PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Tuesday 15 September 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.

TASMANIAN CIVIL AND ADMINISTRATIVE TRIBUNAL BILL 2020 (No. 25)

CAT MANAGEMENT AMENDMENT BILL 2019 (No. 55)

First Reading

Bills received from the House of Assembly and read the first time.

PRESIDENT'S STATEMENT

Return of the Member for Pembroke
Appointment of New Staff Member

Mr PRESIDENT - Honourable members will notice that not only do we have the pleasure of the company of the member for Pembroke with us today - and it is lovely to see you in the Chamber again - but we also have a new Legislative Council staff member, Morris Malone, sitting in the President's Reserve. Morris has been appointed as the electorate officer of the member for Huon, Dr Seidel.

Morris holds a Bachelor of Economics from the University of Tasmania. He has extensive experience in the retail industry and in customer service and he has also worked in stakeholder engagement and events management. His previous work has provided him with people and organisational skills that will support the member for Huon in his role. Morris looks forward to joining the Legislative Council team and supporting the member in his new role representing the Huon, which comprises Blackmans Bay, the Channel, the Huon Valley and Bruny Island. We welcome Morris on board. I am sure all members will ensure he is made to feel welcome and that his time with the Legislative Council is rewarding.

Members - Hear, hear.

SPECIAL INTEREST MATTERS

Wynyard Showground Industrial Hall Project

[11.07 a.m.]
Ms FORREST (Murchison) - Mr President, on 13 May 1885 the very first show was held at the historic Wynyard Showground in Jackson Street. The Wynyard Show continues to be held on the Saturday closest to 15 March each year. This show is one of Tasmania's oldest

remaining centenary shows and it still retains its classic country feel, welcoming over 4000 visitors each year.

These are uncertain times for agricultural shows everywhere, but even more uncertain due to COVID-19. Next year's show is scheduled for 13 March 2021 and, all being well, it will be the 133rd show. Incidentally, the 2020 show was the last event I attended before the COVID-19 lockdown and even then it was apparent things were likely to change rapidly.

At the Wynyard Showground, it is not all about agricultural shows. The showground is used throughout the year by a diverse and vibrant group of users who make up the Wynyard Showground community, ranging in age from toddlers to nonagenarians - quite a wide range of ages.

The Wynyard Show Society was recently successful in securing federal funding under the Regional Agricultural Show Development Grants Program. These funds and additional financial support from the state Government and the Tasmanian Community Fund have enabled the show society to undertake a substantial makeover of this historic showground. The improvements include upgrades to the reception and display areas, to cabinetry, insulation and air conditioning and new improved all-abilities and unisex toilets. These upgrades will improve the comfort and enjoyment of the facilities for all users.

A working group has been initiated by the Waratah-Wynyard Council to develop a strategic plan taking account of the wide variety of pursuits undertaken at the showground. The Wynyard Showgrounds Working Group, as it is called, was formed on 28 May 2019 and consists of two councillors - Celisa Edwards and Gary Bramich - the five showground user group representatives and the general manager, recreation officer and executive officer of the Waratah-Wynyard Council.

The group is working to develop future strategic visions for the use of the showgrounds site and to determine options for the role council may or may not play in the vision. It is pleasing to see council working with the showground community in this way to ensure the facility is more fully used and supports a range of community groups while still maintaining its heritage and history.

The complex covers 2.9 hectares, and the show community is made up of about 800 members.

These organisations are run and supported by volunteers who contribute an enormous number of hours to our community. Furthermore, given that Wynyard's population is about 6000, this means that about 13 per cent of our local residents are part of this vibrant community through the following organisations -

- Wynyard Agricultural and Pastoral Society, which holds the showground Crown lease until 2058.

- Wynyard Cricket Club - the showgrounds are the home ground of the Wynyard Blues - currently has 180 players registered across 10 teams, with entry-level programs for children aged from 5 to 12 years. Five Hurricanes Inclusion Cup players, an initiative to provide cricket-playing opportunities for players with a physical or intellection impairment, are included among their people. There is a new under-13 girls' program and it facilitates a four-team primary school competition involving about an additional 30 children.

- Wynyard Gymnastics Club, which conducts classes and training most days in the industrial hall. The club also actively cooperates with St Giles Autism Specific Learning and Care programs.

- University of the Third Age, or U3A, hosts over 4000 people annually attending its activities.

- North West Bird Club Tasmania, which has grown from 19 members at its inception meeting in a private residence to 60 members, from Devonport through to Irish Town. Its current clubrooms were made possible by a $2500 grant awarded by the government through the late Tony Fletcher, and a loan of $2000 from the Wynyard Agricultural and Pastoral Society. The club is an integral part of the Wynyard community and its clubrooms are used for regular meetings, information days and hosting interstate bird club and bird shows; it is also available for hire for the community.

Other friends of the Wynyard Showground include the Wynyard Axemen's Association and the North Western Poultry Society.

I commend all those involved in these projects and in this rebuild project. It is exciting to watch this new building to house the facilities, including the industrial hall, change rooms and office space. I drove past when heading down here and it is nearly complete. It is amazing how quickly it has gone up.

Many people have given voluntary time to achieve this, including the president, Robert Stokes; secretary, Chris Stunden; and Duncan Sadler, Chris Campbell and Rosalie Martin, who recently provided a site list for me. I want to particularly commend their work. It has been a huge undertaking and it will make such a difference to all the showground users who will actually have some decent public facilities.

Learners' Road Rules Educational Project

[11.13 a.m.]
Mr VALENTINE (Hobart) - Mr President and honourable members, I do have a cold, so I am sure people will give me a wide berth, but I have been tested for COVID and it came back negative. Sorry to disappoint people!

Ms Forrest - I hope you get tested again in four days and it is still negative.

Mr PRESIDENT - You are in good hands. We have a doctor and nurse.

Mr VALENTINE - I may spend a good deal of time out of the Chamber today for that very reason.

Mr President, I wish to speak this morning about a great initiative with humble beginnings that now benefits the broader Tasmanian community - in particular, members of our community who might otherwise have remained isolated and disadvantaged. It is the learners' road rules educational project.

It began in 2010 with a roll of butcher's paper and some toy cars. By the early months of this year it had evolved into a statewide learning tool, with 204 learner licence assistance providers and over 700 candidates successful in gaining their L1 licence.

Retired policeman, Mr Kim Smith, is a member of the Sullivans Cove Rotary Club, of which I have the privilege of being patron. Mr Smith was on the verge of retiring from his career in the force when he put up his hand to assist as a tutor to a large group of recently arrived refugees who were having major issues trying to learn and understand the road rules in order to pass the L1 theory test. Many of them had tried for up to six months without success. Some had taken the test 16 times. Candidates were memorising the answers and would keep going until they passed, still without a genuine understanding of the road rules. Many had literacy and learning issues and simply could not read the manual, let alone answer the questions online.

You can appreciate the extent of their frustration when you understand some who continually failed the online test gave up in frustration, even choosing to drive unlicensed and disqualified, which is not a desirable outcome.

Kim's professional background and work with young people through the Tasmanian Association of Police and Community Youth Clubs gave him a head start, but it was a struggle creating a path to educate folk whose first language was not English and who, in some instances, could not read and write well in their own language. There were other learning difficulties that simply compounded the challenges for students and teachers alike.

However, Kim persisted with that trusty roll of butcher's paper and the toy cars as demonstration tools. He was able to develop and communicate an effective test of students' practical understanding and knowledge. All students from that first group passed the L1 test.

Kim now has sets of purpose-built laminated A3 road maps accompanied by an array of vehicles, animals, trees et cetera that resemble the landscape. These sets have now been rolled out to libraries, schools and other service providers around the state.

Kim has produced no fewer than 19 instructional videos, which are now available on the Department of State Growth website. This is a great achievement, of which he should be most proud. The videos demonstrate most aspects of Tasmanian road rules and have been made locally, involving well-known intersections, and clearly show what to do - and what not to do, more particularly - accompanied with captions and voice-over instructions, often in no fewer than five languages - English, Oromo, Hazaragi, Nepali and Mandarin. I expect more of those are probably in the wind.

The introduction of weekly courses using the video format and the road map kits was the catalyst for change to the whole teaching and testing structure of the program. Partners who have lent their valuable support to the learners' road rules educational project include the Rotary Club of Sullivans Cove, which was involved from the beginning, and more recently the Department of State Growth, Neighbourhood Houses Tasmania, Rotary International, the Future2 Foundation, and schools and welfare agencies. Tasmania Police crash investigators, transport inspectors, the State Library Devonport, filmmakers and driving mentors have all freely played a role in the development of the project. It is bigger than Ben Hur.

Parents, youth workers, teachers and staff from involved agencies all contributed to the coordination of the training courses and with provision of the materials between sessions. For students coming through the program, gaining their L1 theory test was a significant move toward independence for a group of folks who were previously experiencing despair as the lack of travel options was impacting their lives in various ways. Finding work could be difficult; shift work was out of the question; visiting family was not easy; shopping and transporting children to school was a challenge - daily journeys most of the rest of us simply take for granted.

I will finish with one example of the extraordinary impact this program has had on its graduates. A young brother of two of those original refugees arrived in Tasmania with his family after 22 years in a refugee camp in Nepal - 22 years. He completed the learner driver program with Kim at the West Moonah Community House in the member for Elwick's bailiwick, and his brothers helped with the practical hours on the road. He passed his provisional test, and this licence enabled him to undertake a full-time apprenticeship. He facilitated no fewer than nine family members and 11 members of his community into subsequent courses. They all passed. As soon as he qualified for his full driver licence, he ensured they all completed their practical hours behind the wheel. Every one of those 20 people gained their licence and are working either full- or part-time in the community - on farms and in restaurants, aged care facilities and other occupations. This young man has since joined his wife in assisting in interpreter work for literacy and citizenship courses. What a machine.

I commend Kim Smith for the time, energy and creative thinking he has put into the learners' road rules educational project, which has resulted in a really excellent product and outcomes. This is a case of a fellow truly giving back to the community in his retirement.

I recommend the materials to anyone wanting to learn the road rules of this state or those of us more seasoned drivers as an opportunity for a refresher course. Congratulations to Kim Smith for a job well done. I know Sullivans Cove Rotary Club is most proud of you, and I imagine many grateful drivers from the multicultural community are too. Well done, Kim Smith.

Members - Hear, hear.

Dr Richard Geeves - Tribute

[11.20 a.m.]

Dr SEIDEL (Huon) - Mr President, I am well aware that the time to speak on special interest matters is usually reserved to celebrate a new accomplishment in our community - something that has been achieved, somebody who has received an outstanding award, developments that reflect how communities have advanced and progressed, as we just heard from the members for Hobart and Murchison.

Sometimes, but not often enough, we acknowledge something that has been missing in our community. Today I would like to acknowledge a special person who my community in the Huon Valley has lost. Dr Richard Banks Geeves, or 'Dick' as we in the Huon knew him, was one of the finest human beings I have ever come across - a generous, kind and witty medical doctor and general practitioner, and an iconic and quirky Huon resident I had the privilege to call my friend and role model.

Dick passed away on July 18 this year after a brief illness at the age of 95. Dick was born in Port Kembla in December 1924 and although he spent much of his life in New South Wales, his roots were firmly in Tasmania and, of course, in the beautiful Huon Valley. His great-grandfather was a pioneer of Geeveston, the place of many childhood memories and happy holidays.

In his later years Dick would return to Hartz View, the home his great-grandfather built, to enjoy his retirement. In his early years, he was somewhat of a sportsman - a reasonable footballer, a batter, cricketer, a sailor and an excellent rower, but he was also prone to injury. He broke a bone pretty much each and every season. Prior to that he was a Wolf Cub, which, of all his youthful activities, set him on a lifetime path of supporting Scouts Australia, New South Wales and Tasmania.

Dick always wanted to become a GP as his father was before him. Poor school results and World War II were some obstacles to his goal, yet he obtained his medical degree. Shortly after that he met his wife, Barbara. He said later, 'I remember I sold my beloved 150cc Villiers motorbike to buy the engagement ring, but it was well worth it. Barbara was a cracker.'.

In 1954 Dick started to work at his father's general practice. As a young GP, he admits to learning many lessons, including an acute overhaul of his listening skills. There are many funny stories.

By 1960 Dick became interested in helping to establish the University of New South Wales Medical School, and in 1968 he assisted with the development of the Royal Australian College of General Practitioners Fellowship Examination. Recognising his passion for education and love of general practice, the RACGP invited him to undertake the role of censor in New South Wales and later national Censor-in-Chief.

In 1974 Dick left general practice to take the position of regional geriatrician at the Hornsby Hospital and to set up a geriatric and rehabilitation service. This area of medicine was to become his most rewarding work.

In 1989 HammondCare opened a dementia day-care service in Sydney in response to recommendations and the pioneering work of Dr Dick Geeves. He had become a respected force in geriatrics and aged care. In recognition of his work, he received an Order of Australia for providing services to older people in the community.

In 1989 Dick retired and the following year returned with his wife to Tasmania. Barbara sadly passed away in 2002.

Dick had an illustrious professional career as a GP, geriatrician, anaesthetist, obstetrician, academic, medical educator and researcher. However, alongside medicine Dick also raised five sons with his wife, Barbara; was actively involved in the Australian Army Reserve, retiring with the rank of lieutenant colonel; was a world Rotary ambassador for more than 30 years; and received life fellowship of the RACGP in 2002.

In retirement he dabbled in composing, acting and writing, and learned cabinet-making. He was an active board member of the Forest and Heritage Centre in Geeveston and an active supporter of the volunteer Green Shirts Movement. In 2001, Dick was awarded the Centenary Medal for his services to the Huon Valley. In 2008, he was named Huon Valley Citizen of the Year. In the same year he transformed an old Geeveston residence into a medical centre that has played an enormous role in supporting good health in our community.

Dick had a big heart. I will never forget his generosity and his humour. When I arrived in the Huon Valley in 2008 and started to practise as a GP, he sent me a unexpected and very kind welcome letter. I have received a letter pretty much every six months since, handwritten and hand-delivered. I miss his pearls of wisdom; I will miss his wit and I will miss his insights, He was a true Huon Valley treasure.

Vale Dr Dick Geeves.

Members - Hear, hear.

Fragile X Syndrome

[11.26 a.m.]

Ms ARMITAGE (Launceston) - Mr President, today I will speak about a reasonably little-known condition, fragile X syndrome, and the incredible people we have living in our communities with its effects.

The fragile X group of disorders is a family of inherited conditions caused by alterations in a gene located on the X chromosome, hence the name fragile X. These disorders include a wide range of physical, intellectual and behavioural symptoms. According to the Fragile X Association of Australia, an organisation that supports people living with the condition and their families and advocates for greater awareness of and research into the condition, about 90 000 people in Australia are impacted by fragile X in some way - some are carriers and some have the condition itself.

Since fragile X is associated with the X chromosome, both males and females can be carriers of the fragile X gene alteration, and the syndrome is the leading cause of inherited intellectual disability. It affects about one in every 4000 males and about 1 in every 6000 females; however, one in 250 women and one in 800 men are permutation carriers of the gene alteration. This is not an insignificant number of people. For males, the fragile X disorder can manifest by being associated with physical disabilities or mental disorders like autism spectrum disorders, attention deficit and hyperactivity disorders, mood instability, and developmental delay or learning difficulties. In females, it manifests differently; about one-third of fragile X females have significant intellectual disability.

It is likely every person in this place knows at least one person affected in some way by fragile X. This brings me to some of the incredible people in our communities who are working towards raising greater awareness of the condition. On 21 July this year, Jo Ryan and her son, Ben, who has the fragile X disorder, coordinated an event in Launceston to bathe the Town Hall in orange light, the colour of fragile X awareness. Even on that chilly winter's night we had an excellent turnout, dressed in orange and holding orange balloons to bring greater knowledge to our community about people who are affected by fragile X.

Ben Gower, a young man in Launceston, was adopted by Jo Ryan and her husband in 1989. With three days notice Jo and her husband had an amazing time getting to know their beautiful little boy so it was easy to overlook Ben missing his first milestone or two. However, when Ben was not walking or talking way past the point it would be expected, they sought help.

After a long while and many tests, a paediatric specialist in Launceston diagnosed Ben through DNA, but it was not until they discovered the Fragile X Alliance Clinic in Melbourne that they learned what they would be in for. It explained everything. Ben had difficulty in school and connecting with his peers. As a naturally kind, understanding and confident little boy, his difficulties in achieving scholastic milestones made it necessary for him to go to a special school throughout his childhood. When he reached Newstead College, however, Ben began to shine as he worked out what he loved and what he was good at. The challenge then was finding the point at which what he loved doing intersected with the job opportunities available. Not being defined in any way by his conditions, Ben's personality of an outgoing, confident and deeply conscientious and thoughtful young man allowed him to pick up some odd jobs with Gunns and the City of Launceston, working outside and with great pride and dedication.

Not content with taking on paid work, Ben also volunteers with Meals on Wheels and with the Mowbray Golf Club, where he has a well-developed and accurate swing. Ben now has a permanent job at Coles, which he loves, and where he is adored by the staff and customers. He is always willing to lend a hand, and he is not afraid of asking if you need help with something. That is just who he is.

I believe it is important to shine a light on the fragile X disorder and the conditions with which it is associated. I encourage everyone to find out more information from the Fragile X Association of Australia online, so we can better understand and appreciate people who are living with it or affected by it.

Ms Rattray - I have met Ben. He is a lovely young man.

Ms ARMITAGE - I saw Ben recently when I was on my scooter, and the one thing he wanted to do was have a turn on my scooter. He could not quite understand that I needed it, but he just said, 'I want to have a go on Rosemary's scooter'.

Mr PRESIDENT - We are all a bit like that really.

Women's Health Tasmania

[11.31 a.m.]

Ms WEBB (Nelson) - Mr President, Women's Health Week was celebrated last week from 7 to 11 September. It is an Australia-wide campaign centered on improving women's health and supporting healthier choices.

Now in its eighth year, recognition of Women's Health Week continues to grow. In 2019, more than 112 000 women participated in over 2800 events, and almost 45 000 women subscribed to the online campaign.

In honour of Women's Health Week, I would like to recognise a wonderful local organisation - Women's Health Tasmania.

Women's Health Tasmania is a health-promotion charity run by women for everyone who identifies as a woman. Its vision - healthy Tasmanian women - and its values - respect, equity and solidarity - encapsulates the essence of Women's Health Tasmania.

It aims to be Tasmania's key voice advancing women's health and wellbeing, where health is defined as -

> a state of complete physical mental and social well being, not merely the absence of disease or infirmity.

Women's Health Tasmania is overseen by a voluntary board made up of 11 elected women members, and run by a team of dedicated health workers, activity providers, facilitators, administrators, childcare workers and volunteers - all led by CEO Jo Flanagan.

To give you a sense of the scope of the services provided by Women's Health Tasmania, in 2019-20 Women's Health Tasmania had 8812 occasions of service for women across 83 per cent of Tasmania's local government areas. These services included over 4000 class and activity attendances, over 1200 online class attendances, 932 calls to the information line, 480 drop-in clients, and 247 counselling appointments.

I think members will agree that Women's Health Tasmania provides an extensive list of services and support for the Tasmanian community and Tasmanian women. It offers allied health services, including Bowen therapy, community nursing, continence services and hearing tests. They also have counselling and psychology and support services along with complementary therapies, such as hypnotherapy.

Women's Health Tasmania hosts a number of peer-support groups, including breast cancer support, a sewing group, writers support, and the fabulously named Waste to Wonderful - a textile-sharing group for migrants and refugee women.

Included in the suite of services are health-promotion classes, meditation, tai chi, yoga, mindfulness and specialised exercise programs, including the incredibly helpful Encore program, an eight-week post-surgery exercise program for women who have experienced breast cancer.

Women's Health Tasmania also run workshops for all stages of womanhood, from stress management - which comes at any stage of womanhood, I might say - to Baby and Me, managing mother guilt, through to menopause and pelvic floor exercise workshops.

As it did for so many organisations, COVID-19 forced a major rethink of how Women's Health Tasmania offers its services. COVID-19 hit women really hard, and Women's Health Tasmania could see the impact anxiety, unemployment, poverty, family violence - and these are crises - and difficulties accessing help was having on its clients.

Innovating madly, Women's Health Tasmania reached out to connect with people through online services, classes and forums. It recorded a brand-new podcast series called *She's Out There*, covering varied and diverse aspects of sexual and reproductive health.

It started a blog on topics as diverse as why poker machines are particularly a problem for women, to cosmetic surgery on women's genitals, to managing endometriosis. Quite a spread.

I love the ingenuity shown by this group in the early stages of this move to online and diverse delivery. Without proper cameras or tripods, they filmed classes using mobile phones taped to yoga blocks taped to chairs. They filmed in lounge rooms, bedrooms, kitchens; and that is when they remembered to press 'record' on the machine.

Teething problems aside, CEO Jo Flanagan reports that six months in, Women's Health Tasmania's online classes now rival the best that YouTube has to offer.

In 2019, Women's Health Tasmania hit the road talking to women living in rural and remote areas of Tasmania, later also reaching out to women who identified as LGBTQ, particularly those living in rural communities.

They discovered that although countrywomen generally enjoy a strong sense of community and belonging, they also experience huge woman-focused service gaps, poor internet access and digital literacy, and are hit by higher cost barriers in accessing basics from healthy food, services, transport to health care.

Sadly, countrywomen also spoke about their disillusionment with short-term funding and pilot programs that had begun in their areas but were not sustained. Women's Health Tasmania will continue its strong advocacy on those issues in pursuit of its mission - healthy Tasmanian women.

Coincidentally, Women's Health Tasmania is holding its 2020 annual general meeting today. CEO Jo Flanagan kindly gave me an advance copy of the 2019-20 Women's Health Tasmania annual report. It is an engaging read about the resilience of women and their capacity to change direction when encountering the unexpected. I encourage members to look at it when it becomes publicly available after the annual general meeting later today.

I am delighted to advise that Women's Health Tasmania is a semifinalist for a Physical Activity Community Achievement Award. These awards encourage, acknowledge and reward those achievements that make Tasmania a better place. I offer my congratulations on the nomination of Women's Health Tasmania and wish the very best of luck to the whole inspiring team.

Members - Hear, hear.

Mowbray Roundabout

[11.37 a.m.]

Mr DEAN (Windermere) - Mr President, I thought we might see the member for Pembroke's little one here today.

Ms Siejka - Give it time.

Mr DEAN - Maybe that might happen.

I bring members' attention to a success story involving the construction of a roundabout at an intersection known for having had 27 crashes over a five-year period, including a lot of property damage and fatalities. That was the importance of this junction -

Ms Rattray - I actually drove on the roundabout about a week ago, and it worked - I got off it, so well done.

Mr DEAN - It is a great roundabout.

Some members may have seen media stories over the last couple of years about the Government's intention to install a new set of traffic lights at the intersection of the East Tamar Highway and Mowbray Link Road at Mowbray. When this plan was published, my office was contacted by numerous community groups and individuals about the absurdity of having yet another set of traffic lights installed on that part of the East Tamar Highway. As it stood at the time, there were 13 sets of traffic lights over a 2.5 kilometre stretch of the highway, and I think even more traffic lights were shortly going to be put in some other place on the highway.

One community group that contacted me was the Tasmanian Truck Owners and Operators Association, which was lobbying for either an overpass or a roundabout instead of the proposed lights. Many of these truck owners carry loads of 70 tonnes-plus, and stopping and starting at traffic lights causes traffic delays for all vehicles because it is a slow process to move so much tonnage from a dead stop.

I applaud Alderman Robin McKendrick, another spokesperson for the installation of a roundabout, who agreed that a set of traffic lights was a backward move and was probably a cheap fix.

The RACT also supported improvements to this junction and supported a roundabout or an overpass as well.

Given the growing industrial estate site of Bell Bay and the increase of traffic through this area, it was necessary to have a permanent fix that would last well into the future and would accommodate the increase in traffic along this highway. It is not a short fix.

I lobbied the Government during Estimates in 2018 to make my constituents' views known, and the minister's response was that a roundabout was not being considered because it would be more expensive than traffic lights and that the traffic was not flowing from all incoming roads or even back to the junction.

The Parliamentary Standing Committee on Public Works also called for public comments about the intersection upgrade during 2019, and also planned a public meeting to held at Henty House. This meeting never occurred because it was cancelled at the request of the Department of State Growth. Somewhere throughout the process, State Growth listened to the people and supported the installation of a roundabout. Construction of this roundabout is now almost complete - the roundabout itself is a credit to the engineers who designed it. Congratulations also go to the construction team because there has been very little interruption to the traffic flow during the entire process.

There are now two lanes on the roundabout proceeding north and two additional bypass lanes heading north up the highway. North-travelling traffic does not have to stop to pass through the roundabout; both lanes can proceed without a stop; and the extra-long merge lanes allow for the speed of traffic entering the highway lanes to increase to match the bypass traffic.

This roundabout is quite unique in the way in which it has been constructed; it is not like a normal roundabout. The feedback I am receiving from locals is that it has made entering and exiting the Mowbray Link a far safer and less stressful experience. I congratulate everyone involved with its design, planning and construction - it has been a success all round. I must say it is encouraging that the Government and State Growth listened to the local stakeholders throughout the process.

It is seldom government departments are praised for jobs undertaken, but in this case the Department of State Growth listened to, and acted in the better interests of, the motoring public, and it deserves recognition under the circumstances. I do this sincerely because it has helped and assisted all traffic moving through that roundabout in a very good way. It is a great roundabout - well done to all involved.

MOTION

Consideration and Noting - Review of the Effectiveness of Electronic Monitoring for Perpetrators in Family Violence Orders

[11.42 a.m.]
Mr DEAN (Windermere) - Mr President, I move -

> That the 'Review of the effectiveness of electronic monitoring as a condition for perpetrators in Family Violence Orders, under section 16 (3)(c) of the Family Violence Act 2004' report be considered and noted.

Mr President, I have moved this report to be considered and noted for the following reasons: first, it is the first review of this type on electronic monitoring in this state; second, because of the serious nature of family violence and the frequency with which it is occurring; third, to bring further attention to the seriousness of these crimes.

The review's terms of reference are -

(1) What has been the level of perpetrator and victim participation in the trial?

(2) What impact has a trial had on offending and FVO breaches?

(3) Have any technical issues arisen with monitoring?

(4) Any other matters considered relevant.

This part of the review provides a background for the Family Violence Act 2004, the introduction of electronic monitoring as a condition of family violence orders - FVOs - and outlines the intent of this review.

In 2018-19, the Magistrates Court received 747 applications for family violence orders, 326 applications to vary or extend family violence orders, 176 applications to vary or extend police family violence orders, 42 applications to revoke family violence orders, and 64 applications to revoke police family violence orders.

You have to keep up with all of these words and phrases. When you consider police recorded 3579 family violence incidents and 2377 family arguments during this period, it clearly demonstrates the depth and seriousness of this crime in Tasmania. Only a couple of weeks ago the member for Murchison moved a motion to recognise the seriousness of this crime, and I applaud that. In my opinion, we should be doing much more in this place on it.

I am trying to work out what these numbers mean because in the more serious area of family violence incidents - and 3579 cases were recorded by police - only 747 applications were made to the court for family violence orders. What happened with regard to the remaining 2832 cases? Maybe some were repeat offenders. I do not know but I would like to know what happened to the rest. Were they not serious enough for family violence orders to be accepted?

How many operational family violence orders are in the state at this time? That might be a hard one to work out and get the evidence on, but I think there would be thousands.

Ms Forrest - Sadly, there would be thousands.

Mr DEAN - Yes, sadly, but it would be interesting to know the figures regarding the numbers currently in place and working in this state.

Tasmania Police commenced a trial of electronic monitoring in November 2018 following procurement of the devices. The legislation went through the parliament around the end of 2017. We passed the legislation in this place.

I appreciate that the Government and the Department of Justice have been working towards electronic monitoring for many years, as I have. Some members would remember my persistence in this area for many years.

Ms Rattray - I am happy to put my hand up and say I have been listening.

Mr DEAN - I even went to the extent of inviting a Victorian company working in the electronic monitoring area to Tasmania to brief the Government and Department of Justice and the police on this method of surveillance. That is, tracking and controlling family violence offenders, and further than that - to track and monitor people on bail and as a way to control people sentenced to home detention as a penalty.

The briefing and the devices were well received. However, it took another decade or longer before any real action was taken to consider it seriously and put legislation in place. In saying that, I accept there was a lot of work to do. First, getting the devices, working it out, getting the legislation through and so on. I recognise that it was not something that could happen overnight. It has happened, which is the important thing because in its short time of use, electronic monitoring has proved to be somewhat successful, as this report confirms. Having read a more recent report by Tasmania Police on electronic monitoring, which was released on 20 August, I think 'somewhat' could be replaced with 'very' - very successful. I will refer to that report a little later.

I called for a trial of these devices because electronic monitoring is a new area, and not much is known about how it might work, if it works at all. Again, only the longer serving members of this place would remember that discussions on electronic monitoring and other sentencing options became serious when the judges and magistrates starting calling for improved and modern ways of dealing with offenders rather than jailing them. I recall magistrate Tim Hill - I do not know whether the member for McIntyre might recall him - probably the only other member here -

Ms Rattray - Try not to get too friendly with the magistrates, if you do not mind, honourable member.

Mr DEAN - I recall magistrate Tim Hill briefing us; I am not sure if it was to a committee or whether it was a briefing to a number of us; I am not quite certain now -

Ms Rattray - I recall it was a briefing to all members.

Mr DEAN - It was on the need for wider sentencing and bailing options, and ways to keep offenders out of jail. He saw jail as an option only when every other conceivable way to impose a penalty, keeping an offender in the community, was explored. He was an innovative magistrate, always considering the better options and the best options for the state moving forward. I had a great admiration for Mr Hill, the magistrate.

It was clear people were being sentenced to imprisonment and being remanded into custody where that could have been avoided had other controlling options been available.

I have always said jail is a high school or college for crooks. This is where many criminals are indoctrinated in crime, where they learn about committing crimes and avoiding apprehension, although thankfully they are not very good at that.

Ashley Youth Detention Centre has been described as a kindergarten or primary school for the young and impressionable. This is where they learn the trades of motor vehicle stealing and the beginnings of criminal behaviour. I am saying that wherever possible we need to keep those people out of jail.

This review is all about family violence. It is occurring in Tasmania at high levels with no evidence at all to show it has slowed down over the past 10 years. On the contrary, the evidence demonstrates a constant increase annually in the crime, which has been happening over a long time.

The police would prefer to accept - I guess we all would - that the increase is likely to be occurring because victims are now becoming more willing to come forward and report acts of family violence. This is because of improved protection support and more confidence to do so, including less stigmatisation for a victim, so there are a number of reasons why more people might come forward.

If this were so, with the annual increases occurring, it is clear we, the police and authorities have little idea of the real impact of family violence and how much is occurring in the state.

It is not just the impact on the immediate victim - the wife, the partner, sometimes husband - but also the children involved, who also are victims. The impact on children is enormous and with long-lasting adverse impacts on their health, wellbeing, mental health, development and learning. The damage, in fact, goes further than those things, because it becomes a learned behaviour for children - a behaviour some accept as normal and go on to act in a similar way. There is a lot of evidence to support this is the case. Once again, that is why we have to be severe on this crime, to educate people about it and to stop it from happening.

During the COVID-19 period to date, evidence suggests family violence reports have slowed down. That is good if it is a fact, but interestingly contact with some family violence services has increased during this time, despite the police claims.

Ms Forrest - During the lockdown, it reduced because women could not report it. It was not safe to.

Mr DEAN - That is probably the reason for it. The member for Murchison is right. I do have a question on the Notice Paper, which might have been answered, about those services and the contact they had with people subject to family violence or reporting it.

Ms Rattray - This report will not indicate any of those figures and numbers you are talking about there.

Mr DEAN - No, it does not.

Ms Rattray - So, are we are still talking about the report?

Mr DEAN - Yes. What does this mean? More family violence and less reporting to police, or are these contacts from those who are already victims seeking more help? Questions will need to be asked if these other services have not done that.

Executive summary - the review found the preliminary indicators are that electronic monitoring is an effective tool for reducing reoffending among high-risk family violence perpetrators subject to a family violence order with non-approach issues.

If it is accepted when commencing a program that there is a lot of learning to do - such as identifying suitable clients for electronic monitoring, the capacity of the devices, the area they can be used in, functioning times, recharging of batteries, any technical issues et cetera - these points should have been known because other states have done work in this area.

We are not the only state working in this area. Other states are doing it. Other states have put reports in on how it is going and what is happening and so on. In fact, the Queensland Police Service has completed a large-scale experiment on GPS devices to track domestic violence offenders releasing *The Domestic and Family Violence GPS-enabled Electronic Monitoring Technology, Evaluation Report* in April 2019, eight months before this review was done.

While this review relates to what is happening in Tasmania, I was surprised the Queensland Police trial and its findings were not referenced. Maybe there are also other trials in other areas. I did not look at them.

In 2015, a Special Taskforce on Domestic and Family Violence in Queensland provided a report titled 'Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland'. In that report, Recommendations 123 reads -

> The Queensland Government trials the use of Global Positioning System (GPS) monitoring for high risk perpetrators of domestic and family violence.

The findings from the Queensland trials are not significantly different from those in this review - that these devices need more work and are not the panacea, or be-all or end-all for protecting victims from reoffending by perpetrators, and/or providing reliable warning to authorities of likely breaches of court sentences or bail conditions relative to family violence.

Ms Forrest - I know of a case where a perpetrator of family violence was wearing an ankle bracelet, went to the mainland and let it go flat. It was flat for weeks.

Mr DEAN - This is one of the issues that comes out. It is a good point. Are we working with the other states and territories, and particularly with those more advanced than we are with electronic monitoring? If we are, I would have thought we would already be dovetailing into their work, and making change or adjustments to problems identified with the use of these devices.

Having said this, during phase 1, Planning and legislative review, the steering committee consulted with an expert in electronic monitoring from the New South Wales Corrective Services, and a representative from the Department of Justice was brought in as a part-time project officer. It is great those things are happening.

I suspect the Tasmanian Institute of Law Enforcement Studies at UTAS - which is undertaking a detailed study of the Tasmanian trial in its entirety, which will be handed to the Government by 31 December 2020 - will be looking at the Queensland Police Service trials, reporting on this subject and perhaps others. It will be interesting to see whether the TILES report is on track because of the COVID-19 situation. Is it be likely to be tabled in December 2020 as programmed?

We already know what the issues are, which have been confirmed in other jurisdictions, and we should be working on them to make electronic monitoring more reliable. Page 4 of the executive summary of the Queensland Police Service's evaluation report reads -

> Therefore, GPS tracking should not be relied on to replace other forms of verification and monitoring, such as contact with police, service providers, a partner, family and other significant third parties. Without a concurrent, clearly structured and sufficiently resourced case management strategy to address the causes of DFV behaviour and the perpetrator’s criminogenic needs, GPS-enabled technology is unlikely to provide a risk reduction effect for victims of this crime.

Mr President, there is evidence to demonstrate electronic monitoring is an effective tool in reducing offending overall. However, it should be considered as part of a broader strategy because of the current limitations.

A separate report by Australia's National Research Organisation for Women's Safety - which the member for Nelson was talking about earlier - found electronic monitoring devices were effective in reducing offending, but that it should be considered as just a tool in a broader strategy of protecting victims.

As at November 2019, 58 family violence offenders have had electronic monitoring devices fitted. These were classified as high-risk offenders. During this time, 15 victims volunteered to be fitted with the devices, which is good. We always wanted that to happen to trial this process, to see if it would assist and help.

The position of both the Victims Support Services - VSS - and the Court Support and Liaison Service - CSLS - is that Project Vigilance - that is, the trialling of electronic monitoring of high-risk family violence perpetrators - is working well, and they support the program continuing. Some of you may have read this report so I do not intend to go through it page by page, section by section, but suffice to say that statistical information is available to show that during the short trial time it was successful.

Has it been as successful as envisaged at the beginning? I do not know, but I think we all knew there would be teething problems and, further, that it would take several years to iron out some of the issues. These issues include batteries running flat, a very important one, which was the first point they raised; device limitations in certain areas in the state; and delays occurring between monitoring data being relayed from a device to the Monitoring and Compliance Unit - MCU. Those are some of the problems and issues that have arisen.

With the way and speed with which technology is progressing, we should see most problems sorted out in the near future. Electronic monitoring is about assisting victims to have more control over their lives and to remove the fear of their ex-partners, the offenders, turning up without warning to assault or harass them again. There are many cases around the country where the offender has turned up, and not only harassed and caused problems to the victim, but has committed murders, not only of the immediate victim, but of children as well, as we know well. We have read some horrific cases where this has happened.

Pages 36, 37 and 38 of the review refer to the position of other service groups relative to the trial period. In making some comment here, it brings to my notice yet again the different services, areas and units performing services around domestic violence and family violence. I have always felt the better model here would be to fit all groups under the one umbrella. One group identifies with this, and I will refer to that in a moment.

While they might serve different purposes, they are all specifically related to family violence. Victims Support Services, Family Violence Counselling and Support Service and Safe at Home fit into this category, and then we have Community Corrections with a part to play also. I will refer to each of the organisations and what they have said.

Community Corrections supports the program, but identifies that it has limitations and we all need to be aware of the position. Victims Support Services considers that further work and consultation across agencies are necessary. The Family Violence Counselling and Support Service raised a point I had previously referred to - there is a need for a clearer understanding of the roles between all those groups and organisations engaged with family violence.

One part of its position regarding the program is -

> It is suggested that victim support could be further enhanced by developing a greater understanding and consistency in responses to victims when a perpetrator enters a restricted zone, in particular who is responsible for follow up and communication with the victim. It was suggested that further role clarification between Project Vigilance, Safe Families Coordination Unit, Family Violence Units, Community Correction Monitoring Unit and the FVCSS would be of assistance in this regard

That is the very point I have been making, one I have made before, when we have a number of organisations dealing with a similar thing. It is high time we had a good look at it and in my view brought them together so they work together under the control of one organisation, one area.

From my perspective, bringing them together is a point I have been trying to make for a long time regarding family violence matters generally. Does the right hand know what the left is doing, or what it is responsible for? In my opinion, a lot do not. Many groups are involved - when I say that, I am not trying to put these organisations down, they are all doing great work but it can be done better in my view. Many groups are involved and we would do well to bring some of them together under the control of one person or a department.

Another issue raised by the Family Violence Counselling and Support Service was that FVCSS in the south of the state undertook victim safety plan development in partnership with the Southern Family Violence Unit - Tasmania Police, while in the north and north-west the family violence units liaise directly with victims to develop the safety plans, so we have an inconsistency between one end of the state and the other with the way in which some of this has been managed and handled. That really should not happen.

Ms Rattray - That has been happening for a very long time.

Mr DEAN - It should not happen. We need a consistent approach throughout.

Why would that be the case? We should have some state consistency with regard to the management of handling family violence issues. Like it or not it is fragmented, not consistent for the state and needs changing. Electronic monitoring matters need to be dealt with consistently throughout the state - will this be the case?

Safe at Home - what did they think of the electronic monitoring trial? Who is Safe at Home? It is an integrated whole-of-government criminal justice response and intervention system to family violence. If this is the case, where does it leave all the other bodies working in this area? Safe at Home involves a range of services and partner agencies working together to address the risk and safety needs of victims, including children, and to hold offenders to account. Is that not what the other units are doing? Where is the delineation, the boundaries, of responsibilities for each?

