, I appreciate I have been called the 'doctor in the House' and that there are concerns about my credibility and credentials. Again, you ask different doctors and you have five different opinions. That is not that much different.

Realistically as a former clinical professor and national president of the Royal Australian College of General Practitioners, I have a really good idea about the current state of evidence in particular with regard to medical training and the provision that we made in the VAD legislation, certainly with regard to Victoria. So I am not surprised, but again it is not uncommon to have different opinions in science, medicine and health care.

Regarding the question from the member of McIntyre: does it mean you have only one year's experience? The answer is no, it does not mean one year of experience would be appropriate. Realistically, if you are dealing with vocationally registered general practitioners or specialist practitioners or specialists in any other field, you would need to have one year of medical internship after you have completed your studies plus a described course of postgraduate training. The shortest period of time would be an additional three years of postgraduate training for the medical specialty or general practice. That would be four years after graduation from a medical school in Australia or, in fact, in any other part of the world.

The shortest period of time you could have would be four years, not five years. That again is important. Five years is potentially a penalty and would disadvantage people disproportionately. It is just not necessary because it is about demonstrated competence in your area of expertise and within your scope of practice, and there should not be an artificial time limit.

Back to the question, four years would be the shortest period of time for the speciality of general practice and for other specialities potentially there is a longer period of time - so for physicians it might be five to six years. It just depends. But the shortest period of time to become a specialist or to be vocationally registered is four years after you have graduated from university.

Mrs Hiscutt - While the member is on his feet, he might want to address what I asked about his paragraph (bb). Is the member talking about a specialist or is it a vocationally registered general practitioner? Is this driving people towards the specialist?

Dr SEIDEL - With regard to (bb), where I specify the person must have relevant experience in treating or managing the medical condition expected to cause the death of a person, that is again within the scope of practice of the relevant speciality so it is very similar to the concerns the member for Nelson raised.

Ms Webb - Question, not concerns.

Dr SEIDEL - The concern is that it is the scope of practice that is important, and as a specialist and specialist registrar that scope of practice is defined. You need to operate within that scope of practice. If treating a terminal medical condition is not within your scope of practice, you would not be qualified as eligible for the VAD process as a medical practitioner.

Ms FORREST - Thank you, Madam Deputy Chair. I believe this is an appropriate amendment. I think the member for Huon in responding to some of those questions has dealt with this fairly well, but I would like to add a little bit.

It is not actually removing that five-years experienced medical practitioner, because for the person to be a vocationally registered general practitioner or hold a fellowship and have relevant training or experience in treating a particular condition means they have already done the five-year degree. I think they are all five years around Australia now. It was six at one at one stage, but it has been brought to five a few years ago. They have already done a year's internship which they do when they are first out. They usually then go on to do a year of residency while they determine which speciality they are going to do. Some will go directly into general practice specialty at that point, but often they do not get straight into the program.

You are already clocking up the years at this point of experience as a registered medical practitioner. As soon as you come out after five, if you pass your exams and everything, you are a registered medical practitioner and registered through the Australian Health Practitioner Regulation Agency - APHRA. To be a GP, you then have to go on and do further training, which is three years minimum, and GPs already have the medical degree. They then have this speciality general practitioner endorsement. As we all know, general practitioners are skilled in a wide range of medical conditions because they treat everything that comes in the door, except for serious emergencies which go to the emergency department. They do get some emergencies in their rooms at times and have to call the ambulance to get them to the emergency department.

To suggest this amendment removes the five years, essentially it does, but it puts in place a system that requires people specialised in dealing with the specific condition or having the experience of a general practitioner, who are specialists in their own right, to make these assessments. You often think GPs are just ordinary doctors. Well, they are ordinary doctors, but they are a specialty in their own right. They are a specialty in general practice and we should not underestimate that.

It is appropriate to specify this in the way it has been laid out. If this is supported, my amendment regarding conditional registration, which is in the clause, will not be necessary because this deals with that by a different mechanism. I am making that point. When we get to clause 4, if this is supported, I will not be moving that amendment. It is appropriate. It recognises the skills and expertise of the doctors who will be involved in this process and ensures they have the appropriate experience and expertise.

As the member for Huon said, they are credentialed to operate within the scope, but if it is not within their scope then they will not be approved for participation in this process. I hope it has made it clear about the five-year business. It seemed to be a little confused. You have to take out that bit in the clause and then insert the next bit. You are not just taking out five years. You are putting the rest of it in in place of it if you like.

Mrs HISCUTT - I have no problem with the five years. The first amendment is good. It is my lack of understanding, member for Huon. With (bb) -

> the person has relevant experience in treating or managing the medical condition expected to cause the death of the person.

Are we are we talking a layperson, which I am when it comes to this? Is this a specialist oncologist, or this someone like an oncologist, or is it the vocationally registered general practitioner, like a specialised general practitioner?

My concern is I do not want to see us pushing people through to what I deem to be a specialist, when their vocationally registered general practitioner, their GP, is quite capable of this. Is that what it means or do I have it around the wrong way? You might be able to explain that to me.

Mr VALENTINE - I have a similar concern in terms of, I suppose, access to the relevant medical practitioner. If you are on Flinders Island or King Island, how constricting will this be in relation to that?

Going back to what you were saying, member for Murchison, when you were on the Floor talking about the training, I am wondering about this five years experience being replaced. Is five years training equal to five years experience? You can be trained for 10 years and only have one year experience. I hear what you say about one year as intern, one year as residency. I am wondering about like for like in terms of the experience that it has actually had on the ground. Obviously the training is there and you have explained that very well. I thought that was a great explanation. I want to make sure that the experience on the ground is there as well as the question that the member for Montgomery had.

Mr DEAN - I wanted to look at (bb) and the way in which it is written. We have the position here where the person is a vocationally registered general practitioner or holds a fellowship of a specialist medical college, and the person has relevant experience in treating or managing the medical condition expected to cause the death of the person.

You might recall during some of the briefings we were given that we were told that with some patients - and I am aware of this and I guess you all would be - they suffer from two or three medical conditions, all capable of killing them and all capable of being terminal. I wonder at the way in which this is written as to how that would satisfy the circumstances. A person could be suffering from cancer, they could have some neurosurgical other problem as well or some other ailment which is critical, serious and terminal as well. What is the position if we have that sort of a situation arising?

Ms RATTRAY - I appreciate the member for Windermere raising that particular point. My question is to the member: could you have after (ba)(ii) 'or' and then go on to (bb) the person has relevant experience ...? I am concerned that we might be limiting this to the really good point that the member for Hobart made regarding access to the relevant persons, the relevant GPs or the relevant medical practitioner with the experience in areas that might be limited with their access to a GP. I am interested to know, would that upset the applecart if you like having an 'or the person has relevant experience' or does it need to all go together?

That will be something that you might consider in your responses because it is important for that access, particularly in areas where GP access is very limited. I have talked about that churn of locums and having someone able to do this and be that support person.

Dr SEIDEL - Obviously I did not do a good enough job to explain the various registrations or vocational registrations and specialist qualifications because it is really complicated. I think that is a fair enough point.

The amendment was specifically designed to improve access to specialist medical care. Specialist medical care is specialist general practice medical care as well, to be very, very clear. We have over 500 GPs in Tasmania who fit the description of being specialist general practitioners, either because they are a Fellow of the Royal Australian College of General Practitioners or they are a Fellow of the Australian College of Rural and Remote Medicine.

There are some GPs out there who are also specialist practitioners. They do not have fellowship of any of the colleges, but they have been grandfathered through a scheme in 2010. For definition, they are also specialist medical practitioners and specialist GPs. For the latter category, they are the ones who are vocationally registered, but can also be a Fellow of the medical college.

With regard to the question from the member for Montgomery - yes, any specialist general practitioner could do that. There would be no need for a specialist oncologist to be involved. The process could be run by two specialist GPs, but they have to be vocationally registered or a Fellow of the College of GPs or Rural and Remote Medicine.

Mr VALENTINE - To clarify, if there are two conditions this person is coping with, he can still do that with one person.

Dr SEIDEL - Certainly, absolutely right. Realistically, if you think of it, the general practitioner would be well within the scope of practice to assess, manage and treat a medical condition and that is often with input from other specialists, but the assessment, management and treatment certainly would be within the scope of the speciality of general practice.