Safe at Home has said it provides an additional tool to manage family violence matters. It does not stand alone and more time is necessary for Tasmania Police and other agencies to assess the programs at present.

Interestingly, they raised the issue of the purpose of electronic monitoring, which is about managing risk and safety and has no part in facilitating bail. I always thought it would do that, that it would also be used for this purpose as bail is currently causing police some terrible issues and problems.

In the initial discussions on electronic monitoring, it was always mentioned it would or could also be a tool for the Magistrates Court to use when determining bail for family violence offenders. In particular, rather than having an offender remanded into custody before trial, in suitable cases bail could be extended with electronic monitoring. That may be an extension of electronic monitoring in the future once some of the problems are sorted out and more is known about the program.

The legislation provides for uses of electronic monitoring in circumstances other than family violence - as I said, bail in particular - and for home detention. I think electronic monitoring is being used in home detention now. It is a great way to penalise and sentence a person without the need for them going to gaol.

It is pleasing to see electronic monitoring being trialled. It was always accepted it was not going to be a panacea to remove risk and provide safety to victims; it was always going to be another part of the toolkit, as Safe at Home has said, in managing family violence matters. It was never to, and will never, stand alone.

I am looking forward to the detailed study of the trial, which is to be released by 31 December 2020. Could I just check that with you, Leader?

Mrs Hiscutt - I mention it in my response.

Mr DEAN - Thank you.

This is an important program. It is all about protecting victims and managing risk. My position is that a briefing from the Department of Justice and Tasmania Police would be beneficial. Certainly, I will be seeking a briefing whether other members are interested or not.

I referred to a report at the beginning of my talk on this matter. In addition to this review, on the 20 August 2020 another report on electronic monitoring was released by the police. Electronic monitoring is now being hailed as reducing assaults, threats and stalking, and reducing family violence incidents across Tasmania.

According to a recent police report -

> As part of an Australian-first trial which commenced in November 2018, electronic monitoring devices tracked the movements of family violence offenders to ensure they did not enter certain areas where their victim resided or worked.
>
> Victims could opt-in to the trial and be given a small device which would allow them to promptly seek police intervention where there was the potential for a breach of a family violence order.

It is claimed here to be an Australian-first trial, although I cannot be assured that is right because Queensland, Victoria and maybe some of other states have been in this area for some time.

However, this review paper - the subject of this motion - was released on 19 December and I have touched on its findings. In essence, so much more work has yet to be done; however, preliminary analysis and stakeholder feedback indicate the trial is having a positive, and noticeable impact in reducing high-risk perpetrator family violence offending.

Moving forward eight months to 20 August 2020, the findings on success of electronic monitoring are much stronger than in the report I have been referring to.

Quoting again from the recently released Tasmania Police report -

> Preliminary results from the trial showed a 70 per cent reduction in assaults, 80 per cent reduction in threats, 89 per cent decrease in allegations of emotion abuse and 100 per cent decrease in reports of stalking.
>
> It also showed a 7 per cent reduction in family violence incidents across the state and an 82 per cent decrease in high-risk family violence incidents.

I cannot be sure of the additional work done since December 2019. I was taking it from figures I have referred to, but they are quite impressive if that is happening. That is the feedback we are now getting, as I said, eight months on from when this initial review was done.

I will be interested in the TILES report findings, and also whether COVID-19 has had an impact. I have always had confidence in the electronic monitoring program. It has wider uses, in my opinion, in home detention rather than prison, and for bail purposes - and the latter would be the higher risk people admitted to bail.

This is about family violence and the effort put in by many people involved in bringing it to this stage. It is having a positive impact in protecting victims and giving them peace of mind, so it is a wonderful innovation.

We are getting what I always believed we would get from it. If you go back to many of the speeches I have made in this place over the years, that was my view. That was my position, and I am glad to see it is coming to fruition.

I commend the motion to the House, and move aside for the new member for Rosevears.

Mr PRESIDENT - Honourable members, before I call the member for Rosevears I remind you that this is the first contribution the honourable member will make in this Chamber. She is entitled to be heard without interruption, which I do not think will be any problem at all in this very polite Chamber.

I also welcome to the Chamber the member's husband Andrew and her family, friends and colleagues, and, of course, the Premier, who is here to witness your first contribution. Just a little bit of advice: do not be put off by the cameras. It can be fairly daunting, but you get used to them after a while.

[12.13 p.m.]

Ms PALMER (Rosevears - Inaugural Speech) - Mr President, thank you for your very sound advice this afternoon. I thank honourable members, and apologise to those who will have my back.

I acknowledge the member for Windermere for his service to our community - a community I have shared with you for the majority of my life. You have been dedicated to your service to our community in varied roles, and today is just another example of your commitment to the protection of the people we live with. I thank you for that.

I begin my inaugural speech as the honourable member for the magnificent electorate of Rosevears. I acknowledge and pay my respects to the Tasmanian Aboriginal people as the traditional and original owners and continuing custodians of this land on which we gather today, acknowledging Elders past, present and emerging.

Mr President, on 10 April 1971 in the city of Christchurch, New Zealand, a baby was born. On that baby's birth certificate was limited information. There was the sex of the baby, a girl; there was the name of the teenage mother who had given birth; and, at the top of the birth certificate in the section usually set aside for naming a child, simply two words were written - those words were: 'No Name.'.

For four weeks, No Name was indeed my name, for that was my original birth certificate. At the same time a young man from Sydney by the name of Donald joined his young wife, who was a Kiwi, Diane, and they went to that very hospital and were taken to the ward where all the babies who were there to be looked at for adoption were lined up. How very fortunate was I that my parents chose me, and a few weeks later they became parents and I became someone's daughter.

My parents met here in Tasmania at the Missionary Training College in St Leonards. They came from their respective homes, and both felt they had a calling from God to serve the people of our world in all regions. They met at St Leonards at the college; they fell in love; they went to London where they married, and very soon after they moved to Africa to the country of Chad. You will not find Chad on many tourist routes in Africa. It is perhaps the harshest of the African way of living. My mother was a nurse and while she was there, she established a medical facility that took care of women and children, a facility I am very proud to say still exists and still operates all these years later. My father, a brilliant linguist, began work on an unwritten language called 'Tama'.

They remained in Chad for four years and then went back to New Zealand so my mum could see some of her family. That is where they adopted me and a few months later my younger brother, Callum. We were only weeks away from returning to Africa as a family where my parents wanted to continue their missionary work when for no apparent reason my father fell. His leg went from under him for no reason. Within weeks we had a diagnosis of multiple sclerosis and with that diagnosis came the end of their dream to return to Africa with their two young babies to continue their work. But with that door closing another door opened.

They returned to Tasmania. They returned to the Missionary Training College where they became staff members at St Leonards. This is where I spent the first six years of my life. It was a wonderful, carefree childhood. I had a hundred aunts and uncles; I hung out with all the kids of the other staff members, and we all ate our meals in a huge dining hall, all in together. There was always great delight when stewed apples with runny custard was on the dessert menu.

During this time, I was unaware of how my father's body was disintegrating and fading beneath him. I thought when he crawled around our small apartment using his elbows to pull himself along that he was doing it to be closer to my brother and me. I found out years later he was doing it because he detested the wheelchair, and with the illness that was consuming his body, it was his only way of moving around. As his condition worsened, it became impossible for us to stay at the college for dad to work on the staff, so for the first time, we moved to the suburbs - and how blessed we were to move to the magnificent suburb of Trevallyn.

The Cataract Gorge became my backyard. It was wonderful indeed. This is also where I began my official education at Trevallyn Primary School. I loved school. I have always had a love of learning and every single school report from year 1 through to year 6 made the same comment that some of you will not be surprised at - 'Joanne would be an excellent student if she could just stop talking.'.

However, the first few months of my education at Trevallyn were fraught with anxiety and I was constantly found to be missing from the classroom. Most of the time I would be retrieved halfway down the street trying to make my way back home as a six-year-old. If not trying to make my way back home, I would be found somewhere quietly hiding in the schoolyard. By this stage my father had limited use of his body, so 24-hour around-the-clock care fell to the responsibility of my mum, with my brother and me doing the best that we could to support her. We got him up each morning. We dressed him, we bathed him, we fed him, we toileted him. We turned the pages of the books he was reading and we moved the chess pieces on the chess board as he competed in international correspondence chess.

I was constantly worried: If I was not there, who would look after him? Who would be supporting mum? Thus I kept disappearing from the classroom. On one of these occasions I was found sitting on the toilet floor in the girls' toilets. The office lady was sent to find me and take me back to class. Her name was Mrs Bev Morris. I will never forget, despite being so young, her walking into those toilets because she wore the most fabulous shade of bright pink lipstick. I was only six so it was very impressive.

In that moment she had a few options. She could pick me up, dust me off and take me back to class, but instead she chose to sit on the concrete floor with me and try to work out why this kid just kept leaving the classroom.

She soon discovered why I was suffering with anxiety, why it was just impossible for me to learn in a classroom environment. She hatched a plan and the plan was that whenever I felt anxious about my dad, I could just go to the school office and ask for her; she would then sneak me in and I would be allowed to use the old school telephone to ring home.

In that moment of kindness, she actually released me to have the most wonderful education because until that point learning was impossible for me. I am so grateful to her for that gift of kindness shown to a kid sitting on the toilet floor.

I am pleased to say Mrs Morris became a lifetime friend, and remains that way. She still wears the same shade of pink lipstick, despite being in quite her senior years now.

As time went by, dad's condition deteriorated to the point where this brilliant man with a brilliant mind had been let down terribly by a completely useless body and he had very limited movement from the neck down. It became an impossible situation for my mum and for our family for him to remain at home, and a heartbreaking decision was made that this man, only 44 years old, would be placed in institutional care.

He went to Eskleigh Home. It was 22 kilometres from our front door to the car park of Eskleigh. Too far for me to ride my bike. A new level of trauma settled over our family. My father was indeed so saddened that the doctor said to my mum, 'I believe I am going to watch the first man ever die simply of sadness.'. He literally stopped speaking for almost a year.

When I was 11, out of sheer desperation one evening, he asked if I would help him to take his own life. He had run out of strength and he could not go on anymore. I was a kid and there was no way I could do that because I only ever knew my dad to be sick and I just wanted him to be with me, so I could not help him in fulfilling that request.

Somehow, our family struggled on for another nine years until my father passed away at the age of 54. But in those final nine years were some amazing moments, some amazing glimmers of hope where our family was blessed again by kindness from our neighbours and our community. On the fourth weekend of every month, my dad was allowed to come home and for nine years the neighbours, the people who lived in our street, made a commitment to our family that they would be there on stand-by at a moment's notice to come down and help care for dad. They would come and lift him out of the car and into his chair. They would help lift him into bed and out of bed the next morning. They would come anytime he needed to be lifted onto his commode. Anything we needed for that entire weekend, the families who lived in our streets simply made that commitment.

What extraordinary kindness they showed to us; they gave me, my brother and my mum wonderful moments, wonderful memories, in the final nine years of my father's life.

Dad died at the age of 54, 30 years ago last month. In a beautiful turn of events on the thirtieth anniversary of his death, I attended my first official function as the member for Rosevears. At the invitation of the Beaconsfield RSL, I was asked to present medals at Beauty Point to veterans of the World War II. I think my father would have liked that very much.

On two significant occasions, it has been kindness that has actually shaped my life. First as a child, I was freed up to enjoy a wonderful education because of the kindness of an office lady and then for my family, precious and joyful memories were given to us, again a gift of kindness from our neighbours - a gift that endured nine long years.

We must never forget the incredible power that comes with kindness. I have spent years speaking on this very matter at numerous events and indeed at schools right across our state, because you never know when the kindness you show is the miracle that someone else is waiting for. There is no denying our state has been smashed over these past months, from businesses to families to individuals who faced what no-one could have ever thought possible here in our beautiful island state.

The Tasmanian Government has been exemplary in the swift and decisive manner in which it has saved lives and kept us as safe as possible, However, the responsibility of our recovery does not solely lie with government - it lies with each one of us. We must all have an outward focus at this time; rather than looking at what we may have missed out on, we must seek out those who have lost so much more. I believe it is this sense of community that will save us in the coming months and years as we work through the trauma of COVID-19.

Yes, we have seen and we will continue to see extraordinary measures put in place by all tiers of government, as we strategically work through the economic and social impacts of this pandemic. However, I firmly believe it will be our on-the-ground community groups, our grassroots sporting clubs, our neighbours and our communities that will play a pivotal role in catching the individuals who may otherwise fall through the cracks.

As a huge part of my election campaign, I went doorknocking for hours; my husband Andrew joined me in that effort. We had a rule: when you could smell people's dinner cooking you had to come home. Once the COVID-19 restrictions were lifted, I was able to go from door to door, and have conversations with everyday Tasmanians. They shared with me their very strong opinions on what I should and should not be doing, but they also shared with me their story. How they were coping, the sorrow that they had faced, the fears they had for their future.

I told them their stories would stay with me always; they drove me on then and they drive me on now.

One such story has been etched on my heart and I would like to share that story today. Mr Geoff East lives in the west Tamar; he was a young man when he married the love of his life, Roma. He was a footballer and the very first time he ever saw Roma, he was running off the field after a game and he fell flat on his face at her feet. They went on to be married, had two children and in Geoff's words, Roma was the best. She raised their kids, she volunteered for years at the canteen at the football, she made afternoon tea at the cricket and she organised social events for the mini league. She had many years volunteering for Meals on Wheels and with the West Tamar Health and Community Service. She loved greyhounds and she loved her grandchildren.

When I knocked on Geoff's door and handed my little Jo Palmer brochure, he said, 'I do not need that, love, I already know who you are'. He said, 'My wife likes watching you read the news; she does not always like what you wear, and she does not like it when you have your hair up.'. As he spoke her name, he began to cry because just five weeks before, he had lost his beloved wife of many years. She died right in the middle of the harshest restrictions we saw here in Tasmania for COVID-19.

In those final weeks, he was allowed to visit her only twice a day for one hour. His daughters were allowed to visit once a day for half an hour and their grandchildren had to stand outside the glass door and wave. As this strapping man who was a stranger to me stood in his doorway, he was simply overcome with emotion as he spoke of her funeral with only a few people present. Geoff said Roma's funeral should have seen hundreds of people gathered to celebrate her life, her children, her grandchildren, her friends and her community. He said to me, 'I have let her down, she did not deserve to slip away like this and I cannot get over it'. We know Geoff did not let her down, but that is not the way he saw it.

After I was elected, I went back and I found Geoff's house. He was still a broken man, still had not recovered from the fact he had not been able to farewell his sweetheart in the manner in which he felt she deserved. I asked if I could share his story today for two reasons.

First, his beloved wife's name, Roma, would resound in this Chamber, and a little of her life would be honoured in this place in front of all the honourable members who represent every corner of our beloved state. Mr East, the day will come when you can have a huge celebration for Roma's life but right now I hope this gesture will find you a little peace.

Secondly, to remind each one of us that there will be thousands of untold stories of heartache just like this right across our community. There are broken people living in the houses we drive by each day and as members of this community we must find ways to seek out these families and to seek out these individuals. It will be up to every single one of us. We will all need to play a part.

Mr President, what an extraordinary honour to be elected as the member for Rosevears to serve in this place at this time.

I acknowledge today that I have achieved nothing as an individual. Indeed, standing with me today is the Premier, Peter Gutwein, and his team who just kept encouraging me every step of the way and I am so grateful for your support. In particular, my heartfelt thanks to Michael Ferguson and Sarah Courtney, to Guy Barnett and Bridget Archer, Claire Chandler, Jonathon Duniam and Wendy Askew. Much thanks also to Liberal Party president, Rod Scurrah, and state director, Stuart Smith; and local party leadership from Simon Wood and Dorothy Dehays.

To the Leader of the Government in this House, the honourable member for Montgomery, Leonie Hiscutt, thank you for assuring me that one day I will understand what is going on.

To the members of the Legislative Council staff, my sincere thanks. Also, for your reassurance that I will be okay in this place.

To the honourable member for Huon, Bastian Seidel, we have begun this extraordinary journey together and I am so grateful that on my first day in this place we were able to attempt to navigate the many corridors together. Your height played a big part in ensuring we got where we needed to go.

I wish to pay tribute to all the families and all the loved ones who held my family's hand during our life journey and to the strong women who held mine, including my aunt Lyn, my aunt Sal and Muriel Heron. As a kid I never could have imagined that I would have a career spanning more than two decades in a thriving newsroom. This opportunity was given to me by the then general manager, Bruce Abraham, and then how fortunate to be guided for 18 years by my news director, Mr Grant Wilson. To these two friends I say, thank you, and of course my on-screen nemesis but dear off-screen friend, Peter Murphy, who indeed is a trusted friend.

My many thanks also to my old colleague, Tim Robertson. I am so grateful for your friendship and for your loyalty.

To my birth father, Chris, and my sisters, Janine and Susie - we did not find each other for 35 years and it is a jolly miracle we did but now we are family and I love you.

To my family in-law, Kevin and Karen, Dave and Jen and children - I love you dearly.

To my adored friends, way too many to list, but in particular the Page family who are indeed my family.

My dearest friend, Deb Abraham, and my oldest friend, Grant Collins, who at this very moment is undergoing brain surgery whilst in lockdown in a Melbourne hospital - my love and prayers are with you today my dearest friend.

To my adored brother, Callum, there is not a memory from our childhood through to adulthood that we have not shared. Part of my heart has always been and will always be yours.

My beautiful sister-in-law, Meg, and my nephews who mean the world to me, my eldest nephew who is 16 and currently campaigning in the current New Zealand election - I am a very proud aunty.

To my dad, well I simply wish you were here.

To my mum who is watching on line today as she is not well. Six months after my father died she returned to the mission field, this time to serve in Iraq in the middle of Desert Storm. Again, her faith never faltered despite living in the middle of a war zone. I have indeed been raised by a mighty woman.

To my own little family - my children, Henry, Lily, Charlie and Alfie - from the moment they were born, everything I have done has been for them. They are indeed, as I look back over my life, the thing I am most proud of.

My husband, Andrew - this was a big ask.

My decision to stand turned our family on its head and I asked you to risk everything that I might have this opportunity and even when I doubted myself you never did and I will love you forever for that.

Finally, to the thousands of homes whose front doors I knocked on. The western suburbs of Launceston, Prospect, Summerhill, West Launceston and Trevallyn through to Riverside and Legana, continuing all the way up the West Tamar to Greens Beach and Beauty Point. Thank you for your openness and your honesty. Even when you said to me I was such a lovely person but you did not think you could vote for me, you shared a little of your life with me as you allowed me to share a little of my life with you.

The electorate of Rosevears is indeed where I have lived through my greatest moments and my deepest heartaches. This is my home and the people who share this magnificent place with me and my family have my heart. They always have and they always will. Thank you, Mr President.

Members - Hear, hear.

Mr PRESIDENT - I congratulate the honourable member for Rosevears on a very thorough and entertaining first contribution and I am sure I speak for all honourable members when I say that we look forward to your future contributions in this Chamber.

As she mentioned, we are very fortunate with our two new members to have such a degree of life experience and passion so I think things are looking really good for the Legislative Council.

[12.37 p.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - In light of no other speakers, I will take the floor.

Mr President, I am not sure how the honourable member for Rosevears got through that without shedding a tear.

The passage of this bill enabled a then Australia-first trial to electronically monitor family violence offenders which has demonstrated early success in protecting victims of family violence in Tasmania. Our Government is extremely proud that we led Australia with this important reform.

Using electronic monitoring in family violence matters offers an innovative approach to enhancing the protection and safety of victims of family violence. The trialling of electronic monitoring for family violence perpetrators in Tasmania is founded around the innovative use of technology to keep victims and children safe.

The Tasmanian trial to electronically monitor family violence perpetrators was an Australian first in that we are the first jurisdiction to pass specific legislation to place electronic monitoring devices on family violence perpetrators as a condition of a family violence order.

The trial targets high-risk family violence perpetrators and includes monitoring of victim survivors on an opt-in basis. A victim may be offered a victim monitoring device and can opt-in to participate. The objectives of these changes were to improve safety of women and children subject to family violence, increase perpetrator accountability, increase protection for victims of family violence and associated offences and reduce social and justice-related costs in this space.

I will turn my mind a little bit now to the family violence part of this. Everyone in our community has the right to live their life free from violence. Yet domestic and family violence in Australia is widespread. One in four women and one in six men have experienced violence by an intimate partner since the age of 15 and violence against women is one of the most serious consequences of gender inequality.

In Tasmania in 2019-20, there were 5883 family violence incidences and arguments and 206 sexual assault offences reported to Tasmania Police. Of these, 38 per cent were committed more than one year prior to being reported, and 88 per cent were against female victims. The Tasmanian Government takes all incidences of family and sexual violence extremely seriously. As a signatory to the Australian Government's National Plan to Reduce Violence Against Women and their Children 2010-2022, called the National Plan, the Tasmanian Government has committed itself over the past decade to developing and executing family violence action plans aligned to the national implementation action plans.

On 1 July 2019, in line with the fourth action plan of the National Plan, the Tasmanian Government launched Safe Homes, Families, Communities, Tasmania's Action Plan for Family and Sexual Violence 2019-22. Under this plan, the Tasmanian Government set out with a $26 million three-year, whole-of-government commitment to progressing long-term change in the attitudes and behaviours that lead to family and sexual violence. This commitment was bolstered in response to the COVID-19 pandemic whereby the Tasmanian Government committed a further $2.7 million family violence response across a range of key support areas across the government and non-government organisation sector.

Community Corrections, Department of Justice, has employed 28 staff in the Monitoring and Compliance Unit, which operates a 24-hour shift roster. This comprises 24 monitoring staff, including six supervisors, which allows for three monitoring officers and one supervisor per shift and four support management staff. The monitoring team is responsible for monitoring all offenders subject to electronic monitoring in real time and responding to alerts or anomalies in information and tracking in accordance with violation protocols.

I will talk about the review findings. The bill as passed required that a review of the effectiveness of the inclusion of electronic monitoring conditions in family violence orders be undertaken as soon as practical, 18 months after new section 39A commenced, and that is what we are discussing here today. The review was based on the following terms of reference: What has been the level of perpetrator and victim participation in the trial? What impact has the trial had on offending and FVO breaches? Have any technical issues arisen with monitoring? Are any other matters considered relevant?

The review was completed in December 2019 and came not even halfway through the trial period, which, after planning and procurement processes were completed, commenced in December 2018. The work involved in these processes are set out in detail in the review report. It therefore provides an early impression of the trial's progress and found that, although it was too early in the trial to assess the full impact, it is having a positive and notable impact in reducing high-risk perpetrator offending and has been well received by police stakeholders.

Further to this compulsory review, the Department of Police, Fire and Emergency Management engaged the Tasmanian Institute of Law Enforcement Studies at the University to Tasmania, which in completing a detailed study of the trial in its entirety will evaluate its performance. It is due to complete that report by 31 December 2020. Of the 73 perpetrators involved in the trial, 52 were subject to electronic monitoring for at least six months. The preliminary trial's results suggest a 70 per cent reduction of assaults - the member for Windermere went through this – an 80 per cent reduction of threats, an 89 per cent reduction in allegations of emotional abuse and a 100 per cent decrease in reports of stalking.

Additionally, the trial saw a 7 per cent reduction of family violence incidents across the state – and an 82 per cent decrease in high-risk family violence incidents.

The trial also looked at offending patterns by perpetrators after their GPS tracking device had been removed. Of the 52 perpetrators who had been monitored for the last six months, 80 per cent did not reoffend following the removal of the GPS tracking device.

What this data tells us is that electronic monitoring not only modifies perpetrator behaviour whilst being monitored, but also after removal of the device, and therefore it reduces recidivism. These are preliminary results and we look forward to the outcome of the independent review of the trial, which is being undertaken by TILES. A final evaluation report is due later this year. That was one of the member for Windermere's questions.

This new and innovative trial utilising electronic monitoring is part of the Safe Homes, Families, Communities action plan for family and sexual violence. The Government's commitment of $26 million to the action plan to progress long-term change in the attitudes and behaviours that lead to family and sexual violence was bolstered in response to the COVID-19 pandemic, with a further $2.7 million added for key support areas in the family violence response.

Before I refer to my adviser for any other questions, in acknowledging the great success of the trial and the positive outcomes that have been achieved, I, of course, also need to acknowledge the critical and professional work of Community Corrections, which falls within the portfolios of the member for Clark, the Attorney-General and Minister for Corrections, Elise Archer.

Community Corrections has set up and run the 24/7 Monitoring and Compliance Unit, and has done an incredibly professional job in establishing that unit and providing monitoring of offenders on family violence orders and victims of family violence. I commend Community Corrections and congratulate it for its dedicated work and oversight, which has contributed to the success of the trial. The MCU operates on a continual shift basis, and commenced monitoring operations of family violence perpetrators on 1 April 2019.

I just have one more answer to your questions, member for Windemere. As of 15 September 2020, there are currently 1934 police family violence orders and 1384 family violence orders active in Tasmania.

The Government notes the report.

[12.49 p.m.]
Mr DEAN (Windermere) - Mr President, I do not know if anyone else wanted to speak?

Ms Forrest - We would have got up if we did.

Ms Rattray - The statistics have been well articulated by the member. I would only be repeating what the member has already said.

Mr DEAN - I thank the Leader for the position put forward and for emphasising the statistics. The interesting thing, as I said while I spoke, was that the review this motion is about was not as strong in its findings as we recently received in August. To me, that would seem that during that nine-month period between the two, we have seen much more support given in this area, and probably some of the problems already being ironed out in that period to see those improved figures come through.

I think the Minister for Corrections, Elise Archer, also referred to electronic monitoring now being used for the purposes of those people on parole as well. It is a good move in electronic monitoring, seeing it going into that area as well. What that does is allows more people to remain out of jail - or to come out of jail and to be monitored in this way. To me that is an added position we will see benefits from.

If you look at electronic monitoring and where it is going, at some stage we should probably be able to have some financial benefit going to this state. By not having these people in custody, by having these people out and about in home detention, the financial saving has to be quite high. That is something I will probably raise at another time, to see if we can put some value on what is happening here as well.

Mrs Hiscutt - I just wonder, honourable member - being, respectfully, an old copper - whether what was reported in the report is what you anticipated would happen?

Ms Forrest - Old being the word.

Ms Armitage - Probably say 'former'.

Ms Forrest - That is a much better term.

Mrs Hiscutt - I said 'respectfully'.

Mr DEAN - As a former police officer, a previous serving member of the constabulary, I always was of the view - and when I was promoting this many years ago I had done quite a lot of work looking at where electronic monitoring was going around the world, so I came in with that background, knowing the success of this in other countries where they are well advanced and where it has paid enormous dividends in many areas. I came in armed with the evidence I had when I started raising this issue, and bringing in those people from Victoria to show us what they were about. They brought the electronic monitoring devices in, as some members would remember.

Ms Rattray - You even provided some costings, as I recall, through the Estimates process around how much it would cost to actually implement a trial of this nature. You had certainly done your homework, honourable member.

Mr DEAN - To answer your question, yes, from my former background as a police officer, I always believed there was a lot to gain from the electronic monitoring position. I was always strong on that, knowing the time police put into looking and watching people who are on bail. Police know very well that people coming out on bail are going to commit further crime. They know that. They know exactly what is going to happen, and they know roughly the areas they are going to go to commit their crimes, and they know what sort of crimes they are going to commit. The police know that.

Sadly, with just a verbal position from a court - from magistrates and judges in the main - you are imposing bail, in most cases, on people with criminal propensities, and people who do not comply with the law. That is the sad reality of the situation, because we have many people coming back, reoffending and going back in. That is their life, and once again we need to try to break that. I accept that.

You need to have something else that can control that - and electronic monitoring is exactly the position that we need and want. Most people require, even criminals - and, of course, there will be some breaches, that has been identified in the report -

Ms Rattray - How do you look at a flat battery? Is it just irresponsible? I mean, that is a noncompliance.

Mr DEAN - I think what they are saying in some cases is it was probably lack of understanding on the part of the person - the other party wearing the device - and, in some cases, it was a deliberate position of that person, but there are reasons for it. They are saying more education is needed and no doubt the battery life of these devices will be extended in many instances as we know with our phones.

Ms Rattray - It has not helped with my phone; it still goes flat before the end of the day.

Mr DEAN - As we know with these watches and things, the battery life is becoming better and longer; we are seeing the benefits, but they will sort these problems out.

I want to identify the person in charge of the unit in Hobart; Inspector Boyd, clearly, is doing a great job. Some of the quotes I made were from Inspector Boyd's report. She is responsible for the unit that receives the information and polices this area. She said the trials have been well received by victims, and why would they not be? The victim in this instance feels much safer. They have a device that will give them some warning if the other party encroaches into an area where they are.

Mrs Hiscutt - Is that why there is a 100 per cent decrease in reports of stalking? Is that how that works?

Mr DEAN - That is how that works. I am not sure but I would like to know, and I would like a briefing on, how these units can be set. Obviously, the unit being worn by the victim must have a distance thing calibrated into it. In other words, the other unit relates to the unit the victim is wearing and obviously the two would have be calibrated with each other. Once that second device comes within a certain distance of the victim, the victim gets a warning sound that could be reported to police.

Ms Rattray - Has there been an elevation of mobile phone contact? Obviously, this is part of family violence, because if they cannot go and see them because of the electronic bracelet, are they sending more text messages? I heard recently of an incident where a person who had placed a family violence order on their partner, so they were not allowed to go near them, actually received 132 messages in a matter of eight hours from the partner. What do you think he did? He went and saw the person - bang, you cannot do that.

Ms Forrest - I spoke on a motion last sitting and this is the exact same story where the breaches are a major problem.

Mr DEAN - They are. It is great if the victim will wear the device, and it would seem perhaps not all victims are comfortable with that. I am not quite sure why.

Ms Forrest - Try to put yourself in the position of a victim. I have dealt with victims who do not want to know how close that person is. They want the police to manage that, and I absolutely get it. When you are terrified of being murdered by this person, I actually understand why they do not want to wear one.

Mr Dean - Yes. Obviously, they have good reason - you are right - as to why they do not want to wear them; it would be interesting to know why the victim has said that they would prefer not to wear one. It would be good information to have.

Ms Forrest - I want the police to do their job and track that person and keep them away.

Mr DEAN - Yes. The sad thing is the police have many jobs to do and cannot monitor that as closely as they would like; that is very clearly where these electronic monitoring devices come into their own in providing some protection to these people.

You might recall at the time the legislation was being passed, there was a classic case in Launceston of an offender who had threatened to kill his ex-partner, and she was beside herself. She continually said, 'If he is allowed out of jail, I am going to lose my life'. That was her strong position. I can remember this lady coming into my office crying, extremely emotionally upset at what she thought was going to happen with her partner being released at that time. Thank goodness, it did not occur, and I am not quite sure what the situation is now, but it must have been rectified.

Having gone through this I am thankful that this -

Ms Rattray - Honourable member, the Leader said the report was to be released by the end of the year and is on track.

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

QUESTIONS

Ambulance Tasmania - Transition to Practice Program

Ms LOVELL QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

In the last 12 months -

(1) How many graduate paramedics from the University of Tasmania were interviewed for the Transition to Practice program with Ambulance Tasmania?

(2) How many University of Tasmania graduates were offered employment with Ambulance Tasmania in the Transition to Practice program?

(3) Have any Transition to Practice positions with Ambulance Tasmania been filled by applicants from outside the state? If so, how many?

ANSWER

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

(1) Fifty Tasmanian undergraduates from both the University of Tasmania and other universities were interviewed for the Transition to Practice program with Ambulance Tasmania. A total of 427 internship applications were received.

(2) and (3)

Twenty University of Tasmania graduates were offered employment with Ambulance Tasmania in the Transition to Practice program. The remainder were offered to applicants from other universities.

North West Regional Hospital - Work Levels and Staffing

Ms FORREST QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.33 p.m.]

With regard to nursing staffing levels in the North West Regional Hospital -

(1) How many double shifts have been worked by nurses, registered nurses and enrolled nurses in the last three months in each of the following areas - the Department of Emergency Medicine, the Intensive Care Unit, occupational therapy, surgical ward, medical wards and Spencer Clinic?

(2) How many overtime hours have been worked by nurses, RNs and ENs in the last three months in each of the following areas - DEM, ICU, OT, surgical ward, medical wards and Spencer Clinic?

(3) How many unfilled positions for RNs, ENs and medical professionals are there at North West Regional Hospital?

(4) What actions have been taken to fill these positions?

ANSWER

Mr President, I thank the member for Murchison for her question. I will read the answers but there are some tables in them so I will table them.

(1) The total for May to July 2020 is lower than compared with the same period in 2019 due in part to the North West Regional Hospital COVID-19 response. There is a table with all those numbers for you.

(2) The total for May to July 2020 is lower when compared to the same period in 2019 due in part to the North West Regional Hospital COVID-19 response.

Ms Forrest - Not necessarily a good baseline anyway.

Mrs HISCUTT - There is a table there.

(3) and (4)

In such a large organisation, considerable staff movement is anticipated, both permanent and fixed-term. Vacancies at the North West Regional Hospital are primarily fixed-term with small pockets of permanent vacancies. As vacancies arise, they are advertised on the Tasmanian Government Jobs website and other national recruitment platforms. Vacancies are also filled by increasing the hours of existing staff and through engagement of casual staff.

The department has a policy position to fill grade 3/4 nurse vacancies on a permanent basis where possible. Agency nurses are employed by the Tasmanian Health Service to assist in reducing the pressure when there are fixed-term nursing vacancies or difficulty in filling positions in specialist areas.

Currently there are 28.72 FTE RN or registered midwife vacancies. There are 4.35 FTE enrolled nurse vacancies, and 24.5 FTE medical vacancies. This is in the context of more than 700 FTEs who work at the hospital, and that is at levels broadly consistent with previous years. There has been a concerted effort across the THS to decrease the time to fill vacancies for nursing positions, with some success during 2019, although there have been impacts on recruitment more recently resulting from COVID-19.

Mr President, I seek leave to table the answer in incorporated tables in *Hansard*.

Leave granted; see Appendix 1 for incorporated document (page 141).

[2.36 p.m.]

COVID-19 - Public Health Emergency Declaration

Ms WEBB QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

Mr President, these questions were first put on the 12 June. It feels like the caravan has moved on somewhat, but we will proceed.

Today I ask the Leader of the Government about recently announced - no longer recently announced - extensions to both the formal public health emergency declared under section 14 of the Public Health Act 1997 and the state of emergency declared under section 42 of the Emergency Management Act 2006 due to the presence of COVID-19 within the state; could she please detail the following -

(1) When was the Government first advised by the Director of Public Health of intentions to extend the public health emergency declaration beyond the initial 12-week period?

(2) When did the Government decide to extend the state of emergency declaration beyond its initial expiry date of 11 June, and what advice was that decision based upon?

(3) What advice was received by the Government either from the Director of Public Health or any other source that an extension of the state's public health emergency declaration under the Public Health Act 1997 also required an extension to the state of emergency declaration?

(4) Why does the section 15 extension of the emergency declaration signed by the Director of Public Health on 6 June 2020 stipulate the extended emergency declaration commencing on 8 June as 'for a further period of 12 weeks' when the extension of declaration of state of emergency signed by the Premier on 11 June is for a period of four weeks?

(5) Notwithstanding sections 42(4) and (5) of the Emergency Management Act 2006, did the State Emergency Management Committee provide any advice or undertake any role in the process which determined to amend the initial state of emergency declaration by extension, as provided for under section 42(8) of the act; if not, why not?

(6) What advice, reports and recommendations have been received by the State Emergency Management Committee since the state of emergency declaration on 19 March pursuant to section 42(8)(a) of the act, and what advice, reports and recommendations have subsequently been provided by the State Emergency Management Committee under section 42(8)(b)?

(7) What is the membership of the State Emergency Management Committee since the 19 March declaration?

(8) What authorisations of emergency powers have been granted by the State Controller under section 40 of the act, relating to COVID-19, including recipients, nature and purpose of any such authorisations, and -

    (a) the duration and expiry date of each authorisation; and

    (b) any authorisations extended beyond their respective, original expiry date and reasons for that extension?

ANSWER

Mr President, I thank the member for Nelson for her questions. As lengthy as they are, the answer is twice as lengthy.

I would first like to apologise for the delay in that. There was a genuine mix-up in my office and wrong labelling, so I apologise.

The answer has come back and it is very lengthy, so if the member for Nelson is agreeable, I will seek leave to table the answer and have it incorporated into *Hansard*.

Leave granted; see Appendix 2 for incorporated document (page 143).

Government Business Enterprises - Membership

Ms ARMITAGE question to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT
[2.39 p.m.]

Regarding board membership of government business enterprises, state-owned corporations and other government boards, will the Leader please advise -

(1) The current breakdown of board membership by region in Tasmania, as well as members who reside interstate, for each government business enterprise?

(2) The current breakdown of board membership by region in Tasmania, as well as members who reside interstate, for each state-owned corporation?

(3) For each additional government board, what is the current breakdown of board membership by region, as well as how many members reside interstate?

(4) Does the Government understand the value and benefits of retaining board members with local knowledge and understanding of Tasmania's unique social and economic climate, particularly as they relate to Tasmania's regions?

(5) With regard to question (4), does the Government have plans to ensure that a greater number of local Tasmanian board members are recruited and retained to the boards of Tasmanian government business enterprises, state-owned corporations and other government boards?

(6) As of 2018, the GBEs Sustainable Timber Tasmania, Hydro-Electric Corporation, Motor Accidents Insurance Board, Port Arthur Historic Site Management Authority, Tasmanian Public Finance Corporation and the Public Trustee had a combined 15 board members located in the south, 12 from interstate, and two each from the north and north-west. Does the Government have any plans to actively balance these numbers, particularly as they relate to the north and north-west?

(7) Do any members of these boards sit on more than one board? If so, could the Leader please advise the names of these board members, and which boards they sit on?

ANSWER

Mr President, I thank the member for Launceston for her questions. There are some tables in among it, so I will read the answers without the tables, and then seek the member's permission to table those other answers. I will start with question (3) -.

(3) The Women on Boards database holds data of 101 government boards and committees - that is, excluding GBEs and SOCs - as of 30 June 2020. Of the 101 boards and committees, there are 830 filled positions on government boards and committees; of these, 594 reside in the south, 66 reside in the north-west, 140 reside in the north, and 30 reside interstate. Please note that as some members sit

on multiple government boards and committees, they are being counted more than once in the above data. There are currently 24 positions across the 101 boards and committees.

(4) As outlined in the *Guidelines for Tasmanian Government Businesses Board Appointments*, an active approach to board composition and renewal is required to ensure a balance of skills and expertise that match the needs and direction of each government business. The guidelines stipulate that the director selection and appointment process for Tasmanian government businesses is to be undertaken within the parameters of several key principles, one of which is diversity.

(5) The selection process has been developed to recognise the importance of diversity in board membership and the need to maintain a constant and ongoing pool of qualified candidates. This ensures the balance of skills and experience - including geographical background - are identified and considered throughout the selection process.

(6) The Treasurer and portfolio ministers actively monitor diversity of government businesses boards' composition.

(7) There are four people on multiple government business boards, named here in a table. If the member for Launceston is agreeable, I would seek leave to have the answers and tables incorporated into *Hansard.*

Ms Armitage - That is fine thank you. I may have further questions regarding boards next week.

Leave granted; see Appendix 3 for incorporated document (page 148).

Strong Families, Safe Kids Project Evaluation

Mr WILLIE QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.44 p.m.]
Can the Government please table the Strong Families, Safe Kids project evaluation conducted by UTAS?

ANSWER

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

The Government plans to publicly release the Strong Families, Safe Kid's evaluation report, along with a progress report and next steps action for the plan in due course.

COVID-19 - North West Regional Hospital - Workplace Safety Arrangements

Ms FORREST QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.45 p.m.]

With regard to the COVID-19 workplace safety arrangements in place for the staff, paramedics and patients utilising the North West Regional Hospital, particularly the Department of Emergency Medicine waiting room and triage areas, what specific measures are in place to -

(1) Ensure appropriate social distancing?

(2) Provide general warmth, safety and comfort for patients waiting to be seen or be collected when discharged from the DEM, especially when you are waiting outside in the winter?

(3) How are these measures monitored and whose responsibility is it to ensure social distancing and maximum numbers of people in the area is not exceeded?

(4) Have there been times where it has been difficult or impossible to comply with the requirements due to patient numbers in attendance; if so, how often has this occurred?

ANSWER

Mr President, I thank the member for Murchison for her questions.

(1) All staff have been advised and regularly reminded of the requirements to observe social distancing in the workplace. A twice-daily announcement over the loudspeaker advises all building occupants of the requirement to ensure that they are socially distanced by maintaining two large steps from each other. Stickers have been placed on floors throughout the hospital where gatherings or queuing are likely to take place to serve as a visual reminder. Main entrances, ward entrances, and the emergency department entrance are all manned by screening staff during peak times to ensure appropriate flow and distancing through these areas. Bollards and lanes are in place throughout the main entrance to physically separate visitors and staff who are screening.

(2) The waiting room in the emergency department, along with the front entrance foyer of the North West Regional Hospital and the Mersey Community Hospital are all heated to a comfortable temperature.

Ms Forrest - Not outside they are not. Anyway, carry on.

Mrs HISCUTT - Like all other non-clinical areas, the ED waiting room is automatically temperature controlled at 22 degrees Celsius. There is an airlock located directly inside the ED entrance which is designed to prevent heating loss from the internal waiting room. It is possible that at times when patients pass in and out and when both doors are triggered and open at the same time, some heat transfer will occur for a short period of time. Depending on patients presenting and how busy the ED is at that time, patients are able to wait in their cubicles until they are collected. If they are suitable to wait in the waiting room, staff ask them to do so. Blankets can be provided if required. Patients are able to see out to the pick-up and drop-off zone from the waiting room so they are able to stay inside until they are collected. There are two vending machines, a coffee machine and a water fountain in the waiting room. Security staff are located adjacent to the waiting room.

(3) As above, all entrance points are manned by the screening staff who monitor flow and social distancing. In the ED the staff member screening patients into ED has the responsibility of monitoring numbers in the waiting room. Once the maximum number is reached, all those waiting in the waiting room are required to wear a surgical mask. In some cases when demand is high, and to reduce the risk of overcrowding, visitors are asked to wait in their cars until they are able to go into the department. In some cases, appropriate patients are asked to wait in their cars until the time for them to be seen. All staff are required to report incidents to their respective manager and feedback can be provided to work health and safety representatives. During infection control audits, the infection prevention and control team has also been providing feedback about social distancing.

(4) Where room size does not enable effective social distancing, the North West Regional Hospital has proactively put strategies in place, such as the use of surgical masks in certain consulting rooms and for the emergency department waiting area as part of the COVID-19 safety plans in place across the facility.

COVID-19 - Community Response in Eliminating Suicide

Ms RATTRAY QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.49 p.m.]

Recent advice from the Minister for Mental Health and Wellbeing was that the Government is prioritising the delivery of connecting with people, suicide response and mitigation training in line with the Tasmanian Suicide Prevention Strategy. Given the success of the Community Response to Eliminating Suicide - CORES - network in Tasmania which continues to provide suicide prevention training programs as well as building and supporting community networks, my questions are -

(1) Does the Government agree that the CORES network and training is a recognised brand and valued in communities?

(2) Does the Government recognise the self-care component of CORES training fits well with the COVID-19 mental health response and recovery planning?

(3) Will the Government provide support through the COVID-19 recovery funding to the Tasmanian service of CORES Australia? Yes, yes and yes will be fine.

Mrs Hiscutt - It would have been handy, wouldn't it?

ANSWER

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

(1) The CORES network and associated training programs are a number of suicide prevention training programs currently available for purchase within communities in Tasmania. Local communities are able to seek out a program that suits their particular needs, as there are a number of evidence-based programs that support a compassionate response and safety plan for those in emotional distress.

(2) Self-care is an important element of the response and recovery phase of any emergency situation, and is a component of a number of suicide prevention training programs. All Tasmanians can take some steps in their day-to-day lives to look after their own mental health and wellbeing and that of their loved ones.

This includes making use of the resources such as the Mental Health Council of Tasmania's #checkin website, checkin.org.au; reaching out to family, friends and neighbours; maintaining a daily routine; engaging in activities and hobbies, and exercising in a safe and secure way; and engaging with other telephone- and online-based support such as Tasmanian Lifeline, which is 1800 984 434. For crisis support, Lifeline Australia is ready to help 24/7 on 131 114, or the Suicide Call Back Service on 1300 659 467.

(3) The Department of Health is in the process of providing additional funding through community action plans for suicide prevention activity within local government areas as part of the Tasmanian Government COVID-19 stimulus package to support the mental health and wellbeing of Tasmanians during this challenging time. The department is working with Relationships Australia to expand the existing CAPS program to allow communities to determine their needs and if appropriate secure training accordingly.

Derwent Entertainment Centre - Redevelopment Work
National Basketball League Tasmanian Team

Mr WILLIE QUESTION TO MINISTER FOR SPORT AND RECREATION, Ms HOWLETT -

[2.52 p.m.]

(1) Have the redevelopment works started on the Derwent Entertainment Centre? If not, when is the expected start date?

(2) Is the Tasmanian team still on track to join the National Basketball League next year at a redeveloped home court?

Ms Rattray - What is the new name?

Ms Howlett - It is still being decided.

ANSWER

Mr President, I thank the member for Elwick for his question. I know the importance as it is in his electorate.

> As part of the 2018 state election, the Government committed $10 million towards a contemporary multi-sports facility to be built in Glenorchy, with community consultation to determine the site and range of sports to be included.
>
> On 4 June 2020 as part of the Rebuilding Tasmania Infrastructure Investment, the Premier announced an additional $10 million towards a facility, bringing the total Tasmanian Government commitment to $20 million.
>
> The type of consultant services being advertised for tender will provide the Government with continuity of personnel throughout the life of the project, from the design right to the completion of construction.
>
> The two main indoor multi-sports facilities in greater Hobart - Moonah and Clarence sport centres - are ageing and require ongoing support from government to undertake essential maintenance; they need to be replaced.
>
> The tenders will be going out soon and, as I responded to the member for McIntyre's question, the team's name will be announced in the coming weeks.

Derwent Entertainment Centre - Redevelopment Work
National Basketball League Tasmanian Team

Mr WILLIE QUESTION TO MINISTER FOR SPORT AND RECREATION, Ms HOWLETT -

[2.54 p.m.]

I will repeat the question because the minister talked about the community courts -

(1) Has the redevelopment work started on the Derwent Entertainment Centre? If not, when is the expected start date?

(2) Is the Tasmanian team still on track to enter the National Basketball League next year with a redeveloped home court?

ANSWER

Mr President, I thank the member for Elwick for his question and interest.

(1) and (2)

> Yes, the team is on track to participate in next year's NBL League. The milestone agreement paves the way for Tasmania to have a team of its own for the first time in 25 years. The development will unlock significant economic benefits, attract investment and, importantly, create hundreds of jobs. Notably, the sponsorship agreement provides for 14 home games in Tasmania, 11 of which will be at the Derwent Entertainment Centre and the remainder in the north of the state.
>
> This is how we are rebuilding Tasmania - by building on our strengths and providing opportunities for Tasmania, including national league participation to create new jobs, future investment and economic development.
>
> The Tasmanian Government is proud to be a major sponsor of the Tasmanian NBL team and the opportunities it provides for grassroots pathways and planned development in the state.
>
> Tenders for work are expected later this year. Subject to planning and approvals being achieved, construction it set to commence late in 2020 or early 2021. This announcement is welcome news for all Tasmanians as we recover and rebuild from COVID-19. We look forward to releasing further details in the coming months.

Hobart Co-Educational High School - Feasibility Report

MR VALENTINE QUESTION TO LEADER OF THE GOVERNMENT IN THE LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.56 p.m.]
Taxpayers have funded a $300 000 feasibility report into the provision of a new inner city co-educational high school in the municipality of Hobart. Hobart is the only capital city municipality in Australia without a co-educational high school. It is believed to be the case that many other major city municipalities in Australian are added into the mix.

Given the significant expenditure and public interest in this issue demonstrated by the formation of the new Hobart high school community organisation of almost 600 members, no doubt with the potential of providing significant numbers of students to such a facility, will the Government -

(1) Release the feasibility report for public scrutiny along with any other documents related to this important public policy question?

(2) If not, what are the reasons it has chosen not to release the report?

Can the Government also provide -

(3) The current government expenditure, retrieved or otherwise, on transporting children from the municipality to and from high schools outside the municipality?

(4) The number of children per school attending those high schools from the municipality, whether by public or private transport?

(5) Should the Government already have committed to building such a school, can the location of the proposed school and the expected first year of student intake also be provided?

ANSWER

Mr President, I thank the member for Hobart for his question. It crosses two portfolios so I will read one and then the other for you.

(1) and (2)

> This answer comes from the Minister for Education and Training, Mr Rockliff. He has said that planning high school provisions in the greater Hobart region is complex and involves many interconnecting factors. Because of this, the Department of Education Tasmania has considered the findings of the feasibility study as only one piece of a broader suite of research evidence to inform the response on the issue.
>
> The Department of Education is currently exploring collaborative models of education delivery that will provide flexible learning options for students in Hobart. In undertaking this work, it has become clear that there is no single solution to ensuring the sustainable provisions of public education in the region. It is essential that this work be allowed to continue so that sound, evidence-based decisions are made.
>
> The department will combine the findings of the feasibility study with the findings from the Hobart City Partner Schools engagement work currently underway with Ogilvie and New Town high schools and Elizabeth College. The outcomes of this work will be publicly released later this year and will provide guidance on any potential infrastructure requirements.
>
> In May 2017-18, the Tasmanian Government announced a state budget initiative of $300 000 for the development of the education infrastructure planning framework and feasibility study into the new inner-city high school for Hobart. Of the allocated $300 000 the following was undertaken -
>
> (a) Aurecon Australasia Pty Ltd, a global engineering and infrastructure advisory company, was engaged to develop an education infrastructure planning framework - EIPF - a model that systematically analyses a range of data to project enrolment demand until 2036 at a state, regional and cluster level through the testing of scenarios, and perform a study

into the demographic feasibility of the new inner-city high school and provide advisory services.

(b) The development of the Department of Education's geospatial capabilities, including engagement of a geospatial analysis from the Department of Primary Industries, Parks, Water and Environment, to support the development and application of the framework and perform complementary mapping work, including the geospatial skills of the DoE staff.

(c) Community engagement and stakeholder support.

Questions (3) and (4) are answered by the Minister for Infrastructure and Transport, Mr Ferguson -

(3) The student bus network is an open network; that is, students do not need a booking to have seat on a particular school bus. Accordingly, the Department of State Growth does not have records of which students from which areas use buses to travel to particular schools, either to government or non-government schools.

(4) It is not possible to determine the number of students travelling to particular schools by public transport from within or outside the municipality.

MOTION

Consideration and Noting - Review of the Effectiveness of Electronic Monitoring for Perpetrators in Family Violence Orders

Resumed from above.

[3.02 p.m.]
Mr DEAN (Windermere) **-** Mr President, I commend the motion to the House.

Motion agreed to.

Paper Noted.

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

Second Reading

[3.02 p.m.]
Mr GAFFNEY (Mersey) **-** Mr President, I congratulate the member for Rosevears on her wonderful speech, and I wish her all the best in being elected to this place representing your community. I also congratulate the member for Huon who spoke so eloquently at the last

sitting. I also welcome back our colleague, the member for Pembroke; I am sure you are going to balance being a mother and your professional life very well.

Mr President, I move -

> That the bill be read the second time.

Honourable members, the bill before you today seeks to provide for, and regulate access to, voluntary assisted dying, to establish the Commissioner of Voluntary Dying, and for related purposes.

I begin by explaining how this legislation came to be. As members may be aware, the issue has had a long history in this state. Two inquiries have been held, and three bills pertaining to voluntary assisted dying have been tabled in the other place. I thank former members, Lara Giddings, and now Senator Nick McKim, and the current leader of the Greens, Ms Cassie O'Connor, for their hard work and tenacity in constructing and presenting those bills.

Voluntary assisted dying - in fact, end-of-life choices in general - is a difficult topic for many people to discuss openly, let alone agree upon. Therefore, it was not entirely unexpected, in previous political and social climates, that the bills were not successful, despite the best intentions and efforts of their proponents.

The Greek philosopher Heraclitus said 'The only constant in life is change' - and change things have. Honourable members, it is not a difficult task for any of us to recall times - which perhaps seem like only yesterday - when political, familial and community views were very different from those we experience today.

I was born in late 1959 - a time the societal landscape seems, to younger generations at least, completely removed from current norms. To name but a few issues –

- The Vietnam War conscription policy, which caused painful divisions between families and friends and ultimately resulted in huge numbers of unsupported and marginalised veterans.

- The absence of rights for, or recognition of, Indigenous people, then still referred to in the Constitution as natives, which seems almost hard to believe in 2020.

- The first wave of feminism since the suffragettes took off, with many women foregoing the norm of life at home - keeping house and raising children, women being re-identified upon marriage from Miss Jane Jones to Mrs John Smith - and women protesting, demanding equality in the workplace, and having control over their own bodies and finances. Changes are still needed within those areas.

However, things have changed. Time has marched on. So many of the freedoms, privileges and rights we enjoy today were hard fought for and often just as fiercely resisted. But as I found frequently on the path to tabling this bill, the things in life that really matter rarely come easily.

Voluntary assisted dying became legally accessible in Switzerland with an amendment to its criminal code in 1942. Since then other countries and jurisdictions have adopted the practice for their citizens, using a range of legislative structures. Interestingly, 50 per cent of all voluntary assisted dying legislation in the world has been passed in the last five years. As VAD has become legal in more jurisdictions, including two Australian states, our communities have become more educated and more aware. As members may have noted from their own polling, the average statistic indicates 85 per cent of people in Australia support the implementation of voluntary assisted dying legislation. As Mr Ian Wood of the Christians Supporting Choice for Voluntary Assisted Dying stated during his presentation to us on 26 August, the most recent YouGov poll of Christians in Queensland showed 79 per cent Anglican, 68 per cent Catholic and 83 per cent United Presbyterian supported voluntary assisted dying.

In late 2018, the then president of Dying with Dignity Tasmania, Margaret Sing, advised that after decades of research and lobbying and having observed the groundswell of support and ultimate success in Victoria, the organisation's executive and members were extremely keen to table a revised bill that will allow Tasmanians access to voluntary assisted dying.

We had lengthy discussions about the best manner in which to introduce the legislation, and it was decided that instead of carrying the bill - if it passed in the other place - I would in fact table a private member's bill in this Chamber. This anomaly in parliamentary process was the subject of much discussion during my community forums and communications with many groups and constituents. Some optimistically believed or assumed that if I were introducing the bill, that must have meant it had already passed in the other place. If only that were the case.

Following from my meetings with Dying with Dignity Tasmania, I travelled to five jurisdictions where VAD currently occurs - the Netherlands, Belgium, Switzerland, Canada and Oregon in the United States. I was introduced through Dying with Dignity Tasmania connections to 11 international experts, all highly regarded in their fields. They included palliative care experts, medical practitioners, university researchers and senior legal counsel; there were current and former politicians and several health practitioners who are directly involved in the assessment and administration of and eligibility for VAD - their collective knowledge of constructing and strengthening legislative frameworks, ensuring adequate safeguards and best practices, legal protections for the person and the practitioners as well as detailed anecdotal evidence of their own experiences with people utilising VAD and working closely with other end-of-life services, such as palliative care, and the families who generously and candidly shared in the interests of trying to help craft a bill absolutely tailored to suit the Tasmanian environment - absolutely tailored to suit our place.

The insights gained through these meetings and discussions have been invaluable to the process and the international experts have all remained but an email or phone call away in the months since my visits. I remain utterly grateful to each and every one of them.

Over the past year, I have had frequent meetings with the Chief Parliamentary Counsel, Ms Robyn Webb. Robyn has been an absolute powerhouse throughout the entire process. I take a moment here to thank her for her extraordinary contribution in researching, constructing and reviewing this bill from start to finish.

There have been a number of versions, as is common with all legislation, as feedback was received and expert advice taken. Suggestions for strengthening the bill were continually raised. Robyn's professionalism and experience meant that there were never any moments of panic or despair. Perhaps the odd raised eyebrow now and then, but the sense of calm resolve was ever present.

When former premier Will Hodgman gave permission for OPC to assist in this process, I could not have conceived that not only would we have the most senior and experienced drafter on the job, but that over 210 hours of work from Robyn would go into the drafting, followed by a question and answer process and preparation for clause briefings with members. I extend my thanks to the Premier and his Government for allowing continued access to OPC. The resultant bill is a testament to the skill, dedication and tenacity of Robyn Webb and the Office of Parliamentary Counsel.

I did not tell this to Robyn, but at the end of January when her first draft bill was sent to Jocelyn Downie in Nova Scotia - and Jocelyn is responsible for the Canadian bill - she was so impressed, she said to me, 'Would this lady like to come and work for us?'. I just have to say that was the high regard that Jocelyn Downie, who is one of the international experts, had for the craftsmanship of our senior officer of Parliamentary Counsel.

In January this year, which seems a very long time ago, I took the bill on the road to present a series of community forums in every local government area in the state. I found it to be an exciting month, presenting 35 forums across 29 councils. It was a whirlwind of travel: assembling and disassembling IT equipment, projectors and the screen. For the benefit of my electorate officer in the back corner, who received one or two panicked phone calls just before the forums, I would say that this aspect of the process was one of the more challenging for me.

However, it was after the forums talking to people that I had my very first taste of how many people had a story. So many of them were distressing and sad experiences ,and so many, altruistically, were desperate to support the bill. They advocated to me, 'Please get this through: we do not want anyone else to go through what our beloved brother, sister, partner, mum, dad, nan or grandpa did.'.

Indeed, when one person would stand to the side at the end of the forum to speak with me with tears in her eyes, waiting to tell me about their lost loved one, that was hard enough. But when there were two people both with tears in their eyes, I often knew that one would not be here for very much longer. That was very hard.

I suppose perhaps one of the most beautiful things about Tasmanians is that they are loyal, strong and they are community-minded. Here these people were, laying bare their most upsetting experiences, knowing this legislation could not in any way tangibly help their loved one but wanting to help those who may be faced with a similar end-of-life journey.

These face-to-face meetings and letters, phone calls and emails, as well as the hundreds of submissions we received - which members received copies of two weeks ago - have been a constant reminder to me never to lose sight of how vital, how important and how needed this legislation is.

Even though, in Tasmania, it may only involve small numbers of people and their loved ones, to those individuals contemplating or already experiencing a painful and intolerable decline, the comfort and security this bill will provide in ensuring they will find relief from their suffering at a time of their choosing cannot be understated.

Throughout the year I have sought and received input into the consultation draft of the bill by meeting with and contacting a huge number of stakeholders, groups and individuals, including the Australian Medical Association, Tasmanian branch; St Vincent's Hospital in Victoria, where I travelled to; members of the Royal Australian College of General Practitioners of Tasmania; Dying with Dignity Tasmania; the Australian Nursing and Midwifery Federation; the state president and manager of the Pharmaceutical Society of Australia, Tasmanian branch; and the project pharmacist from the PSA in Victoria.

I have met with the chairperson and board members of the Voluntary Assisted Dying Review Board in Victoria, the Australian Pain Society, Palliative Care Tasmania, the Commissioner for Children and Young People, DPAC, TasCOSS, disability advocates, doctors, nurses, Tasmanian medical students and staff and college students studying ethics and social issues. I have arranged briefings for members with representatives in support of, or opposed to, the bill - in some cases, against the very issue of voluntary assisted dying itself.

I have recognised at every opportunity the right for people to voice their opinion, whether they are for or against, and I have respected that opinion all the way through this process.

Mr President, I would like to welcome Jacqui and Natalie, who are here for this parliamentary sitting. I take this moment to mention the involvement of Nat and Jacq. It is fairly likely that most Tasmanians are now familiar with the sisters' story, their mother's heartbreaking and cruel decline, and their decision to fight for Tasmanians to have access to assisted dying in memory of their mum, and to honour what literally were her dying wishes. From what started out as a simple email explaining their story and sharing a diary entry from their mum's last days, Nat and Jacq were soon openly reliving their family's experience and appealing to Tasmanians to become involved in the debate. Through print, radio and social media, the sisters created Your Choice Tasmania - and what a success it has been. You should be very proud.

The impact these young women have had on the community and their fight for VAD legislation cannot be underestimated. They have been fearless, they have been selfless, and they have provided human faces to what may be seen as a complicated and clinical issue.

Your Choice Tasmania created a website where people could obtain more information, Facebook and Instagram pages, and produced a brochure urging Tasmanians to take a moment to consider this issue and to be involved. They made their voice heard: 120 000 pamphlets were delivered by volunteers across the state. Recently, the Your Choice Tasmania campaign was extended to include electronic signs and billboards, and posters encouraging Tasmanians to share their opinions and stories with members of parliament.

Jacq and Nat did not restrict their efforts to raising awareness in the community. They encouraged those in support to sign the paper and the e-petition, whose wording was as follows -

> The petition of the undersigned residents of Tasmania draws to the attention of the House the urgent need to legalise Voluntary Assisted Dying within Tasmania.

> Palliative care cannot always relieve the intolerable pain of those with a terminal diagnosis nearing the end of their life, despite the best intentions and efforts.
>
> Many terminally ill patients unnecessarily experience intolerable, prolonged pain. These people should have the right to die a peaceful death in a place and time of their choosing.
>
> Tasmanians deserve freedom of choice.
>
> Your petitioners therefore request the House to support the forthcoming End of Life choices (Voluntary Assisted Dying) Bill 2020.

On Wednesday 19 August, the largest ever e-petition was tabled in the other place. Ms Cassy O'Connor, MP supported the petition that was supported by 13 082 Tasmanians - 13 082 people took the time and made the effort to sign that petition. I can remember the excitement we all felt on reaching 5000 signatures - we were gobsmacked at 5000 - it really felt as though Tasmanians were on board at that point. To have reached 13 082 is nothing short of staggering. I extend my sincere gratitude to Nat and Jacqui Grey and your friends and family for all their efforts. I fully appreciate this fight has taken an immense toll on you and your families; I know your mum, Diane, would be so very proud of both of you and your initiative, your resolve and your consideration through this process for everybody. It has been remarkable.

I think she is looking down on you right this minute and is smiling and glowing at her daughters and her grandchild-to-be. I congratulate you both on your work and effort.

Mr President, on the subject of saying thank you, it is really a process fraught with danger at the second reading stage. I acknowledge those Tasmanians who have contacted me with their concerns and who will not or cannot support this legislation. I recognise, appreciate and respect your opinion and contribution to this valuably important community discussion.

However, so many people have given this bill their all through expert contributions and personal stories. I do not imagine any member who has read the submission document, Voluntary Assisted Dying - Tasmanian Perspective, could have done so without being affected. So many harrowing accounts of suffering, it would be impossible not to be moved by the pain and distress so many of our fellow Tasmanians have experienced. Many have volunteered with letterbox drops, distributing posters, sharing information on social media and in so many other ways.

Before I discuss the crux of the bill itself, I want to place on the record my sincere thanks to everybody - absolutely everyone who has assisted in bringing the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 to its tabling in this place on 27 August. I hope this parliament and its 40 elected representatives will give you the result you are all hoping for. The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 seeks to provide for and regulate access to voluntary assisted dying, to establish the commissioner of voluntary assisted dying and for related purposes.

For far too long terminally ill Tasmanians have been unable to legally end their suffering, I mention the word 'legally' because it is a somewhat disconcerting, perhaps uncomfortable fact, that a number of families have been devastated by the violent or lonely death of a loved one who made it clear that because they were unable to access a legal safeguarded, supported and painless process by which they might alleviate their pain, it was simply too much to bear and they took matters into their own hands.

On the 7 August 2019, the Western Australian Minister for Health spoke of the coroner's findings that indicated around 10 per cent of suicides are linked to chronic disease or terminal illness. He responded -

> These are the wrongful deaths we should be concerned about. This is where our compassion is lacking. We can do better than condemn people to suicide. There is also an unknown cost -the consequences of unsuccessful suicides. That people are left so desperate is shocking, and the distress for their families unimaginable.

Often the decisions that were made did not just impact upon the person and their loved ones but also upon our first responders - police and ambulance members, neighbours, those who chanced upon some very traumatic and confronting situations, and, in some cases, the emergency department personnel, mental health teams and allied health personnel who supported the person if the attempt was survived.

Mr Robert Cooke in his submission stated -

> I am a serving police officer with over thirty years of operational experience. Too often have I attended incidents of suicide of persons suffering terminal illnesses….
>
> At times the methods employed by people suffering are extremely traumatic and involve the use of firearms, self asphyxia and often drug overdoses. This leaves a terrible legacy for their loved ones, not only grieving for the loss but also dealing with possible lifelong trauma themselves due to the sometimes extreme and violent methodologies employed by the person suffering …

He went on to say -

> It is the greatest of certainties that all our lives must end. The right to choose the timing and most humane method of ending one’s life is an inalienable human right that none but the person themselves should have the ability to choose, free of fear of prosecution of loved ones and medical staff who may assist them.
>
> I firmly believe that this legislation is well overdue, and is capable of being enacted with the strictest of oversight to ensure it is only available to those who meet the required standards. It has been successfully passed in other jurisdictions and I see no reason for the continued denial of choice and dignity to those enduring untold suffering, pain and ultimately death.
>
> I hope this issue can be debated maturely and in a timely fashion to expedite its passage through parliament.

Honourable members will recall from reading the submissions I tabled when we last sat a number of utterly heartbreaking stories of desperate people taking desperate measures because there was not a kinder or a more compassionate option open to them.

Mr Bill Godfrey spoke of his family's experience. He said -

> I would like members to consider the case of Elizabeth Godfrey, my mother …
>
> Over the last ten years of her life she battled intractable pain, which became less and less possible to manage (she was allergic to all opioids) and increasingly destroyed her mobility.
>
> In the absence of VAD legislation, she made four attempts at suicide … At the end of 2002 she made the final two attempts. My brother had to tell her to stop the first attempt and she tried again the following night, this time successfully.
>
> This led to 2 years of prosecution and ultimate conviction of my brother for an offence against Criminal Code Sec 163 'Any person who instigates or aids another to kill himself is guilty of a crime.' The definition of 'aids' is so loose that any one of the family could have been accused …
>
> The comments made by Justice Underwood on passing sentence make it clear that he was unhappy with both the legislation and the sentence that the law required him to pass.
>
> Having been closely involved with this case, I am also aware of other cases where the sufferer and family have gone through a similar agony. It is not humane, it is not necessary and it should be changed.

Throughout this process, I have had a number of people share with me that their loved one would willingly have adopted this action, but for the fact that they were fearful of implicating a family member. Some people whose pain has been unable to be relieved by palliative care methods or medication with no other legal option available have literally chosen to suffer through the discomfort and agony because of their care, concern and love for their family members' futures. They simply did not want to take the risk. It is a fact that without voluntary assisted dying as an option for eligible people, some have contemplated the unbearable choice of two options - ending their life alone so as not to involve family or enduring the pain to the very end. What kind of choice is that?

Members would undoubtedly have been moved by some of the harrowing accounts of families' distress at being unable to relieve their loved ones' suffering. Some authors recounted feeling of helplessness, guilt, anger and shame, some decades after. Many of them felt they had let the person down because they simply were unable to answer their cries to stop the pain. In some of the stories, people said 'Just get a gun and shoot me', or 'Please, just do something to end it, I can't take it anymore.'.

What of the people who had an undignified, painful and frightening end to their lives? What of them, whose pain, embarrassment, fear and suffering was only relieved after a lingering, painful and intolerably miserable death? Leanda Stone wrote of her father's passing -

> We sat by his side, swabbed his dry mouth with moisture, tried to keep his aching body comfortable while we waited for him to die.
>
> I remember watching his malnourished body twitch, seeing him with head injuries from falling after trying to rush to the bathroom in a delirious state.
>
> The amount of times I collected and laundered his faecal covered clothes would be enough to shred any man of his right to maintain his dignity, but someone had to do it, while watching, waiting for him to die.
>
> He lasted only two days from when he refused nourishment, thank God, because I couldn't possibly watch him suffer any longer.

Is that what we want for our terminally ill whose pain is unable to be managed or relieved by the most fervent efforts of dedicated excellent palliative care specialist doctors, nurses and support staff? I do not think so. That is not what we want. That is not what our community deserves. Honourable members, from the submissions and anecdotal evidence from medical professionals we know there have always been situations in which people were assisted to die but it remains, and always was, an unregulated, spoken-in-whispers practice whose mere existence speaks volumes about the need for this legislation.

Doctors and nurses whose loyalty to and compassion for their patients led them to provide assistance that is essentially illegal and in breach of their code of ethics, and at great risk to themselves professionally. It happens and we know it happens. As Ms Julia Greenhill wrote in her submission -

> The opposition of the AMA to the End-of-Life Choices Voluntary Assisted Dying Bill 2020 should now be considered as **resisting a call for reform from the community** …
>
> Indeed, many doctors already take action to relieve unbearable suffering in their patients, as they are called upon to do, even if this action shortens the lives of their patients.
>
> However, at present they are unprotected by law and could face disciplinary and criminal charges

In a recent paper titled 'Doctors and the Voluntary Assisted Dying Act 2017' - a Victorian act - by a Queensland academic, Jodhi Rutherford, a doctor, was quoted as saying -

> The slippery slope is much more of a risk where you don't have legislation because that's where, behind the scenes, things are happening and being done without any oversight, without any jurisdiction being in control of it….So, coercion, if it's happening, it could be happening now…

So, coercion, if it is happening, could be happening now.

Honourable members, let us work together in this Chamber today to implement a legal framework that can provide a safe, guarded and protected process for our medical fraternity and the admittedly few people who are in genuine and desperate need to access voluntary and assisted dying.

It is a fact that palliative care can help the majority of people in achieving a peaceful, comfortable end to their lives, but it cannot and does not work for all patients with all conditions.

I received a submission from Ms Madelin Corbin, a registered nurse, who summed this up more succinctly and genuinely than I possibly could. She wrote -

> There is a need for palliative care, very much. But for when things haven't worked. For when pain has escalated beyond the realms of being controlled by medication. When a soul is aching for losing their journey, there needs to be an option.
>
> And let me assure you, this is all VAD is. It's an option. Just because it exists does not mean people are obliged to use it …. The passing of this Bill would simply mean that Tasmanians get a choice.

Mr President, to expand for a moment on the concept of choice, there is a growing body of evidence from other jurisdictions, including Canada and Victoria, that a number of terminally ill patients who were assessed as eligible were so comforted that they had an option to access if their condition became intolerable that their mental health, their capacity to cope, and their quality of life actually improved. Some did not go on to use the VAD substance, but they had a choice.

Statistics show that usually about 33 per cent of people who are eligible do not continue - so, 33 per cent of the people who are eligible for VAD do not continue, secure in the knowledge that they have options.

Dr Nick Carr of St Kilda, who presented a briefing to us, recently wrote -

> Overwhelmingly, people have asked for the option of VAD to regain some control and choice; to not have to wait for a possibly unpleasant event to finally kill them; to not have to suffer the indignities of further losses of bodily function but to go quietly and comfortably at a time and with people of their choosing.
>
> For many people, just having the option has been an immense relief, even if they never went on to use it.

Honourable members may have read the Voluntary Assisted Dying Review Board's Report of Operations from 1 January 2017 to 30 June 2020 from Safer Care Victoria, released in late August. Interestingly, in a population of approximately 6.6 million people, of

341 applicants in Victoria during the period from 19 June to 30 June, 124 people self-administered, or were administered, a VAD substance that ended their suffering.

Tasmania has a population of about 535 000 people, approximately 8 per cent of the population of Victoria - so Victoria is 12 to 13 times our size. On the raw data, this provides a projection of the figures in Tasmania being in the region of 28 applicants, with perhaps 10 people in a calendar year progressing to actually utilising the VAD substance.

I remember when Victoria released that report, it said 124 deaths - that is, more than two a week - and they had 42 000 deaths that year in Victoria. So, less than 3 per cent of the people who died in Victoria that year accessed the VAD substance to relieve their intolerable suffering. Put simply, the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 will allow a small number of terminally ill Tasmanians who wish to make a choice about the timing and the manner of their death the legal right to access voluntary assisted dying, giving themselves - and by extension their loved ones - surety about their capacity to end their suffering when they so choose.

Dr Christiaan Barnard, who is perhaps most famous for performing the world's first successful heart transplant, wrote in his book *Good Life, Good Death* that a doctor's duty is not only to give the patient a good life, but also to give the patient a good death. He acknowledged that his views on patient autonomy had changed from 'preserve life at any cost' during the course of his training and work as a doctor and a surgeon. He described the story of a critically ill elderly patient who was found dead in his hospital bed having disconnected his respirator, leaving a note which stated -

> The real enemy is not death. The real enemy is inhumanity.

I think it is humanity, the right to personal autonomy and compassion, that is at the centre of this bill which seeks to allow eligible people who are suffering intolerably the option to access voluntary assisted dying.

I would like to touch briefly on the research of relatively modern philosophers, Beauchamp and Childress in an article by the Ethics Centre. The four principles Beauchamp and Childress identified in their book, *Principles of Biomedical Ethics*, as healthcare's 'common morality' are -

- First, respect for autonomy - they describe how -

  > in a healthcare setting, where patients are often vulnerable and surrounded by experts, it is easy for a patient's autonomous decision to be disrespected.

  The authors stated that -

  > Respecting autonomy isn’t just about waiting for someone to give you the OK. It’s about empowering their decision making so you’re confident they’re as free as possible under the circumstances.

- The next is non-maleficence - 'First do no harm'. Beauchamp and Childress suggested that the Hippocratic Oath, used in the past as a moral and ethical framework for doctors, be nuanced in practice, so that 'First do no harm' be regarded to mean 'avoiding anything which is unnecessarily or unjustifiably harmful'.

- The third principle is beneficence: do as much good as you can -

> Beneficence refers to acts of kindness, charity and altruism … the applications of beneficence in healthcare are wide reaching … beneficence will require doctors to be compassionate, empathetic and sensitive in their 'bedside manner'

- Finally, the fourth principle identified is justice - distribute health resources fairly. The authors identified that -

> healthcare often operates with limited resources … They observe(d) how resources are distributed will depend on which theory of justice a society subscribes to

I have had the privilege of meeting with Palliative Care Tasmania on a number of occasions because I wanted to understand what services are currently available and to discuss the concept that voluntary assisted dying is simply another end-of-life choice - unlikely to be required or accessed by many - but for those in need, a great comfort. While I have heard a number of spurious arguments pitting voluntary assisted against palliative care, after learning more about the existing options and the amazing support provided by PCT, it was generally accepted that while the number of people who will choose voluntary assisted dying is quite small in comparison with those engaged with palliative care, the two are not mutually exclusive, nor does a person's engagement with voluntary assisted dying preclude them from receiving support from palliative care providers.

Colleen Johnstone, CEO of Palliative Care Tasmania, whom members will recall from briefings, gave us the assurance that -

> Those people living with a life-limiting illness and exploring VAD will be able to continue to receive palliative care right up until their death.

In other jurisdictions, between 80 and 90 per cent of people accessing voluntary assisted dying are also supported by palliative care services. They were already being supported by those services. I believe the figures are likely to be similar in Tasmania. As an aside, the bill precludes any doctor or nurse from participating in the VAD process unless said professionals have voluntarily taken the requisite training package and have the appropriate qualifications. Furthermore, any health professional who has a conscientious objection to any form of participation in VAD would not be required to be involved. Of course, these protections also apply to professionals working in palliative care services.

It is a well-known fact that Palliative Care Tasmania's resources are oversubscribed and the group has repeatedly been required to reapply for funding by constructing a lengthy budget submission, something I appealed to the Government to address in a special interest speech this year, and I recently wrote to the Premier advocating on the organisation's behalf.

Pleasingly, an independent Australian report by Aspex Consulting, 'Experience internationally of the legalisation of assisted dying on the palliative care sector', commissioned in 2018, stated that in every other jurisdiction where voluntary assisted dying has been legalised the resultant focus on the palliative care sector has seen funding increases. Where voluntary assisted dying is part of the framework, there is increased funding from governments.

I know people in this Chamber would like to see Palliative Care Tasmania receive more and guaranteed recurrent funding through the budget Estimates process in any event. It is a wonderful organisation with providers working incredibly hard to support Tasmanian families during what must be very challenging and distressing times. If the implementation of voluntary assisted dying in Tasmania proves to be a catalyst for expanded investment in this area, this will be a welcome side effect of the legislation.

With all this in mind, I am now inclined to shine a light on the bill and spend some time examining what its provisions allow and how the process will work in an operational sense.

Members will have perused the supporting documentation and perhaps used the flowcharts provided. I hope these documents and the briefings to be provided by the Office of Parliamentary Counsel are and will be helpful.

I am advised that objectives and principle clauses are not always included in legislation because they can often be no more than a restatement of what the act already does; however, I will be tabling the following amendment to the End-of-Life Choices (Voluntary Assisted Dying) Bill -

A. Objectives and principles

(1) The objectives of this Act are -

(a) to provide, to persons who are eligible to access voluntary assisted dying, an efficient and effective process to enable them to exercise their choice to reduce their suffering by ending their lives legally; and

(b) to ensure that the process provided for the exercise of that choice protects and prevents persons from having their lives ended unwittingly or unwillingly; and

(c) to provide legal protection for registered health practitioners who choose to assist, or who choose not to assist, such persons to exercise their choice to end their lives in accordance with that process.

(2) A person exercising a power or performing a function under this Act must have regard to the following principles:

(a) every human life has equal value -

Ms Forrest - Are you foreshadowing an amendment here?

Mr GAFFNEY - The amendment will be circulated.

Ms Forrest - So this is not in the bill we are dealing with?

Mr GAFFNEY - The amendment is coming, yes.

Ms Forrest - So it is not in the bill now. It is an amendment.

Mr GAFFNEY - No.

Ms Forrest - Okay, I need to be clear on that.

Mr GAFFNEY - Okay. This is an amendment that will be circulated in response to the Premier's correspondence of last week.

(b) a person's autonomy, including autonomy in respect of end of life choices, should be respected;

(c) a person has the right to be supported in making informed decisions about the person's medical treatment, and should be given, in a manner the person understands, information about medical treatment options, including comfort and palliative care and treatment;

(d) a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person' suffering and maximise the person's quality of life;

(e) a therapeutic relationship between a person and the person's registered health practitioner should, wherever possible, be supported and maintained;

(f) a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

(g) a person should be supported in conversations with the person's registered health practitioner, family and carers and community about treatment and care preferences;

(h) a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in Tasmania and having regard to the person's culture and language;

(i) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region;

(j) there is a need to protect persons who may be subject to abuse or coercion;

(k) all persons, including registered health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

Mr President, I will now explain the eligibility criteria in this bill.