With regard to access, the member has specifically written to improve access, particularly with regard to rural and remote areas in Tasmania. We have the workforce in Tasmania, because we have done such a good job to ensure people go into a GP training scheme, become vocationally registered and become fellows of the two respective colleges.

With regard to the member's further question, we move away from experience towards demonstrated competence. Sometimes it is impossible to demonstrate competence without experience so again, with regard to training, you would need to have seen and demonstrated certain medical conditions. To have treated and assessed the patient with a particular medical condition is part of the curriculum that informs the training of GPs and indeed other medical specialists also. That is why there is this required training time to achieve that.

With regard to member from Windermere's question - yes, if we have three medical conditions and they are all terminal, again that would be considered well within the scope of practice for a general practitioner.

Mr Dean - Why is it written the way it is, if that is the case? It is written here that the person has relevant experience in treating or managing the medical condition. If what you are saying - and I am not disputing what you are saying - is right, it could have been written in a general way that is accepted, that a person with that background and experience has all the qualifications to treat all the issues that might be going to cause the death of a person. It is particularised here.

Dr SEIDEL - It is possible. We could write a medical condition or medical conditions but it is not going to change to main intent of the amendment, and that is a medical practitioner needs to have demonstrated competence in any of these areas or conditions that could result in the death of the person.

Ms RATTRAY - Before the member leaves the lectern, my question about do you need 'and' between (ii) and (bb) or could you have 'or'?

Dr SEIDEL - My recommendation would be to leave 'and'. I do not think you can have 'or' because if you had 'or', it would open up the area to all non-VR medical practitioners. It has to be a qualifying condition so 'and' is absolutely essential in those amendments.

Ms RATTRAY - Again, before the member leaves, if you had that focus on training and it does not necessarily need experience, it is the training that is relevant, why do you not have relevant training and experience in treating?

Dr SEIDEL - We have dealt with the training in the previous section, so the training is part of the vocation of the registered GP, who can potentially also be a Fellow. The training aspect, not the experience aspect, has been dealt with in (i) and (ii).

Ms Rattray - Good question though.

Amendments agreed to.

Dr SEIDEL - Madam Chair, I move that clause 8(b) be amended by-

Third amendment -

Leave out 'within the 5-year period immediately'.

There is an argument for credentialling medical practitioners who have demonstrated expertise, but who also need to be specifically credentialled with regard to the VAD process. That is not dissimilar to what the Victorian legislation provides, it is not dissimilar to what the Western Australian legislation provides, and it is not dissimilar to the legislation as proposed for Queensland. There is an additional credentialling process there.

The question really is whether we need to specify a time period for that. The question is whether credentialling can be done at any time; it just has to be done, it has to be credentialled.

Whether it is within five years, or every three years, should actually be inconsequential for the process; it needs to be a credentialling process.

Again, that is not dissimilar to any other area of health care. For example, if you provided contraception through a certain device, you need to be credentialled, to be doing a training course. If you are providing other services that require certain credentialing, you do a one-off credentialing, and it becomes part of your scope of practice, and you will demonstrate expertise while you are performing those therapies, or while you are offering those particular treatments.

With regard to the VAD process and the credentialling process, my recommendation is to leave out the 'within the five-year period immediately', which is actually redundant with the regard to the credentialling of the already qualified practitioner.

Ms RATTRAY - I thank the member for that explanation. I am interested to know whether this aspect will be one that the commission will be looking at. Will that be part of their role? Is that something the member might be able to address? Seeing as we are taking out that specific reference - if the amendment passes, of course - 'within the 5-year period immediately', and I will read it without that -

> the medical practitioner has successfully completed an approved voluntary assisted dying training course -

And take out the suggested words -

> before the person makes a first request to the medical practitioner under section 16 or is referred to the medical practitioner under section 35(1); and

We are asking the medical practitioner to have successfully completed the approved voluntary assisted dying training course, but it does not matter when that has to be - but who will look and make sure that is being approved and everything is being complied with? Is that a role for the commission?

Ms WEBB - I am rising to again ask a clarifying question rather than raise a concern, because that is important and I would like to be accurately represented in what I am doing. I do not believe it poses a problem to take that out. The way it might be a little different to the credentialling is that this training is not about medical proficiency as such. It is a broader training about the legal process and all the different aspects of this VAD process as defined in legislation.

Probably the concern might be that if it was not quite contemporary training that had been undertaken, potentially time has passed, potentially reviews have been done and legislation may have been changed, that sort of thing.

I do not know that we need to anticipate that, though, and try to capture it here. I think that this amendment can probably function, and what would be appropriate would be potentially in regulation when the training course is being approved and developed, and when regulations are being made, probably other sorts of details around that. It could be something that is recognised in regulation that should the bill, for example, be significantly amended at some future point, those who have undertaken VAD training need to renew that training; that is what I am thinking. At the moment, we do not necessarily need to capture or anticipate that here.

It is worth pointing out that we can imagine times that we might expect that those who had undertaken VAD training at some further times past, may need to have it updated, and it be a more contemporary reflection of that training.

I do not have issue with the amendment, but I think it should be something contemplated as implementation around the training, and potentially contemplated at a regulatory level underneath the legislation if necessary.

Ms Rattray - There would have to be some body looking at the compliance of meeting those standards.

Ms WEBB - The member will answer, I am sure, what you said, and he will probably say it is the commission, but that is fine.

Mr GAFFNEY - I have a concern with this amendment, and the concern comes from when you go out to the public to sell this bill or sell this position, you go out saying you are putting in as many safeguards into the bill as we can, and we want to assure you that the medical practitioner who volunteers to do this gets some extra training to do with the bill, so they understand the process. That is why we put in clause 115(3).

It is not like in Victoria, where a body of medical practitioners is represented. We went -

(a) a body which represents medical practitioners; and

(b) a body which represents registered nurses; and

(c) a person nominated by the Public Guardian within the meaning of the Guardianship and Administration Act 1995; and

(d) a person nominated by the Chief Civil Psychiatrist within the meaning of the Mental Health Act 2013;

(d) a psychiatrist or psychologist.

because we were approached by a number of concerned advocates for disabilities and mental health issues who said many doctors may not be aware of many of the nuances in dealing with a person who may have a mental uniqueness, and they therefore wanted to make sure the training modules reflected the public and the community.

That is why we did that part of the commission, so that it was a much broader modular-type approach than, say, in Victoria and Western Australia, where they specifically deal with the doctor part, the medical practitioners.

We had to convince the community that whichever doctor was involved with the process, they would have undertaken a relevant course of training that would deal with all those modules. We went five years to start with, to get the ball up and rolling. We were thinking that at the end of the first three-year review period, the question might be raised that doctors do not have to do it every five years. It might be when there is a significant change to the module, or something else comes along which has been introduced.

From my point of view, introducing a bill, it was important when the community was asking any medical practitioner, to say, yes, but they must volunteer and they must have done the training. That has been a very big selling point, a marketing point and a point of reassurance for the community that the person they are dealing with not only wants to be volunteered, but has also undertaken the appropriate training, that they know definitely the processes and are aware of the other aspects that could be in the bill to make it a more holistic approach to the safety and wellbeing of the person, not just from a doctor/person relationship.

This is why I will not be voting in favour of this, although I understand where this might go. In the first instance, to introduce into the bill, I believe, 'within the 5-year period immediately', everybody knows if they go to see their doctor and they say, 'Yes, I want to be your primary medical practitioner', that person knows that doctor has had training, and that training is ticked off by the commission and if that training is out of date and nothing changes to the act, then that is part of the reason why the commission is there to say you must redo your training unless something happens in the next three to five years within the review.

Whilst I agree with the fourth amendment, because we looked at that very carefully about how best could we reassure the community all the doctors had done the correct training and that was one way of doing it, we felt that was a fair and reasonable approach to try to reassure there were safeguards within the legislation. People could say, yes, my doctor who is doing this is up to speed with all of the modules, has done all of the work within the five-year period, because that could change.

I will be not supporting this amendment.

Mr VALENTINE - This is obviously much more serious than somebody having first aid training, but we expect people administering first aid make sure that their practices are up to date and relevant. When we are dealing with somebody in this circumstance it is very important that they understand the system not only for the individual's sake but also for their own sake from the legal perspective.

I do not know that I support this amendment. I do not think it hurts to make sure our medical practitioners assisting in this regard are seen to be competent. It is probably not necessarily the right term to use - that they have the training and fully understand the process. That there is no chance when dealing with a person who is wanting to die, the doctor is going to inadvertently lead them down a path that for some reason is not valid. It is important this is contemporary. That their understanding of the process is contemporary. That is way I see it.