First, the person must have attained the age of 18 years.

The person must meet the residency requirements, in that the person -

- is an Australian citizen or is a permanent resident of Australia, or has been a resident in Australia for at least three continuous years immediately before the person makes the first request, and

- the person has ordinarily been resident in Tasmania for at least 12 months immediately before the person makes the first request.

The person must be assessed as having decision-making capacity.

- Importantly, decision-making capacity is assessed at every stage of the VAD process where the eligibility criteria are determined - at first request, second request, consulting medical practitioner determination, final request and at final permission. This is a significantly important safeguard to protect the person and the health professionals involved in the voluntary assisted dying process.

According to clause 11(1) of the bill, a person has decision-making capacity when the person has the capacity to -

(a) understand the information or advice that is reasonably required in order to make the decision; and

(b) remember such information or advice to the extent necessary to make the decision; and

(c) use or evaluate the information or advice for the purposes of making the decision; and

(d) communicate the decision, and the person's opinions in relation to the decision, whether by speech, in writing, by gesture or by other means.

Decision-making capacity is something doctors assess on an everyday basis as part of their practice. The assessment process will reflect current clinical practices in Tasmania.

To quote a submission from the WA Joint Select Committee on End-of-Life Choices in 2018 -

> The Victorian Ministerial Advisory Panel felt that given the view of Royal Australian and New Zealand College of Psychiatrists and after feedback from nine months of consultation sessions across the medical community, to add a further consultation to a process that was already rigorous for a person who is dying a of an advanced, progressive, incurable disease, illness or medical condition, was not consistent with the compassionate nature of the legislation and was unnecessary unless there was a question of impaired decision making capacity

So, the PMP or the CMP cannot make the determination if they do not have enough or the correct information. Clause 11(4) was included as another safeguard for the person and the health professionals involved in the VAD process.

The person must be deemed to be acting voluntarily. Voluntariness is a core principle of this bill. In fact, the very title of the bill is a clear and finite expression of what it seeks to provide for those determined eligible - the End-of-Life Choices (Voluntary Assisted Dying) Bill. The bill in fact contains protections that ensure that acting voluntarily with regard to the VAD process is necessary for the person, for the medical professionals in their various roles and for witnesses and contact persons in case of private self-administration. However, in this eligibility criteria context, acting voluntarily pertains to the person seeking access to voluntary assisted dying.

In drafting this bill and seeking feedback from stakeholder groups, the issue of coercion was discussed repeatedly at length. It was acknowledged that many of the safeguards within the bill - that is, fines, training and mandatory reporting processes - are specifically aimed at deterring and identifying coercion and, if necessary, immediately ceasing the voluntary assisted dying process. It is also worth noting that the Victorian training package for practitioners who wish to participate in the VAD process contains a module on coercion. I anticipate that the planning for the training package here will draw on the Victorian experience and that the commissioner of voluntary assisted dying in Tasmania and experts involved will make amendments in accordance with this bill and for the Tasmanian setting.

Two very experienced Victorian doctors who actually work in that space, Dr Nick Carr and Dr Cameron McLaren, who provided briefings, stated that medical professionals deal with this issue regularly, both within and external to the voluntary assisted dying process, and doctors are very attuned to, 'weeding out' any signs of coercion. If there is a hint of suspicion, that doctors would, and have in the past, scheduled additional consultations and assessments to ensure the person's safety and genuine voluntariness.

The fifth one, the final eligibility criteria, is clause 13, 'When person is suffering intolerably in relation to a relevant medical condition'; relevant medical condition is defined in the bill as follows -

> Section 5(1)
>
> … 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.
>
> Section 5(2)
>
> … 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 … is acceptable to the person and … can cure or reverse the disease, illness, injury or medical condition and prevent the expected death of the person from the disease, illness, injury or medical condition.

Just as a person who seeks to become involved in the voluntary assisted dying process must be deemed to be acting voluntarily, similarly our medical practitioners and registered nurses may also only be involved if their participation is voluntary. Any professional may be excluded from involvement at any stage by stating a conscientious objection.

In any case, no health professional may be involved unless they have a minimum of five years experience following registration as a doctor or registered nurse and they have voluntarily undertaken the voluntary assisted dying training course as dictated by the commissioner of voluntary assisted dying. The health professional who chooses to be involved must update their training every five years. It is also the responsibility of the commissioner to keep track of individual professionals' training requirements. Even if a health professional has undertaken the voluntary assisted dying training course, they are not under any obligation to be involved with any or all cases presented to them.

I imagine that the instances of someone undertaking the training and then wishing not be involved would be rare. As an example, if a doctor in a small town has been approached by a terminally ill patient whose family are openly opposed to the idea of voluntary assisted dying and the doctor feels uncomfortable with being involved, the doctor is not obliged to accept a request but may provide the details to the commissioner and support the person in order to find another doctor who may be comfortable in being involved.

Similarly, clause 15 of the bill states that a person may at any time, orally or in writing, inform the person's primary medical practitioner - PMP - or administering health practitioner - AHP - that they no longer wish to access voluntary assisted dying.

At the time of this statement, the process ceases and a note is made in the person's medical records, and the commissioner of voluntary assisted dying will be informed they no longer wish to access voluntary assisted dying.

It should also be noted that if the person withdraws from the process at any point, there is nothing to prevent them making another first request at a later stage, and the voluntary assisted dying process starts again.

In Tasmania, as in Western Australia, doctors are permitted to discuss the legality and potential availability of voluntary assisted dying as an option with patients. Indeed, it is required that all options regarding end-of-life care must be fully explained. This is not the case in Victoria, and it has been reported that this limitation has proven both an oversight and a hindrance to patient care and autonomy.

This is not to suggest that the practice is encouraged or advocated, merely that a doctor may advise a person of its availability - and in the same manner, a patient may ask their doctor or specialist for more information.

Honourable members have heard Dr McLaren and Dr Carr mention the shortcoming in briefings, and provided in articles that they believe it to be an issue that the Tasmanian bill has improved.

Should a person decide they wish to make a first request, the bill dictates that the person must have received the relevant facts in relation to access voluntary assisted dying before doing so. The relevant facts are to be contained in a form approved by the commissioner for voluntary assisted dying, and under clause 7 of the bill they have to provide the following -

(a) information as to the operation of this Act;

(b) information as how the person's eligibility … is to be determined;

(c) information as to the functions of the Commissioner [of voluntary assisted dying] and contact details for the Commissioner;

(d) information as to what assistance to die the person may receive from a PMP or an AHP;

(e) information as to where advice in relation to palliative care, or other treatment or pain relief, may be obtained.

They are the relevant facts a person must receive as determined by this bill.

As members would appreciate from the fifth point, it is a condition of proceeding to the point where a person makes a first request that they have also received detailed information as what all of their end-of-life choices may be, and where to seek further help, clarification or support.

I felt that clause 7(e) was particularly important to include in the relevant facts to ensure that any person contemplating engaging with the voluntary assisted dying process was actively encouraged by their medical practitioner to fully consider and investigate all the options - all the options - for managing their condition and potential decline before being permitted to make a first request. These are safeguards we have throughout this bill.

If the person has not received the relevant facts, the person is not to be taken to have made a request, but must be given the relevant facts by the medical practitioner. If a person who has received the relevant facts wishes to make a first request, the person may orally or in writing or in person request the medical practitioner to determine whether or not the person is eligible to access voluntary assisted dying.

At this point, the medical practitioner has 48 hours in which to decide and advise the person whether or not the request is accepted. This is not to determine eligibility. This is to say, 'Yes, I accept your request', or 'No, I do not accept your request.'. You have 48 hours to do it, but a medical practitioner who is not an authorised medical practitioner - that is, they have not completed the requisite VAD course, and they do not have the appropriate years of experience - must refuse a first request. If you are a medical practitioner and you do not want to be involved in voluntary assisted dying, you do not do the training and then you cannot be involved.

A medical practitioner may refuse to accept a request for any reason, including but not limited to a conscientious objection to voluntary assisted dying, and the person must be advised as soon as possible but within seven days that the request is refused. So, as soon as possible, but within at least seven days the person has to know because that is a fair and just thing to happen. A medical practitioner who refuses to accept a request may, but is not required to, provide reasons for accepting or refusing to accept the request.

A medical practitioner who accepts the first request becomes known as the person's primary medical practitioner - PMP - and I will refer to this now as the PMP throughout my contribution. The doctor is qualified, understands, has done the training, accepts the person's request and becomes the PMP. That person is in control of this process and, hopefully, that person will go from stage 1, first request, and, if need be, all the way through to the final request. However, it is incumbent on the PMP to advise the person of their decision to accept the request within seven days, to note on the person's medical records the PMP has accepted a first request from the person and to notify the commissioner for voluntary assisted dying a first request has been accepted.

I have been asked, as an aside, why we use the term PMP - primary medical practitioner. In Western Australia they use the term coordinating medical practitioner and consulting medical practitioner. That is two CMPs. We thought our bill made it clear that the primary medical practitioner is the person who has followed the case through. That is important for people to understand.

We can see this legislation already has detailed safeguards incorporated. Clauses 22 and 23 provide a detailed list of all of the actions that may or must be taken by the PMP, the primary medical practitioner, prior to determining the first request. The PMP is obliged to obtain all the relevant information in relation to the person's medical condition, the treatment, any other medical conditions, the prognosis, any complications that have arisen or that may arise, and information relating to reasonably available treatment that may relieve the suffering of that person. The PMP may, for the purpose of determining the first request, refer the person to another medical practitioner for examination and request the person to provide more information they believe is required. They can request medical records from another medical practitioner and/or request a psychiatrist, psychologist or registered health professional to provide information the PMP believes necessary to make a determination. They are the requirements of the PMP and would be spelt out in their training courses so they understand.

I was grateful to receive a query from another member about the involvement of specialists in the voluntary assisted dying process. As members would be aware, one of the more complicating and operational roadblocking issues experienced in Victoria, where a specialist opinion is required, is the difficulty of people involved in voluntary assisted dying being able to obtain appointments with voluntary assisted dying trained specialists.

Given the difficulty in accessing specialists in Tasmania already and the fact that general practitioners are specialists in general medicine, clause 23 was introduced to provide assurance that should a PMP require the advice of another specialist in order to prepare for making their determination, they may do so. Before they make a determination, they have to have all the relevant information regarding that condition. It should be noted, though, that the PMP is not involved in the process to make a specialist determination about the person's condition if that is not their specialisation - for example, a general practitioner would not make a very specific diagnosis or prognosis of a complicated multiple cancer case. That report would have to come from an oncologist. The PMP's role is to assess the person against the eligibility criteria for voluntary assisted dying. A determination of the first request, whether eligible or not eligible, is to be provided to the person. Copies are to be placed on the person's medical record and also given to the commissioner of voluntary assisted dying. If the PMP has determined a person's first request renders them eligible to access voluntary assisted dying, the person may make a second request to the PMP.

The process for the second request is nearest that of the first request, but the second request requires the signatures of two witnesses. The person must not make a second request to the PMP within 48 hours of the person having made a first request unless, in the opinion of the primary medical practitioner, the person is likely to die within seven days or the person is likely to cease having decision-making capacity within 48 hours.

If you go back to the first request and the person is determined eligible that person goes away, they may not come back for two months to see their PMP again. At that stage the PMP is required, once the request comes in, to reassess the person in their decision-making capacity, their voluntariness; the terminal disease would probably not have improved and they do not have to recheck their age or their permanent residency, but they still have to recheck their decision-making capacity and their vulnerability.

Two people must witness a second request and one of the witnesses must not be any of the following - a family member, a person who believes they may benefit financially, a residential care provider or employee in relation to the person, or a person who is a resident in the facility in which the person resides. Neither the person's PMP or CMP, consulting medical practitioner, may witness a second request. If the PMP has determined a second request is rendering the person eligible for voluntary assisted dying, the primary medical practitioner is to refer the person to another medical practitioner for a second opinion.

The primary medical practitioner says, 'Yes, you are eligible'; the second request comes in, it is signed by two witnesses, 'Yes, you are still eligible', and you then have to refer that to another medical practitioner and it starts again, so there is some consistency throughout the bill. A medical practitioner to whom the person is referred must advise the PMP within 48 hours whether they accept or refuse to accept the referral. The medical practitioner may refuse the referral for any reason and is not required to, but may give reasons for their decision; a medical practitioner who accepts the referral from the PMP becomes the CMP or the consulting medical practitioner. That person responds to the PMP and receives copies of all the medical reports and all the information in relation to the person.

The CMP may examine or ask questions of the person and may seek further information from the PMP in relation to the person. The consulting medical practitioner may also refer or request that the primary medical practitioner refers the person to another medical practitioner for examination or to a psychiatrist, psychologist or registered health professional to provide information which the consulting medical practitioner believes necessary to make a determination.

These are all the safeguards within this bill. A CMP who makes a determination in relation to a person must, as soon as practicable but within seven days, place a copy on the CMP's medical records in relation to the person and give to the commissioner a copy of the determination. The person's primary medical practitioner is to advise them of the determination, place a copy on the person's record and also send a copy to the commissioner so it is a double-checking thing. One from the consulting medical practitioner and one from the PMP.

In order to prevent undue pressure on doctors and misplaced optimism on the part of the person, if two CMPs determine the person is not eligible, the process ends. If one CMP determines it is not eligible, the person can have a chance to have a second consulting medical practitioner assess and determine, that if two of them say it, then the process ends.

Although this does not preclude the person from commencing the VAD process again and making a new request, the former PMP may not accept a first request for 12 months so you cannot go back to the same doctor and say - 'I want to go again' because you were found ineligible in the first place. There has to be some breathing space, except for certain unique circumstances, as explained in the bill, and it is too involved to go into in the second reading speech.

If the person's CMP has determined the person eligible to access voluntary assisted dying, the person may make a final request to the primary medical practitioner. This request, again, may not be made within 48 hours of the second request, unless the person is likely to die within seven days or to lose decision-making capacity within 48 hours, because if they lose decision-making capacity, they are not eligible to be part of the VAD.

A final request is an instrument in writing; once again it must be determined by the PMP if the person is or not eligible to access the voluntary assisted dying so. At the third request the primary medical practitioner still has to see whether it is voluntary and the person has the decision-making capacity.

All the way through this, we are putting in as many safeguards and checks and balances as possible. In some places, they say that perhaps we have too many, but we want to make sure this is right.

The determination of the final request must be provided in writing and must be made as soon as practicable, but within seven days. The person must be notified of the determination. A record is placed on the person's medical record and the commissioner is forwarded a copy.

If the person is determined eligible, the PMP must decide whether or not the PMP intends to continue as the administering health practitioner. The PMP can make a decision. AHPs may be medical practitioners or registered nurses who have at least five years of relevant experience since registration and have voluntarily completed the VAD training package.

I think the PMP would be heavily involved and invested in that person and would more than likely see the process from the start of the process all the way through to the end. In situations where something may occur in the PMP's life that they may not be here - and that something might happen - we cannot have the process just stop, because the person would then be then left in limbo and would have to start the process all again, so we have introduced the AHP. If the PMP cannot be the AHP, the commissioner of voluntary assisted dying has a list of the doctors and registered nurses who have done the training and have the experience, who can be called upon to act in that role.

The inclusion of VAD-trained registered nurses as potential administering health practitioners acknowledges the unique skill sets, precision and professionalism that our nurses may offer their fellow Tasmanians during the administration stage of the VAD process and is one of the things unique to Tasmania. Our community nurses are very highly regarded and highly skilled.

If we examine the most usual clinical path, we might find that the doctor and/or specialist examining and diagnosing the patient determines the most suitable courses of treatment and perhaps prescribed medicines. At this point, a pharmacist makes inquiries of the patient to ascertain if there are any other medical conditions or existing prescriptions as a safeguard before supplying the medication, and we heard this from Jarrod McMaugh.

In many circumstances in hospitals, aged care facilities, hospices or in our communities, it is in fact nurses who administer the prescribed substances to patients in accordance with the doctors' and the pharmacists' instructions.

In applying this existing clinical structure to the voluntary assisted dying process, the involvement of nurses - especially in a state like Tasmania where remote and regional communities rely heavily on the support of the community nurses if they do not have a permanent doctor or a choice of doctor - seems completely logical. For example, if we had a community and the doctor on that island or in that isolated community who was not supportive of voluntary assisted dying, but there was community nurse there who was - the person might be bedridden, the locum comes in and does the assessment, and 'Yes, you are eligible.'. It goes all the way through the process, but the locum says, 'Look, I can be there Thursday, but the flight is out at four o'clock on Friday so we are going to have to have the event at 10 o'clock on Friday morning because I have to catch the plane back to where I have come from'.

A nurse practitioner, a community nurse who knows the family, who understands the relationship, could say, 'Well, when do you want to have this?', 'Well, we would really like to have it Saturday afternoon; the whole family is around, and they are coming from all over the place and we can have the event and the nurse could be there when we take the substance.'. That would be really good because it is workable. It is a more realistic way of dealing with the situations we might face in Tasmania and that is why we have introduced the registered nurse.

The administering health practitioner's role in the VAD process, whether they are a registered nurse, a doctor or a specialist, is once again to assess the decision-making capacity and voluntariness before taking the required steps to administer the VAD substance.

Unlike the PMP and the CMP or the pharmacist, the AHP does not diagnose a person's relevant medical condition or eligibility, nor do they require qualifications to prescribe a substance. As the title suggests, the role is to administer under instruction and in accordance with the process as the bill dictates. Their role is as an administering health practitioner.

In a state like Tasmania, which has many regional or remote communities, nurses are often the first port of call for people. They regularly serve for long periods in an area that may not have a permanent doctor, providing familiarity and continuity of care. It is a fact that our skilled and experienced nurses are members of one of those trusted and highly regarded professions in society. Community feedback consistently reinforces this concept.

Having researched and spoken extensively with the ANMF, and doctors and specialists both here and in other jurisdictions, it seems appropriate to create a legislative framework for Tasmanian registered nurses who volunteer to undertake the training to act or participate as AHPs.

The AHP must sign a statutory declaration declaring that they have completed their training course within five years before the appointment, that they are not a member of the family of the person and that they do not know or believe that they are likely to benefit financially as a result of the death of the person.

As members would have noted from their research and indeed from the summary of the process, there are safeguards at every juncture for the person, for the family and for the health professionals who are involved. I do not believe a bill dealing with something as important as VAD can really be structured in any other way.

While the procedure must be accessible to those eligible, it cannot and should not be rushed. Corners must not be cut. Every person involved must be both protected and responsible for their role.

Clauses 64 to 75 provide great detail with respect to the request and for the issue of the voluntary assisted dying substance authorisation; the issuing of a substance prescription to a pharmacist who is appropriately trained and authorised; the destruction of a substance in certain circumstances; and supply of a voluntary assisted dying substance to the AHP by the primary medical practitioner.

I will not go into great detail for this section as most clauses are reflective of behind the scenes actions taken by the medical professionals involved. The person will have little to do with this part of the process with one exception, clause 69.

Clause 69 allows the pharmacist access to the person either in person or by way of video link in order that the pharmacist might be satisfied that the prescription relates to a substance suitable for use in relation to the person for the purposes for which it has been prescribed. The Pharmaceutical Society suggested that this consultation is vital as certain types of medical conditions - for example, a malabsorption issue in the stomach - could render the usual substances ineffective.

The bill outlines the final administrative requirements and provision of assistance to die for both the AHP and private self-administration pathways in parts 13 and 14. If an AHP is satisfied that a person is likely, on the balance of probabilities, to die within six months from a disease, illness or medical condition or where the person has a disease, illness or medical condition that is neuro-degenerative, and the AHP is satisfied that the person will be able to self-administer a VAD substance, the person's AHP must complete and sign a private self-administration certificate. If the person has met the criteria for, and been issued with, a private self-administration certificate, and a contact person has provided written acceptance of their appointment to the AHP and the commissioner for VAD, the administering health practitioner may supply the VAD substance to the person. In doing so, the AHP is to show the person how to self-administer the VAD substance.

Clause 91 details the duties of the contact person, including the requirement to notify the person's AHP that the person has died after privately self-administering the VAD substance and storing and returning any unused substance to the administering health practitioner. A person's AHP must notify the coroner of the death of a person. If the person has not been issued a private self-administration certificate, they will proceed with the administering health practitioner pathway.

The bill requires that an AHP makes a final determination of the decision-making capacity and voluntariness within 48 hours before the AHP receives the final permission from the person. Once again, the AHP may refer the person to another practitioner or request more information in order to make the determination. If the person is determined and is entitled to receive assistance to die, the AHP must advise the person and confirm the manner in which the VAD substance is to be administered, whether self-administered, with assistance or administered by the AHP.

A person who wishes to receive assistance to die may give to the AHP a final permission which is a signed form stating that the person has received advice from the AHP as to the manner in which the substance will be administered, a statement that the person wishes to access voluntary assisted dying and understands that as soon as practicable after permission is given, that person will be provided the substance for self-administration or be assisted to administer the VAD substance according to the wishes of the person as set out in the final permission, and a statement of intent with respect to unexpected complications.

As for the private self-administration pathway, a person's AHP must notify the coroner of the death of the person.

I will now touch briefly on the administrative functions, processes and miscellaneous matters contained with the End-of-Life Choices (Voluntary Assisted) Dying Bill.

The bill contains provisions in Part 15 for the review of decisions. Eligible applicants may apply to the commissioner of voluntary assisted dying for a review of a decision by a person's primary medical practitioner, consulting medical practitioner or administering health practitioner. The commissioner has the authority to review and make decisions upon applications in this part but may also state in the form of a special case for a decision by the Supreme Court any question of law that may arise in the hearing of, or determination of, an application. Similarly, a party to proceedings aggrieved by a determination of the commissioner may appeal to the Supreme Court against the decision, the right of appeal.

Part 17 of the bill outlines information pertaining to the appointment of the commissioner for voluntary assisted dying, the deputy commissioner and the officers of the commissioner. This section also details the functions and powers of the commissioner for voluntary assisted dying, delegation, the commissioner's role in determining voluntary assisted dying substances and in approving courses of training that will be constructed in consultation with bodies which represent medical practitioners, registered nurses, the Public Guardian and the person nominated by the Chief Civil Psychiatrist.

The commissioner for voluntary assisted dying is also responsible for keeping records of any notices, requests or other documents provided to the commissioner by primary medical practitioners, consulting medical practitioners, administering health practitioners and other persons. The commissioner must provide an annual report to the minister, who will then table the same within five sitting days after receiving the report.

> Part 17 also contains details of another safeguard in that a person who suspects any contravention to the act may notify the commissioner. The commissioner may require additional information in order to investigate and may refer the matter as she or he thinks fit. This is a critical safeguard as it allows the commissioner to involve agencies such as Tasmania Police, the Coroners Court and the Australian Health Practitioner Regulation Agency to assist with the investigation of any suspected breach of the act.

The bill contains an extensive outline of offences and penalties in clauses 122 to 130. Offences include inducements and dishonest or undue influence, false representation on being authorised to communicate on behalf of a person, not communicating faithfully on behalf of the person, falsification of records, false statements, dishonest inducement to use a VAD substance, failing to provide a notice to the commissioner, not returning unused or remaining VAD substances to the AHP contact person and offences in relation to review.

I spoke earlier of the protections for the persons involved in the voluntary assisted dying process. Part 19 of the bill provides details of the safeguards that protect persons who assist in good faith, such as the person who is present at the event, protections for medical practitioners or registered nurses or for anyone using electronic communications to discuss the person and/or the voluntary assisted dying process.

The bill concludes with the miscellaneous section in Part 20. Quite often we may regard a miscellaneous section of a document as perhaps inconsequential or an afterthought. This could not be further from the truth in this bill. One of the most important and sometimes misrepresented facts regarding VAD is the concept of VAD deaths not being suicide for the purposes of law of state. I would like to read this clause in full. It is an important distinction to make, not only for the purposes of administration issues such as insurances or wills but also for the peace of mind of any individual and their loved ones who may be struggling with long-held views - perhaps religious - on the process of voluntary assisted dying.

Clause 137 reads -

> For the purposes of the law of this State, a person who dies as the result of the administration to the person, in accordance with this Act, of a VAD substance or a substance under section 87, or the self-administration by the person, in accordance with this Act, of a VAD substance, does not die by suicide.

In accordance with this law the person does not die by suicide. The miscellaneous section also notes that if there is an inconsistency between a provision in the bill and a provision in the Poisons Act 1971 or the Misuse of Drugs Act 2001, the provision of this bill prevails. This clause with respect to conflict of acts is designed to provide clarity to those involved in the VAD process with respect to the usage of VAD substances. The bill provides authority on a number of reports and reviews which are to follow the implementation of the act.

Finally, the commissioner is, within 10 months, to provide a report to the minister on the operation of the act. Furthermore, the Governor is to appoint a panel of persons nominated by the minister to conduct the review of the operation of the act, the matters relating to the operation of the act, the scope of the act and the potential scope of the act as soon as practicable after three years.

Perhaps one of the more controversial and misreported parts of the bill pertains to the review after two years with respect to young people. I will take a moment to explain why this review is included and why I have been comfortable in weathering the inevitable sensational media storm that has ensued. It says -

> The Governor is to appoint a panel of persons nominated by the Minister to conduct a review to obtain information in relation to whether persons under the age of 18 years in other States or Territories, or other countries, are able to access processes similar to the voluntary assisted dying process under this Act.

As members will be aware, nothing in this clause indicates enthusiasm for or bias towards extending the act to include children.

Nothing in this clause means the bill will instantly mean persons under the age of 18 will be eligible. Nothing in this clause guarantees an outcome or recommendation to this independent review. Nothing in this clause compels a government to act on the information collated in such a review.

The review pertaining to young people simply provides a mechanism for an expert panel to review, in detail, legislation that exists in other jurisdictions.

Whether a panel finds legislation allowing access to voluntary assisted dying processes or similar in other jurisdictions, whether that is deemed acceptable, or required, is entirely at the panel's discretion.

The reality is that any finding or recommendation must still be adopted and actioned by the government of the day.

I am completely aware that this topic makes for an uncomfortable and somewhat confronting discussion, and it may have been easier for me - and for this bill's debate - to simply remove the review before the bill was tabled - do not put it in, it is going to be a criticism of the bill.

However, Mr President, I was not about to do that.

Earlier this year I was contacted by a Tasmanian constituent and a Victorian family who had experienced similar circumstances. They both relived the horror of their teenage daughters' illnesses, decline and death. Their beloved daughters were terminally ill and suffering intolerably. Each young lady in question, under the age of 18 - and her family - wanted her death to be peaceful and in their home environment, with loved ones by their side.

Sadly, that was not to be in either case. It was simply impossible. Those loving parents witnessed their darling girls slip away after some extremely trying and inconceivably difficult times in a hospital bed. Those conversations genuinely inspired the inclusion of this clause. I have to be honest. Discussing those families' circumstances and their angst at not being able to take their little girls home for the tranquil and gentle deaths they so wanted made me feel we should definitely put structures in place so that this issue can be thoroughly examined and considered in the future.

Research in this situation is not a bad thing. We need the knowledge of an independent review group to come back with some recommendations to the parliament. Though I met with experts in Belgium and the Netherlands, where mature minors may have access to VAD with parental permission in exceptional circumstances, I had not planned to address the issue of young people in this bill.

In other jurisdictions the idea is being explored and reviewed, but, of course, it is a difficult thing to understand or contemplate, even if, as a parent, you consider what you might do if your terminally ill child begged for your consent as their pain and suffering was unable to be relieved. I urge members to consider compassionately and objectively the importance and the genuine intent of this clause. It is not to predict or assure an outcome; it simply allows a panel to gather information and gain a deeper understanding of the issue of terminally ill young people who are suffering intolerably, and whether attaining the age of 18 years should be a permanent criterion for assessing VAD in Tasmania.

Also, at the three-year mark, the Governor will appoint a panel to conduct a review as to whether persons suffering from a disease, illness, injury or medical condition that are not expected to cause the death of the person but that is advanced, incurable and irreversible and causes the person suffering from pain that is, in the opinion of the person intolerable, to have access to the voluntary assisted dying process under this bill.

I reiterate: this is just a review - a review is in this bill to ensure those reviews take place and it comes back to the parliament of the day for those people to decide and for the government to decide whether it wants to act upon it.

I will perhaps elevate this further in the Committee stage in response to questions raised by members if need be.

Finally, the bill requires the review of the operation of the bill be undertaken at the end of each five-year period.

Members, I can fully appreciate the detailed description of the bill was perhaps a little more formal and certainly lengthier than my usual contributions in the Chamber, but with a bill of this magnitude, I felt it was necessary to provide an in-depth outline of the bill's intent, its operation and the legislative structures required to support its implementation and review.

I am really grateful for your attention today, your attendance at briefings, the research you have conducted to prepare and indeed your questions and feedback over the past few months. I look forward to your valuable contributions to the debate which I am sure will be respectful, learned and informative.

On his election the Premier, Peter Gutwein, expressed to the Tasmanian people his commitment that our Government will be a government of conviction, of compassion and, importantly, of opportunity for all.

I believe this is a worthy goal for any government and perhaps something we should all consider whether party-affiliated or independent, in opposition or in government, when we ponder our position on any piece of legislation - conviction, compassion and opportunity for all.

Once again from Jodhi Rutherford's paper in the *Journal of Law and Medicine*, a Victorian doctor was quoted as saying -

> We know that a lot of people who access voluntary assisted dying help, never actually use it. But they get enormous relief knowing it's possible.
>
> I'm talking to a bloke at the moment who has terminal cancer. And the change in his experience now that he knows this is possible, has been enormous.
>
> He is so much less anxious, so much less worried, because he knows that this is going to be a possibility.
>
> He might never use it.
>
> But there is a huge benefit to him from knowing that it's there.

The bill has been thoroughly prepared and rigorously consulted to ensure its operational functions are safe and logical for those who are eligible to choose voluntary assisted dying and that the person and health professionals are adequately protected.

The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 provides terminally ill Tasmanians who are suffering intolerably with a humane, safeguarded and compassionate framework that supports their right to access voluntary assisted dying.

I genuinely hope it will provide Tasmanians with the reassurance and comfort they may choose in their time of need.

Mr President, members and those listening in their offices, I ask you to indulge me just for a few moments. Why are we here? This is not an existential or even a rhetorical question - it is a very personal and practical one. What I mean to ask members more specifically is: Why are you in this Chamber today? What made you put your hand up for the public scrutiny, time away from family and the pressures that come with standing for politics? If it is not your first term, what made you want to do it again? I suspect that if members were to provide answers to those questions right now, there would be a range of reasons as to why they entered politics and/or why they continue to work in this space. I imagine the one thing we all have in common is this: we all thought that we could make a real difference for those in our communities and wanted to help by being their voice in this parliament.

Perhaps we had this thought and waded into politics, immediately starting at a state level, as our two newest members, the members for Huon and Rosevears have done, or as many members here, including myself, by working in and around our communities, in local government, before we found ourselves in this esteemed Chamber.

Perhaps we did not see it in ourselves but some encouragement from someone who thought, yes, you could do a good job. You just need a little push. At some point we all made a commitment to try to make this state a better place, to work hard, to strengthen and support our communities and, above all else, to do our best for those who choose us to advocate for them. It is fairly simple if you think about it. Every time a piece of legislation comes to us we consider the impact on our communities, both immediate and long term, and we vote accordingly. That is why we are here. That is why we choose to be here.

Honourable members, I know we disagree on many things in this Chamber and sometimes outside but during this debate I hope we can all agree to put our communities' wants and needs to the forefront of our thinking.

Every now and again we find ourselves reviewing a bill, whether it is passed or not, that stands to impact literally every person in this state, now and into the future. Today is one of those days and I commend the bill to the Council.

Mr PRESIDENT - Honourable member, I notice many members have fairly large amounts of documentation with them. If you wish to speak from the lectern, if it is easier than using your chairs, please ensure you give the lectern a wipe down and observe the COVID-19 conditions. It may be easier for members to use different lecterns rather than have copious notes on their small desks.

[4.48 p.m.]

Ms FORREST (Murchison) - Mr President, this bill is one of the most challenging areas of public policy I have considered in my 15-plus years here, and we have had a few of those over the years. This is certainly not a criticism; it is a complex and fraught area of public policy. The consideration of euthanasia, however described, has been and will continue to be, a complex matter, as well as controversial. I have been personally challenged by this question - that is, euthanasia or voluntary assisted dying - more than once in my time here.

When I say I can equally argue for and against the principle of this bill, it is not as though it is not from a position of equivocation. I have felt the enormous weight of responsibility that such an important decision on this serious matter of life and death carries. I have found the scrutiny exhausting. Sadly, I believe much of the public debate on this matter has been driven by fear - fear of our own mortality and inevitable death, fear of unrelieved pain, fear of unmitigated personal suffering, fear of existential suffering, fear of witnessing the suffering and pain of a loved one. These fears are not irrational. In the bill before us we are seeking to treat an ethical matter as a practical matter and this is difficult indeed. Ethical considerations are not religious considerations. It is essential to separate the two and if we are to have an open, meaningful, frank and respectful debate about such an important existential matter we have to separate the two and set them aside.

Unfortunately, due to the circumstances beyond my control, we are presented with this bill at a time the world is facing a very challenging time. We are all very aware of the current and ongoing crisis in our aged care sector. This is not new and is still subject to an ongoing royal commission established by the Morrison government.

In addition, our country and state continue to deal with the ongoing challenge of the COVID-19 pandemic. Sadly, we are still seeing a challenging and tragic number of people succumbing to this lethal virus - I must say it was with enormous relief I saw that no more Victorians had died yesterday in the last 24 hours. It has been a shocking time for Victoria but we had our turn here, and we had 12 out of 13 deaths in Tasmania on the north-west coast and that has kept me particularly busy during that period.

Mr President, my role as the local member in north-west Tasmania, along with others but in my area of the north-west, the heart of the Tasmanian COVID-19 outbreak - the 'COVID-19 capital' we were called - and the effort required to support my constituents and my work with the Subordinate Legislation and Public Accounts committees as well as other work that we all undertake, has been all-consuming over recent weeks and months. My personal workload has been extraordinary over the past six months and has left me with what I consider to be limited time to fully consider this bill as it has been developed but also not being able to attend any of the community engagement meetings arranged by the member for Mersey due to other parliamentary committees and other duties. Even though I had intended to do so, I could not. Parliament was still calling me at that time.

Despite my own personal challenges, I commend the member for Mersey for his work on this bill and of course the work of the Office of Parliamentary Counsel; I appreciate what a large and significant task this bill is.

I have studied the tabled version of the bill since it was provided. As you can see my copy is as filthy and dirty as any you will ever see, because I thumbed through it, backwards and forwards, and tried to link it all together. I have many questions about a number of the provisions in the bill. These questions are better dealt with in the Committee stage of the bill rather than the bill's second reading contribution, assuming that the bill is supported into that phase.

I have also sought a number of amendments; I apologise to members for these not being circulated, but they have not been finalised to date. As members would be aware, Robyn Webb who is doing all the work on this bill and other legislation is extraordinarily busy and doing her best to fit it in. I will circulate my proposed amendment as soon as they are available, but they are not and I do apologise, even though I have been doing this for two or three weeks now. It is not a criticism of the OPC. It is a reality we are facing.

Mrs Hiscutt - No, it's the thorough work you are doing.

Ms FORREST - And a reason not to try to rush this.

I will use this opportunity to speak broadly on the principle of this bill and leave the detailed scrutiny of the 144 clauses of the bill until the Committee stage.

I note there is broad community support for the opportunity to have a range of options or choices as we face the end of our lives where this is not a sudden or unexpected death. One choice not currently available to Tasmanians is active voluntary assisted dying or VAD. This bill seeks to introduce VAD as a choice through a proactive measure and as a medical treatment. I know from conversations with many people over the years related to the question of end-of-life choices many people conflate the concept of euthanasia or VAD, however described, with other aspects of end-of-life care that are current rights we all have, including the right to refuse treatment, or to have futile or overly onerous treatment withdrawn. Then you have conversations within the community. You can see that is clearly the case. Some people conflate them together and see them as one issue.

Withdrawal of futile treatment and the right to refuse treatment is everybody's right, and there are different healthcare approaches that are evidence-based and considered in consultation with the patient and their family, or the family of the patient if the patient has lost capacity to participate - that is, they are unconscious or they are on life support and are unable to participate through brain damage, or whatever.

I believe we really do not practise the options of a refusal of medical treatment and withdrawal of treatment well, much of the time, and some of the reasons account for people's experiences of death and dying. That is the case. Of course, this can be the result of pressure on medical practitioners to do all they can to treat the person or their loved one rather than let the person die when they are actually trying really hard to do that, and that is what they are wanting to do.

We do see this conflict at times with loved ones urging, and almost demanding, medical treatment for a loved one when the person themselves - the patient themselves - may not really want that.

I also believe that many in society do not know what death and dying really looks like. I want you to think about that. Do you really know what death and dying looks like? Do you have one experience of death and dying, and then is that what your view of death and dying is? Not many of us, thankfully, have lots of experiences of death and dying.

I say thankfully, because dying is not pretty. It can be quite messy. It is always sad, even when it is someone who is dying from a terminal illness after a long time of illness. You only have to see the messages sent to people after a long illness and the person dies. It is still sad. That person is still someone's mother or father or brother or sister. They still have loved ones who are left behind. It is always sad.

Furthermore, our beliefs and understanding of the dying process are often clouded by our own fears. I think we need to be alert to our fears and acknowledge our own fears. We all have them. We are reluctant to speak about our own mortality generally, and really consider and discuss this with our loved ones. We often are reluctant to tell them what we want them to know about our own death in specific rather than general terms.

Talking in specific terms about what do you want in terms of treatment in certain circumstances? What do you want your funeral to look like? Who do you want there? What sort of coffin do you want? What sort of burial do you want?

None of us really likes talking about that, but we should.

We have heard and received many accounts of death and dying from relatives of those who have died. So many deaths have been described as horrendous and full of unrelieved pain and suffering. If we really are seeing such a high number of deaths in Tasmania where pain and suffering are not well managed or relieved, we actually need an inquiry into this.

It would suggest a complete failure of our health system if so many people are dying difficult, horrendous, painful deaths full of suffering, because the evidence I have from the medical profession - and being one of them myself - is that there are very few cases where pain and suffering, whatever the suffering is, cannot be mitigated. Yes, there are some, but if this is almost a daily occurrence, which has been portrayed by some as being the way it is, that is either a gross misrepresentation, or our health system is completely stuffed.

If our health service is so deficient in the area of the relief of pain and suffering during the end-of-life experience of a person, this is a disgrace and it must be addressed, regardless of the outcome of this bill.

I was unable to find actual evidence of the extent of deaths occurring with such great suffering. Therefore, we must ensure research and investigation of these deaths that do involve great suffering and unmitigated pain, that they are researched and fully investigated to ensure that we do better. We must do better than this. We can do better than this, especially for those of us who, for their own reasons, do not wish to choose voluntary assisted dying. There are plenty of people who will choose not to participate. It is voluntary. For many people, for whatever reason, it might be a personal reason unrelated to religion, unrelated to the deaths of other family members, but a personal reason. We need to assure those people that they will not be subject to a death of long suffering and great pain because that is what our system provides for at the moment. If these things are happening, they need to be investigated and they need to be addressed.

The community engagement the member for Mersey has undertaken has been extensive, visiting every Tasmanian local government area as well as travelling overseas and to the mainland of Australia to meet with those engaged in this area and to look at how these jurisdictions implemented and now operate under their legislative arrangements.

This bill deeply engages two broad parties in its application: those Tasmanians seeking to end their life through voluntary assisted dying and the health professionals who choose to participate in the process. It seems to me from my consultation there has been broad community consultation, not just by the member for Mersey, but more broadly through polls and community engagement, surveys; however, I am not confident there has been full and open consultation with the medical health professionals and their representative bodies which are key to this bill's operation.

I know the member for Mersey listed the bodies he has consulted with in the development of this bill and, yes, I agree there has been some consultation, but many of the concerns I am hearing around certain aspects of this legislation relate much more to the role of the health professionals, doctors and nurses who will be involved in this. Even the College of Nursing as a professional body of nurses. The ANMF is the industrial body, the union, which has an important role, but the college also has a very important role as the professional body. They have not been consulted and they have concerns about some of the aspects of the engagement of nurses in this bill as it is framed.

Some of my amendments, and I know others are being proposed, may address some of these concerns. I appreciate how challenging this is as within every professional body there will be differing views. On a matter of such complexity and controversy with all the ethical questions and underlying personal beliefs and experiences within these bodies, whether it be the AMA, the ANMF, the College of Nursing, the College of Physicians, the College of GPs, whichever body it is, achieving a consensus position is difficult, if not impossible.

The statements put out by the relevant colleges are fairly bland and fairly non-committal because they represent all their members who have very differing views. We need to listen to those who support the principle but are concerned about the process. This reality should not be an unsurmountable barrier, but it will take some time and is crucial to the success or otherwise of this significant change in this area to get this right.

Consultation with these bodies is vital and must be central as this debate is not only about the person's right to choose the timing of their death when they have a terminal illness and the choices around their care when they are approaching their death, it is also about those who provide care for those people at that time.

We all face death, either suddenly or unexpectedly or with some time, be it lengthy or short, to contemplate our mortality and ultimately our death. None of us will escape it. This bill is not only about a person's right to choose this time. Importantly, it is also about whether, when, and how doctors and other health professionals, including nurses and pharmacists should, in certain circumstances, be able to assist that person's death ahead of such time at which they would die without such intervention. We must be honest with ourselves and those who we represent here as this is about actively bringing forward the time of death. Yes, we understand the people who will access this are facing death as a result of their medical condition. This bill will enable the time of their death to be sooner than it would occur without voluntary assisted dying. My consultation around this matter and this bill have made it clear to me that support for the principle relates to the relieving of intolerable suffering at the time when a person is actively dying, not months before the likely death of a person.

I can say that universally with the people I have spoken to in my electorate, that is what they perceive this to be - support of the principle of relieving the suffering of someone who is actively dying. Many I talk to in my community and beyond support the principle as they personally do not wish to endure unmitigated suffering and pain or loss of physical control of their bodies. They also worry that having to care for a loved one experiencing such pain or suffering.

Suffering and pain is a unique and individual experience, and I suggest it is almost impossible for another person to predict or describe their own experience as it is also impossible to accurately describe the anticipated or expected personal experience of suffering of another person. I have witnessed much severe and very difficult to control or manage pain and suffering. It is, of course, easier to cope as the person experiencing such suffering of pain if you know that the time is limited. It is easier to cope if you know that it is not going to go on and on with no obvious end point, even when you are not sure exactly when that time is but you know there is going to be an end to it.

Most of us will do whatever we personally need to stop pain and suffering if we find it too much. Most of us are not averse to reaching for the Panadol if we have a headache, same principle. Think about the use of torture and why it is used, an abhorrent practice, but also think about childbirth. As a midwife I have witnessed what other observers, such as partners, see as unmitigated pain and suffering and often out of the partner's distress rather than the woman in labour, seek pain relief or an end to the suffering for their partner. I do not know if any of you dads have been in that situation where you just wanted to make the labour pain go away, to stop it. Plenty of them have, as the member for Huon would be aware.

The woman herself may refuse the pain relief and then afterwards state, 'Yes, it was painful but I was not suffering, I was fine', but from the outsider observers' point of view it looks like extraordinary suffering. We should not presume to know how anyone else will experience pain or suffering personally. The opposite is also true - what we think would not normally cause pain and suffering may often, because of factors unknown to observers, cause extraordinary suffering. For example, the experience of a labouring woman may be more painful and causing significant suffering much greater than their own experience or perceptions would expect. We always need to believe the patient, believe what the woman is telling you.

I note and accept that access to a participation in the end-of-life choice in this bill is voluntary, and this is absolutely crucial, as is protection for those patients who do wish to utilise this option and those medical professionals who do not wish to be directly involved. Equally as important is legal and professional protection for those who wish to participate or access this choice. It is very difficult for members of the health profession who do not wish to actively participate to distance themselves. Almost all health professionals, particularly GPs and nurses, deal with and provide care to the dying and terminally ill patient regularly. Even though they may object to the principle of the bill, they cannot totally avoid it should it become law.

We also know that directly engaged medical and nursing staff are impacted psychologically through their participation, as evidenced in other jurisdictions, some more than others. I know from engagement with some involved in the care of these patients that some of them experience extreme sadness and distress even though they support the principle and have consciously agreed to be involved. We must be aware of this, and ensure adequate and appropriate support of these professionals is available if this bill is to proceed.

In a recent article written for the *Australian Medical Journal* by Associate Professor Odette Spruijt, founder and chair of Australasian Palliative Link International, and a palliative care specialist working in Victoria - and a conscientious objector to VAD - she stated -

> As a palliative care specialist with over 25 years of practice, mostly in Victoria, I have found the institution of the Victorian law to have a devastating effect on my practice of palliative medicine. I have witnessed the devastating impact of this law on the cohesion of teams, on the relationships within clinical units, and as a cause of deep moral distress among many of my medical colleagues, for whom this law, and its accompanying narrative, is anathema to the very core of our sense of what it is to be a doctor.

Mr President, Associate Professor Spruijt does not speak of these concerns from a religious viewpoint. She speaks as a health professional working in the field, and it is her observation, her experience as to what has happened.

These comments beg the question: At what point does a patient's doctor - especially their GP, or specialist in this case - who may have a conscientious objection, and have cared for the patient for many years, become uninvolved? Could they be seen as seeking to convince a patient not to go ahead with VAD after discussing it with them?

Much of this debate has been and will be framed around the notion of personal and individual choice. We cannot overlook the fact that humans are relational. We are not like animals in this sense. Associate Professor Spruijt states this reality clearly in the article I referred to previously. She said -

> It is not enough to talk about patient choice as if autonomy means 'only me'. Autonomy is also relative, we are relational beings, we depend on each other, and what we do affects each other.

There are many multitudes of influences and relationships in our lives, as we do not live fully autonomous in a fully autonomous state. Many GPs, oncologists, palliative care specialists and other physicians care for the dying patient as part of their ongoing management of the patient's medical condition.

We have been helping people die for centuries. This is not new, we do it every day.

Sometimes, I believe we health professionals try too hard to stop people dying, who are essentially trying really hard to do just that - to die, and they just want to be let go. Sometimes, I think, as I mentioned earlier, it is at the request of family members.

I believe there must be a much greater focus, education and support for assisting those who are actively dying, allowing them to die when they have made it clear that this is what they want. I know many see this as assisted dying, and in technical terms it is. It is when we do not actively intervene, but let nature take its course - that is, assisting dying at the time that the person would die without the treatment.

I am not talking about the circumstances where narcotic analgesia is increased at a rate that appears to hasten death - though there is some evidence now that suggests this impact is less significant than has been suggested because this treatment is generally appropriate pain and symptom management. These days, narcotics are often not the primary method of pain relief because of the rebound effect they can cause, actually increasing pain as opposed to relieving pain.

Regardless of the outcome of this debate, I believe we urgently need to have a meaningful and thorough review into the process available to people to understand their capacity to have a say in what they want when facing the end of their life.

An understanding that having an advanced directive in place, and a responsible person or enduring guardian in place, is as important as having a will.

This actually requires legislative change itself, as identified by the Tasmania Law Reform Institute in recommendation 5 of its review into the Tasmanian Guardianship and

Administration Act, which outlines the need for a legislative framework for advanced care directives. I hope the Government will actually take that up and get on with that. Regardless of what happens with this bill, that is necessary. It is a really important aspect to this whole care of dying people, or people facing their loss of capacity if they have an enduring guardian.

Advanced care directives must be legitimised and respected. There is still work to do in this space. We need to ensure the competence of all health professionals in the understanding of and being able to deliver or refer to effective and appropriate palliative care when indicated well before a patient's condition deteriorates to the point where the Tasmanian patient would think the only thing left for them is to ask for direct treatment to bring about their death. If we get to that point, we really have lost the plot.

Thank goodness we are not the United States - for lots of reasons at the moment - but I understand that in some parts of the United States, you must have only six months to live before you can actually access publicly funded palliative care.

Palliative care should be accessed right from the beginning of a patient's journey when their chance at life, their life expectancy, has a finite sort of expectation about it. Palliative is not for when you are actually on your last week of living. It should be months leading into the care of a person. It is not the last minute. It is not the last thing you do when there is nothing else you can do. Palliative care must start and be available well before that point if you understand what palliative care really is.

I believe we are all well aware that palliative care is not a miracle solution for all patients, a point acknowledged by Associate Professor Spruijt, a palliative care physician herself, and in the article I referred to previously she wrote -

> I am very aware that many doctors have reconciled the law on the basis of patient choice. I am also very aware that palliative care is not a panacea for all suffering. That would be a ridiculous claim especially since the majority of people who access voluntary assisted dying (VAD) worldwide do so not for the relief of physical suffering but rather because of the loss of ability to engage in meaningful life activities, 82% in Canadian cases of assisted suicide -

She is actually quoting a report which I will go to in a moment -

> Loneliness 13.7%, and concern about causing burden to those they love, 34% were also prominent in the list of reasons for requesting assisted suicide in this Canadian report.
>
> Such suffering is not within the realm of medical practice alone to alleviate but calls for an examination of what we as a society understand is a life worth living, with honouring and living.

When I read that article, I thought I should actually go and reference the source document to see what it actually said to understand the outcomes and the use of the Canadian model.

The Medical Assistance in Dying in Canada 2019 report stated, and this is a direct quote from the report -

> When asked to describe the nature of the suffering prompting their request patients most often reported 'a loss of ability to engage in meaningful life activities'

Most patients reported that -

> followed by 'loss of ability to perform activities of daily living' reported in 82.9% and 78.1% of cases respectively.

These findings record the patient's own reasons for requesting medical assistance in dying and personal experience of suffering, not the doctor's record. It is what the patients themselves said.

Being perceived a burden on family, friends or caregivers accounted for 34 per cent and loneliness and isolation accounted for 13.7 per cent of the nature of suffering of those who requested and accessed medical assisted dying in Canada.

This is a sad indictment on our societies. We must do better to support those who are older and have life-limiting illnesses and risk social isolation or feeling they are a burden to family or society generally.

Many of us would have received an email from a Tasmanian with a personal experience of medical assisted dying in Canada, and I will refer just briefly to parts of his email.

In noting this person's experience, I also acknowledge and respect other accounts where pain and suffering could not be relieved. These have been provided by the member for Mersey in a bound volume of a number of stories relating to those and others over the general period of consultation. I am sure everyone's emails inbox has been the same as mine. It is about 50:50 for and against. There are stories on both sides.

It is interesting that it is about 50:50. I think people who support it perhaps do not send emails as often as those who oppose it. I do not know; if you go by the public sentiment surveys, I believe you must listen to alternative views on this, not just focus on the ones that support a view we may hold ourselves.

Mr Chris Reynier described the death of his sister in Canada from inoperable pancreatic cancer. If you do not know about pancreatic cancer, it is pretty much a death sentence. There are some positive treatments being progressed at the moment, but ultimately most patients only have six months to live and it is very aggressive and not a pleasant experience. His sister had inoperable pancreatic cancer. You cannot take your pancreas out. You need it. His sister was diagnosed in July 2018 and died in a hospice in January 2019. His sister had commenced the MAiD process; however, she did not elect to go through this option in the end. With regard to his sister's experience, Chris stated, and this is words -

> Since 2016, Medical Assistance in Dying (MAiD) has been legal in Canada. On the surface, it appears there are more safeguards in Canada than are being proposed here in Tasmania. However, my direct experience is that it is a very flawed and dangerous system. I witnessed overt and covert coercion. I

> witnessed very little rigour in adhering to the medical assessment process. I witnessed a disregard of any cooling off period.

He stated that pro-MAiD advocates -

> actively championed MAiD and openly discouraged others from 'trying to talk her out of it'
>
> 'The decision was made and should be respected', was their view.
>
> There was no consideration given to the fact that not everyone was necessarily comfortable with the decision. Individuals felt coerced into silence for fear of appearing disloyal to Judy [his sister]
>
> .

It is important to note that I do not necessarily accept family members should be able to override a patient's informed, clearly made and articulated decisions, whether it be organ donation, the fear of medical treatment or if this bill becomes law, override or seek to coerce a patient from a decision made with capacity. Coercion in either direction is unacceptable. Death can be experienced as a huge relief and an end to intolerable suffering, and it can also be sudden, unexpected and shocking. Either way the family and friends are impacted and they are part of the person's dying experience.

You could argue it was the patient's choice and no-one should try to talk anyone out of a freely made decision. However, death does have a direct and significant effect on family members. It is important the family is involved in this. I go back to my earlier point - have these discussions with your family, tell them what you want. I am an enduring guardian for my parents and we have had the discussions. I do not want mum and dad to die, but I know ultimately they are not going to be here forever. Dad is in his 90s and mum is in her 80s. I am lucky to have had them for as long as I have.

Mrs Hiscutt - The old farming saying is where there is live ones, there are dead ones.

Ms FORREST - Mr Reynier expressed concern regarding the process around the experience of his sister's death a bit further. He wrote -

> There was no consideration of consulting with the family or wanting to listen or hear the family's views.

If that is the case, it is sad. If the family is there, they have to be included in this decision-making. I do not agree they should be able to override the person's decision if it is made with the full capacity, but you need to include the family.

> There was no attempt to discuss the option of a natural death in the hospice v the MAiD option.
>
> …
>
> There was an almost zealous urgency to 'get it done by Friday' based on an assumed belief that it needed to be done to fit in with the timing of my visit

Imagine the pressure he was put under at that point -

> MAiD advocates were all too ready to assume that a practising Catholic -

which he is I am informed by his email -

> will automatically be opposed to MAiD with the inference that anything you have to say can be dismissed or disregarded as ‘well you would say that wouldn’t you’. This was highly disrespectful but as importantly simply an assumption.

That is what I said at the outset. We have to separate religion from this. The member for Mersey in his contribution talked about a recent survey in Queensland that included a number of religious people or people who identified as Anglican, Catholic and Presbyterian that had well over 50 per cent support for the principle. We have to move away from this. If this was this man's experience, that is pretty tragic. He travelled all the way from Australia to Canada to be with his sister and this was his experience. I can understand why he is concerned about overt and covert coercion. He went on to describe his observations of the overt and covert pressure, which even bordered on coercion.

As I have said, I believe coercion at any level in such important matters should be condemned. He noted that his sister changed her decision to have her life ended that Friday after he told her he was very uncomfortable and not happy that his arrival to see her had been touted as the event that determined the date of her death. That is pretty unfortunate. He said her GP had talked through - he must have had some influence in asking her GP to come and talk to her - how the hospice would care for her through to the time she died naturally in probably no more than four weeks time. So she was imminently facing death at that time. She subsequently died in the hospice, peacefully and naturally a little under four weeks later.

Some may see this story as an example of family members pressuring their loved ones to choose another option and that maybe there was coercion here from the family. There certainly seemed to be some pressure from the medical professionals or others who were providing advice. I cannot assess this myself personally; obviously it is a personal experience I am relating. But my comments stand: coercion at any level is to be condemned.

Mr Reynier went on to state that during the four weeks after the decision not to proceed with MAiD, after his sister made that decision -

> She was calmer and less anxious.
>
> She enjoyed innumerable visits from friends and had periods of lucidity in which they were able to converse and reminisce.
>
> She had two more visits from siblings from the UK that wished to say goodbye to her. (This would have been denied to Judy and her siblings if her life had been terminated on 14th December).
>
> Since July she had been looking for answers to what she really believed about life after death. She had discussions with a number of different people, both religious and non-religious. During that time, she moved from not wanting a religious funeral service to wanting a religious funeral service. This decision was confirmed after 14th December.

This is just one account, and I am not going to go into any other stories. I wanted to raise this to make us really aware that this is a very complex area and we need to be very sure that what we bring into this place deals with some of these really difficult challenges. There are also the side issues of advanced care directives and the need to have those legislated. As I said, I hope the Government will pursue that.

This is one account and a personal experience that I believe is important to share to ensure the bill has adequate protections for patients seeking this option or the person, as referred to in this bill, and the health professionals caring for them. It also highlights the need for close engagement with family members.

It also highlights the fact that patients need time to fully consider the full range of options available to them and clear advice they can change their mind at any time. It also highlights the importance of having end-of-life discussions with our loved ones well before these difficult conversations become urgent. It is really hard to have these rational discussions in the middle of an emotional time; anyone who has been there would know how difficult it is.

I remember having to say goodbye to my dad when I went overseas for six weeks a few years ago, 2013, when he had a heart attack the day I was leaving. He was in Launceston General Hospital. Thankfully I was flying out of Launceston; I went and saw him. They let me in; I was not supposed to be allowed in but I said, 'I have to see my dad.'. I had to say goodbye to him because I was getting on a plane for 44 hours - no communication - and he could have been dead by the time I got to the other side of the world. We did; it was pretty sad and pretty tough, but he is still with us. He told me I was not allowed to come back if anything happened while I was away and I said, 'You will be dead, dad, you will not know what I do'. I am very lucky he is still with us.

None of us really wants to openly face our own mortality, as I said, but we need to talk about death and our wishes with our loved ones to avoid misunderstandings at such a crucial time.

Regardless of our own personal views on this matter, life is complex and death is inevitable. The experience of entering and leaving this world are influenced by our culture and societal structures; both are fundamental. These events are not trivial, nor are they insignificant. Families and societies are involved with and are impacted by these most significant life events. The intervening period is unique to the individual and shaped by many influences and circumstances.

Suffering is a part of the lived experiences of all people. Suffering takes many forms, and life is precious. Some suffering, however personally experienced, can be extremely difficult, if not impossible, to relieve. Ask any new parent of a baby who does not sleep whether they are suffering. Of course they are. Sleep deprivation is a form of torture intended to cause suffering. Ask all those people in Victoria whether they are suffering at the moment. Is my family suffering over there? Yes. Different sorts of suffering. At this time in the COVID-19 pandemic, many parents are suffering sleep deprivation, and they cannot seek direct assistance from families from interstate or overseas, or even in the next suburb.

Our duty here is to ensure, as much as possible, that if this end-of-life option is to be legislated, these very real and important matters are addressed. It is also an important task to ensure a framework to assist those facing imminent death and unmitigated suffering, whilst ensuring effective, appropriate and robust protections, is in place to support those individuals seeking this option and those who are called on to assist.

Regardless of the outcome of this bill, we must ensure greater access to, and awareness of, quality palliative care. We need to understand and appreciate all forms of suffering, and how we must care for and assess the whole person. We must do more to support and respect advanced care directives where they are made without the legislative framework, until we can get one.

I absolutely accept and acknowledge that as humans, the vast majority of us, myself included, try to avoid pain and suffering. There are very few, if any, individuals who would welcome any form of physical suffering or mental anguish. We really do have a responsibility as a community, not only to seek to relieve physical pain of those who request this, but also to find ways to mitigate - or if possible avoid - the suffering that occurs for those who lose their ability to fully engage in life activities, or people concerned they are a burden to families and are just waiting to die.

The COVID-19 pandemic has forced us to confront and appreciate the way we as humans interact with others, and the importance of community.

I have spoken before in debates early in the year about some of the positives we have seen, as well as the negatives of COVID-19 , the forced lockdown and the subsequent social isolation we have faced during this period - and as I said, many Victorians are still facing.

I think we have all celebrated many of the creative ways we have engaged with family, friends, neighbours and other elderly and vulnerable members of our community. Our elderly family members now have video chats with their children, grandchildren and great-grandchildren, in ways and with a frequency we have not done so before. That is a really positive thing. We have seen young people actively reaching out to older community members and those impacted by the isolation of physical distancing rules, and I believe we have recognised more clearly the importance of community caring. These same actions and engagements can transform the suffering of many people approaching the end of life, facing isolation, loss and grief, dependence on others and physical frailty.

We have also seen the tragedy of not being able to be with our loved ones who are dying, particularly those with COVID-19 infections - at a time when we most always have a loved one at our side.

We have seen the anguish of aged care residents and families being separated and not able to visit or provide care, being physically separated from their loved ones for months, and then we saw the unmitigated disaster that occurred in aged care facilities in Victoria, and some in New South Wales earlier in the pandemic.

This separation has not only occurred when there have been outbreaks, as we have seen in Victoria and New South Wales, but also here in Tasmania, when we could not visit our elderly loved ones in residential aged care, because we needed to keep some of our most vulnerable citizens safe from infection as we have seen the devastating impact COVID-19 has had for elderly members of our community. That isolation is particularly devastating for some older people.

I respect and acknowledge the views of those who are opposed to the principle of this legislation based on their religious views. I do not share those views, particularly much of what is written about regarding the perceived benefits of suffering and God's will.

I approach this bill, this topic and this principle from a humanistic viewpoint. I approach it with principles including universal human dignity, individual freedom, compassion and empathy to guide my decision-making in ethical matters such as this, but also in my former work as a nurse and midwife and my work here as a parliamentarian.

I know there are those who seek to focus on what is referred to as a slippery slope. This language is unhelpful in my view. However, the attitudinal change that can occur where protections are gradually removed as normalisation of these practices, instilling desires to remove barriers to more and more people who may consider assistance to die, does need to be considered as part of this debate, not as a barrier to the bill's progress, but as a means to ensure we do not overlook the risks of such significant change. We also need to ensure those health professionals who exercise their right not to participate have their views respected. It is not simply about religion as some seem to suggest.

Doctors Waran and William are both specialists in palliative care - a relatively new discipline in many respects because it has only been recognised as a speciality since 1998 - worried about conscientious objection and the risk of moral injury to those working in areas where conscientious objection may be a factor.

They also wrote a recent article in the *Medical Journal of Australia* where they stated -

> … moral injury was defined as 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations'.
>
> Health care professionals are subject to moral injury as a result of 'being unable to provide high-quality care and healing in the context of health care'. In this context, conscientious objection becomes integral to the psychological safety of health care workforce as voluntary assisted dying is introduced into mainstream medicine.

It is really important we ensure that care and support are available for medical practitioners and others who may participate should this bill become law.

Obviously, health professionals also suffer moral injury when the health system is at the point where they cannot provide the care people need too, and you do not have to look too far to see how devastating this is when we are having a health crisis in any situation. You would not have to read much online to understand how terribly difficult it has been for some of the health professionals working in Italy, the US and other countries where COVID-19 has been completely out of control to have to decide who they treat and who they do not.

You cannot imagine what that is like if you have not been in that position. How do you decide? That is moral injury.

Professor Spruijt is a professor directly engaged in the care of dying patients and does not wish to be involved. She said -

> I experience it in my new hesitation to invite open discussion about end-of-life care wishes, for fear that this interpreted as an invitation to discuss VAD, with which I cannot engage. Previously, this discussion took place in a secure space of 'even if I (the patient) wished for this, I know you (the doctor) cannot do it and will do all you can to help relieve my suffering', whereas now there is uncertainty as to what I am saying or meaning and what the patient is saying. The elephant in the room is now enormous and … those of us who express a different response to end-of-life suffering are berated as obstructing the patient's free choice.

This is the lived experience of someone who is a conscientious objector working in the space where VAD is legal. We need to be very conscious of this and make sure there are really clear processes and part of that will come back to the training provided to those who do participate. Make no mistake, there will be an impact on people who choose not to participate as well as those who do.

Berating those with a conscious objection is a very unhelpful response to those who support the principle. Respect for each person's view on this matter is paramount. As Professor Spruijt also stated -

> How can I be sure that my exhaustion, my anxiety, my discouragement, my fear of my own mortality, as well as my value system and the limitations of my knowledge are not adversely influencing this patient in their decision making?

It is not a simple thing we have to consider. There are huge ramifications for those involved, the medical professionals, regardless of whether they support the principle or not. I do not believe any engagement between a doctor and their patient can be entirely impartial and the doctor's own beliefs, values and experiences will have no bearing on the interaction or the patient. It is impossible because I know as a nurse and a midwife that you have to be aware of your own thoughts and feelings and be careful not to try to express those more forthrightly to a patient.

We all know the high regard with which the medical profession is held - not so politicians. The high regard that medical professionals are held in has been even more evident during the COVID-19 pandemic as so many health professionals have risked their own health and welfare, and that of their own families, to save the lives of many Australians, many of whom were elderly and vulnerable. Sadly, many of those elderly people have died. This has taken a huge physical and psychological toll on many.

The trust in our health professions is the highest of all professions. We know that politicians are well down that list.

There are many who genuinely and rightly question what the impact of that voluntary assisted dying will be on this trust. This is why we must not rush this scrutiny. We must engage fully with health professionals in completing the process. An article in *The Age* published on 18 June 2020 noted that a relatively low number of doctors, particularly specialists, have undertaken the mandatory training for VAD. This article included a call urging the Victorian Government to embark on an education program in order to attract more doctors to complete the training. If this is a problem or barrier in Victoria, we can assume it will probably be a problem here to.

It also made me question why this may be the case. It seems doctors who are supportive of VAD are more than willing to come forward and publicly state their support. Other doctors are less forthcoming or willing to publicly state their reservations. I am informed this is from fear of organisational rebuke, the emotional toll of taking a public stand against VAD and the time it takes them away from providing care for their patients.

The role of health professionals in this bill is central and critical. I am not confident there has been adequate consultation with the professions in the formation and drafting of the bill. I am happy to be corrected on that but I have direct emails from some of these organisations that suggest otherwise.

I have attempted to consult as broadly as I can in the time I have had available to consult with a range of medical professionals: those who support the principle of this bill and would engage with it and those who are opposed to the principle, including some who are not opposed to the principle but do not want to participate. It is a broad range - both those in support and those opposed agree that the bill as it stands does not adequately address the genuine and legitimate concerns they hold, including those who support the principle. They have ongoing concerns around some of the process.

Some concerns I raised I believe have been addressed. Some, in my view, will need further consideration in the Committee stage, which will be challenging in itself because it is a complex bill to try to amend in many respects. There may need to be broader and further consultation before we can proceed much beyond the second reading of this bill.

The medical practitioners who do support the principle are adamant that the bill needs to be robust and workable for it to be accepted, and I agree. I have met with a number of medical professionals, some who have retired, who support the principle and would participate if they were still in practice but see flaws in the current arrangements of the bill as it stands.

I also ask: If this legislation is supported by both Houses, what measures will be put in place to support health workers who will be impacted by this? Will the Government provide adequate resourcing to make this work, both for those who participate and those who do not? I am not sure the member for Mersey can answer this question, but it does need a response and I hope the Leader may be able to give some indication about this, even though I appreciate it is not a government bill. I am not sure what the Leader's personal position is on the bill.

If this is passed, the Government will be called upon to implement and put in all the processes that are necessary to make it work. For example, in Victoria a fund has been established that provides funds to enable pharmacists to travel to every patient prescribing a VAD substance, enabling them to consult with the patient, as required. Victoria's population is much more concentrated than ours, but there is still a lot that is rural and regional. The pharmacist, as I understand, still travels to those places and that is a state-funded initiative - not a Commonwealth Government commitment like a Medicare payment, it is a state government-funded thing. Obviously, it does not fit under Medicare so the state has stepped up.

I am not sure what discussions the member for Mersey has had with the Government regarding this. I will be keen to hear his reply on what discussions he has had with the Government about implementation and process that will need to occur to make this work.

This bill calls for the establishment of and support for a commissioner and that will also require some adequate resourcing to make it work as intended. That is another area I would be interested to know whether the Government is keen to adequately resource. If it becomes law, it is going to have to - I do not deny that - but it is important there is some sort of commitment from the Government on this.

The structure regarding the role of the commissioner needs some amendment to create greater rigour and I will address that when we get into the Committee stage, if we do.

It grieves me greatly when I hear and read some proponents of such legislation as this suggesting the only way to achieve a dignified death is through voluntary assisted dying. That is so far from the truth, it is ridiculous. Of course, voluntary assisted dying is just that - voluntary and no-one is or should be forced or coerced into choosing this.

I also acknowledge that in the absence of this option, there will be some who will sadly, tragically and often violently end their life through suicide, and that is not okay either - a terrible, tragic and extremely sad outcome for the person, their family, their healthcare providers and our society generally. We have a duty to care for people at their point of need.

We, as legislators, regardless of our personal views on the principle must ensure that if the majority support the principle, as indicated in the polls of the general public, and the parliament agrees, my job is to ensure it is legally, ethically, practically and legislatively sound.

I will listen to all contributions on this bill. As we all have a conscience vote on this bill, I look forward to all members' contributions.

If the second reading is supported, I will raise areas of concerns and the areas I believe need clarification as to their intent and effect, including amendments in the Committee stage.

Mr President, before I complete my contribution, are we having a dinner break? If we are, we should consider when to adjourn to enable this. I know there was some discussion earlier about just working through - I do not think that is a good practice; we should have a break. That is my personal view. I am happy to adjourn at this time so we can have three-quarters of an hour, or whatever, for a dinner break. I guess I will have to resume my seat, but it may be the next person I think it is important to have a break for all of us. This is heavy going. It is not easy and we should not sit for hours and hours without a break. It is not a healthy and appropriate process.

[5.48 p.m.]
Ms LOVELL (Rumney) - Mr President, voluntary assisted dying, end-of-life choices, euthanasia. There have been many ways to describe and capture what we are debating today over the years. Often, the kind of language used is coloured by whether that person or group

supports or opposes the principle of this matter. Some of the terms used are, I am sure, deliberatively emotive and evocative.

This is a sensitive topic; it provokes strong reactions in many of us and in many of those in our communities. People have strong opinions about what is the right thing to do here and not everyone agrees and that is okay. For me, the term that best describes this issue is, in my opinion, also the most accurate - voluntary assisted dying. Voluntary - because that is exactly what it is. Assisted - because the very people legislation like this is designed for need the assistance of trusted medical professionals to varying degrees. Dying - because whether any of us like it or not the people this legislation is written for are doing just that - they are dying - so that is how I will refer to it throughout my contribution.

In his contribution, the member for Mersey urged us to think about why we are here. At times when I have been faced with a bill or a concept that is challenging, sometimes controversial, that people feel strongly about and that challenges me personally, I like to remember what I said when I was first elected as the member for Rumney, when I stood at this lectern and gave my inaugural speech. I spoke about how humbling it was to be elected to represent the many diverse communities across my electorate. I said it was not only a great honour, but an enormous responsibility, and one I took very seriously. I spoke about the values that I hold dear - fairness, respect, and dignity - and I made a commitment to the people who elected me to stand up for my values and my community, to always be honest, and to strive to be courageous.

This reminds me of why I am here, and how I should approach each issue.

I believe in the right to live a life of dignity. Fundamentally, this comes down to choice - being empowered to make choices about our own lives, our health care, including at the end of our lives. There are many arguments that have been made in letters and emails, in the media, on social media, both for and against voluntary assisted dying, but it is this concept of living a life of dignity that I keep coming back to - being afforded the dignity of making a choice about how an inevitable end to life occurs.

There are those who will, and who have, argued that this bill encourages suicide, or that you cannot be an advocate for suicide prevention and a supporter of voluntary assisted dying. I could not disagree more. Suicide is always a tragic outcome, and in many cases is a result of people feeling helpless and hopeless, where the choice to continue to live seems unacceptable - more than unacceptable.

As a society, as a parliament, we should always do whatever we can towards suicide prevention, and I will never argue against that. I will be honest, because I made that commitment in my inaugural speech to always be honest: I struggled for a long time with how to articulate why suicide and voluntary assisted dying felt so fundamentally different to me. Then I heard the member for Mersey speaking on ABC radio one morning, and he referenced the words of Dr Cameron McLaren in addressing this very issue, so I went back to my office and I looked up Dr McLaren, whom we have all now had the pleasure of hearing - and I would like to thank Dr McLaren and Dr Carr for the time they have given us on this bill, and their openness and willingness to answer our questions.

I looked up what Dr McLaren said on this, and it was really very simple. In his article, titled 'An Update on VAD: (Almost) a Year in Review', which was published on 16 June 2020, Dr McLaren says -

> Suicide is a choice between life and death, whereas VAD is a choice between two deaths.

While this may have been completely obvious to everyone else, I do not mind saying this was a bit of a light-bulb moment for me. Dr McLaren succinctly captured what I had been struggling to articulate, and I have used his words many times since.

As we have already heard today, the truth is that some of the deaths by suicide that occur in Australia each year are deaths of people who are terminally ill. The *Brisbane Times* reported in September 2019 that in Queensland, seven terminally ill patients were dying by suicide each month. In Western Australia in 2018, a submission by the Western Australia Coroner to a parliamentary inquiry into voluntary assisted dying included that at least one person with a terminal or debilitating disease died by suicide each fortnight in Western Australia. In South Australia, one in 10 suicides involves a person with a terminal illness. In Tasmania this data is not captured, so we can only assume our numbers would be similar.

Despite the fact that Australia has one of the world's best palliative care services, our system is failing too many people. People are dying now as a result of suicide, when the alternative is death at the mercy of their terminal illness. Voluntary assisted dying is not suicide. That fact has been well established. If we want to reduce the number of suicides of terminally ill patients, we need to give people a dignified choice.

People who access, or who want to access voluntary assisted dying are dying. In my view, it is not for me or anyone else to determine what is an acceptable death for someone else. I cannot think of a more personal thing to determine. What is an acceptable level of suffering? An acceptable level of dependence on another? An acceptable level of pain? When the end result is going to be same, who determines how much another person should bear? It is this question that highlights for me why it is so important that people have choice and highlights that it is, indeed, voluntary assisted dying we are considering.

I am a firm believer in the separation of church and state, Mr President, and while I respect that many people lead a life based in faith and that this may be a reason for them to oppose voluntary assisted dying - equally it may not - an objection may have nothing to do with faith or religion, to be clear. I believe just as firmly that nobody has the right to impose their faith on another. In my opinion, religion is no more valid a reason to restrict the choice of others than any other reason you can think of. Legislating to give people the option of voluntary assisted dying does not, and will not, impede anyone from living their own life according to their own faith, religion or values, faith-based or otherwise, with robust principles to allow conscientious objection for those who do not wish to be involved. Failing to legislate based on a religious, faith-based or values-based argument will do just that.

However, when all is said and done it is not my personal opinion that I am here for. Like all of us, I have been contacted by many people about this bill. I have been contacted by people from all over the state and all over the country. I have had a great many deeply personal stories shared with me by people both for and against this bill, as I am sure all members have. I have done my best to respond to everyone although I will admit I am a little behind in that just now having not been able to catch up from the correspondence I have received in the last few days.

I truly appreciate the time that people have taken to contact me about this issue that is so important to so many. I am the member for Rumney so in considering how I will vote on this bill, I have paid particular attention to the feedback from members of my own electorate. While I have received correspondence both for and against this bill, the feedback I received from my own constituents was overwhelmingly in favour of voluntary assisted dying.

The very first time I spoke in this parliament, I said that I would take the responsibility of representing my electorate very seriously and I do, Mr President. In voting in support of this bill, I firmly believe I am representing the views of my electorate.

I want to thank some people who have been involved in this process: the member for Mersey and his very small team who have worked tirelessly to bring this bill to the parliament, consulting with the community at length, keeping us all informed with briefings and other correspondence, thank you; to Dying with Dignity for its many years of advocacy on this issue; to parliamentarians both past and current who have supported voluntary assisted dying legislation in the past and have paved the way for us to be where we are now; and to Jacqui and Natalie Gray, who have bravely campaigned in memory of, and on behalf of, their mum Diane who I know they loved so much.

I am not going to say much more at this stage. I hope this bill is supported into the Committee stage at which point there is no doubt more robust debate to come around the details of the bill and how it will operate. I have some questions and concerns around some of those details myself, and will be seeking to move some amendments to address those concerns as I am sure other members will too. Like the member for Murchison, I will circulate those as soon as they are available. At that point, I would also acknowledge, Robyn Webb and OPC, for the enormous amount of work that has been dedicated to this bill.

I welcome that process and I look forward to working constructively to ensure we have the most robust bill we can have moving forward, including a framework people can be comfortable with, especially those we will be asking to participate in this process, or it will be no good for anyone.

The time has come for Tasmania to legislate voluntary assisted dying. Our community overwhelmingly supports it. There are medical professionals who support it and who want to be able to offer their patients a dignified choice. There are families like Jacqui and Nat who have made promises to their loved ones as they died that they would fight to ensure others were empowered to choose a different kind of death. The time has come.

Business of the House

[6.00 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I have seen an email trail going around with regard to dinner. It is Private Members' Day, so it is not usually my position to do this, but, in light of what the member of Murchison was saying, I will just defer to the member for Mersey, because it is his bill. He has informed us all already that he wished to work through the dinner break, and people just depart and have dinner.

I could give the member for Mersey a moment to interject, or I could put the adjournment forward for dinner and -

Mr Gaffney - I feel quite happy to speak. I circulated last week in the schedule what the arrangements were for tonight, because I realised there is a lot on the agenda, and we really need to get this completed. I received no feedback at all from anybody about that, except tonight from the Member for Murchison. I made it fairly clear I thought it was good practice for us to work through. Those people who want to get something to eat can take it back to their office and still listen to the debate.

I am aware that we can only attend to this situation on Private Members' Day. I would prefer to work through, or we have a break and we work longer into the night until we finish. I do not mind if we break for an hour and we continue working past 10 o'clock until 12 or whenever, but we have to get it done. I thought it was an easy arrangement for people to go back to their office and listen, so that was my preference.

Mrs HISCUTT - That is my preference also, Mr President, but, in light of that, I might just try it with a vote, so that everybody has their say. I will ask to move for adjournment for a dinner break, and if the answer comes back no, I am happy to proceed.

Mr Gaffney - Just on that, is the adjournment going to say for a dinner break and we continue - if we do take an hour out - until 11 o'clock?

Mr PRESIDENT - The sitting arrangements are very much in the hands of the members here. It would be the case that if someone moved to adjourn debate, it would go to - the hours we sit has always been in the hands of the members. The way to resolve that issue would be to have a vote, and then if it gets later in the evening, the question can be put again, but we do need to remember that we are in times where we do need to distance ourselves socially and keep sensible time frames.

It would probably assist members who want to have a break to refocus - and it would probably help yourself as well because it has been a fairly big day - but that is a question members need to answer. The motion would have to be that the sitting be adjourned for the purpose of a dinner break, and the time frame around that would be specified as well. The member for Montgomery wishes to put that motion, we will put it to the vote and -

Mrs HISCUTT - I will put the motion, but before that I would like to say that I personally will vote to work on. Mr President, in light of the recent conversation, I move -

> That the sitting be suspended until the ringing of the division bells for the purpose of a dinner break.