Ms RATTRAY - In regard to the member for Hobart's point regarding having up-to-date training, who checks? Where are the checks around when somebody has had their training? Again, it comes back to, is this the commission's role? Do you only have to do it once? Within a five-year period. Say we take that out if the amendment is successful, I would like some more detail on how that process is going to work. Apologies if the member for Mersey has already provided this as I needed to step out.

Mrs HISCUTT - I am toing and froing here with this third amendment. I hear what the member for Huon says about competence qualifications. I can only refer back to what I understand and I know that within the agricultural system, a lot of the apprentices are now competence-marked. It is not sitting in the classroom ticking off a box; you have to be able physically to do it, so things are moving that way - if you can do it, yes, you get the tick you can do it.

As the member for Hobart says, we are not talking about a first aid course here. So the jury is out on this one for me at the moment. I am erring on the side of not going with it because I think there is nothing wrong with the five-year, know what you are doing-type of thing. That should be the way it goes. I can understand where the member for Huon is coming from because of the competence-based qualifications, but it is not a first aid course, is it?

Mr GAFFNEY - The way I see it at the moment, member for McIntyre and member for Montgomery, is that it was the role of the commission to ensure that each medical practitioner, each doctor, is up to date with their training qualifications. I suggest that they would set up a time frame eight months out from 'Dear Dr so and so, you need to renew'.

I am not suggesting but I think this will be worked out effectively. It might not be a case where they have to go back and do the 10 modules or whatever again, whatever they decide to be an appropriate training course. It might be that one section of a module has been reintroduced since they did their training a year or two years ago so they may have to repeat that. I think that would work out with the commission organising it.

With all due respect to our doctors, who are brilliant at what they do, some of them do not have the bedside manner that perhaps a nurse would bring into that relationship, or somebody who deals with somebody who has difficulty communicating or has a whole range of different unique characteristics. I think it is really important in this process, that our medical practitioners are exposed to the whole range they will get out of the learning program. I think that for the first five years that is not an unreasonable expectation because that is what I would want, so that every doctor or nurse who goes through this gets that experience and then there is a comfort within our community that they have all been trained appropriately.

I hear what the member for Huon is saying - that it will come as part of the deal - but I think it is better if it is worded within the five years. That would give the commission a clear indication that one of its responsibilities is to make sure that every medical practitioner who volunteers is authorised to do it because their training is up to doing it. In fact, if it is not up to date, they cannot make a determination. They cannot be a PMP because that is one of the reasons they have to be, so I encourage members in this place not support this amendment.

Mr DEAN - I certainly will not be supporting this amendment because I think it is the wrong amendment. I agree absolutely with the member for Mersey and the other members who have spoken in relation to the issues here.

We all know that with any specialist training, any training at all, there is a requirement for refresher training at periodic times right through it. I could go back to my previous employment where the specialist people employed within the police department are required to have refresher courses every 12 months in some cases. I know in one part of it they have to have refresher training every two to three months so this a specialist area we are talking about. This is dealing with the people's lives.

We know people do forget things from time to time and things continually change and are changing all the time. The fact that the person might have had the training, the approved voluntary assisted dying training, 10, 12 or 14 years ago does not necessarily make them competent in that area at a later stage without having had the refresher course.

The way it is written is good; it is solid and sound and people accessing this sort of treatment and requirement could be satisfied that it is being done right and they are getting the right support and assistance.

I certainly cannot support this amendment.

Ms FORREST - I fully understand the issues around credentialling, and competency and competency-based assessment is the way we all go now. I note the member for Mersey referred to clause 115 which describes how the training program is developed and the broad range of people who are involved in that. That is appropriate and we will get to that at a later time.

The commission's job will be to determine the appropriate course of training and to ensure that the relevant people are engaged in that. I hope that the commission would also consider providing a refresher rather than a full training course for those who may need to update, particularly should the legislation change. All medical practitioners and nurses must comply with the acts they operate under at the risk of losing their registration if they do not or there is some professional misconduct or unprofessional conduct.

I hear what the member for Huon said - once you are credentialled and you are competent, you are competent. As a health professional, as a nurse, a midwife, I had to do annual CPR training. There were a few others we had to do: emergency management, the different codes that we had to do and some of the other training in terms of being up to date because if you are not, you cannot tick off on your competencies as you are required to with your registration. The member for Windermere talked about this with the policing - the need to constantly be up to date and do refreshers.

Whilst the initial training program should be very comprehensive to ensure that all health practitioners who operate under this understand all their obligations clearly, they are also instructed in the psychological impacts with the involvement of a psychiatrist. With a psychologist and the Chief Civil Psychiatrist, there would be consideration given to those matters about assessing decision-making capacity, another really important aspect of it. You have also got the body that represents nurses and medical practitioners as well from that clinical point of view.

I also hear the comments made by the member for Mersey when drafting this particular provision, to give confidence to people in the community that their medical practitioner is up to date with this. They can do the training, be up to date and nothing might change so a refresher would reiterate that, making sure that they are up to date with the decision-making frameworks and all that sort of stuff.

We do not need to prescribe a refresher course in legislation. That would be something the commission would do, and I am sure that would be an appropriate response to updates or refresher programs rather than the full training program.

I appreciate the fact that once you are credentialled in an area you are credentialled. Things like putting in an IUD does not really change. We are talking about credentialling for certain practices. I am not talking about IUDs being relevant to this bill. I am saying that is a matter you can be credentialled in. Nurses can be credentialled in a range of different areas too.

Taking this five-yearly currency requirement away is not necessary and it can potentially undermine public confidence. I will not be supporting the amendment.

Ms WEBB - It has been really interesting to hear this debate and I really appreciate the contributions made by members. While I began in my first speak by saying I do not believe it is a problem to take this out and make this amendment, I am now convinced from hearing from a number of colleagues here there is value in leaving it as it is, because of community confidence. Because of it being an explicit expectation there is contemporary understanding and training. I have been convinced of the value of this and that would best be achieved explicitly in the legislation, rather than relying on perhaps it may or may not be appearing in regulations.

Thank you for the contributions. I appreciate the assistance in thinking it through.

Dr SEIDEL - The intent to remove the five-year clause was really specific to make it actually not contemporary because you could have done the course four years ago and then six months before you are trying to engage in the VAD process, the VAD substance may have changed. To say you have done a course four years ago would not be good enough. I would very much hope the commission would say no, because we have changed the substance you need to have an update on your training. So it is very specific, very contemporary.

To describe the time frame for every five years might not meet the needs of the patients or the practitioner, so it should be contemporary. In a very similar way, if you do your IUD credentialling, if the IUD actually changes and the device changes you need to retrain again, you need to be re-credentialled. When you are medical practitioners and you are trained in reading an ECG for example, I am getting re-credentialled every three years on how to read an ECG. That does not seem to change. It is different compared to CPR and so forth as well. The reasons why we re-credential CPR or try to demonstrate competence in CPR is because the CPR protocols change all the time.

Let us make it contemporary. Let us ensure they are qualified medical practitioners who are a different medical practitioner than the member for Mersey had in his bill originally. Remember, before it was medical practitioners, and you do not have to be specialists of any area particularly. You do not have to be Fellows and for them, fair enough. There could be an argument made for saying you need to have more comprehensive training and we need to have the training every five years or so, but because we are now dealing with qualified specialists it is absolutely important for them to be credentialled. To prescribe them to have training every five years, no matter what, might not be meet the need of the patients and the practitioners.

Mr Valentine - This is about process as much about medical procedure?

Dr SEIDEL - That is right.

Mr Valentine - Is it protecting the person seeking VAD? They can be sure the person is up to date with what the processes are, not the medical procedures, but the processes?

Dr SEIDEL - Absolutely right.

Mr Valentine - I do not know that credentialling the medical procedure equates with that.

Dr SEIDEL - You are absolutely right. But if the processes change, then the medical practitioner may need an update or re-credentialing in a shorter period than five years. If you want to make it contemporary, the commission would be allowed to say you need to re-credential, although we appreciate you had formal training only just 12 months ago, because things may have changed. So, to put five years in there does not achieve anything to ensure contemporary practice and the contemporary credentialling of medical practitioners who are involved in the VAD process.

Mr GAFFNEY - Actually, it reassures the community that at least every five years the medical practitioner doctor will be updated, or kept up to speed, with the new modules and thinking. If something comes along that needs to be alerted to all the medical practitioners on the commission's list then they would be sent out something saying, 'By the way we have another module now. This has been updated. The substance has changed and so therefore you will need to do this'.

That can still happen and happen through the commission. We are not stopping that, but what we are saying is that at least every five years, everybody dealing with this is going to be up to date. That is good. I do not think this is an either/or. This is the baseline and then if something comes along where the substance might change, or something might change in the knowledge about how to deal with somebody who has a certain condition, then that would be updated and changed as needed.

Whilst I understand where the member is coming from, this makes common sense for our community and I encourage people to vote against the amendment.

Mr DEAN - I will be very quick with the comment I am going to make here. If you do not continue to have refreshers - and this is what the member for Huon is deleting here, to have refreshers - and being kept up to date, and you continue to practice in that same way that you have over that period of time, the way you are practising may not necessarily be the right way. There may well have been changes in that period of time from when you first did that course. There could well be changes, so you continue to practice in the old way, the old method, repeating your errors over and over again. Ten years experience in a job is not necessarily 10 years experience. They used to say in the Police that it is probably one year's experience repeated 10 times, which does not give you any more experience at all, whatsoever.

I cannot support this amendment. As I said before it is the wrong amendment and does not do justice to what this bill is about.

Ms LOVELL - I have been listening to this debate with a great deal of interest and find the arguments being put forward fascinating. I appreciate members are speaking openly and frankly about this.

Mr Valentine - That is what we are her for.

Ms LOVELL - That is true. Democracy in action.

This comes down to the fact that when I go to see my doctor for any reason I trust my doctor is up to date with their training. I trust they are competent. I trust they are competent, because they have undertaken their years of training. There is not another procedure I am aware of that I go to the doctor for where they are required to do regular updated training every five years, unless something changes. With any procedure doctors are required to retrain.

If we want voluntary assisted dying to become an accepted and a normal treatment option for people, then I do not understand why we would treat it so differently in relation to the training required. We do not retrain neurosurgeons. We do not require them to do their training every five years. We do not require heart surgeons to redo their training every five years. They maintain their competency, but not by requiring them to redo their training course every five years.

Mr Dean - They have to keep up to date with what is going on.

Ms LOVELL - Yes, which in this instance is, despite removing this requirement, doctors would still be required to keep up to date. If there are changes to the procedure, if there are changes to the process that would be reflected in the training, then they would be required through the commission to update their training.

I accept members might not agree with this, that it is fine, you are entitled to your opinion. My opinion is I trust my doctor to be up to date with contemporary practice. I trust my doctor to know what they are doing when I go to them for treatment and for advice. Personally, I do not consider this to be any different. We do not require people to retrain as a matter of course based on a time frame for any other procedure.

Mr Dean - We do.

Ms LOVELL - No, we do not, not for a normal medical procedure, which to me this should be.

Mr Dean - Maybe you should talk to the member for Launceston. She might tell you of a big error that was made.

Ms LOVELL - I am not talking about errors. Member for Windermere, that is an interesting point you make because you raised the point that if somebody is doing something the wrong way and they are not regularly doing their training every certain time, whatever that time frame is, that they are going to continue to make those same mistakes. If somebody is making mistakes in this area, that is going to be picked up. This will be monitored by the commission. Part of its role will be to make sure this legislation operates the way it was intended.

Mr Dean - It should not be up to the commission to have to do that. The doctor is already kept up to date.

Ms LOVELL - That is part of the commissioner's role. Any health practitioner making the same mistakes over and over again is picked up, believe me.

Mr Dean - The way this is written, it is right.

Ms LOVELL - It would not stop it from being picked up. It would not prevent the commission from requiring doctors to undertake updated training if the training significantly changes. I have been really intrigued by this debate and quite fascinated by some of the arguments put forward.

I will support the amendment, because I trust that my doctors are up to date with their competencies. We are talking about basing this on competency, not basing it on a length of time, or a training course being undertaken in a particular period of time, or a particular amount of years of experience. We are talking about competency. We have agreed to that in the previous amendment. We either agree that it is competency-based, or we do not. I agree that it should be competency-based, so I will support the amendment.

Ms WEBB - It is an interesting one. At other times in the debate we have talked about what community expectations and community confidence might be promoted through the inclusion or not of things in this bill. We have talked about who can be trusted with oversight to a certain level or a lower level.

I think we should probably apply fairly consistent thinking to all the players involved. Hearing more about this, I am more convinced that leaving it in this bill - that a five-year time frame is required to refresh training or re-engage with training - is a very modest and reasonable expectation that would be there.

We are not talking about just any other medical procedure, because this is not just a procedure, remember. The training is not just about performing a procedure. What we are talking about is a significant process, a multi-stage process. It involves multiple stakeholders and professionals, multiple decision points and assessments to be made. It has a legal component and it has a medical component to it.

That is the training we are talking about, and the competency is not a simple matter of medical competency. Competency is about competency in the process. To my view, it is absolutely not comparable to any other medical process that you expect a doctor to know how to do. It is just a procedure generally - not a multi-stage, multi-decision-point, multi-level process that this is.

The other thing around that is we can leave the five-year element in the legislation by voting against this amendment, and still have the expectation that the commission - in designing the training, and then setting up the arrangements around medical professionals doing the training - can include, through regulation or requirement, that should new things arise - should new elements be introduced to this process or this legislation at any point - refreshers are required then too. To leave the five-year expectation of refresher and re-engagement in there ensures that it does happen, and allows for other nuanced updates and refreshers.

If we take it out, and we say the expectation is that updates and refreshers will be dealt by the commission in the regulations and elements that come through that subordinate process to this legislation, we risk that it might not be done in a manner that, we, as the legislators of this legislation now, would feel confident in or would agree with.

For us, when we are thinking about this bill and whether we can ultimately vote for it, we need to have confidence that it contains the minimum that we want to see there, knowing that can be added to through regulation, and through the processes that are built in the implementation phase.

It is a big ask to expect us - as legislators on this highly sensitive topic and complex process that we are building here - it is a big expectation to think that we will leave things on trust to that next stage.

I do not think we lose anything by leaving this clause as it is. I think we risk something putting an amendment in there. It might be a small risk, but as legislators it is important for us to think about it. I will not be supporting the amendment.

Amendment negatived.

Dr SEIDEL - Madam Chair, I move that clause 8(d) be amended by -

> **Fourth amendment -**
>
> *Leave out* all the words after 'indirectly,'.
>
> *Insert instead* 'benefit from, or directly or indirectly receive a financial benefit as a result of, the death of the person, other than by receiving reasonable fees for the provision of services as the PMP, CMP or AHP of the person'.

This is meant to be a very simple amendment, and basically just stipulates that a health practitioner who is involved in the VAD process is still allowed to receive a reasonable professional fee for the services. The legislation, and the paragraph as it currently stands, would potentially be a direct conflict with receiving a reasonable professional fee, and that is why I felt it was appropriate to specify that as part of the amendment.

Mr GAFFNEY - We support this amendment. We think it is a good one.

Amendment agreed to.

Clause 8, as amended, agreed to.

Clause 9 agreed to.

Clause 10 -
When person meets residency requirements

Ms LOVELL - Madam Chair, these amendments are the amendments I referred to when we debated my earlier amendment, which is changing the wording of 'Commissioner' to 'Commission', to reflect the amendment we voted on earlier in the evening. I will read them and move them together.

I move that clause 10 be amended by -

First amendment - clause 10(2) -

Leave out 'Commissioner'.
Insert instead 'Commission'.

Second amendment - clause 10(3) -

Leave out 'Commissioner'.
Insert instead 'Commission'.

Third amendment - clause 10(4) -

Leave out 'Commissioner'.
Insert instead 'Commission'.

Fourth amendment - clause 10(4)(b) -

Leave out 'Commissioner'.
Insert instead 'Commission'.

Amendments agreed to.

Mrs HISCUTT - Looking at 'residential status' in the bill, I am thinking of my personal circumstances as a parent living in Tasmania, and I am sure it happens with other people, where we have children on the mainland or overseas who have been there for quite a while.