[6.04 p.m.]

Ms FORREST (Murchison) - Mr President, I support the motion because I think it is important legislation. I want to listen to all the contributions, but I think we also need to have a break. There is also the staff in here to consider as well. I mean, we have sat through when we were dealing with COVID-19 emergency legislation, and we all made concessions around that. We took the bills under suspension. We worked very hard.

I think there is still a lot of work to be done on amendments. I know the member for Rumney mentioned that her amendments have not been declared. Neither have mine. I am not sure about other members.

It also means the member for Mersey can actually get a break too and leave the Chamber. Anyway, he remains unperturbed about his wellbeing, but it is not a good practice. This is not emergency legislation. If we start doing this, it becomes an expected norm. I do not think it is okay. We should be having a break for all of us. Those who wish to listen to everybody are not going to be popping in and out of the dining room, waiting for a meal and missing contributions. It is important and respectful for each of us to have that time and also not to start a practice of sitting through to God-knows-when without a break. I remember back in the day when the Labor Party did that to us in this place, where they say we are going to break and then they keep pushing on.

It was inappropriate and it is not the way of doing business when we know we are going to be in for a long session generally. We also have a long week. As far as what time we finish tonight, that is a matter for the Chamber, as the President said.

[6.06 p.m.]
Mr VALENTINE (Hobart) - Mr President, I would appreciate a break, because I too do not want necessarily miss what people have to say. My only question is: why would it be necessary to work past 10 p.m. in any event, regardless of whether we have a break or not? If it is going to go through to next week anyway, which I believe it might, it would be a good time to break at 10 p.m. regardless of whether we have the dinner break or not. I will be voting for the dinner break so I can concentrate on listening to members' contributions.

[6.07 p.m.]
Ms RATTRAY (McIntyre) - Mr President, I am mindful we are taking up time here when we could be having dinner, but in the interests of informing the House, I support a dinner break for all the reasons the member for Murchison talked about. It is not only us, it is our staff who need a break from this place. I have already indicated to the member for Mersey that I will not be doing my second reading speech tonight. We will be here next week and again this is not something we are going to get done tonight. The House will decide when we will adjourn.

Mr DEAN (Windermere) - Mr President, I do not want to waste time. I must say the member for Mersey has been quite open about his position on this and has spoken by way of email and verbally to me also. I am in a position where I do not want to miss the debate. That is why I am staying here, and why I stand up occasionally to make sure I am able to keep going. The position now is when I go for a break because I do not want to miss the call.

Mr Valentine - It has happened before.

Mr DEAN - That is my position. If I go and get dinner, will I get the opportunity to speak? That is the problem I am dealing with at this time, and the member for Hobart is right - we will have next week. I have spoken to the member for Mersey about this matter, that I would have the call next week with my bill, the T21 bill. I have already agreed with the member I will not move that next week to stand aside for this bill to be completed, because I do not think it is a wise idea for the two of them to continue next to one another. It would be a bad move for members in this place. I am also conscious of that. I am and will stand aside from that next week. That is the undertaking I have given to the member.

Ms Forrest - I thought we would have discussion and did not realise it was a given.

Mr DEAN - I indicated to the member at lunchtime that I would work through, but my position now is that I do not want to miss a call, so I am not sure how to handle it.

[6.09 p.m.]
Mr GAFFNEY (Mersey) - Mr President, I am really not overly fussed. Either way it is fine. I put it out last week to see if there was any feedback. I did not get any feedback until now. I am happy for us to have a break.

Sitting suspended from 6.10 p.m. to 7.05 p.m.

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

Second Reading

Resumed from above.

[7.05 p.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - I do understand how difficult it is to get your second reading speeches organised sometimes, member for Mersey, but some of the things you said in your second reading speech I have covered here too and it would have been cross-referenced. So excuse me if I happen to repeat something.

Mr President, euthanasia, or voluntary assisted dying as we now call it, is something I struggle with on a huge scale. I remember the former member for Pembroke, Vanessa Goodwin, inviting me many years ago to listen to a proponent of a similar bill. I remember thinking at the time, no way, but here we are again.

I am going to concentrate more on the principles of the bill and my experiences, of where I have come from and how I have got to this point here today.

Of late, as this bill neared its second reading date, the information and the lobbying has just been pouring in. It has come down to information overload. I do not mind pro forma letters or emails. I have read and replied to many which come from outside my electorate but I only counted the ones in my electorate when it came to a survey that I did.

I found both sides of this debate to be disrespectful of each other as we neared the end. Everyone should be respected and allowed an opinion. After all, we are presumably living in a democracy. I note that we are all copied into a letter from DWD, a call to action newsletter, dated 27 August 2020. I believe it came in response to a letter writing advice which was supplied by the Christian side of the debate. I am not going to delve into it really deeply but I will read a little bit from either side, just to let people know how annoyed I get with the disrespect that comes out with such an emotive subject like this. The letter from Dying With Dignity, the newsletter, says -

> An unnamed church has issued a 'Letter Writing Guide' to their congregation for them to respond to the above Bill. So, DWD Tas is issuing the following Letter Writing Guide for Members & Friends to send to all Upper House MP's … to create letters for all Newspapers, either large or small … to publicise our 'FOR' message and refute the blatant lies being told by the 'ANTI' Brigade in the hope that if enough mud is thrown, some will stick.

I will not read it all but they did talk about how to go about letter writing. It says, 'use emotive personal stories, do it in handwriting' and I noted they have given all our email addresses, which is always very helpful. On the other side of that debate, we all would have had these pro forma letters from the other side. This one is opposed to the end of life choices bill that is being promoted by Mike Gaffney MLC: 'I am concerned that by legalising assisted suicide' - which is another provocative word - 'the vulnerable people blah blah blah'. This lady who is 77 and I will not mention her name, it is not handwritten because down the bottom she simply says, 'Please excuse my printed letter. My age is affecting my writing ability.' They are all doing as they have been asked to do, which is fair enough, and they are lobbying us.

They member for Mersey has done a fantastic job of public consultation and I have attended a couple of his forums. I attended one where a lady wanted to know how the member for Mersey could avoid letting religious people vote on the bill. I thought the member handled it very well and moved on without a blink. I was a little bit stunned. After all, shutting up your opposition is dictatorship, wrong, disrespectful of the community diversification.

During the last week's sitting in August there was a lot of jostling for spaces to come and brief members of the Legislative Council during parliament. The people who have briefed us represent a good cross-section of views. After a shaky start, the member for Mersey and I tried to make sure that it was even, given the limited amount of time on Private Members' Day and the large number of requests being made. I have encouraged groups that missed out to forward all members of this Chamber their submissions and I know this opportunity has been taken.

Like all good debates, there are those for and those against. I find in life that there are only two answers to every question. When my children were younger, in their teenage years and they had issues, we would sit back and talk it through. My first question was, is it that serious that you will die? The answer was always no, of course it was not that serious. Then we went on to explore the issues and how to sort the problems.

The answer to the question before us today is yes, if this bill passes, yes you will die if you access it. The debate here today is to decide if the outcome, which is death, is the desired outcome, that is providing it passes to the Committee stage.

Many debates and briefings over the years in this Chamber have seen us receive opposing views to digest. I am always amazed when we have lawyers present to us on how a bill works. There are always different views on the same point and this is the same.

I suppose we have to decide if we are going to vote for the bill and there are only two answers each way you turn, yes or no. If the answer is no, then that is the end of it. If the answer is yes, the next question is, is the bill before us good enough, strong enough and tight enough to do what it is that we presume it will do? Or are there some hidden or underlying consequences that we are not quite aware of yet?

I have gone through the bill with a fine-tooth comb and I will have quite a few questions tagged when it comes to the Committee stage, if it gets that far.

I do not think about assisted dying all the time, but of late it has been the subject on most people's lips, knowing that the member for Mersey was bringing it on. I have been asking my constituents for their thoughts. I ran a survey and I got results and I will come back to that later in my contribution. I was surprised that a handful of people really had no idea what we were doing, but so be it.

Ms Forrest - Some people are not interested in politics at all. They are not as tragic as us.

Mrs HISCUTT - Fair enough. They were happy. This social subject has always been open to a conscience vote. I must admit that is one subject where I wish I did not have to make an individual decision, but I represent the people of Montgomery so I asked as many as I could. I presume that the Labor Party has a conscience vote also but I have not heard that being said. Maybe some member who gets up to speak might be able to clarify that for me.

I had a strange phone call recently from a lady who we all know so I will not mention her name, and who wanted to talk to me personally about why the Liberal Party was not giving a conscience vote to its members on this. I asked her who had told her that because it was the first I had heard of it. Actually, I was a little miffed, although at a time like this, I would have appreciated being told what to do. But no, the Liberal Party members are being granted a conscience vote and this is a subject that I really struggle with.

The other thing I will touch on, amongst other things, is I often hear people say that you would not let a dog or an animal suffer like this, the way we let our fellow humans suffer and that if your pet is old, in pain or suffers a disease, you put them down to avoid any further pain or suffering. It might be because I am a farmer that I think differently about this. I certainly do not believe in animal cruelty as these animals provide an income for farmers and they feed the world. A cattle dog could be worth a yearly wage if it is good enough but when it comes to sick or injured animals, I am quick to make the decisions when euthanasia is needed. I think like this because it is an animal and not a human. I suppose it depends on where you place your values.

As an aside, I had Parliamentary Research do some work for me on pet ownership in Tasmania and Australia. It looks like Australians do place a lot of value on their pets, and I might have to rethink my position in this role as a parliamentarian when it comes to pets.

Parliamentary Research provided this for me: there are over 29 million pets in Australia. We only have a population of 25.5 million people. Tasmania has 66 per cent pet ownership, which is the fifth highest in the country. There are more than 4.8 million dogs out there somewhere. Roy Morgan ran a single survey in 2006 about pet ownership in Australia, and found a higher proportion of us lives in households with a dog and/or a cat than with a child. Fifty per cent of Australians live in a household with at least one cat or dog, whereas

35 per cent share their household with a child under 16 years. Maybe I will have to reconsider where I come from there.

I love my cat, I love my dog - but the dog was there to chase cattle and sheep; the cat was there to chase rats and mice. We all had a job on the farm. I was not so sure about the pet mouse one of my sons owned at one stage, and I do not think the cat was really happy about it either.

Mr President, I will now touch a little on palliative care. Palliative care nowadays is extraordinary. Advancements in palliative care and medical research are moving forward in leaps and bounds by the day, by the hour and by the minute. I have just heard that there is now a new emergency response team on the coast. My friend has informed me that he has accessed it for his wife. He says they have just been mobilised, and his words were, 'They are awesome, and they are available from 7 a.m. until 9 p.m., seven days a week'. This is good news for him as he is in desperate need.

Research into cures for any sort of ailment could be just around the corner. They have been working on cures for cancers for a long time, and now the race is on for an immunisation for 'Rona'.

I often wonder, what if a terminal sufferer wakes up tomorrow and that day proves to be the best day of their life? What if they have just been delivered the news that they now had a cure for their illness or disease? You will be out of this hospital, out of this palliative care bed in just a couple of days or a couple of weeks. How would you feel if you had witnessed your loved one access assisted dying? If only you had just held on for one more day.

One example of research happening is red light for Parkinson's. It is a repair-oriented therapy aimed at stabilising defective neurons. This is very interesting. Who knows where it will end up. It is just one example of research having grabbed my attention. Friends of mine had a parent who died of Parkinson's disease, and I know they lived in hope for many, many years of a cure being found. My husband and I went through this roller-coaster of emotions with them.

Only last fortnight, we all heard that a young Australian scientist has made a potentially groundbreaking breakthrough in the research for a breast cancer cure. A study by 25-year-old Dr Ciara Duffy has found that venom from honey bees can rapidly kill aggressive, hard-to-treat and often deadly breast cancer cells. It is all very exciting stuff.

I also spoke to a registered nurse I know well to glean his opinions of palliative care in VAD. The member for Murchison would know him also, Paul Sava. He gave me his permission to use his name.

Ms Forrest - He trained after me. That is a bit frightening when you think about it.

Mrs HISCUTT - Yes. He is a trained midwife, he has critical care qualifications and an advanced life support certificate. During our conversation he talked about palliative care. It is his belief that palliative care, when utilised correctly, can help with nearly all pain. Also, one point he wanted to put forward was that if heroin was also allowed to be used in Australia, it would make a world of difference to pain relief in the instances we are discussing today. He also talked about the need for more pain specialists. Needless to say, he felt very edgy with this bill.

I have a lengthy contribution here about life insurance. I know the member for Mersey, in his second reading speech, talked about sections 137 and 138, but I had a few concerns that euthanasia would negate any life insurance policy an individual might have. I thank the member for Mersey for providing some answers for me, which I will now share with members, as I would like it recorded on *Hansard*.

The member for Mersey says that based on the information and advice he has received so far there does not seem to be a conflict between life insurance policies and voluntary assisted dying laws for several reasons. I will go through it all as it is important to have it recorded -

1. There appears to be no evidence of a problem in the many jurisdictions that now have voluntary assisted dying laws, in some cases for many years, because VAD is not treated as suicide for insurance purposes. He had contacted people he met on his overseas study tour to check this and I thank you for that and the feedback on that. For example, in Canada the insurance industry's position as stated by the Canadian Life and Health Insurance Association Incorporated is that member companies would not treat deaths resulting from MAiD, medical assistance in dying, as a suicide for policy purposes provided the legislative processes had been followed. Other defences such as misrepresentation or other exclusions would remain open.

2. Previous Tasmanian VAD bills in 2013 and 2016 have included provisions that VAD provided legally in accordance with the act is not suicide, assisted suicide or a crime under the Criminal Code and must not impact on life insurance policies. This includes information on how these issues are addressed in other jurisdictions, including Victoria and Western Australia. The insurance issue is under consideration by the insurance industry because of the Victoria VAD law, the Western Australian VAD bills and developments in other states like Queensland and South Australia. This means we still should have some more up-to-date information at the time of this debate.

Is that possible? Do you have any more up-to-date information you can share with us during summing up?

Mr Gaffney - I will get something up.

Mrs HISCUTT - It continues -

3. The voluntary assisted dying is not suicide as we understand it in society. This is because there are very significant differences between people requesting and receiving voluntary assisted dying that will be legal under the proposed Tasmanian legislation that the member for Mersey supports and intends to move in our parliament based on similar laws and suicide which everybody regards as tragic and which every effort must be made to prevent.

4. There is no evidence or sensible explanation to assume that as a result of VAD laws suicide rates increase or there is a decrease in society's commitment to prevent suicide particularly among young people. Government's funding and support for suicide prevention programs, all the efforts of so many people working to improve the effectiveness of those programs.

5. There seems to be some misunderstanding about the impact of suicide on life insurance policies. It is not the case that suicide negates all life insurance policies and the member has been advised there are differences between policies but -

    (a) most life insurance companies have clauses in their life insurance contracts that exclude suicide, but normally for only the first 12 or 13 months,

    (b) many life insurance policies will pay a terminal illness benefit if people's medical condition is likely to result in their death within 24 months which means that many people who have life insurance policies will have received a benefit long before they decide whether or not to request VAD.

Member for Mersey, you may have something more to say on this.

Mr Gaffney - Can you just remind me what date I sent you that?

Mrs HISCUTT - I have just copied and pasted the words, I am sorry. I can find it.

Mr Gaffney - If you can let me know because I think it was a while ago. Thank you.

Mrs HISCUTT - It was a long time ago and I am sure it is updated now.

I would now like to touch on surveys. For anyone who has watched *Yes Minister*, which is a political satire British sitcom written by Antony Jay and Johnathan Lynn, you would know that it is all about how the question is posed to be able to get the answers you are looking for. One episode springs to mind where the minister wanted more social housing, but by the time the adviser had finished posing different questions to him it became obvious to the minister his ideas of more social housing were preposterous and definitely not needed. I am sure that this manipulative measure has been used many times in the past, the present and will continue into the future.

Roy Morgan is quoted on the Australian Care Alliance webpage posing many different questions to get many different answers on the subject.

I have some of the questions on the subject for discussion today, which were posed in recent times to New Zealand. I will only quote a bit of it, because it is quite lengthy -

> It is hardly surprising that when Roy Morgan asks Australians “A question on hopelessly ill people experiencing unrelievable suffering. If there’s

> absolutely no chance of a patient recovering, should a doctor be allowed to give a lethal dose, or not?" the majority (85%) say YES.
> …
> A significant majority of New Zealanders shift from initial support of euthanasia to opposition once questions are asked about the how such a law might actually work in practice.
>
> An opinion poll conducted in April-May 2019 by Curia Market Research found that although initially 57% of respondents said YES and 29% NO to the question "Should a doctor should be allowed to give deadly drugs to deliberately kill a patient?" these results flipped when respondents were asked "Would you like New Zealand to have a law that would allow a terminally ill person to receive a lethal injection because they feel depressed or that life is meaningless?" - 56% said NO and only 35% said YES.

I will not go through the rest, because it goes on a bit. I have read a lot of information coming through from Australian Care Alliance. Some of it makes sense, and some of it does not. As with these subjects based on social conscience, it all depends on what you think or you believe.

I cannot find anything wrong, and I cannot find anything right, other than it is someone's opinion based on their personal beliefs, and we all know that we can find literature to back up anything we want to believe. I really do struggle with this subject.

Ms Forrest - It is called confirmation bias. That is what it is - confirmation basis. You look for the information that supports your argument.

Mrs HISCUTT - You do and we all do it.

I now turn my mind to the mechanics of the bill. I have quite a few questions to ask during the Committee stage, but I will first make a few comments here - not that I need you to discuss them now, but just to give you a heads-up. I will have questions about the relevant medical condition, and I need a watertight comment how this bill will not be available to people who suffer depression or the like, which is not associated with any life-threatening diseases like cancers, et cetera. I need to know that depression on its own is not a relevant medical condition.

What does 'intolerable' mean? The word 'intolerable' first appears in the bill on page 21, where it says, 'whether the person is suffering intolerably in relation to a relevant medical condition'. If I go to the *Oxford Dictionary*, the meaning of intolerable is 'unable to be endured'. It says the 'intolerable pressures of work'. I am feeling it right now. 'Unbearable, insufferable, unsupportable' and words of that kind. I am not so sure about the 'intolerable' word, because different things are intolerable to different people.

I have seen some of my nieces over the years stamping their feet saying things like, 'This is intolerable. I just can't tolerate it anymore' - and of course, all they are talking about is their sister's indiscretions or the colour of their hair or shoes, or whatever it may be. I note the section says 'and' to the seven-odd parts in it, but I will ask the member for Mersey to turn his mind to this subject and I will ask that during the Committee stage if we get that far.

I am also a firm believer that at least one of the visits to the doctor should be a face-to-face meeting, and it should probably be the last visit, but I just want to flag that with you now.

On numerous occasions throughout the bill, it mentions requesting a psychiatrist or psychologist's opinion. I would like to know why the member has decided not to make it a mandatory requirement in the bill. I hear what you are saying about doctors being professionals, but I would have thought to gauge someone's mental capacity that it might have been mandatory, so I am interested to hear why you did not make it mandatory.

I also have some concerns about people under 18 years, and people who are not suffering yet, but have an incurable disease, who may wish to access VAD from anticipated suffering. As I mentioned earlier in my contribution, medical research is moving forward in leaps and bounds.

I had intended moving some amendments, and I have put one around to members today, but most of my concerns are covered by others who have beaten me to it and some have done some pretty good jobs.

Ms Rattray - We have not seen any other amendments, have we?

Mrs HISCUTT - I suppose that is my privilege as the Leader's office. The member for Mersey did flag it.

Ms Forrest - I have not circulated it because it is not yet complete.

Mrs HISCUTT - I sent mine around about 3 o'clock; it would have come from Mandy Jenkins.

Mr President, I would like to talk about some of the correspondence, comments and emails I have received over the past few months. Then I would like to talk about the results from a survey I did in my electorate of Montgomery. I have tried to stick to the comments from people in my electorate, but for connecting reasons I have ventured into comments from others. I will not venture into the many sad stories presented, although I will have one story I would like to share with members now.

By way of some background to this person I want to talk about, to give you some context, in a past life I was a member of the Army Reserves, the 44th Transport Squadron. This is where I got my heavy rigid vehicle licence, which was easily converted into a civilian licence, and I met many good lifetime friends. One of those friends is Randolph DeBoer also known as Dutchie. I have fond memories of a particular bivouac we were both on many years ago. He was a sergeant and i a lowly lance corporal. I was the first and only female instructor at a truck driving training recovery and camouflage exercise held at Shale Road in Latrobe. We and many of our colleagues are featured in a book which is called *With the Volunteers*, which documents the volunteer military forces of the north-west and west coast of Tasmania from 1886 to 1986. I featured at the very end of the book.

Dutchie was a good support for me during those days. Dutchie is now on a walker and he uses a mobile scooter to get around. He is vehemently opposed to this bill and came to see me in my office. I asked him if he would like to write some words for me to deliver to my colleagues here in the Council. He has taken the opportunity to write four pages and I will not refer to it all. He speaks about his faith at length and the care he took of his wife who passed away due to Alzheimer's. It was a little bit hard to read and there is not a lot that I will read out but it is just the pertinent parts. He says -

> My name is Randolph DeBoer and I am a retired army Warrant Officer, served for 35 years and saw active service in South Vietnam in 1967-68. I am also a committed Christian and this is the reason why I am persuaded to submit my comments on euthanasia.

He goes on to talk about his faith -

> To illustrate my strong and resolute stance on the vexed subject as is follows. I was blessed for many years, 60 years, to be married to a precious, wonderful woman who in her late 50's was affected with Alzheimer's which created a world we were both totally unprepared for.

Then he goes on to talk about his wife's struggles and how he looked after her -

> I was born prior to World War II in Holland and witnessed many evil, satanic offences but what struck me most was how the rise of a godless, evil dictator rose up in a cultured country like Germany and the Nazi's dictatorship.

He goes on to talk a little bit about that -

> Currently in the EU, some nations including the country of my birth have enshrined euthanasia in law, even children as young as 12 years have the right to choose this option without their parent's consent. One consequence from that is the sick and elderly are loath to go to hospital or an aged care facility because their offspring cannot or will not wait for God's will to take place.

He talks a bit more in depth about that. He makes a comment to us here -

> I feel for the people who need to make this decision to have this bill enshrined into law. However, I am a realist and I see what has occurred in the not too distant past that the majority of the constituency are in favour of the bill passing. I hope this submission may cause someone to pause and consider and vote according to what God's will is and not submit to the clambering of the majority.

Dutchie was quite keen to deliver a few messages, which I have done.

Mr Gaffney - Did you check if that was factual?

Mrs HISCUTT - No, this is his thoughts.

Mr Gaffney - You have just put that on record and what he has said is not factual.

Mrs HISCUTT - That is right. This is his thoughts.

Mr Gaffney - Okay, that is fine. As long as people do not assume that that is correct.

Mrs HISCUTT - To match that, Mr President, there was an email that we all received from another Dutch gentleman - I did not ask his permission so I will not mention his name - and he reiterates what I have just read. I acknowledge that this is their opinions and their thoughts and it is not based on fact. This is the way they feel. There is a large Dutch descendent community in my electorate. It makes me wonder, when they talk about the slippery slope as mentioned earlier. I note the article in the *Mercury* from our good friend, Greg Barns, talking about the slippery slope.

To my survey. As all members know in this place a newsletter can only be approved if it has a survey on the front. Mine was simple. The survey simply said -

> I need your assistance to make sure I am representing the people of Montgomery to the best of my ability. I would appreciate your feedback on this very important topic for our community.

It says -

> Do you support voluntary euthanasia?

I used the word 'euthanasia' because that was before we had changed our term.

> Yes, no or unsure. Any more comments?

For a while I stopped reading people's stories. They became too depressing for me. The story was, although individual, the same, having to watch a loved one die. So after a while I read to the point where they said yes or no to the bill and I recorded that. The survey results came in. There were 66 yes, 22 no and one unsure.

That was roughly three to one in favour. This was a very small sample of returns, so then I made an effort to talk to nearly everyone everywhere I went. When people at parties or gatherings knew what I was doing, as discreet as a I was, I found people were coming up to me in a quiet moment and giving me their opinions, which I appreciated. I also recorded some of those numbers: 137 yes, 28 no, and 17 unsure. It was now up to about 3.5 to one.

I still did not think that was a big enough sample so I asked at as many places and meetings as I could. I even stood in the streets of Ulverstone, Penguin and Sheffield. I asked residents at Wilmot and Upper Burnie. The results came back the same, a little over 75 per cent in favour.

I had a small rush of emails from my electorate on Thursday and Friday night, and I thought how strange. Then I noticed one late night driving home there was a big LED sign on the side of the road that said 'VAD soon - contact your local MP'. I had a fleeting moment's thought that it might have been targeted at me. I hope it was not. Did any other members notice anything like that in their electorates?

Ms Forrest - The signs? Yes.

Mrs HISCUTT - That is good to hear.

Ms Rattray - There was nothing in mine.

Ms Armitage - Nothing in mine.

Mrs HISCUTT - In conclusion, the VAD bill reflects the changing beliefs of society, as noted by my friend, Dutchie DeBoer, in this letter and the solid belief that we should have a choice to end our own life peacefully and legally in these circumstances if we so desire and fit the criteria.

For me to be sure that there is no coercion I am going to divest myself of all my assets long before I get to that stage.

As much as it pains me I will be voting to take this bill into the Committee stage. I am looking forward to debating many clauses and amendments that I reckon will come forward.

[7.40 p.m.]
Ms PALMER (Rosevears) - Mr President, I start by acknowledging the extraordinary efforts of the member for Mersey in bringing this legislation to us today. There can be no denying that this has taken an enormous personal toll on you and you have remained steadfast in your commitment to see it through. If not for COVID-19 there were many times I wanted to grab you in the corridor and hug you.

If you had asked me six months ago my opinion of voluntary assisted dying I would have categorically told you that I would never vote for such legislation. Having been raised by two Baptist preachers, I fundamentally could not have supported assisted dying being available in our society in any form. As it was stated to me by one of the many dedicated nurses in my community who reached out to me as part of this debate, for VAD to work, for our vulnerable to be protected, everyone involved in this process must act with integrity. You do not have to spend 24 years working in a newsroom to know that is an impossible scenario.

However, having just been elected to this place I come fresh from the streets of my electorate where for weeks I pounded the pavement speaking with everyday people in the privacy of their front door and it was here that my opinions were challenged. I was forced to look inside myself to truly justify the position that had come so easily. Suburb after suburb and street after street, house after house, the stories were shared and some were so hard to listen to, not only of the inhumane way in which people were telling me their loved ones had died, but also the great trauma that was left behind by the loved ones who had to watch on helplessly.

Then in the very next house there would be a story of a wonderful experience with loved ones being cared for with such dignity through palliative care. There was hardly a day during my campaign I did not go home in tears over this matter.

I wish that I came to this debate with the medical background, such as the member for Huon and the member for Murchison, but I am here with a background in journalism so for me this had to become a fact-finding mission and this is where I struck exceptional trouble. There were palliative care workers who firmly stated there was no such thing as a death with intolerable pain. Morphine or such medication was used to ensure there was no discomfort endured at the end of life and that, indeed, an intolerable death of pain was a myth. Then in complete contrast, others who worked in palliative care shared some of the horrendous deaths that they had been part of over many years. It had left them so traumatised they were begging me to play my part in ensuring this bill was passed.

So, is it a fact that palliative care can relieve intolerable end-of-life suffering? I cannot tell you, despite having spoken with dozens of health professionals. Medical professionals, local GPs that I went to, say they are already assisting people to die. They cut off their food supply. They cut off their hydration supply. They up their medication in the hope this will speed up the dying process. Their horror at basically starving and dehydrating people in their final days was apparent. In the words of one local GP, 'I am already doing this, just in an inhumane way'. While the next GP I spoke to would stress to me the unimaginable danger to allow legislation of this sort to become part of our law. There were completely conflicting expert opinions across all the briefings that were provided to us by the member for Mersey and the briefings I sought independent of that, and still as a journalist of over two decades I could not find the facts.

I spoke with church leaders who shared with me beautiful Bible verses about how precious life is, while other Christians shared Bible verses speaking to me of God's love and compassion for his people. When you add to that hundreds and hundreds of emails, letters and phone calls - as I know all the members have received - this became overwhelming, not only for me but for those who were assisting me in trying to manage all of this correspondence and this information.

So, I realised I had to simply reflect on my own personal experience with my dear father and I spoke to this briefly in my inaugural speech earlier today.

At the age of 11, my father asked that I help him to end his life. I would need to be his arms and his hands. I would need to find the medication - remembering I was only 11 - put it in his mouth and hold the cup of water with a straw to his lips. I simply could not do it.

Years later, on the night of my grade 10 formal, when my mum took me all dressed up to the nursing home where he lived, he thanked me for walking away from him that day. My father would have been eligible for assisted dying under this bill. He was over 18, was in intolerable suffering, he was an Australian and he certainly had the capacity to make his own decision and to understand what was happening. Years later this would have been the wrong decision for him.

However, his request left me with exceptional guilt for many years of my childhood, that he had suffered because I was unable to help him with that request. I now cannot help but wonder, if voluntary assisted dying had been in place, his request may have gone to his doctor, an adult, rather in desperation to his child. An adult, a professional who could have worked through this with him. I cannot help but wonder how many other children have been put in the situation I was put in, and how many other family members have been put in that position.

At the end of months of deep thought, contemplation in my own faith and indeed my father's story, I came to the only conclusion that would represent my electorate while still finding peace in my own heart.

I do not choose voluntary assisted dying. I was raised in a Christian home. When you combine that with my personal experience with my father, that has led me to that decision. This would not be my choice and that is my right. The important word here for me is 'choice'.

I have struggled to see how my own faith or my personal baggage should dictate how other individuals or families wish to handle end of life care. I quickly came to the realisation through my doorknocking, that a topic I assumed was dividing my community, in fact, was not. Voluntary assisted dying was not dividing my electorate. There was overwhelming support for it.

Some of the most interesting data that I have heard through all of these briefings has come out of Victoria and other countries that have introduced assisted dying. The data shows that a number of people who begin the voluntary assisted dying process often do not end up actually using it. The more I ponder this, the more obvious the answer became. When you feel you are backed into a corner and there are no options on the table, it is hard to focus on anything other than the circumstance you find yourself in. However, if you knew there could be another way, if other options were available to you, would you begin to focus on living, rather than on how you might die?

I am here today representing the electorate of Rosevears, the majority feelings on this issue and what they are expecting of me, although I find it very difficult. While the member for Mersey has been quite exceptional in responding to the numerous questions I have surrounding this legislation, I still find myself quite conflicted over many of the issues.

When looking at the section of the legislation relating to when a person is eligible to access voluntary assisted dying, we see an age requirement, a decision-making capacity, that a person is acting voluntarily in a voluntary capacity and is suffering intolerably in relation to a relevant medical condition. However, there is no time limit at this point with regard to life expectancy so we could find ourselves with a patient who has years to live but would still be eligible to start this process.

If this is end-of-life choice, how can there be no reference at the beginning of this process that indicates when end of life may be? It is not until much further into the bill, at the final request stage, that there is mention of an expected time frame for death.

When looking at communication in relation to accessing voluntary assisted dying, where medical practitioners involved do not speak the same language as the patient requesting assisted dying or there is provision in the bill for a third person to be brought in, the guidelines are extremely loose. The patient themselves did not nominate that person. Surely this would need to be an independent, accredited interpreter? When looking at health professionals who need to successfully complete an approved voluntary assisted dying training course, who is the approved provider of this course? Is this course recognised in other states of Australia? Indeed, if you have trained in another state, is that recognised here in Tasmania?

Then I turn attention to the opportunity in two years time for a review of this bill under clause 142, with the purpose of gathering information in relation to a person under the age of 18 and the voluntary assisted dying process. Now I readily admit that this has been taken out of context. It has been sensationalised in many aspects. This is not, as the member for Mersey stated, an opportunity to make an amendment to include children in assisted dying; it is an opportunity to undertake research. However, research can be undertaken at any time and I simply cannot understand why this needs to be part of this legislation.

For me, if my children cannot vote under the age of 18, cannot drink, cannot drive alone in a car, cannot even enter a gambling facility, how on earth can they make a decision independent of their parents with regard to this? I understand research could be undertaken but it can be done at any time. I do not understand why it needs to be part of this legislation. I am new to this place and its workings, and now I find myself with a piece of legislation that addresses a life and death matter.

While I have come to accept it is the right of my community to have choice in that, I know the legislation must be as watertight as it possibly can be, not only to protect those who are vulnerable in our society, but also to offer the same level of protection to health professionals who will be the ones actually implementing voluntary assisted dying. They will be at the coalface, and I am still hearing overwhelmingly this legislation is not yet offering enough clarity to our health sector.

While I support the right for our community to have a choice here, I still have so many questions, as do people in my electorate, and I am unable to answer them. They, like me, support choice. They want the very best legislation possible, as Tasmanians should expect to have. Personally, I feel rushed through this process.

There are questions over how it should be funded if it comes into law, questions over the training process - so many questions I cannot answer and cannot offer answers to those who are asking that of me. At this point I certainly look forward - should it go that far - to debating the clauses in the Committee stage. The debate must be robust, it must be diligent, so we can offer our community and our state the very best version of voluntary assisted dying.

Ms ARMITAGE (Launceston) - Mr President, I commend the member for Mersey for all the work he has done on this bill and the commitment he has made to voluntary assisted dying. This has taken a huge toll on him, and I am sure also on his wife, with the time he has put in and that was evidenced by his emotional contribution this afternoon.

We are about to consider a bill that has garnered much debate with members, receiving a larger number of inquiries and submissions than usual, the vast majority of which are well articulated, well reasoned and impassioned. I am, of course, referring to the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020. I read every email and letter sent, whether in favour or against, and I continue to have discussions with constituents, members of the medical fraternity and anyone else wishing to speak with me.

I have piles of research in my office and it has been heartening to see so many people engaging with their local members in a lawmaking process. While the majority of mail is overwhelmingly in favour of voluntary assisted dying, there is also much correspondence against. I appreciate everyone taking the time to tell me their thoughts and beliefs, which I will consider when we debate this bill.

It would be naïve to think covert forms of VAD are not already occurring. What VAD legislation should do is bring regulation to these practices and create order by codifying a system of safeguards to minimise the harm that would otherwise be occurring. I support voluntary assisted dying in principle and believe if someone is dying and in intolerable pain and misery that I, as a member of parliament, have no right to decide how they end their life if they choose to do so. It is, however, our responsibility to ensure that a terminally ill person does not feel so ill and alone that they take matters into their own hands to end their suffering.

I am only going to share one of the many stories we have received as this is a story of the father of a friend of mine. With her permission, I share her story of her 91-year-old father who I will call Fred, who was suffering constant and ever-increasing pain from his bone cancer. Fred hung himself after seeing what happened to his beloved wife over a 12-year period. He preferred that to going through the constant and ever-increasing pain of his bone cancer. Up and down to the toilet he went, half awake, doing battle with his angry growing tumour which prevented him from relieving himself with the ease we all take for granted. Maybe six times a night he repeated this journey. For him to receive the relief he needed so badly he needed to walk up and down and up and down until he felt he may be able to have that critical bowel motion that always must precede the urinary event. Every time he rose from his bed it was with anxiety. He feared the time when his formula, his desperate need to urinate, would fail him. The two hospitalisations to reduce the tumour over the previous 18 months had been, as every other time, so painful. He would declare it was like peeing razor blades for a month afterwards. He craved a good night's sleep but he knew that sleep would never again be his. He could have cried with tiredness daily.

Fred's beloved wife, Gwen, whom he had known for 64 years, had Lewy body dementia for 12 years and this had broken his heart. He would go out into the garden and cry quietly - tears of grief slowly running down his face, keeping his grief within, protecting her from the truth. Watching her slowly drifting into the abyss of fear, disorientation and depression had nearly killed him. She would wake crying and continue all day, grieving, afraid of being put into a home.

His daughter, Claire, said it was the cruellest thing, he said, to see her suffer, lose ability, fall, become violent, damage herself, finally break a hip and then enter palliative care for 13 long days and long nights.

In those last four and a half months of her life she had been moved between respite, nursing home, hospitals and assessment centres 11 times. No wonder she had no idea what was happening to her and the saddest thing - she could not tell them of the pain. The pain of moving her for 10 days with a broken hip, unable to convey the problem, to verbalise her distressing state and then the palliative care. The nursing staff were kind, but Fred was there by her bed as she slipped under the morphine, unable to communicate. Thirteen days, no water, no food, no medication, just the morphine.

Claire said he watched as the symptoms of dehydration claimed her - the blackening of the mouth, the little choking sound she made, the face sinking in. Finally, the desperate panting all through the night before she died. Nature's undertaker, pneumonia, claimed another soul. She suffered so badly and he suffered alongside her for so long.

Fred was a man who contributed to life and cared for everyone. Claire said he motivated the elderly to get out and enjoy life. He read and studied, he volunteered and kept active. He joined and promoted the local citizens, organised monthly dine-outs, always had a joke for everyone and spoke to strangers in the street who looked lonely. He did that because he cared for humanity and just wanted to make everyone feel important. He knew that many of the elderly, unable to leave their homes often, may not have spoken to another soul all week.

According to his daughter, Claire, he lived by his principles and never faltered. One morning it would appear Fred slowly and painfully negotiated the old ladder he had dragged from the garden shed the day before. He had been smart enough to put this into place against the trunk of the tree that hung over his back fence the day before. He then fitted the noose he had previously prepared around his neck. He knew it would deliver him out of his shocking pain. When the moment came, that beautiful, fine, old man jumped out into space. Sadly, he had to face this horror alone.

I thank Claire for allowing me to tell the story of her wonderful father who took his own life at 91, rather than continue in uncontrollable pain.

I reiterate that I support choice. It should go without saying any VAD legislation should contain built-in protections that do not oblige a terminally ill person to participate or be coerced into VAD, nor any medical practitioner be compelled to provide it. Again, choice is what I believe matters most. As I mentioned earlier, it would naïve to think that covert forms of VAD are not already occurring.

I emphasise I believe palliative care has a very important place in caring for the terminally ill. Should the VAD bill successfully become law, I would remain a fierce advocate for the support and funding of palliative care, and its ongoing improvement, in parallel with the rollout and responsible implementation of any VAD laws.

What has guided me on my thoughts on this bill is hearing the individual stories of those who have supported their loved ones through traumatic, painful and unreasonably drawn-out deaths. They are many and varied, but all have the same wish for a peaceful end of life for their loved ones, without pain and suffering.

Witnessing suffering of the type Fred experienced over a prolonged period is difficult and takes a heavy toll. Actually experiencing it would be an entirely other thing. I ask everyone to place themselves in 91-year-old Fred's position, exhausted and in intolerable pain, and then ask: is it wrong to end it at a time of your choosing with peace and dignity? I am told that VAD laws, when done correctly, provide this choice in a manner that is regulated, overseen and protects the vulnerable from existing practices which can go under the radar.

There is no replacement for quality palliative care, and in the most severe and dire circumstances I believe that voluntary assisted dying has a place in a compassionate healthcare system.

I note that this bill is version 18. Member for Mersey, it is version 18? We have not had one since, have we?

Mr Gaffney - The final bill was 19.

Ms ARMITAGE - There have been many changes since the original bill was discussed.