Does the commissioner have the ability to make a judgment call if, say, that child no longer has residence in Tasmania, or a driver licence or anything to say they are still Tasmanian? Are they able to be brought home to the parents' home for nursing and caring in a situation where they were facing these terrible diseases, and perhaps looking at this finality to their life?

Do you envisage the commission, as it is now, having leeway for those sorts of circumstances, bearing in mind that many of us as parents have children on the mainland or overseas who have been there for a length of time and no longer reside in the state.

Mr GAFFNEY - I have to say the residency part of the criteria is one of the improvements we have had in this bill compared to Victoria and Western Australia.

Mrs Hiscutt - I am sure you understood I meant an adult child.

Mr GAFFNEY - One of the things they found in Victoria was that there was a bottleneck because some of the people who had lived in Victoria, who may have lived there for 60 or 70 years, had not taken out Australian citizenship - they had not become permanent residents. Then when they needed to, they found to become a citizen was a long, delayed process and it was not easy to get all the paperwork done.

One of the people from Victoria said the proposed Tasmanian bill allows access for patients who have lived in Australia for three years, regardless of citizenship or residency status. They had several cases where people who have lived in Australia for many years but have never taken out citizenship or permanent residency are excluded from accessing VAD.

We did not want that to happen in Tasmania. If you go back to those documents we put out two weeks before this was tabled, I included one submission from a gentleman from New South Wales, the only non-Tasmanian - and there was another from Canada - who wrote to us saying 'Please, can you allow your residency criteria eligibility to include people from other states?'. In New South Wales they do not have VAD, nor do they in Queensland, South Australia or NT.

We took the lead of other states here; Western Australia and Victoria said you had to be at least a citizen or living there for 12 months. What we came up with, I think, is a fairly robust way of saying the person is an Australian citizen or is a permanent resident of Australia, has been resident in Australia for at least three years continuously immediately before the person makes the relevant first request, and the person has been ordinarily resident in Tasmania for at least 12 continuous months immediately before the person makes the relevant first request.

There are some other residency requirements there but rest assured, the person who travels to the mainland and has six months on the mainland, has lived most of their life as a permanent resident here in Tasmania, can travel back. The idea of a young person living overseas - if there was any discrepancy, they could apply for the commission to have a look at that and the commission could make a determination on it.

If the PMP, the primary medical practitioner, was not certain of the residency requirement, they could put that case to the commission and the commission would make a determination. They could assure the PMP that they have looked at the situation and they have ascertained that the person satisfies the criteria or not. That would not happen very often.

Ms HOWLETT - Can I clarify: are you stating that if an adult child is studying, for example, in Sydney or South Australia, they can apply for an exemption to come back to Tasmania?

Mr GAFFNEY - In that situation, if an adult is training overseas, they would be ordinarily resident in Tasmania, being a Tasmanian resident, and that would be fine.

Ms HOWLETT - Their driver licence? If their driver licence stipulates a non-Tasmanian address?

Mr GAFFNEY - They may provide the commissioner with a statutory declaration as to where at a particular time the person is or was ordinarily resident. There is a process there that they can apply to the commission for verification of that.

Ms HOWLETT - What would that time be? Would it be two years, three years of living interstate?

Mr GAFFNEY - The residency requirement is 'ordinarily resident' which means they would pass the residential requirements here so they would be accepted.

Ms LOVELL - I just wanted to clarify this because I think there is some confusion over it. My understanding - and I will try to articulate this clearly - of what the member for Prosser and the member for Montgomery are asking is whether, hypothetically, an adult person who falls under the age requirement, who may have grown up in Tasmania, and their family are here in Tasmania, but they now live in Melbourne or another mainland state, and for all intents and purposes are a resident of that state: would that person be able to come home to their family and be eligible or be able to apply for an exemption to the commission from the eligibility requirements, the residency requirements, currently in the bill?

Mrs Hiscutt - That is what I was trying to say.

Ms LOVELL - My understanding is that they would not. They would have to be an ordinary resident of Tasmania and the instances that the member for Mersey was describing where the residency of that person might be unclear because, again hypothetically, they might live in Tasmania but not have reapplied for their driver licence - they may have been living in Tasmania for 12 months but someone's driver licence could still be Victorian.

That person could apply to the commission for a review of that to prove that they are an ordinary resident of Tasmania but they still need to be an ordinary resident of Tasmania for 12 months to be eligible under this bill, and there are no exemptions to that requirement. That is my understanding so perhaps if the member for Mersey could confirm if that is correct. I think that is the question.

Mrs HISCUTT - Just for clarity, that is what I am trying to say. For example, my son is 35 and he is not a child. He lives in Sydney; he no longer has contacts with Tasmania. He has a New South Wales driver licence; he has a New South Wales residence.

So, being my son, if something were to happen and he wanted to come home, would there be any leniency because it clearly says in clause 10(1)(b), 'for at least 12 continuous months immediately before'. Well, he would not qualify for that. I really think, as the member for Rumney is saying, he would not qualify because he has been out of the state for a year and he now resides permanently elsewhere. As a mother, you cannot bring that child home for nursing or to access VAD because it does not stipulate in this bill. Is there room for leniency within the commission for that to be able to happen?

Ms WEBB - I am going to add to that because these are all the same questions I had marked up for this section. I think there may be even greyer areas than the example just provided by the member for Montgomery with a distinctly adult child who lives in another state and is residing there, with owned property and those sorts of things.

My clarification relates more to the tenuous situation - in fact I just asked questions this morning in this Chamber in relation to the COVID situation about students. Adults but students who live in other states, whose families are still based here, who are living as students potentially for four or five years while they are completing study and residing in another state, would still consider themselves to be Tasmanian, residents of Tasmania. They would come back during semester breaks, during holidays. It is being reported to me that at the moment a number of them are finding they are not allowed to come back because they are not regarded as residents here anymore. So that is the question I asked this morning in the Chamber.

I think those same issues, particularly for that cohort of young adults who are residing perhaps out of the state for a period of a number of years, but perhaps temporarily to ultimately return - and certainly still based here in a family sense - who if they were to find themselves with a relevant medical condition under this bill and would likely return to the state to be cared for by their family, on my reading of this part about ordinarily resident there in part (b), they would not be eligible to access VAD here in those circumstances.

This is a very tiny hypothetical situation we are contemplating, but the COVID situation has highlighted there are a number of people who are potentially in this situation. Therefore, this could become a relevant conversation and it would be a sensitive one. We have this exact situation in my family. I would be interested to know the resolution available as to how that would be dealt with. Maybe we cannot clarify it further here today based just on this clause. My reading though it is black and white they would not be able to access it, because they would not have in proposed subsection (5) any of those elements to show they are ordinarily residents. They might have a driver licence for the state that they studying in. They might have a lease there. They might have enrolled to vote there because they are going to be there for a four- or five-year period while studying. They would be lucky if they had purchased property as a student, but they may well be based there in that sense of driving and enrolled to vote.

The member for Mersey may not have a categorical answer for us at this moment but there is not anything in there at the moment that says the commission has discretion to scoot around that section (b) there about ordinarily resident.

Mr GAFFNEY - Madam Chair, the intention of this section is to ensure any Tasmanian that has been ordinarily resident here has the capacity to come back and be catered for under this act. If they are a student, on the mainland or whatever.

I would like to report progress on this. How do you postpone?

Madam CHAIR - We have a couple of options.

Mr GAFFNEY - I would like to postpone the clause, come back when we come back in two weeks to ensure what is being discussed here is actually catered for within this, if that is possible.

Madam CHAIR - We can report progress. At this hour knowing we are not possibly going to get through the rest of the bill at this time, we need to consider the time when we could report progress to continue the bill at a later time and we pick up at this point when we come back next sitting week.

If you are going to move to report progress, that will be an option.

Ms LOVELL - I wanted to be clear and to put on record whilst I was explaining the hypothetical situations before, it would be my view, and I understand there is no amendment before the Chamber at the moment to capture that scenario, that there should not be an amendment. At this point I would be inclined not to support an amendment because I believe these residency requirements are in the bill for good reason and they should be in the bill. It really should not be up to the commissioner to determine exemptions to that. My argument for that mainly is when we think about who is going to be accessing voluntary assisted dying, we are talking about patients who are terminal. We are talking about patients who have a long ongoing medical condition. They will have, you would expect in most cases - I would be surprised if not in all cases - an ongoing relationship with their medical team over a lengthy period of time. I would be very surprised if there were any circumstances where it would be appropriate for somebody to leave that medical team in the state where they do reside, to come home to be with their family and have doctors or medical professionals in Tasmania who would be willing to pick that up and facilitate their access to voluntary assisted dying with no history or involvement in the care of that patient or the management of their condition.

Mrs Hiscutt - I know of two circumstances already, unrelated to me, of two people I know who specifically came home to die.

Ms WEBB - And I understand why someone might want to do that, and particularly for the family why they might want that person to be at home. My concern would be around what involvement we would be asking medical professionals to have in that circumstance, without being involved in that person's care to that point. Whether there would be medical professionals who would be willing to do that and what sort of precedents that sets in terms of access generally.

It is a little problematic. If people want to move amendments they can move amendments. I am not suggesting we do not report progress at this time. I want it to be clear in light of my earlier comments about my position on that and where those comments were coming from.

Mr DEAN - If I can raise an issue as well. It is along similar lines. I can use a good example here - if I look at (a)(iii) 'has been resident in Australia for at least 3 continuous years'. I can give an example here to explain what I want to do here. A close friend of mine is resident in Australia, resident in Tasmania, and has been resident here for the last 70-odd years but they went on a cruise and were away from this country for several months, it was a world cruise. They came back and within a relatively short period after that he was diagnosed with cancer and suffered tremendously. He passed on within a fairly short period of time after that. In that situation would he satisfy the criteria as it is set out here - 'has been resident in Australia for at least 3 continuous years immediately before the person makes the relevant first request'? Would it satisfy that?

Mr GAFFNEY - If the person is an Australian citizen, which your friend would be, or is a permanent resident of Australia, which they would be, number (iii) is for an international person who is coming into Australia and would be here for three years in Melbourne or Sydney. They relocate to Tasmania. They would have had to have been a resident here for at least 12 months before the first request, before they could start the process. With (iii) and (b), we might have people living in Australia, who are not Australian citizens and not permanent residents because they have not done the right paperwork, but they could have lived here for 20 years. If they can prove they have been here for at least three years in Australia and then of those three years, 12 months in Tasmania before the request, in that situation they would qualify.

Ms WEBB - To clarify around that situation of going on the cruise, they would still have qualified as being ordinarily resident for the 12 continuous months because even if they were away for a few months on their cruise they still would have been enrolled to vote here, have a driver licence for Tasmania, owned property in Tasmania, the things that are over here in number (5) that define ordinarily resident would apply to them, and they would be regarded as ordinarily resident, I believe.

Mrs HISCUTT - Member for Mersey, I was looking for clarification on the question I asked. I received that clarification and I know the answer. I was not looking to make any amendments or anything. I am satisfied with the answer, not happy with the answer, and I am happy to vote on the clause and move on. So it is your decision.

Mr GAFFNEY - Thank you. That would be my preference but what I will do - I hear what you are saying and I know this legislation was written in a way so that the person would be capable - I will find again from OPC what we have missed out in our thinking on this. We looked very carefully at the residency one, because we want to make it more appropriate and better than what they had in Victoria.

Mrs Hiscutt - While you are on your feet, there are a lot of people's parents in Tasmania whose children have moved away, and even though the family still resides here, the child may not, that was the only thing I am thinking of.

Clause 10, as amended, agreed to.

Mr GAFFNEY - I will move that we report progress. However, I am concerned that we need to get this bill dealt with and there are other bills on the Table we need to do as well. We have only one more private member's day before the lower House begins, so if we are going to deal with this bill - I am happy to report progress - I will be looking at ways where we can lengthen our sitting the next Tuesday to get this bill completed. I have indicated it would be an 11 o'clock finish, which is my preference, but it is the will of the Chamber in this.

Mr DEAN - Point of order. I think I have the call when we resume on Tuesday fortnight; however, I need to talk to the member about that because I do not want to have two bills running together; that would not be desirable. I am also getting to the stage of running close to the end of the year. We will work something out.

Madam CHAIR - The reality is that it is late and we are not going to get through this bill tonight; we need to consider the staff as well as the members here. If the member for Mersey wants to continue, we can call the next clause and see how it goes, but any other member can get up and move we report progress. It is the will of the Chamber, and we need to be sensible about our approach. It is up to the Chamber, but this is an important piece of legislation that deserves to be debated fully.

Ms Howlett - Is there any way we can start earlier?

Madam CHAIR - Those matters can be discussed with the Leader at a later time, not in here at the moment.

Mr GAFFNEY - Madam Chair, I move -

> That we report progress and move to sit again at a later date.

Mrs HISCUTT - I will vote against reporting progress because I think we can do another hour. The member for Mersey indicated 11 o'clock and I know there have been times when I, as Leader, wanted to sit late and indicated that, and I really do appreciate people who are willing to do that for me. The member for Mersey has indicated he would like to be here at least until 11 o'clock so I am happy to comply with that and will be voting against moving.

Motion negatived.

Clause 11 -
When person has decision-making capacity

Ms RATTRAY - Clause 11(1)(b) talks about when a person has decision-making capacity, to -

> (b) remember such information or advice to the extent necessary to make the decision.

Obviously, this is going to be a very stressful time to remember such information. I am interested in having that fleshed out a little bit further because some days I get a little bit overwhelmed and I am of good health. How does that work in a practical sense? How much of the information do you have to remember? Do you get some sort of test, or is it just, 'do you remember what we have talked about?' I am interested in how that might work in the practical sense around the decision-making capacity of a person under clause 11.

Mr GAFFNEY - It is explained in (2) and (3). It says in (2) -

> For the purposes of subsection (1) -
>
> (b) … a person is taken to understand information and advice in relation to the making of a decision if it reasonably appears that he or she is able to understand an explanation of the consequences of making the decision.

There are times when people may not completely - so in (3) it goes down to 3(b) -

> a person's lack of capacity to make a decision may be temporary and not permanent;

If somebody is on medication, or if somebody is in a situation where they may not remember the square root of 81 but they understand what is going on in what has been advised to them, that will be taken into consideration.

It is trying to at least have a person's decision-making capacity, to be aware of the condition they may be in or the medication they may be taking. In that situation, that would be how sometimes, yes, they would remember the advice but if you think about it, there are times when we forget in our role. There would be a determination by the medical practitioner, by the PMP, the CMP or the AHP.

Clause 11 agreed to.

Clause 12 -
When person is acting voluntarily

Mrs HISCUTT - One quick question. What is the test? How do you determine when a person is acting voluntarily? I presume it is, as we have discussed before, left up to the intuition of the medical practitioners and the people around. Do you have an answer for that one?

Mr GAFFNEY - I do. It is a very good question. This was the eligibility criteria that was also in the Victorian and the Western Australian act - I think it was in both. I imagine, as it was explained to us, in the training modules that the people undertake they would have some training around that particular aspect. As in our briefings, Dr McLaren and Dr Carr said that doctors are trained in that situation where they are constantly picking up on whether there is some pressure being applied. I think it was Dr McLaren who said that on one occasion he went back to the person's place four times to ensure that.

Whilst I understand it is very hard criteria, it is one put in there. Again, it is like the community one about the 12-months or five-year training period; it is a voluntary process and this is what is happening.

Clause 12 agreed to.

Clause 13 -
When person is suffering intolerably in relation to relevant medical condition

Ms FORREST - Madam Deputy Chair, I am not intending to move these amendments now. Since we have put in the six-month and 12-month prognostic time frame, these become much less important in terms of removal. When a person is imminently facing their death it is right and appropriate to consider the anticipated suffering at that point because it is very real. They are facing imminent death. I wanted to make that point that I will not be proceeding with these amendments.

Clause 13 agreed to.

Clause 14 -
When person's communication under Act may be made by another person

Ms LOVELL - Madam Chair, I move that clause 14(4)(b) be amended by

First amendment -

Insert the following paragraph -

(ba) the other person -

- (i) is not a member of the family of the VAD person; and
- (ii) where subsection (3) applies in relation to the other person - is a person who is accredited by a prescribed body as a translator in the relevant language; and
- (iii) does not know or believe that he or she is likely to directly or indirectly benefit from, or receive a financial benefit, directly or indirectly as a result of the death of the VAD person; and

(iv) is not a residential care provider in relation to the VAD person; and

(v) is not directly involved in providing health services or professional care services to the VAD person; and

To be clear, I have some further amendments to clause 4, which has been postponed, which will add definition around the meaning of 'professional care services' to make that clearer.