I have concerns with the continual changes and amendments to the bill, and it does appear to be a bit of a moveable feast. My preference for this extremely important legislative change would be for an expert panel, as in other states, or at the very least an inquiry into the bill itself to ensure that it has all the necessary safeguards.

I support the principle of this bill, but I am concerned about the process. I am concerned whether there has been adequate consultation with the drafting of this bill, as it is expected that any VAD legislation would be thoroughly consulted with all key stakeholders - for example, patients, community, palliative care providers, doctors, pharmacists, nurses, ANMF, HACSU, medical educators, medical colleges, the AMA, the legal profession, insurers, and the list goes on.

It would also be reasonable to expect that any VAD legislation would be very carefully and thoroughly considered by parliament. It must contain all the checks and balances, legal and professional protection, as well as safeguards to protect all patients, including the most vulnerable, providing confidence to all.

I understand that many people cannot accept VAD because of their personal religious beliefs. Most people have some form of religion in their lives. I was brought up as a Catholic, as well as my sister, yet we see our religion very differently, and that is life. Who is to say who is right and who is wrong? I do not believe either of us are wrong. We just believe differently. To me, to be a Christian is to live a good life. We should be honest, generous, work hard, love and care for others, and never hold grudges. Life is too short to be angry. My mother used to say, 'Live in the moment and make every moment count'. My mother had an advance directive. She told the hospital staff she did not want to be resuscitated, and no amount of talking to her would convince her otherwise - and we tried.

I have also had many doctors contact me, both for and against. Initially, some were much against this bill - and later those same doctors, while still not in favour, their attitude had changed to one of acceptance that this bill could go through, and they simply wanted it to be as robust and safe as possible.

There are quite a few areas of the bill with which I have concerns. As mentioned previously, my personal preference would have been for this to have been a government bill, with perhaps a ministerial expert panel as existed in Western Australia guiding this process. However, this was not to be, and we need to work with what we have.

I have heard the member for Mersey's reasoning as to the inclusion of the review to include children. That is one clause I certainly cannot accept, and I would certainly vote against that clause. There are many other clauses I have some concerns with, but rather than go into detail now on the second reading, I will speak to those when they come up, when and if we get to the Committee stage.

I have also appreciated the many briefings on this bill, both for and against, in particular, those briefings from the doctors in Victoria who are currently delivering voluntary assisted dying. I note their comments that it is sometimes the case that people have the medication, but never take it. Simply having it there gives people a feeling of relief, and removes much of their anxiety with their illness. Knowing they have a way out if they need it. It is important to again make clear that everyone should have the availability of top-quality palliative care, and it should not be voluntary assisted dying or palliative care. They can work together, and we were told many people are very clear about their views and wishes at the end of their lives.

Sometimes there is nothing palliative care can do - and sometimes with certain illnesses choking can be the way they die, and that would be a terrible death. What right do I have to deny someone the right to die peacefully, when the alternative death can potentially be horrible? I feel I need to respect other people's wishes at the end of their life. As I do not have the right to tell people who are suffering intolerably with a terminal illness that they cannot participate in VAD, I feel I must support the principle of VAD.

A couple of years ago, I was speaking at a nursing home, and one gentleman in the back of the room was in a wheelchair and could hardly move. He called out and he said to me, 'I want to die'. When I asked him why he wanted to die, he told me he had motor neurone disease and he knew the death that was coming. He knew he was not going to get better, and he simply wanted to die before he had a terrible death that he could not control.

There are some very sad cases. I have heard many times that sad cases and hard cases do not make good laws, and I appreciate that. I do believe that we need to do the very best we can and provide choice for people. We know that people sometimes take their own life in a horrible way. Should a hanging or other suicide to alleviate pain go wrong, it can be shocking, not only for the person but also for their family - and someone always has to find them.

I believe that no medical person should have to take part in voluntary assisted dying, whether it be for personal, ethical, religious or other reasons. They should not have to give a reason. It should be the case that the patient raises the subject of voluntary assisted dying with their medical practitioner and not the other way around.

Interestingly, recently in one of the many conversations I have had with the medical fraternity, it was suggested to me that a palliative patient, perhaps without food or drink or medicine and only on morphine, was not suffering. But who would want to put their loved one through such an undignified death, with dehydration, organs failing, and families sitting, waiting and watching for that person to fade away? I contend in that case everyone suffers, whether the patient feels anything or not. What a horrible death.

I accept that this bill may have many changes, many of which are likely to come up and I will support if and when it goes through the Committee stage, but I will support this bill through the second reading into Committee.

[8.08 p.m.]
Ms SIEJKA (Pembroke) - Mr President, I wish to begin by thanking the member for Mersey for introducing this bill. Your efforts in ensuring we have considerable and quality information before us from all sides of the debate are admirable and much appreciated. My contribution will be limited to the principle of this issue, although it is informed by the evidence that we have received.

As an individual, this debate feels all too raw for me, as my father has recently been diagnosed with stage 4 pancreatic cancer. As such, my contribution will be relatively short, but hopefully just as meaningful a contribution to the debate.

I have always been a supporter of voluntary assisted dying. It was a conversation held long ago with my grandmother when I was just a small child when these opinions were first established. As background, my grandfather worked as a matron at Royal Derwent, after having served in World War II. In those days medicine, disability and aged care support was far from what it is or could be today.

My grandmother would often talk about those poor souls who were in nursing homes. She saw these people as without family and in very sad circumstances, living in equally sad environments. She would often say that if she ever ended up there, then she did not want to be alive. In her mind she had lived a good life, and did not want it to end without control, in an environment and with the care of her choosing. My grandmother was lucky in that she had a short illness and did not suffer for long, being able to stay in her own home until a brief period in hospital before passing away with all her loved ones around her. These conversations with my grandmother led to longer conversations with my mother. We spent a lot of time in the car together on the way to school in New Norfolk so there was always ample time for a curious girl to ask questions. It was at this early time that I learnt of and became curious about and formed some of my views on this matter.

Now today my sister is a passionate and caring aged care worker and I am the shadow minister for ageing and for disabilities, two such cohorts that may well be impacted the most by our decisions related to this bill.

You might argue that opinions like these are formed largely on emotion. I wholeheartedly reject that as what followed has been a lifetime of learning. I believe that one can have both an emotionally intelligent understanding of an issue, as well as an intellectual understanding of it. The complexity in competing demands of this matter, the desperate urge to have your loved ones with you as long as possible but for them to not suffer, all whilst experiencing the roller-coaster of hopes, resignation, fear and loss as a dying person's journey unfolds.

As I mentioned at the beginning, my father has recently been diagnosed with cancer. Pancreatic cancer is terrible. It has one of the lowest survival rates, the shortest time to live, and few treatment options. More people die from pancreatic cancer than do from breast cancer each year. The symptoms are not obvious so most are diagnosed once the cancer has taken hold. Patients are only given a 10 per cent chance of survival beyond five years. Stage 4, of course, is a much shorter time frame.

When Ivy was born, all my dad could say at first was that we are so lucky. He was overjoyed and in love with her immediately. I am so glad he has had the opportunity to meet her but sadly it could be argued that his luck ran out not long after. Separate scans only three months apart show a healthy pancreas and one ridden with cancer, along with a spot on the liver. Given the speed at which things can change, I can see how difficult it would be for one to consider voluntary assisted dying, let alone make that decision. Of course, like everyone my hope is for my father to stay with us as long as possible, but his story is just one of many in the community.

We have all heard from many people of their own experiences, from their families and from stakeholders in emails, letters, meetings, submissions, briefings and calls. We have heard that the experience of no two people will be alike. All individuals' experience of pain and suffering and how their illness unfolds varies greatly. We have all known and heard from people who have suffered greatly and for a long time, with their quality of life long gone and no hope or expectation for improved palliative care options, let alone a cure.

My portfolio areas of aged care and disability include our most vulnerable people in the community. Aged care clients are considered the most vulnerable in our community and people living with a disability our second most vulnerable. Many older Tasmanians and people living with disabilities have contacted me directly, most in support of voluntary assisted dying and this bill.

Voluntary assisted dying is not about everyone choosing to utilise that option or to even consider doing so. It is about those who want to do so having autonomy and choice. In my mind, in the absence of cures, when suffering is great and options for care are limited, this is the least we as a community can offer. However wonderful modern medicine can be, cures cannot always be found. Suffering cannot always be alleviated and choices are not always available.

What I would want and what I want for others is choice. As raised by the Council on the Ageing in its submission, I also believe that giving an individual choice at the end of their life can assist them to live a longer and more satisfactory life. Where pain and suffering cannot be alleviated, voluntary assisted dying provides an important alternative.

It is essential that thoroughly considered safeguards are put in place. This includes rigorous governance protections for vulnerable people and processes to inform, enable and support all who are involved in this process. But through this process and with safeguards in place, I maintain that an individual's right to choose should be paramount. Voluntary assisted dying is for people who are already dying and who are suffering. It is for people who have exhausted all other options. As we have heard in the lead-up to this debate, it is for people, sadly, who are already taking matters into their own hands, alone.

I have considered this bill in full, held discussions with colleagues, constituents and my networks. I have examined and analysed information and evidence extensively, read the opinions of many and heard the experiences of others.

It is my firm belief that voluntary assisted dying is necessary. At this stage I will leave others to go into the merits of the bill in more detail and I will leave my contribution at this and I look forward to hearing the progress of the bill.

[8.15 p.m.]

Ms WEBB (Nelson) - Mr President, speaking on the End-of-Life Choices (Voluntary Assisted Dying) Bill, I begin by thanking the member for Mersey deeply for the time, the effort, the intellectual commitment, the values-based approach, the respectful engagement and the significant personal investment on every level he has brought to this effort, to have us today considering this bill.

I acknowledge the support he has had from many people, and he has spoken about that and named some, but the network is vast and there are many people with an investment in the debate we are having here today.

I acknowledge those who have previously brought this matter to public attention and generated discussion, examination, refinement and our understanding of this issue and those who have brought previous bills that also at their time, progressed that public conversation. In particular, the Honourable Lara Giddings, previous premier of the state, now Senator Nick McKim and Cassy O'Connor, the Leader of the Tasmanian Greens.

My third acknowledgement I will make before speaking in detail is to those thousands of Tasmanians who have engaged with us on this issue, through petitions, emails, through phone calls, letters - typed and handwritten; I read and appreciate all - and through the personal discussions that many of us have had with many people.

This is not an easy topic. For many it is highly personal. In many cases it directly relates to deeply personal experiences, often distressing and in other cases, it connects to deeply held beliefs and values.

That we have had the opportunity to hear from Tasmanians and share in those personal, important experiences and views is a real privilege. The member for Mersey tabled a document in this place which includes personal stories from many Tasmanians and they are only the tip of the iceberg.

In my contribution here today, I am not going to bring more of those stories forward or introduce more into the debate, but I recognise the ones we have received. Though it has been difficult and distressing, as acknowledged by other members, I have read all that have come through my inbox, my letterbox and through my phone.

There is always a risk to opening up community conversations on such fundamental life and death issues, a risk that in doing so, we will cause pain, additional suffering and moral distress. It is a risk that we will cause division and antagonism, and I recognise that risk and we have probably all felt it as we have progressed through this experience.

The fact is, that different views do exist on these matters. They already exist and can already be a matter of pain, suffering or even of distress. Engaging in the conversation provides a purposeful opportunity by which we can ultimately move to better resolve these matters.

What we do next, after the conversation, after this legislative decision has been made, will be most important in ultimately delivering a less divided and better supported Tasmanian community, regardless of the outcome.

Often in matters of gravity that relate to life and death, change does not come about as a result of single moments or single decisions. It comes about from sustained effort over time. We have had a long pathway towards the decision today, and should this bill pass, we will have a substantial period of transition and adjustment as it becomes part of our societal landscape. Should it not pass, we will then continue on a pathway and may encounter the conversation and another decision at another time.

The overwhelming majority of people in our community agree with the fundamental idea that people should have an opportunity to bring their life to an end with dignity in the context of an advanced illness and in the face of significant suffering. Decisions and actions relating to end-of-life care are being managed in a range of settings every day in hospitals, hospices, aged care facilities and private homes. For time immemorial we have been faced with these decisions. In particular, doctors and other health and care professionals are faced with situations and decisions that relate to this, in some cases with uncertainty and limited guidance and protection. But they face this regularly.

Many people regard as fundamental their right to bodily autonomy; their right to make choices about the nature and circumstances of their death. They view the lack of options currently available to give effect to those personal rights to be a breach of our obligations as a society. I see it that way too. Canadian provinces established their VAD laws after a decision of the Supreme Court of Canada found that to deny access to voluntary assisted dying was a breach of human rights and was contrary to the Canadian charter of human rights.

It is interesting to note that Victoria was the first state of Australia to enact a VAD act in 2017. It too was the first jurisdiction in Australia to have a Charter of Human Rights and Responsibilities Act. In the context of this VAD debate, I would like to see a human rights act for Tasmania. Such an act would provide a basis on which we can discuss matters such as voluntary assisted dying. It would be a standard against which we could better measure protections. It would also help us make determinations when balancing competing rights against each other and commit us to the aligned responsibilities that come with a framework of human rights.

In the absence of a human rights act in this state, I still contemplate this issue as one of rights and a decision about how best to give full effect to the rights of the people of Tasmania. In the communications we have received from Tasmanians in support of VAD, some of the common sentiments include the view that people should be able to make their own choices in relation to their death. No-one should have the right to tell a person they must suffer unnecessarily in the process of death.

Questions that commonly come through include: Why, when people are able to decide to stop treatment, are they not able to ask for release rather than suffer a slow and lingering process of death once the treatment has been stopped? Why, when a person is imminently going to die, can it not be on their own terms? We talk so readily of how we can best achieve quality of life. Equally we need to acknowledge a conversation about quality of death. It is complex to do so during such times that those two things may need to be contemplated concurrently, at the end of life during end-of-life care.

I acknowledge that some people will approach this issue very differently to me. Perhaps the starkest difference will be found in those who have a moral objection or a faith-based objection to voluntary assisted dying. I do not hold such an objection or such a principle. I note that consistent surveys find that the majority of people of faith support a voluntary assisted dying option being provided as part of end-of-life care. However, there is a distinct minority within the community who find they cannot support it on the basis of their faith or their moral value space. This is also the expressed position of a number of religious institutions.

I respect the right of people to hold this view and for it to be expressed. I respect the right of people to make choices in their own life according to their values and morals; however, I find it problematic when some seek to impose their moral or faith position on others, or to constrain the options available to others in alignment with their moral, personal or faith position.

While people arguing from this moral or faith basis often pivot to points about inadequate levels of protection for the vulnerable or the potential for abuse in relation to the VAD, my observation is that for many in this category, there will never be any circumstance that makes voluntary assisted dying acceptable. There would never be a level of protection offered in any piece of legislation drafted on this matter that could be supported, in their view. That is a valid view to hold. My preference would be for people who hold such a view to prosecute arguments on the basis of their fundamental belief and values and not engage in what amounts to a smokescreen of objections on other matters of detail, the resolution of which would still not satisfy their fundamental objections. I would also prefer to see a commitment from all not to use misinformation, unsubstantiated evidence and misleading claims in the prosecution of these arguments. The vast majority of Tasmanians do not hold the view that VAD is morally wrong.

The vast majority of Tasmanians want us to find a way to provide an option for voluntary assisted dying in the end-of-life care. I believe the question is no longer, 'Should we do this?' Rather, it is, 'How shall we go about this as best we can?' What this means is making decisions on the level of risk we are prepared to accept because we cannot eliminate it entirely. We can, however, make determinations on how to balance and address risks based on evidence and we can resist the temptation to be drawn into consideration of fearful or unsupported assertions.

I believe we can and will find an acceptable and responsible balance between rights against protections. Delivering that in legislation is possible. It will not be a perfect piece of legislation if it passes this Chamber. There is no such thing as a perfect piece of legislation, nor is legislation fixed and permanent. If the bill is passed now, over time, as with all other legislation, there will come occasion for it to be reviewed, amended, added to or even repealed.

A concern that I hold is that in the interests of seeing this bill passed on behalf of the Tasmanian community, we will likely deliver a piece of legislation that does not represent best practice and best thinking on this issue, that it will be made restrictive to an unnecessary degree. I say 'unnecessary' not because there is a need for anything less than the highest level of protection and care in relation to VAD, but because I contend that a requisite high level can be provided under less restrictive and burdensome legalities than exist in some other jurisdictions and to some extent exist in this bill.

It is my concern that we may mimic these more restrictive and burdensome legalities that are not demonstrated to be necessary to provide a higher level of care and protection but have rather been found to present barriers to access for some who may be eligible and have a desire and need to access the VAD option. By holding these concerns, I also accept that politically it may be that this approach is required to secure parliamentary support. It also may be that such an approach in its perception of a more robust set of protections could provide additional reassurance to the public and to medical practitioners and, indeed, to parliamentarians.

I would like to speak about how I see the relationship between voluntary assisted dying and palliative care because it comes up as a key part of any discussion on this matter. In essence I see no incompatibility in having an excellent, well-funded and supported palliative care system and an option for voluntary assisted dying as part of end-of-life care.

I see no reason that we have to pitch them one against the other; that one obviates the need for the other or that they are somehow mutually exclusive. I see a partnership between the two. Interestingly, I heard the member for Murchison in her contribution refer to some advocates for VAD saying that it is the only way to achieve a dignified death. I have to say I have never heard any VAD proponents or advocates say such a thing.

I have heard opponents to VAD make claims that palliative care should be the only permissible option and is an appropriate option in all cases. I have heard an absolute claim made from that side of the debate but I have never heard an absolute claim of such a kind made from VAD proponents. Perhaps we have heard from different stakeholders.

Credible expert advice indicates that even with a high standard of palliative care there will always be a small percentage of people whose suffering and pain and distress will not be effectively managed. The reality we see from other jurisdictions is that many of those who access VAD will likely also be palliative care patients and have a successful and positive experience of the palliative care system through to the point that they have chosen to access VAD.

During consultation on this bill, I have heard from some the palliative care system and options are not currently well understood in the general community and that there can be a reluctance in the community to access palliative care. I have also heard there are longstanding issues of palliative care not being adequately funded, supported or accessible to all Tasmanians. I believe these observations that have been made to me; however, I regard any current deficiencies in community understanding of palliative care or the overall funding of or access to palliative care to be matters quite separate to this VAD legislation. It is for the government of the day to make decisions about the level of funding and support provided for palliative care. That is true now and it will remain true in the future should an option for voluntary assisted dying and end-of-life care be legislated for in Tasmania.

Insisting that a perfect palliative care system is achieved before making a voluntary assisted dying option available is an insurmountable and unnecessary barrier, especially as we know that even a perfect palliative care system will not be sufficient to meet everyone's needs. Further, it saddens me some advocates who use this argument for better funding of palliative care services to oppose VAD do not seem to be vigorous and visible advocates for better funding and support of palliative care outside of the context of the VAD debate. If the current deficiencies of palliative care are so apparent, which I believe they are, and the rectification of these deficiencies is so essential in removing the need for a VAD option, I wonder why I have not observed these same individuals or groups at the forefront of an active public campaign for better funding and support for palliative care in Tasmania.

Over the time we have periodically had public or parliamentary discussions about VAD some of these voices emerge to point to a need in palliative care and then once the VAD discussion quietens, so too does their call for better palliative care. It almost looks as though some of those calls are a debate device utilised in an attempt to prevent a VAD option becoming available rather than a genuine commitment to see better palliative care options available to Tasmanians.

That is a real shame because palliative care needs all the allies and support that can be mobilised for it, and I hope all those who have come to us with concerns and assertions about the need to better support and perfect palliative care in this state in the context of this debate will continue to prosecute those arguments and be advocates after we have concluded this debate, regardless of the outcome.

Should this bill come to pass, there will need to be comprehensive discussions about how the implementation of VAD can best intersect with and work alongside the palliative care system in Tasmania. I hope to see a concerted focus on education, information and the primary importance of developing and continually improving how we support and communicate about end-of-life care issues.

Another key matter understandably raised in discussion of voluntary assisted dying is a concern for the vulnerable elderly members of our community. I began my working life in community aged care. I went on to manage a volunteer befriending program for isolated older Tasmanians and when I eventually began working in social policy research and advocacy, I maintained a strong interest in and affinity for social policies related to older people. including spending time on the Policy Council for Council on the Ageing Tasmania.

I have been involved in advocacy regarding elder abuse for many years. I was one of many who celebrated when the state Government finally funded the development of an elder abuse strategy, after years of advocacy from the community sector and older Tasmanians. I was on the board of Advocacy Tasmania when it was funded under that strategy to provide the Elder Abuse Helpline.

On the issue of providing an option for voluntary assisted dying, I see two sides to be considered when it comes to older Tasmanians. Their right to be protected if vulnerable and their right to self-determination and empowerment to make important choices affecting their own lives and deaths. A common negative experience for older people in our community is a loss of empowerment and choice as ageing occurs, particularly, as frailty and vulnerability increase older people can experience a progressive stripping away of self-determination or control of choice. This loss of self-determination has an impact. I see that the loss of these things can cause grief, distress, anger and can lead to a loss of sense of meaning and contribution and purpose, and a disengagement from life.

A central tenet of our aged care system recognises this, and holds that we should be helping people maintain their independence for as long as possible, and we should be empowering people with choice on matters to do with their lives for as long as possible.

Knowing you can exercise choice is empowering. It helps to maintain meaning, to build hope and to promote engagement. Empowerment reduces vulnerability and increases quality of life.

Mr President, we continue to be challenged as a community to better address the empowerment and the care of our elders. The COVID-19 pandemic has certainly exposed our failings on many fronts when it comes to elder care. In the context of this debate, we are prompted to consider what impact the introduction of a VAD option in end-of-life care will have on the rights, wellbeing, empowerment and care of older Tasmanians.

It is my personal belief that the simple existence of the voluntary assisted dying option as part of end-of-life care, knowing that the choice is available if necessary, will be fundamentally empowering to older Tasmanians. It will provide reassurance and reduce distress. That is a personal view, Mr President, but it is confirmed anecdotally, on the one hand, in the large number of direct communications I have received from older Tasmanians stating that it is the case.

It is also confirmed by the fact that the peak body representing older Tasmanians - COTA Tasmania - has given consideration to this issue via its Policy Council in consultation with its members, and has taken a position in support of this VAD bill in support of older Tasmanians being empowered to have a choice.

Mr President, I am aware that some people fear that the provision of a voluntary assisted dying option in and of itself will devalue the lives of elderly Tasmanians. That fear has been expressed to me in communications I have received in recent weeks. Some have expressed a fear that it will create an expectation amongst the elderly that they should remove themselves as a burden on their families and community, and that it will encourage them to judge their own lives as lacking value and make them susceptible to being coerced into requesting assisted dying.

I accept that these fears are held by members of the community, but I have not - and I have looked - seen any credible or compelling evidence that this is what has occurred in other jurisdictions, or that this is what would be likely to occur in this jurisdiction.

I cannot say that this is not the case; however, I cannot rule it out. But I can look to best evidence and best indications. The briefing we had this morning helped to confirm that a range of robust evidence, from jurisdictions that have voluntary assisted dying, have not furnished any clear indication that people who are vulnerable become more likely to be harmed under this sort of legislation.

Mr President, if the presence of an empowering choice in clearly defined end-of-life circumstances further exposes some of the existing failures we have in the support, care and the community regard that is given to older Tasmanians, that should be a strong impetus to rectify such failures - but not an argument to block the choice of VAD being provided.

I am going to talk a little now about language. We currently have a situation where some people are making the decision to end their lives prematurely when they are faced with a terminal illness, and without an option to be assisted to manage their death in the latest stage possible - to commit suicide, in effect. We have heard statistics on this already from other members and I will not repeat them.

In these cases, to ensure that they still have the physical capacity to do it, people have to take action to end their life at an earlier stage than they would otherwise have chosen. In doing so they miss out on precious time with family and loved ones, time they would otherwise have had, if an option for voluntary assisted dying existed. They have to take that action in isolation from the family or other support, and the method for ending their life in many cases will be violent and could be uncertain in its outcome.

Furthermore, this not uncommon scenario can also expose others to distress, first responders or others who may discover the person, either deceased or not having achieved a fatal outcome. I find this an appalling situation. I find this an entirely unnecessary situation. Because we have tangible evidence that tells us it is occurring, it is something we have to contemplate quite distinctly as we think about the passage of this bill, because unlike other assertions, fears or concerns expressed that are theoretical and do not have an evidence base or numbers to put to them, this one does.

In recent public conversations generated by this bill, we have seen many conflate voluntary assisted dying with suicide. The COTA Tasmania paper expressing its position on this issue touches on this and points out that attempted suicide is quite distinct from an enduring, considered and rational decision to end one's life in the face of unbearable suffering. I agree with the position put forward by COTA on distinction between the two. I have also heard the member for Mersey and others articulate a distinction between voluntary assisted dying and suicide, where suicide is the choice between life and death and voluntary assisted dying is a choice between two forms of death. That distinction also resonates with me.

I have also seen many communications from people insisting that voluntary assisted dying should be called suicide, as according to a dictionary definition that is what it is, a personal voluntarily ending their own life. That has been expressed in a number of communications to me in recent times. We know this is not just an issue of semantics. People use language with intention. In the course of this community discussion and debate each side is being specific and purposeful in the language they use, particularly in relation to the use of the word suicide.

With supporters of voluntary assisted dying taking pains to make a distinction with suicide and not use that terminology, while in materials distributed, I note, in parishes to encourage churchgoers to write to parliamentarians on this issue, campaigners against voluntary assisted dying, amongst other instructions, specifically instructed letter writers always use the word 'suicide' when referring to voluntary assisted dying.

Why does this matter? It matters because language has an impact. Beyond the dictionary definitions, suicide is a word laden with emotions, with judgments, stigma and assumptions. It is also a word that carries significant pain, grief and loss for many, many people in our community. For those of particular faiths, it can also be a word laden with eternal consequences. Suicide is fairly universally seen as bad, a negative; it is painful. Many of those in support of voluntary assisted dying want to present it as a positive option and so they assume the negative connotations of what they regard as the inaccurate characterisation of calling it suicide. I do not believe their choice to do this has any unintended impact on the community and I do not believe it damages the integrity of the debate for them to make this choice around language. However, many of those against voluntary assisted dying want to paint it as a negative in every possible way and so purposefully link it to suicide. That has an impact, a negative one I contend, among many people living in the community right now.

I hope much of this impact is unintended by those who use that language but, regardless, it is damaging to people and damaging to the integrity of this debate. Suicide is something that has touched my family and my life, and this aspect of the debate has occupied my mind in recent times. I must admit it is an aspect of the public discussion that I find somewhat distressing and which, as a result, also raises my ire. I do not like seeing what I regard as purposefully hurtful words and actions used to scare people toward a particular position. I do not believe it is an action of integrity.

As I was considering these matters of language, and in particular the use of the word 'suicide' in the context of VAD, I happened upon an interesting analogy. It is an analogy that perhaps illustrates, in a different circumstance, the distinction between a choice of life and death, and a choice between two forms of death.

Let me describe the analogy. It is from a time just recently when I was reading articles reflecting on the anniversary of the 9/11 event in the United States. I read an article about people who were photographed falling from the towers while the fires were raging inside. I think we would all recall those images from the time. Apparently, there were many, many people who jumped from the towers before they collapsed. Those people were faced with certain death - either infernos inside the buildings, which would have caused their death through smoke inhalation or incineration, or falling to their death from the windows. Reading this article made me wonder. Would we say that those who jumped to escape the inferno had committed suicide? I do not think we would, although technically, according to a dictionary definition, it could be labelled as such. They chose to take an action that ended their lives. They could have chosen to stay in the building and be burnt to death in an inferno, or perhaps perished when the towers collapsed. They jumped, and in doing so I personally do not think they suicided.

This analogy is far from perfect, but I found it an interesting one to contemplate, and it resonated with me as part of perhaps illustrating the distinction that we had heard articulated previously.

I think the vast majority of average reasonable people would make a clear distinction in the actions of those people jumping from the towers - between that and suicide. I similarly think the vast majority of average reasonable people would make a clear distinction between VAD and suicide. I think they would readily identify that the elements that are commonly associated with suicide - of depression, despair, desperation, self-harm, violence, not to mention the tragedy, the shock, the loss, the grief and unanswered questions of those left behind of suicide - are not comparable or similar to the circumstances of voluntary assisted dying.

In voluntary assisted dying, I think most would readily identify the purposeful acceptance, the rational and considered choice, not to mention in many - if not most cases - the loving involvement and care of family members, and loved ones provided with an opportunity to say a meaningful and conscious goodbye.

I am generalising here, because we cannot make absolute claims, just in the same way that we cannot take individual anecdotes to be representative of the whole.

Mr President, I suggest that all those who insist on calling voluntary assisted dying 'suicide' reconsider this choice, particularly once VAD legislation has been passed in this state, which I think it will be at some point.

Once we have determined, as a community, that an option for VAD as part of end-of-life care will be legally available, I invite those same people to think about the impact of labelling some Tasmanians who begin to make that choice at the end of their life as committing suicide.

I invite them to consider, then, the impact that characterisation would have - especially on families who, in general, would support the choices made by their loved ones.

I invite them to consider how the use of this characterisation fits with the compassion and the love that I am sure are also key components of their values or faith.

Mr President, I will move on to just a couple of matters from the bill.

I am pleased that the member for Mersey is proposing to amend the tabled bill to include a set of objectives and principles. In my view, these are required to provide a context and points of reference through which to understand and interpret the bill. I have high regard for the set of guiding principles in the Western Australian bill, and will be supporting the amendment to include such in this bill.

I also believe these principles will have resonance beyond the functioning of this legislation. I hope they will also serve as a strong prompt for review and assessment of some other associated concerns and issues raised in the context of this VAD debate, in particular, matters relating to elder and palliative care.

I will speak on the eligibility requirement of the relevant medical condition in clause 5. This bill requires as an aspect of eligibility, the person has a relevant medical condition and it is defined as 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 and also with no reasonably available treatment that is acceptable to the person and can cure or reverse the disease, illness, injury or medical condition and prevent the expected death of a person from the disease, illness, injury or medical condition.

I find this definition comprehensive. An important element in the definition is the word 'advanced'. A concern has been expressed from some that this bill will enable people to access voluntary assisted dying in the early stages of a condition that may ultimately be incurable and cause their death.

Under my reading of this legislation, that would not be possible as it would not meet the eligibility criteria written as it currently stands. I am interested to see further discussion of this in the Committee stages when we have questions on this and answers from the member for Mersey.

This definition strikes the right balance between establishing a clear and appropriate requirement without creating such a high bar that would limit access to an unnecessary degree. I am also not especially convinced by a need to include prognosis time frames. This is something we will probably discuss and talk about in the Committee stage and I will engage in that discussion then.

I will talk about the decision-making capacity in clause 11. An important aspect of eligibility in the bill is the confirmation the person has decision-making capacity. This is a familiar concept in the medical and legal sphere and is well dealt with in the bill. The bill has a number of safeguards, including the requirement to refer to a specialist for an additional determination if the medical practitioner involved in the VAD process is not able to make a clear determination. There is also a safeguard of at least two medical practitioners involved in the process overall and in the confirmation of eligibility.

I am reassured that if decision-making capacity in relation to voluntary assisted dying is lost by the person, then the process cannot proceed because the essential element of voluntariness is the ability to change your mind or withdraw from the process at any stage and that would no longer be present.

This bill includes the accepted approach that decision-making capacity is to be assumed unless determined otherwise, which I agree with. No doubt, as in other jurisdictions, the matter of decision-making capacity will be a key part of the training for medical practitioners in relation to voluntary assisted dying, should this bill go ahead and it becomes established in this state.

On the matter of voluntariness in clause 12, this bill rightly covers legal matters relating to voluntariness including duress, coercion and threat. It has been a commonly raised concern by many who oppose this bill, that vulnerable people, especially elderly people, may be subject to family members or others acting in bad faith and insidiously influencing them to request voluntary assisted dying.

There are robust protections against coercion in the bill we are considering and those protections would identify reliably instances of intentional influence. I am confident that it would be extremely difficult, if not nigh impossible, to progress through the full VAD process legislated in this bill, under coercion or insidious influence.

I am confident it would be near impossible to progress through it in the absence of a strong, active commitment of the person themselves, to the choice they are making. Speaking directly with medical practitioners involved in the voluntary assisted dying process in Victoria has provided me with additional reassurance on this. It will still be a matter of some discussion and debate as we go through Committee stage.

I will talk now on the more complex matter of suffering intolerably, which is in clause 13 of the bill. The bill requires that to be determined eligible, a person must be suffering intolerably in relation to a relevant medical condition. The only way the presence of suffering and its degree of tolerability can be assessed is subjectively from the person's point of view. We are not called on in this bill to compare one person's suffering against another or to measure in some form the quantum of suffering, nor to make an objective judgment about the person's ability to tolerate that suffering.

We are not establishing an objective threshold or a quantifiable test such that we can say to a person, 'Yes, you are suffering a sufficient amount to meet the requirement to access voluntary assisted dying'. We are reliant on the person's subjective assessment of both those elements, the suffering and its tolerability. The bill says there must be persistent suffering that is in the opinion of the person intolerable.

That suffering may be caused by the medical condition or anticipation of the suffering in relation to the medical condition; the treatment for the medical condition or anticipation of the suffering in relation to the treatment for the medical condition; complications arising from the medical condition or anticipation of the suffering in relation to complications from medical condition; and there must be no reasonably available treatment that is acceptable to the person that will lessen the person's suffering to an extent that is acceptable to the person.

In the bill, this is a wordy and complex clause when you read it in full. I gave a very brief summary of it there. This section shows it gets complex when you try to describe and include all the ways relative to a relevant medical condition that someone may be suffering. I suspect this may be why in the US jurisdictions that have implemented voluntary assisted dying there is no requirement that a person be suffering as part of their eligibility test. Perhaps this is in recognition of the fact that this element of the person's circumstances is entirely subjective. To some extent, it is a given that it exists as an element of their motivation to make a request for voluntary assisted dying.

Perhaps it acknowledges the fact that there is something almost perverse in requiring a person to demonstrate a degree of suffering which in some way earns them the right to access voluntary assisted dying. It certainly becomes complex and problematic to bring it into the legal framework. The inclusion of the concept of anticipation of suffering in clause 13 in relation to the relevant medical condition or the treatment for or the complications from that condition gives some people pause.

When I first read this bill, it gave me pause too. In this context I believe it is reasonable that the anticipation of inevitable suffering is in itself recognised as a form of suffering. I believe that it would be meaningless to require people to distinguish between their physical, mental and emotional suffering within the context already provided by the definition of a relevant medical condition, remembering that it is advanced, incurable and expected to cause their death.

Remembering that the person is already required to have those elements in their relevant medical condition as part of their eligibility, it would be my preference, perhaps controversially, to remove from this legal framework for voluntary assisted dying the eligibility requirement for intolerable suffering. I believe it would remain in our shared concept of the purpose and intent of having a voluntary assisted dying option and in practice we could predict that it will be a common and inevitable element of the picture for those people accessing this option.

I do not think that intolerable suffering can be a legal test for eligibility. Let us talk it through. To assess this, I will pose a question and we can contemplate it. Is there a circumstance where all the other eligibilities are met and that we would deem someone ineligible for voluntary assisted dying on the assessed absence of intolerable suffering? If we cannot contemplate or imagine that situation, that someone meets every other requirement of eligibility in this bill and we have arrived at an assessment that their suffering is not intolerable or in some measure able to be quantified such that we can tick that box under this bill; if we cannot then say no, they are not eligible, that element of eligibility in a legal sense is meaningless. It is window-dressing. This is likely to be a controversial thing and I certainly will not be moving an amendment in relation to it to test it. I am merely expressing my view here that in terms of a legal framework, that element, I think, is more for the benefit of us as legislators, the general public, and perhaps medical people who are involved in this bill. It is more a reassurance or perhaps a sense of safety that we have articulated it in the legal framework.

Ms Forrest - Do you not think it is a bit of a community expectation though, when you think about the community debate around this, and that is their understanding?

Ms WEBB - Absolutely. As I said, what I think is that we would always have it as part of our conceptualisation of voluntary assisted dying as an issue as a matter for community. We would always imagine that suffering is part of that.

Ms Forrest - So why would you not have it there then?

Ms WEBB - Because this is a piece of legislation and it is in the eligibility requirements which means that it is a test for eligibility. As I have just described, if someone were to meet every other element of eligibility, can we contemplate a situation in which they would do that and then we would say they did not meet that intolerable suffering eligibility test?

Ms Forrest - Why would they seek it if they were not suffering in some way?

Ms WEBB - Exactly my point - why would they? So therefore it should be an assumption. It is not a legal test. We cannot test for it legally as a matter of eligibility. Of course, in almost every sense we cannot imagine it not being there.

Ms Forrest - Because, I mean, you can - that is an assessment that health practitioners make all the time. We ask people what is your pain score out of 10.

Ms WEBB - Yes.

Ms Forrest - And we believe them when they say it is 10 or 9 or 2.

Ms WEBB - So what I would put to you is that in every circumstance we could imagine where someone comes to request voluntary assisted dying who meets every other eligibility criterion described in this bill, can you imagine a circumstance - medical people - in which they would not have described that they are suffering intolerably? It will be part of their picture. It is not something we can legally test for because the bill says we take their subjective assessment of that. We take the person saying, 'I'm suffering intolerably'.

We are not legally testing for it. We are never going to exclude somebody from voluntary assisted dying on the basis of not meeting that eligibility criteria. It is legally superfluous to the bill. Of course it will be part of our common community understanding.

Ms Forrest - It is an interesting comment. I mean, if you are going to go down that path, you take it right away from the medical profession altogether. Why would we have the medical profession there to make an assessment at all?

Ms WEBB - So the medical profession here is required to - we are getting into a debate that may be better put during the Committee stage. I will wrap things up but I put to you that the medical profession is required to assess the eligibility requirement that relates to having a relevant medical condition -

Mr Gaffney - I will let you two girls do it during the Committee stage.

Ms WEBB - But that is where the medical requirement absolutely has to be there as part of eligibility assessment. When eligibility is being assessed there is residency, there is age - they are fairly straightforward -

Ms Forrest - Anyone can do that.

Ms WEBB - Exactly. And then the thing that has to be determined is that the person has a relevant medical condition as defined in the bill. Only medical people are going to do that. If it has to be determined that the person has the capacity to make a decision, only medical people are going to do that and it has to be determined that the person is acting voluntarily. Only medical people are going to do that. So that is where the medical people come in.

You will not be making any objective assessment of people's level of suffering and ability to tolerate that suffering. They will say to you it will be there; it is not a legal test. As I said - I thought this might be a little bit controversial - I am not going to move an amendment on it. I think it gives everybody comfort to have it there. It does reflect our common understanding. I do not think it is a legal requirement to have it there. I think it is a meaningless legal matter to have in the bill.

I bet I will get picked up on that by many people, but I am just saying there are certain things we test for with eligibility, and that does not have to be one of them.

Ms Rattray - It might take the member for Mersey's headline in the morning, I think.

Ms WEBB - Just to be clear, I am not saying people are unlikely to be suffering intolerably. I think it is highly likely 100 per cent of people accessing this - were it to be an option - would be suffering intolerably. I think it is the way we would understand this sort of process to work. It is in our common conception of voluntary assisted dying. It just does not have to be and is not relevant to be part of the legal assessment.