The purpose of this amendment and what this amendment would achieve is to ensure that where an interpreter is required for communication between the VAD person and their medical practitioner, PMP or other medical practitioners, that it is a requirement of the bill that an accredited interpreter is the person who can interpret on behalf of that person.

It is critical that doctors can be sure that when they are hearing from a patient that they are acting voluntarily and that the treatment they are seeking or the option they are seeking is what they are seeking - as with any medical treatment - and that the doctor can be 100 per cent confident that what they are hearing from that patient is what they are hearing from the patient. They are hearing it directly from the patient and there is no opportunity for anyone involved in the translating of that - or no likelihood that the communication could be misinterpreted or skewed.

This is about providing a level of protection to the VAD person. This comes down to where members of the community have raised that they want to ensure that particularly vulnerable people are protected. It also provides a level of protection to the medical practitioner who can be 100 per cent confident that what they are hearing is what they are hearing from the patient themselves.

I know there have been some concerns raised around the accessibility of interpreter services in Tasmania and particularly where we might have immigrants in the state with not a large community speaking that language in Tasmania, that that might be limiting. I have been assured that there is a nationally accredited body that is currently used by doctors in Tasmania for circumstances where they need translation. Currently, with that service, there are 160 languages available for interpretation. Bearing in mind that this can be done over the phone, it can be done online, it does not need to be face to face. There should be no barrier to obtaining a language translation for any patient.

The other consideration is that given the eligibility requirements, particularly around residency, the VAD person will have been living in Tasmania for 12 months. Considering they are suffering from a terminal illness, it is likely they have had an ongoing relationship with their medical practitioner so doctors and patients will have been dealing with this already. It is highly unlikely that the first time a doctor needs to be able to get consent or have a conversation with this patient, it is going to be a conversation around VAD. They will have had those established practices in place already.

It has been raised, and I understand there is a further amendment, that there may be circumstances where it is not possible to have somebody from an accredited body interpret on behalf of the person. I understand and accept that places people in a difficult position. However, it must be up to the primary medical practitioner or the consulting medical practitioner to be able to say they are 100 per cent confident they have heard from the patient, without there being anybody who might have any reason to skew that message in any way or misinterpret it. This is not just about protecting vulnerable people and ensuring people are not being coerced or that a message is not being passed on that is not accurate. There is a government policy in place currently around interpreters or government advice around interpreters available on the Department of Health website. The fact sheet talking about how you can access an interpreter, makes a series of questions and points. One of the points is -

> If your doctor or a health service asks you to bring in a family member or a friend, say NO. Family members and friends cannot be expected to be neutral and interpret everything they hear. They may be emotionally or personally involved with you and this may affect their interpreting. Your confidentiality as a patient and the objectiveness of the information cannot be guaranteed.

I do not want anyone to think I am suggesting family members or friends or people who are known to the patient would deliberately or inadvertently interpret in a way that was not accurate. What I would argue is that for the safety of both the patient and the doctor, we have to leave that decision with the doctor to ensure they are 100 per cent sure what they are hearing from the patient is what the patient is saying directly to the doctor. I urge members to support this amendment. It is common practice currently in Tasmania for this interpreter service to be used and I do not believe it would place any barriers in the bill in terms of access for people.

Mrs HISCUTT - This is a very wise amendment to have in there. In my past life as a marriage celebrant, getting an interpreter was not a problem, there are places out there you can go, without any question they are there. The only question I have really is at 1(e) talking about communication. Does that cover sign language, where you have any other communication because other than the fact that it is a language some people cannot talk. I presume 1(e) covers sign language as well. Would the member for Rumney's proposed amendment cover an interpreter who does sign language? Are you happy that is all covered?

Ms Lovell - Yes.

Ms WEBB - I absolutely agree and accept everything that has been said around the interpreter aspects of this amendment, and would support that. The thing that concerns me about this amendment is it has been placed in clause14(4), which is essentially providing us with an understanding of what relevant matters the practitioner needs to satisfied about. That is in relation to both 14(2) and (3), where somebody needs an interpreter. That is fine, but it also relates to clause 14 (2). Clause 14(2)(a) is talking about communication, not as a language issue, but where -

> (a) the VAD person is unable to communicate to a person who is unfamiliar with the VAD person's method of communication; and
>
> (b) the VAD person's means of communication is comprehensible to another person who is familiar with the VAD person or the method of communication -

That is not about language and being interpreted in terms of what language you speak or whether you are deaf and use sign language. That is about circumstances under which a person communicates differently to verbally, or in a verbal way that is quite unique.

My issue with what is captured in the amendment is that I do not think it is well suited to these situations, potentially, because often in those very special unique situations, it is a family member who is the only person who fluently understands the communications being engaged in.

This is an area I followed up with a conversation directly with one of the Victorian doctors who has been briefing us, because I wanted to understand what some of this has looked like in practice. I wanted to check about experiences of going through the VAD process as a medical practitioner, with someone who cannot effectively verbally communicate directly to you as a practitioner, and requires assistance with that, not because of language, but because of physical limitations, or others.

I was able to hear a very clear example about it, and that was where a patient had motor neurone disease and was only able to whisper in a very constricted, constrained way. The family members were able to understand that communication because they lived with the person and were there every day, but the medical practitioner was not able to fully understand without their assistance what was being said.

It is a real challenge there, and I feel it is not well captured by the amendment. I feel the amendment in some ways puts barriers up around that situation, because you have the family member there who is likely to be the one - and I am also thinking about situations of other forms of non-verbal communication that people might use, in which family members might be the ones who assist them with that, as well as implications from the condition itself, as with the motor neurone situation.

I am concerned about the amendment on that front, and what it means to put a barrier there by saying in the amendment that you cannot be a member of the family.

That is my first speak, so I will leave that to be responded to, and I may have further clarifications.

Ms FORREST - Madam Deputy Chair, when I received this amendment and had discussions with the member for Rumney about it, I shared a concern that has been expressed by the member for Nelson in that there are people who communicate through unique means.

It is not a matter of translating from French to English, or even Auslan sign language or another mechanism.

These people would have been being treated by a doctor for a period. It is possibly - and likely to be - the doctor, who may be the primary medical practitioner, who takes them through the VAD process, should that be the pathway they choose.

I have an amendment to the amendment, to add a provision for, again, an exception. The absolute default should be as the member for Rumney has proposed. It is an appropriate amendment, and it is important to use people who are completely separate and independent of the process wherever possible. However, in some cases where there are more unique communication issues, and where obviously the doctor would need to be happy they understood the communication - because any previous communication would have been made with the person's carer, family member, or other person who has been able to communicate with them and for them or on their behalf.

Obviously, a doctor is not going to start the process if they are not convinced that what they are hearing from the person who is doing the interpreting, by whatever means, is legitimate, genuine, is acting without coercion, acting voluntarily - all those sorts of measures. Those measures still persist.

Amendment to amendment -

Madam Deputy Chair, I move that the amendment proposed by the member for Rumney to clause 14 be amended by -

> After subclause (4), *insert* the following subclause:
>
> (4A) Despite subsection (4)(ba), subparagraph (i) or (ii), or both, of that subsection do not apply in relation to a person if the Commission is satisfied that there are reasonable grounds why the subparagraph ought not to apply in relation to the person.

It actually provides a mechanism for an application to the commission to be made - for a determination to be made - to override the requirement that the person not be a member of the family perhaps, or is not part of an accredited body. It may be a very unique form of communication that is not understood by the general interpreter services, for example.

I go back to the point that in asking members to consider this amendment, it does not override the need for the doctor to feel confident that the person is acting voluntarily, acting without coercion, and has decision-making capacity.

If any of those other tests are not met, it would not matter what this interpreter said. If the doctor believed that person was not acting voluntarily, without coercion, and with capacity, they would not meet the criteria anyway. This provides an exception for a small number of people who may find communication very difficult, particularly non-verbal communication.

I urge members to consider this amendment to the amendment as an important step to provide that additional provision, an exception rather than the norm.

Mr GAFFNEY - Thank you very much. I appreciate both the amendment to the amendment, and the amendment. I am now comfortable we have it covered, and the fact that we were concerned, especially with the accreditation.

In talking to some doctors from Victoria, they pointed out that it is entirely likely that the first conversation between a VAD doctor and a patient will revolve around VAD, but given the low uptake of VAD training in other jurisdictions such as Victoria, it might not be that person's doctor.

There is a situation where the doctor might have a great relationship with the person, understand them, but that doctor may not choose to be involved with voluntary assisted dying, so that person will have to go to somebody else who is not aware of that communication. The member for Murchison, introducing that, solves that issue.

The other one, interestingly enough too, is the accreditation. Sometimes for those people who are extremely autistic, or at the end of the spectrum, where they have confidence with the person they live with or know, and they might point to their tablet and be able to converse through the tablet, for toilet, drink or whatever - they may not want somebody else, who they do not know, in that position with them.

With this amendment from the member for Murchison, it is saying that the commission has a role to play here to allow the medical practitioner to have confidence that the interpretation of whatever has been agreed to by the commission, so therefore the process can take place.

I am supportive of both the amendment and the amendment to the amendment, because that covers all the bases and we want that to happen in Tasmania.

Ms WEBB - I am pleased with this amendment in the sense it does go towards the concern I had with the other amendment. I am still wondering about its completeness and perhaps the member for Murchison could clarify it for me. It is a good constructive element to bring in to allow for exceptions to be assessed. Most of the ones I was hypothesising before having an issue with the first initial amendment are going to be exceptions, they are not going to be the norm. The amendment to the amendment refers to subsection 4(ba), the initial amendment of only subparagraph (i) and (ii).

Ms Forrest - They are the only relevant ones.

Ms WEBB - I am not sure they are, because (iii) does not know or believe he or she is likely to directly or indirectly benefit from or receive financial benefit directly or indirectly as a result of death. If it is the partner of the person who is assisting with the communication and we have exempted them on the basis of being a family member, we are still going to disqualify them because they are probably going to inherit, for example, when the person dies. They will still be captured by (iii) which we have not put into the amendment to the amendment.

You could probably have included all of the (i), (ii), (iii), (iv) and (v) potentially because this is going to be a specific examination of a unique circumstance, an exception. Even (iv) and (v) - (iv) being a residential care provider and (v) being directly involved in providing health services or professional care services.

Some people are very fortunate and they do have close family members around. Those family members may be the ones who are able to help with the difficult communication situation. Others may be in a situation of other kind of care where they have carers of other sorts, whether they might be residential care providers or other personal care or health service providers who assist them regularly. It is those people who regularly in normal circumstances would be the ones who understand and assist with the communication aspects we are talking about here, those difficult non-verbal ones.

The amendment to the amendment in not including (i), (ii), (iii), (iv) and (v) still leaves the opportunity for exclusion there, for there not to be a contemplation of those special circumstances and an exception made. Certainly, I would argue (iii) must be included in this amendment to the amendment. We have to exempt the direct or indirect benefit being received from this also, otherwise if it does not go alongside the family bit it does not quite make sense. I would say we would compassionately include (iv) and (v) knowing it is not a given, it is going to be allowed. It is going to be a special circumstance and special consideration given by the commission to assess whether it is appropriate or not, so we have a lot of safeguards there. It is not just any old person who happens to care for the person every now and then being allowed to do the communication and interpretation for them. I feel a bit conflicted, because the intent of this amendment to the amendment assists me to feel confident about the amendment, but feel it is incomplete.

Ms LOVELL - The member for Murchison and I have had conversations about this amendment. I was initially reticent to agree to it for the reasons I articulated earlier, that ultimately the decision should rest with the doctor. It is the doctor that needs to be confident they are getting informed consent from the person. The only way to do that is to hear it from the person directly whether that be - yes, sign language would be included in my amendment; written communication is another method. We are talking about very rare circumstances where this exemption would be needed. Because it is so rare that this may be required and because ultimately the doctor still has the decision of whether they agree to be the primary medical practitioner or consulting medical practitioner or play a role in this process, that decision still rests with them. I am comfortable with this now, and I am happy to support it.

I take on board what the member for Nelson has raised in regard to the other subparagraphs. I suppose if we are going to have an exemption for one or two, perhaps the exemption should apply to all of them. I am not sure if anyone has an amendment to that effect. I am sure the member for Murchison will comment on that but, yes, I would be happy to support the amendment. Thank you, member for Murchison.

Ms FORREST - The reason I was reluctant to include (iii) is that if the commissioner approves a person under the fact that they are a member of the family, they would do that in the knowledge that they may be a recipient of the will, that there is actually some benefit there. They would have to take that into consideration of their determination, I believe.

I fear that if that were included, the risk of coercion for financial or other gain would be very real, particularly when this is a very unique form of communication and difficult particularly for a doctor who is not the normal treating doctor who may be the primary medical practitioner.

A member can propose a further amendment if they wish, but I think we are dealing with unique and rare circumstances. It is usually a carer or a family member who would be in this situation. This is asking that this provision provide for the commissioner to say in this circumstance, 'We do not need to apply that principle that it is not to be a family member or it has to be an accredited interpreter.'. I have some concerns about removing that financial or other benefit clause because of the risk of coercion and that sort of thing when communication is very difficult.

If communication were not very difficult, we would not need this clause, this provision, at all. We would assume that everyone can communicate freely and be understood by their health practitioner without any need for additional support.

Ms Webb - While you are on your feet because it is your second speak and I do not want to necessarily use up another one for you, it is the commission that is making the determination about whether to grant the exemption. In terms of a level of protection around coercion, it is not just the medical practitioner's decision; it is in fact elevated to the commission to consider that risk and that likelihood in your amendment. Is that correct?

Ms FORREST - It is giving the commissioner the power to determine that there may be a person who is well known to the person seeking to access VAD who is able to communicate for that person.

Ms Webb - Yes, but only if they are a family member or a translator.

Ms FORREST - It removes the requirement that they not be a family member or they have to be -

Ms Webb - They could not be a carer, for example, under (iv) or (v)?

Ms FORREST - Well, true, it is a family member who is most likely to be the person who is communicating for this person. I am sure we are all aware of people in these circumstances.

I will leave the amendment. If anyone wants to further amend it, that is up to them. I will leave it as it is. It is getting late and I think we need to be conscious of tiredness and making errors at this point.

Ms WEBB - I would certainly be interested to make an amendment to the amendment to the amendment but I do not think it is practical to do it now. Does that mean -?

Madam DEPUTY CHAIR - No. Because we have an amendment - well, we have two amendments before the Chamber - that would mean that the member for Murchison would have to withdraw hers and then the member for Rumney would have to withdraw hers. We will need to have a decision.

Ms WEBB - The reason I would like to do that is because I think we are talking about exceptional situations anyway that are not likely to be occurring very often. We are allowing for some of those exceptional situations but not others. If the rationale is there to provide an exception in some form, as in, there is a family member who assists and understands that method of communication, and the commission deems that the risk is not there, we can allow that family member to assist with communication. But we could equally say that in the situation where it is not a family member but it might be a carer of some sort, that we would assume the same level of careful consideration and examination by the commission to be able to determine whether to provide an exemption in that circumstance too. If the level of protection provided by the process in this amendment to the amendment is sufficient for the first instance, the family member, I think it also quite rationally sufficient in the second instance when there might be a different form of carer.

I would like to do that so whatever process has to happen I am just going to sit down and see what other people have to say.

Mrs HISCUTT - Is it possible to deal with the amendment to amendment, then the amendment, then report progress before the clause is put? Isn't that the way to do it?

Madam CHAIR - You can support this one and then support the other one and then further amend it later.

The member for Montgomery made a very useful contribution there. My advice is that we deal with the two amendments we have before us but before the question is put that the clause as amended be agreed. That is when we will move to report progress.

Amendment to the amendment agreed to.

Amendment agreed to.

Mr GAFFNEY - Madam Deputy Chair, I move -

> That we report progress.

Progress reported; Committee to sit again.

RESIDENTIAL TENANCY AMENDMENT (COVID-19) BILL 2020 (No. 37)
STATE SERVICE AMENDMENT (VALIDATION) BILL 2019 (No. 52)
ANZAC DAY TRUST WINDING-UP BILL 2020 (No. 33)

First Reading

Bills received from the House of Assembly and read the first time.

ADJOURNMENT

[11.07 p.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

> That at its rising the Council adjourn until 11 a.m. on Wednesday 14 October 2020.

Mr President, for those of who do not have an 8 a.m. meeting tomorrow morning, the first briefing we have will be at 9 a.m. in Committee Room 2.

Motion agreed to.

The Council adjourned at 11.07 p.m.