That went on for a bit longer than intended. Apologies, Mr President, and members.

I am going to speak briefly about the medical practitioners' involvement in this bill and we have touched on that a little bit there already. There is some sensitivity around it and I know there is a lot of debate and discussion in relation to the roles and the framing of the involvement of medical practitioners in this process. I acknowledge that views among the medical profession do vary on this matter, broadly and generally, but also on the detail. In other jurisdictions I note that they have seen times of transition and acceptance after the introduction of voluntary assisted dying and in some cases they are continuing in that process and have unresolved matters that relate to the involvement of medical practitioners.

The degree of involvement of medical practitioners will vary and close involvement in this process would be voluntary, which is an absolutely essential element to have there.

We can anticipate that should this bill pass, matters relating to voluntary assisted dying including an understanding of the legal requirements around it will become part of medical training and the medical landscape more broadly. Some features from the bill that I note are that assessment is required from two medical practitioners as part of the process. It is a requirement in all jurisdictions, I think, that have legislated for voluntary assisted dying. We are following a pattern. Australia, however, is the only jurisdiction that has put qualifications above and beyond what is required to practise medicine, which is what has been in other places. Canada has nurse practitioners included as does Western Australia in the capacity of consulting practitioners.

I am going to acknowledge that there are those who are focused much more on ensuring that matters relating to the involvement of medical practitioners are well considered in this bill and in the process of debating this bill. I appreciate their focus on those elements and I will participate in those conversations in more detail as we go through the Committee stage.

While there are many more details and elements of this bill that could be discussed we will no doubt do it in a very granular fashion during the Committee stage of the debate. There are a number of matters that I am interested in clarifying on the Floor of the House and I am sure there will be a number of amendments proposed that I will be receptive to considering and I will participate in debating these.

As is the case expressed by all members so far, they are interested to ask questions, to consider amendments. In fact, I note the member for Rosevears indicating her support for the broad premise of the bill and her reservations on detail and looking at some particular matters as we are going through Committee. All of us are similarly placed.

I would briefly like to reflect on what we face in the next stage of this debate when we go into Committee with that viewpoint. That is that we will be coming to talk about the granular detail of this bill. We will come with questions; some will come with amendments. We are going to be faced with a situation in which we will start the debate perhaps with broad support and questions and we will have to end the debate with a decision. During the Committee stage we may have the opportunity to have some questions answered. They may be answered to our satisfaction, or not quite to our satisfaction. For some questions it may be no actual answers are able to be provided.

Ms Rattray - That will certainly be the case of the funding. We will not be able to have that information.

Ms WEBB - Certainly, because that is a matter for implementation. It is not a matter for the legislation.

Ms Rattray - Just for one example.

Ms WEBB - Indeed, and we will be having amendments presented. Each of us may support some, may not support some; we might find the ones we support go through, we might find the ones we support do not go through.

What I am trying to paint here is a picture that we will likely each of us have entered the Committee stage, potentially with broad support, but with questions - I think that is the most common scenario expressed so far. We are likely to end the Committee stage with each of us individually to some extent satisfied and to some extent not satisfied with what has occurred in the process. It is almost a guarantee each of us will enter the Committee stage of this bill not entirely happy with the bill in terms of, it does not have every element we wanted it to have. Every question we had has not necessarily been answered. What we will be faced with then is a very specific question for ourselves of what are our thresholds for support or for not supporting the bill.

I wanted to highlight that as a bit of an expectation, particularly in light of the member for Rosevears' reflection of support, but with questions, that we will be deciding and we will need to justify why in the context of an imperfect satisfaction with the bill, which all of us can assume we will have, we will then have to vote to support or not support. We will have to justify that back to our community and those who have been interacting with us on this matter. I am just flagging that is where we are going to get to.

Personally, it concerns me the fact of not being able answer every question or the fact of not being able to arrive on every issue where we might have liked to arrive might become a blockage to this bill. I hope that is not the case,

Ms Rattray - That happens with every piece of legislation.

Ms Forrest - We do not all get what we want.

Ms WEBB - It is a function of our role here.

Ms Howlett - What is the financial cost here?

Ms WEBB - If I may continue, I am imposing on a great deal of members' time and attention. I would finally like to mention implementation. A period of implementation will be important should this bill pass to establish the procedures, the education to accompany it and the oversight processes. The education and readily available information will be an absolute priority both in a broad community base level in specific VAD training programs for medical practitioners, but also in a generalised training and awareness raising amongst health practitioners that on the whole will be required.

Given the range of inaccurate claims and misleading assertions that have been made in the public domain during this discussion on this VAD bill, I hope if the bill passes and we move into implementation a thorough approach to community education and educational support to the medical profession are made a high priority to provide reassurance and confidence. In Canada, Victoria, and some other jurisdictions, there have been various methods of assisting people navigate the system as it has been established with advice lines, community education and resources navigators, centralised care coordination services and the like. This looks like a very positive model to assist people to understand and navigate new processes and could be coordinated with existing medical and palliative care systems.

To some final thoughts - I believe providing the option for voluntary assisted dying as part of end-of-life care is entirely compatible with excellent palliative care. A meaningful and rich experience of end of life, a hopeful and empowered death with celebrating and valuing of life that is compatible with medical practitioners doing their absolute best to care for the patients. I believe there is a community expectation in the most meaningful way that requires us as elective representatives to establish the option for voluntary assisted dying in Tasmania.

For those who fundamentally think it is not right to assist in ending a life, then all other issues compound and are insurmountable. But if you expect that it has been determined that assisting the end of life is possible and legal under certain circumstances then most of the concerns raised are things that can be balanced, managed, solved or developed over time.

Tasmanians overwhelmingly fall into the latter category there, and the introduction of an option for voluntary assisted dying in our end-of-life care would be a profound shift. This would be a positive shift and a valuable opportunity for our community. It should prompt a productive reflection, reassessment and recalibration of other connected parts of our medical care and social context. I would hope that this will have an ultimately positive effect.

I hope that we will see that impact in aged care, in palliative care, in advance care directives and planning for end of life, in support for individuals and families including grief counselling and the human right to autonomy and access to medical care.

Acceptance and inclusion of voluntary assisted dying may be the release, the impetus, the long-needed drive to progress the full suite of those important associated matters. While some fear that providing an option for voluntary assisted dying is telling people that their lives do not have value, I see the provision of this option as allowing people to make choices about the value, the quality and the conditions of their life in the face of their imminent death.

I want Tasmanians to have access to voluntary assisted dying as an option at the end of life. I want to see this bill passed.

[9.16 p.m.]
Mr WILLIE (Elwick) - Mr President, before I start I would like to recognise the member for Mersey and the power of work he has done to get to this point. The openness and the way that he has conducted himself is commendable.

Death is unavoidable to all of us and there is no right time. In your contribution you talked about our own experiences of death. Unfortunately, death is all too familiar to my family. My brother passed away when he was 13 and my father passed away suddenly at 60. I have talked about them in this Chamber. I have talked extensively about my father and how proud I am of him, the conversations he had with us before his death, his organ donation and the gift that gave to others. I am incredibly aware of this issue, of the emotions attached to it. I can relate to the experiences. I am deeply aware of the personal nature of this discussion.

I wanted to start with that because we all come to this with different experiences. This has been a real challenge for me, particularly reading the testimonials of the families involved.

As a community we struggle to talk about it, we struggle to prepare for it, deal with it and make peace with it. This bill concerns a most difficult social, legal and personal issue because it requires a frank discussion about death in circumstances that are often involved with great suffering and pain for individuals and their families.

Like the majority of Australians, I support the principle that the terminally ill have the right to choose a dignified end. The alternative is that some people experiencing end of life are condemned to immense physical and psychological suffering.

I do not plan to speak for long on the principle of this bill. No doubt we will scrutinise the detail in Committee. That said, there are four important areas I would like to discuss that have guided my support for the principle of the bill.

The first is that this bill will bring into the open what is happening now and regulate it. The second point is that I do not believe this bill facilitates suicide. This is not a choice between life and death; it is a choice between two deaths. The third point is that it is voluntary. This bill does not mandate assisted dying. There are strict eligibility requirements and protections against coercion. Finally, it offers protections for conscientious objectors and it protects the rights of patients not to have others' beliefs imposed upon them.

If I could go back to my first point. It is currently legal if you are terminally ill and suffering beyond medical intervention to commit suicide. I can only imagine the difficult circumstances some terminally ill people find themselves in because there are no other options. According to statistics from state coroners around the country, about one in 10 suicides in any year are carried out by people with terminal or debilitating chronic illness.

We have all read the harrowing testimonies, whether it be an elderly mother using a knife on the couch to end her life; a father suffering asbestosis shooting himself with a shotgun; a person in their eighties jumping off a car park roof here in Hobart; a poor 91-year-old climbing a tree to hang himself in his backyard. My heart breaks for these people and their families. These stories are hard to hear and they are hard to read, but they all have something in common:

they all died a violent death alone. It is tragic and unacceptable to me that they were alone instead of being surrounded by people they love and their deaths were violent instead of peaceful.

It is legal for someone to refuse medical treatment, food and water in the hope they can end their suffering sooner. It is also medically supported; assisted by dehydration and starvation, death can be expedited and it is not defined by law as suicide. It is also legal for a doctor to drug you into a coma, as long as the motivation is to relieve pain and not cause death. As a patient there is not a lot of choice in this option. You have no legal right to insist you are administered more. It is entirely a decision of your doctor. These decisions are made in an environment where there is little regulation, oversight, record keeping and no requirement for doctors to examine either capacity or the potential of coercion.

This bill will bring regulation and reviewed analysis to an area that has little regulation. It will provide greater protection for medical practitioners and guidance. It will provide more options to complement our compassionate palliative care system which, despite efforts, is unable to relieve the suffering of somewhere between 5 per cent to 10 per cent of patients. I believe you can be a strong supporter of palliative care and voluntary assisted dying and we can have better laws to guide the end-of-life decision-making.

To my second point made earlier, some of the correspondence I have received in opposition to this has raised the sanctity of life and that this bill facilitates suicide. I respect people can have religious views but contrary to this view, I do not believe voluntary assisted dying is a choice between life and death. What this bill provides for is a choice between two deaths, a choice for the terminally ill person to choose the timing of their death and the suffering they are prepared to endure.

The member for Nelson used an analogy but there is also a ruling of a medical examiner in the post-9/11 tragedy and I will read the quote in full -

> The distinction between suicide and a rational decision to end suffering was clearly understood by New York’s chief medical examiner, Charles Hirsch, when investigating the deaths of office workers who jumped from the Twin Towers on 9/11. Faced with a terrible choice - a slow, agonising death by fire, or a quick death by jumping - many chose to jump. Seeing this as a rational choice to avoid needless suffering, Hirsch refused to classify their deaths as ‘suicides’.

That was taken from a Go Gentle Australia document as a secondary source.

Ms Webb - To clarify, we did not coordinate referring to the same second set.

Mr WILLIE - It might have been used as an analogy in what you were reading, but it has come from a ruling.

Ms Webb - The article I read did not pose it as an analogy. I made that analogy myself when I was reading the article. It occurred to me in the context of this debate.

Mr WILLIE - To the third point I will make: in the provisions of this bill it is voluntary and there are protections against coercion. There are time periods between requests and a person can withdraw from the voluntary assisted dying process at any time. There is oversight at each stage to ensure the person is eligible and they have decision-making capacity. I also trust the professionalism of medical practitioners and their high level of education and training. That is an important point. I trust they will make the right inquiries with their patients who meet the strict criteria to ensure they are complying with the legislation, if it passes, that is.

In briefings we heard from Victorian oncologist, Dr Cameron McLaren, who others have referred to, who explained to us how he and other doctors worked through the VAD process in Victoria. I am comfortable that participating medical practitioners here will demonstrate a high level of professionalism under our legislation, if it passes.

To my last point, throughout the bill there are provisions for conscientious objectors. Medical professionals can refuse to participate in the voluntary assisted dying process. They are not required to give reasons for refusing a request. After the Committee stage, there may be further safeguards in this regard and also for entities.

These protections encompass religious, moral and ethical convictions without sanction or criticism. At the same time, it protects a patient's right to choose and to not have the beliefs of others imposed upon them at a deeply personal moment.

This is about choice and compassion, protecting conscientious objectors, regulating what is occurring in practice now and I respectfully disagree that this bill will facilitate suicide. There is much more to discuss but I am happy to do that in the Committee stage now I have my expressed my in-principle support for the bill.

[9.26 p.m.]
Mr VALENTINE (Hobart) - Madam Deputy President, I too acknowledge the work of the member for Mersey for his unflagging work on this bill. There is no way it was ever going to be easy to research and deliver a bill of such magnitude. I acknowledge the power of work he has done on it, the consultation program, the overseas travel he has undertaken to look at other jurisdictions, and to learn from them when refining the bill before us.

Congratulations on that effort. You must almost be very relieved but there is a little time to go yet. You must be relieved that the bulk of that work is now behind you and we can concentrate on the bill itself. Well done on that score. Everybody understands the amount of effort you went to, all the different community meetings you had and the way you took our calls. Not one stress in your voice. Every time we asked a question, you would be there to answer it. I appreciated that and I am sure others did too. You did a fantastic job in that regard.

Ms Rattray - Through you, Madam Deputy President, the member has a good way of camouflaging his stress.

Mr VALENTINE - He might, but he was pretty good.

If you have not guessed already, it is one of the most controversial bills we have dealt with in this Chamber. Make no mistake, it is fair to says the eyes of Australia are on us again. I have had calls from the east and the west. I was charging my car on the new charger here in Dunn Place and I got this phone call from an oncologist in Western Australia and I had 30 minutes with him on the phone. He was a Christian fellow and he talked to me about the bill and all sorts of things in the bill. We had a really good discussion. I challenged some of his thinking and he challenged some of mine. He said, 'Thanks for taking the call as I am out of town'. I said I do not care where the ideas come from. It is important that we listen to them and that is what I did, quite a bit of. We had passionate churchgoers from South Australia against the bill.

I don't know whether anyone else received calls from the mainland but I had quite a few calls from the mainland. Was I on a list somewhere? Must have been *The Examiner*, that is probably where they got it from. Nevertheless, there were lots of calls.

We have heard from quite a number of churches and religious-themed organisations. They came here to present to us in Parliament House. I thanked them for coming as well and giving their points of view.

It is important that with a bill like this that we get all of those opinions and we get the fears and concerns that come out so that we know what to look for and what not to look for and what to consider and what not to consider. Interestingly, we also heard from Christians Supporting Choice for Voluntary Assisted Dying, also a retired chief justice who was a governor in the past. I thank them all for taking the time to talk to us.

I have received many emails - both for and against - in the hundreds, I expect, but nothing like some other legislation like same sex marriage. I received 2450 emails for same-sex marriage. This is probably only in the vicinity of 300 or so and they were evenly balanced - for and against. It is one of those things in the community. People are either one way or the other, hardly ever in between. They will not bother ringing you if they are in between or not concerned so it is no wonder we get that balance happening.

They have an opinion on it. I have received many from across my community, urging me to pass it and some that say, 'No, do not want it passed'. One said, 'It is a mess'. To my mind that is code for, 'I spun out trying to read it'. I can understand that, given its protections, the complexity is inevitable in the bill. I have to say, welcome to the world of the computer programmer because that is exactly what it is, trying to chase things down to make sure you get all of the phrases and clauses in there to be able to make sure that the bill works.

We have been bombarded with statistics and reports from all sorts of directions with individual biases, some laced with claims supporting, or not, the principle of voluntary assisted dying. We cannot possibly verify all the claims made as there simply is no time and we do not really know the full operational context of whichever jurisdictions individuals are choosing to bring to our attention either. That is important to understand.

It is something that our two professors actually spoke of this morning about needing to verify the facts and figures that are put before us. You can try to verify but at the end of the day if it is from a far-off jurisdiction it is not always easy to verify. Some of the things that I received in emails, they were quoting, 'Oh, there have been 125 deaths in Victoria since this bill was introduced'. Well, I have to say that they still would have been deaths. It is just that they happened a little earlier than they would have normally.

The member for Nelson and others have said, 'Well, it is a choice between death and death; it is not a choice between life and death'. Anyone who goes down this path is actually dying and there is not a lot they or anyone else can do about it.

Mr Dean - It is fair to say they might not have been dead by now, some of them might still be living.

Mr VALENTINE - They might be but again, that is up to a proper medical practitioner to make those sorts of judgments, I guess.

Mr Dean - They are not always right.

Mr VALENTINE - Yes. I appreciate the passion that people have in putting forward their points of view. A bill such as this is really not for the faint-hearted. It has taken an enormous amount of effort, as I said before, on Mr Gaffney's part. No bill is perfect and nor can it be and I think the member for Mersey would have to agree with that. No bill is perfect. There will be some parts that need tweaking here and there and into the future. You cannot expect to get it perfectly right. We see them all the time. We have them coming forward with small amendments, do we not, 'This is something that we missed back then or' -

Mr Gaffney - For the record, now that you have brought it up, I have never said this legislation is perfect. It has been interpreted that way by some other groups who have perpetuated that. I have never ever said that so I am pleased you raised that because now I will be able to put that on the record.

Mr VALENTINE - I think with the public expectation, the public have to realise that this bill will see amendments to it if it gets through and, if it becomes an act, it will see amendments to it as a result of reviews or some other process; things the medical profession might bring up and say it has to be changed here or changed there to protect this part of the process or people involved in this part of the process. I do not think we should expect it to be perfect, but we need to do our best to make it a bill -

Ms Forrest - That is robust.

Mr VALENTINE - that is robust. It will be up to us to put it through its paces to see if it is functional and in the operational context that it protects the vulnerable as well as the workers, the doctors and nurses involved, providing them with an opportunity to step back should they not wish to participate.

Mr Dean - Then the House, the other place, will look at our work to see if we have got it right.

Mr VALENTINE - I was thinking about that and it is true - the roles are reversed. In a sense we are reviewing this bill. It is private members' bill. It will get two reviews.

It is not a take or leave it bill. It has brought out the passion in people, the fear, the concern, the compassion for those who have suffered. I hear about the language the member for Nelson brought out. I also have been close to those who have lost a family member to suicide and indeed two in the one family. Very sad circumstances. What this bill is trying to achieve is this is not suicide.

I am sure we have all been affected by the stories presented to us from the families of those who have suffered and some who are still suffering. I know there have not been too many read out but I want to read a couple to give the people in the community an understanding of what people do go through. It is important for the debate a couple are shared at least.

Ms Rattray - Very difficult to choose which stories to share.

Mr VALENTINE - It is very difficult to choose. It is almost impossible, but I have been through a lot of them and I have always asked permission. This one said, yes, you can read it but I do not necessarily want my name mentioned and their right to remain anonymous.

> I am 67 years of age, a Christian, well-educated Tasmanian, with a passion for people and community. Until 4 years ago I was against voluntary assisted dying based on my strong belief in the sanctity of life and no doubt because I had been blessed that mum and dad both experienced 'good quick deaths'.
>
> Since that time I have been close to 2 traumatic deaths. One, a close friend who died in Palliative Care from a rare cancer, and the other a friend who chose to take her own life given the diagnosis of Creutzfeldt-Jakob disease, CJD. Both these women were intelligent, independent women with a deep love for their family, life and their fellow human beings.
>
> My friend pursued every pathway to treat and cure the cancer. When she finally accepted it was terminal, she simply requested the right to die on her own terms which unfortunately couldn't be met legally. I recall visiting her in Palliative Care a few days before she died when she was literally dying of thirst and her organs shutting down as they managed the morphine dosage. We were both farmers and she gripped my hand as she drifted in and out of consciousness and said, 'We wouldn't let a cow die like this would we?' These were the last words I heard her say.
>
> To understand my other friend's choice to take her own life I beg you read up on Creutzfeldt-Jakob disease, CJD, before making any judgment. Knowing it would be terminal within 6 months she had no wish to put her husband and daughter through the horrific end this disease involves. Nor did she wish to experience it herself. Her death and the aftermath for her husband and daughter would have been far less traumatic if she had been able to choose voluntary assisted dying, a cause she had been a committed advocate for.
>
> My experience and understanding of what these women and their families endured led me to revisit my values and beliefs regarding voluntary assisted dying. Since their deaths, I have read widely both the for and against viewpoints, researched legislation and how it works in practice around the world and reflected on the reality of peoples' stories. I have now made an informed decision to support the Voluntary Assisted Dying Bill 2020 tabled by Mike Gaffney MLC.
>
> I respectfully request you give this your utmost consideration and please read the stories in the Voluntary Assisted Dying Tasmania Perspectives, the group of stories you gave us, member for Mersey.

One from Carol -

I write to provide you with my personal thoughts and experience regarding the current Voluntary Assisted Dying Bill (VAD). My name is Carol and I have stage 4 melanoma cancer. This disease has spread to my lungs, thyroid, stomach and lymph nodes and I have been given approximately two months to live. While the cancer is inoperable I have undergone all forms of available treatment. I am still able to function and while I am able to I would like to take the opportunity to inform all parliamentarians of my strong views on the VAD bill.

My views on dying with dignity have not altered in over 30 years when my family needed to make the heartbreaking decision to end the life of our beloved Old English Sheepdog, Nina, who had been diagnosed with a brain tumour. At this time during our many family discussions my words to my children were, 'We don't do this for us, we do this for Nina'. Nina was suffering and again there was not an option to operate. We accepted that to allow Nina to die with dignity was the kindest thing we could do for her. We stayed with her whilst our family vet gave the extra dose of anaesthetic. She closed her eyes and gently went to sleep. It was gentle and peaceful.

At the time I thought, and continue to consider, why do we allow humans to suffer leading up to their end of life? Why can't we show humans the same kindness that we are allowed to show our beloved pets?

I am of the belief that Christian/conservatives groups have lobbied to block similar VAD bills. Whilst I respect their right to hold their views, I make it very clear that these people do not represent me. I had a strong religious upbringing, having completed my church exams, taught Sunday School, knowing my Bible from front to back, but my intellect has led me to have a strong belief in evolution.

I have accepted my diagnoses and my life is soon to end but what I am most distressed about is the unpleasant end I am going to experience. I am aware there is medication for the pain and every attempt will be made to make me comfortable, but my death is inevitable and I want a dignified end.

I would refer you to Kerry Robertson and her family's description of her dignified and peaceful death surrounded by loved ones in Victoria. She was not bullied into dying, which is so often used by opponents as a reason to stop such a Bill. I want the opportunity to say my final farewells to my family and loved ones. Sad, yes, but peaceful and happy as well. I should not be made to Google trying to find an effective and painless way to end my life. There is always the risk of taking something that could make my death more agonising and prolonged and cause additional stress to myself and loved ones.

I also wish to die before I deteriorate to the point where I no longer have any quality of life. This wish is for myself but also for my loved ones so their memories of me are not tarnished, but are beautiful and peaceful. It would

> be a great worry out of my life if I had the peace of mind that I could die with dignity surrounded by loved ones at a time of my choosing. This is the most worrying part of my journey. Why should I have this added stress to what is already an extremely stressful situation? Please show respect to my views and all of us in a similar situation and give us the peace of mind we deserve. I have broached my thoughts on this Bill with many family and friends. All are aware of my desire and support my wishes to be provided with a safe alternative, allowing death with dignity. I hope I can live long enough to see a commonsense approach and this Bill passed.
>
> Please show kindness and compassion and pass the VAD bill without delay.

There are just two. I thought it was important to read them in so members of the public who may be listening had an opportunity to hear what it is like.

The e-petition had 13 082 in support, an amazing petition. E-petitions have not been going forever, but I think it is the largest.

Mr Gaffney - Mr Finch will tell you the largest petition ever was the pulp mill one.

Ms Forrest - E-petitions were not used when the pulp mill was on, was it?

Mr VALENTINE - No. We will all come at this from different angles, and I have been most interested in the points of view expressed by each of you.

I acknowledge and congratulate the new member for Rosevears on her inaugural speech today. It was fascinating to hear your life story, but I acknowledge your contribution to this bill, too. You have obviously had some personal experience and it is important to hear that.

I have listened to everybody's presentation, even if not in the Chamber but in my office.

The member for Mersey talked about our role here. I find debates such as this, with deep, significant, ethical or moral questions, absolutely challenging, but we have been chosen to do this job and each of us has about 25 000 or 26 000 people behind us. I often say it is a big selection panel when you go for that job. Whatever our stress is with regard to this bill, remember the privilege we have of carrying the sovereignty of about 26 000 people on our backs. We are individuals here, and we look at each other as individuals, but we each represent 26 000 people. That is a lot of people when you line them up in a line. The sense of responsibility is both empowering, and heavy.

Ms Forrest - It is also daunting when you know you are really going to annoy some of them, and you are going to make some quite happy.

Mr VALENTINE - That is the job, isn't it?

Ms Forrest - Exactly, I have been doing it for a long time. It is reality. Some people are going to be unhappy with the decisions that we make, and others really happy.

Mr VALENTINE - That is the job. I spent a long time in local government on planning matters, and you are never going to please all the people all of the time.

Mr Dean - Haven't you had anybody in your electorate saying, 'You don't represent me'?

Mr VALENTINE - No, that is it, or yes, that is it. It is better to be here helping to think these things through than not having the opportunity. We really are in a privileged position being chosen to scrutinise legislation, especially such as this, and I am sure none of us want to resile from it.

I have provided opportunities for private briefings with various individuals and groups. Jacqui and Nat Gray have been here all day. They were saying it is opening up choices, not forcing others to undertake it. The disease takes over control of your life. This gives some control back to them.

I met with the Australian Care Alliance. They were saying wrong diagnosis, wrongful death; wrong prognosis, six months left may in fact be many years; can be incorrect by 12 to 18 months; 20 per cent are accurate. Some may be unaware of available treatment; no access to palliative care; denied funding for medical treatment. Mentally ill or at risk. Bullying or coercion. Social contagion of suicide. Killed without request or while resisting. Not a rapid or peaceful death. Lacking capacity.

They are all things that cause you to think, no question about that. But as we do think about some of these - say, mentally ill or at risk - we know the bill has some protections in there, and the same for people with a disability. Bullying or coercion? Again, there are some protections there. The social contagion of suicide? The figures presented to try to back that up, you wonder whether they are factual.

When you do research you have to make sure it is absolutely watertight. I used to be a research technical officer for the first four years of my existence in the horticultural section of the agriculture department and I participated in many trials. You have to be rigorous. If we unpicked some of those things that we see coming before us, like the professor said this morning, you might find things are not quite as they seem. There might be other pressures or other things that have caused those suicides, it is economic circumstances that have changed over recent times. There are pressures that happen that might make some of those facts skew the result.

Lacking capacity is measured - we could go through each one of those and we could show how the bill has protections for them. I heard from a hospital chaplain it closes off the opportunity for family, friends and the medical community to exercise love and care to the dying. It places unnecessary guilt and pressure on the vulnerable. It relinquishes our community of our responsibility to care for the dying. It may lead to those with non-life threatening conditions to end their lives. It will not improve the fabric of our society. It should be modelling care and love for the dying.

Clearly opinions that people have seen things through a different lens. I had one submission, a slide show from the Christians Supporting Choice for Voluntary Assisted Dying, and they had a list in the middle of this, a summary of the case to legalise voluntary assisted dying. I will read some of the headings -

> Even optimal palliative care cannot relieve all suffering.
>
> The excuse of sufficient safeguards are not possible and is not supported by facts and data from Oregon State 1997.
>
> The other five states with legal voluntary assisted dying and now also data from Canada.

Again, we would have to drill down into that data.

> The advanced care directive incorporating the option to legal voluntary assisted dying would provide an ultimate protection against possible abuse.
>
> VAD laws are working responsibly with no slippery slope to abuse in Oregon State and other countries and states with legal assisted dying.
>
> The current law prohibiting voluntary assisted dying, voluntary euthanasia is not working.
>
> The current law is driving desperate people to desperate self-deliverance.
>
> Palliative care is not threatened by voluntary euthanasia legislation.

And on it goes. I will not go through them all. They have thought it through and are presenting their thoughts and their feelings.

There is an interesting statement in the executive summary of a report Go Gentle Australia; it is titled, 'The Full Picture: A Critical Analysis of Allegations of 'Wrongful Deaths' Hon. Nick Goiran MLC's Minority Report', in his dissenting response to the majority WA Parliamentary Committee report of August 2018 on end-of-life choices -

> Given that Western Australian doctors already assist people to die, how can the proposition of a law - which mandates regulation, oversight, record keeping, and mechanisms for a review around assisted dying - be said to be *less safe* than existing law which contains none of those things?

Upping the morphine, so called, to cope with the pain but it goes up that little bit high and they die, removing the sustenance and the fluids.

I have my own experience there because of my mum. She died in 2013. She had a massive stroke and she was totally paralysed down one side. She had lost all of her peristaltic movement in her oesophagus so she could not eat. She was fed by a tube. She was barely conscious, could not communicate. My dad has gone now. He was asked, 'What will we do now?' because he is deeply Christian and so was my mum. 'I want her to die naturally'. So they took every tube away, they took all the fluids away and she just lay there. It took a fortnight to die. She was not in pain. They did not have any morphine that they needed to give her, but she took a fortnight to die. Is it right to withhold sustenance from someone, basically starving them to death as they slip across the great divide, as happened to a member of my family when there was no hope of any quality of life for mum? Why is that right but it is not right for them to choose a way to go?

Mum would not have had that chance because she had a major stroke and under this bill it would not have been able to happen. It is happening now. Is it not better to have a process in place for a person's wishes to be dealt with in an orderly manner than the grief and loss experienced by all parties, as people decide to take the circumstances in which they find themselves into their own hands? Is it not better to organise a dignified, peaceful death than seeing people try to do it themselves with sometimes disastrous consequences?

Is it okay to increase the morphine and they end up in what I imagine is a state of suspended animation or stupor instead of allowing them the opportunity to help family and others cope with their loss by being able to hold their hand and converse while they are still able to communicate before they get to a stage of unconsciousness? They are in the process of dying. It is a choice between death and death, not life and death, as happens when someone suicides. The emotive language in many of the emails sent to me seem to echo a sort of anger they must have been feeling when they wrote them. They have a right to their opinion and I was always respectful when writing back. They have a right also to choose the way they die, unless it is by some misadventure.

The rights that they have is exactly the same right that others may exercise when choosing VAD, if this becomes law. Some say the bill will hasten a person's death; equally it allows an individual to choose their path according to their belief system and not be controlled by someone else's beliefs. Any of the churches would not force people to follow their teachings yet they want to see enshrined in legislation the process that prevents people from exercising their rights.

Similarly, in a pluralist society, as we now have here in Australia, if there are doctors and nurses prepared to comply with the wishes of a person, why is it our role to see people suffering needlessly if it is not their wish to do so and they are not infringing the rights of others? It is for them to deal with according to their belief system providing they are not harming others. That is the key with bills like this. Regardless of what our personal belief system is, do we have the right to force that onto someone else? I do not think we do.

It is a bill for everybody. It is not just a bill for certain sections of the community. Everybody has to live under this. There are many different faiths and different belief systems and we have to cater for that. It is basically a human rights issue, whether we would take this path or not, whether it offends our belief system or not. It is their choice and they have to have the capacity to make such a decision.

The important thing is it is not compulsory. We often hear it is a slippery slope. Do we hear people saying that when trying to extend someone's life through artificial means? Or is it taken as a given it has divine sanction because life comes before all else? Or that when a person of faith is killed in a car crash that it was the will of a loving, caring God, thinking of it in the context of Judeo-Christian faiths? I have gone through every clause of this bill and I have chased down every clause and reference to make sure nothing was amiss in terms of those cross-references. I do have some queries and questions which I will bring up during the Committee. Even though this is a private member's bill the role we play here is exactly the same, as I was saying a moment ago, the member for Windermere, exactly the same as if this were a government bill. We need to critically scrutinise it and look for those unintended consequences and the mechanics of its operation. We need to ensure there are protections for vulnerable to make sure there is minimal opportunity for them to be taken advantage of by unscrupulous individuals, and I believe we do that well. It is a part of our role that I am sure flies under the public radar, although these days there is greater opportunity for the public to see us in action via the web that we have, which makes it all quite transparent.

I wish you all well with this most serious of bills and we will continue to listen carefully to what each of you have to say. Many of us have already spoken. I value your thoughts, either for or against, and I am leaning towards voting it into Committee where we will do the hard work associated with this bill, unless there is something profound that would see me do otherwise.

Debate adjourned.

DANGEROUS CRIMINALS AND HIGH RISK OFFENDERS BILL 2020 (No. 28)

FINANCIAL MANAGEMENT (FURTHER CONSEQUENTIAL AMENDMENTS) BILL 2020 (No. 16)

EVIDENCE (CHILDREN AND SPECIAL WITNESSES) AMENDMENT BILL 2020 (No. 31)

First Reading

Bills received from the House of Assembly and read the first time.

ADJOURNMENT

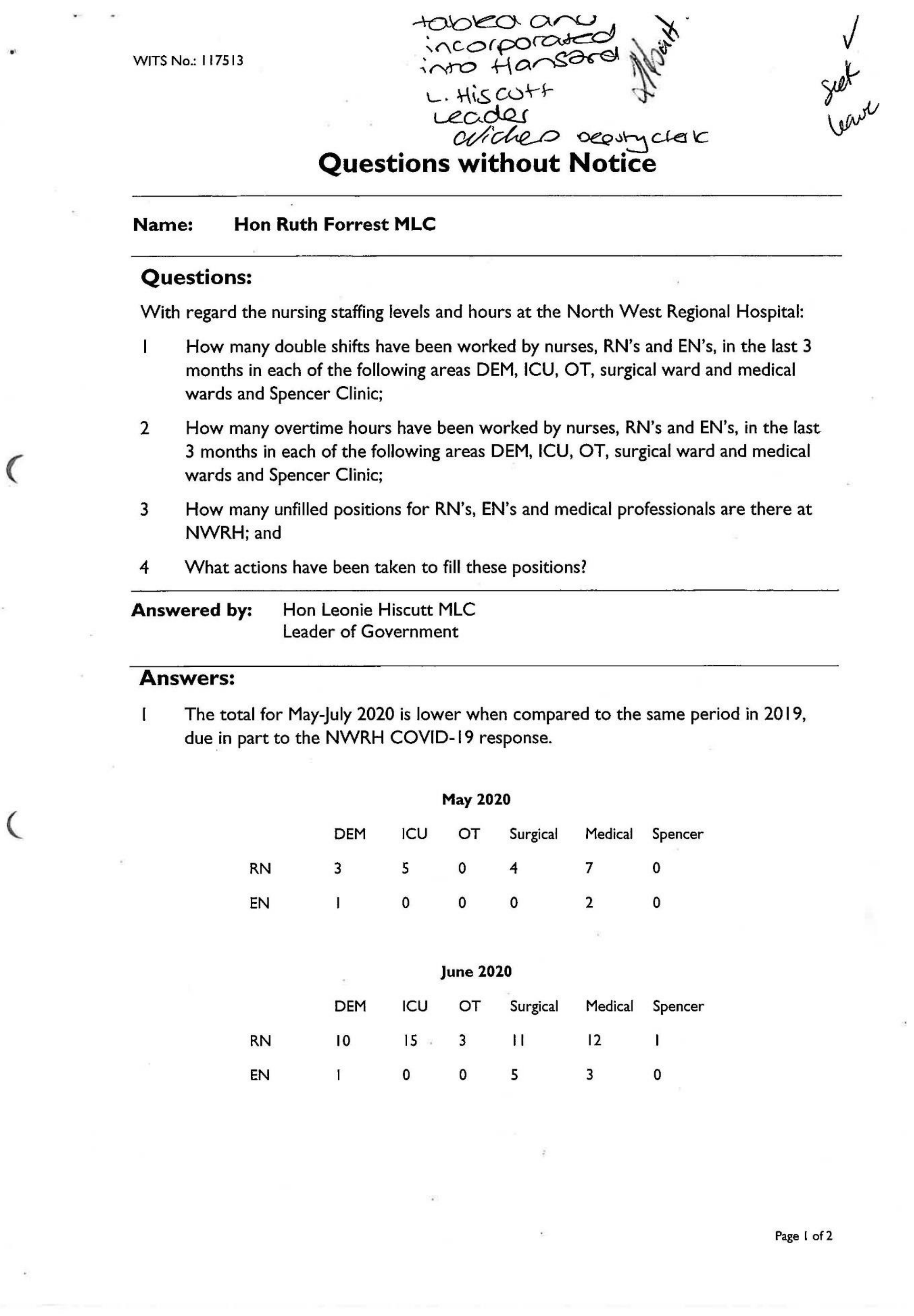
[10.05 p.m.]
Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

> That the Council at its rising adjourns until 11 a.m. on Wednesday 16 September 2020.

Mr President, before we adjourn, I remind members of tomorrow morning's 9.00 a.m. briefing with the Office of Parliamentary Counsel in Committee Room 2. We will then move onto the Land Use Planning and Approvals Amendment (Major Projects) Bill 2020. We have managed to be able to get the member for Hobart's request through, and we will have a representative from the TPC to talk to us, so we will work our way through that.

The Council adjourned at 10.05 p.m.

Appendix 1



WITS No.: 117513

tabled and incorporated into Hansard
L. Hiscutt
Leader
[illegible] deputy clerk

✓
Seek leave

Questions without Notice

Name: **Hon Ruth Forrest MLC**

Questions:

With regard the nursing staffing levels and hours at the North West Regional Hospital:

1 How many double shifts have been worked by nurses, RN's and EN's, in the last 3 months in each of the following areas DEM, ICU, OT, surgical ward and medical wards and Spencer Clinic;

2 How many overtime hours have been worked by nurses, RN's and EN's, in the last 3 months in each of the following areas DEM, ICU, OT, surgical ward and medical wards and Spencer Clinic;

3 How many unfilled positions for RN's, EN's and medical professionals are there at NWRH; and

4 What actions have been taken to fill these positions?

Answered by: Hon Leonie Hiscutt MLC
Leader of Government

Answers:

1 The total for May-July 2020 is lower when compared to the same period in 2019, due in part to the NWRH COVID-19 response.

May 2020

	DEM	ICU	OT	Surgical	Medical	Spencer
RN	3	5	0	4	7	0
EN	1	0	0	0	2	0

June 2020

	DEM	ICU	OT	Surgical	Medical	Spencer
RN	10	15	3	11	12	1
EN	1	0	0	5	3	0

Page 1 of 2

July 2020

	DEM	ICU	OT	Surgical	Medical	Spencer
RN	20	13	4	19	11	5
EN	2	0	0	2	3	0

2 The total for May-July 2020 is lower when compared to the same period in 2019, due in part to the NWRH COVID-19 response.

May – July 2020

	DEM	ICU	OT	Surgical	Medical	Spencer
RN	721.25	439.15	155.15	615.55	516.75	108.55
EN	125.5	0	0	100.15	93.25	2.15

3 and 4

In such a large organisation considerable staff movement is anticipated, both permanent and fixed-term. Vacancies at the North West Regional Hospital are primarily fixed-term with small pockets of permanent vacancies.

As vacancies arise, they are advertised on the Tasmanian Government jobs website and other national recruitment platforms. Vacancies are also filled by increasing the hours of existing staff and through engagement of casual staff.

The Department has a policy position to fill Grade 3/4 nurse vacancies on a permanent basis where possible.

Agency nurses are employed by the Tasmanian Health Service to assist in reducing the pressures where there are fixed-term nursing vacancies, or difficulty in filling positions in specialist areas.

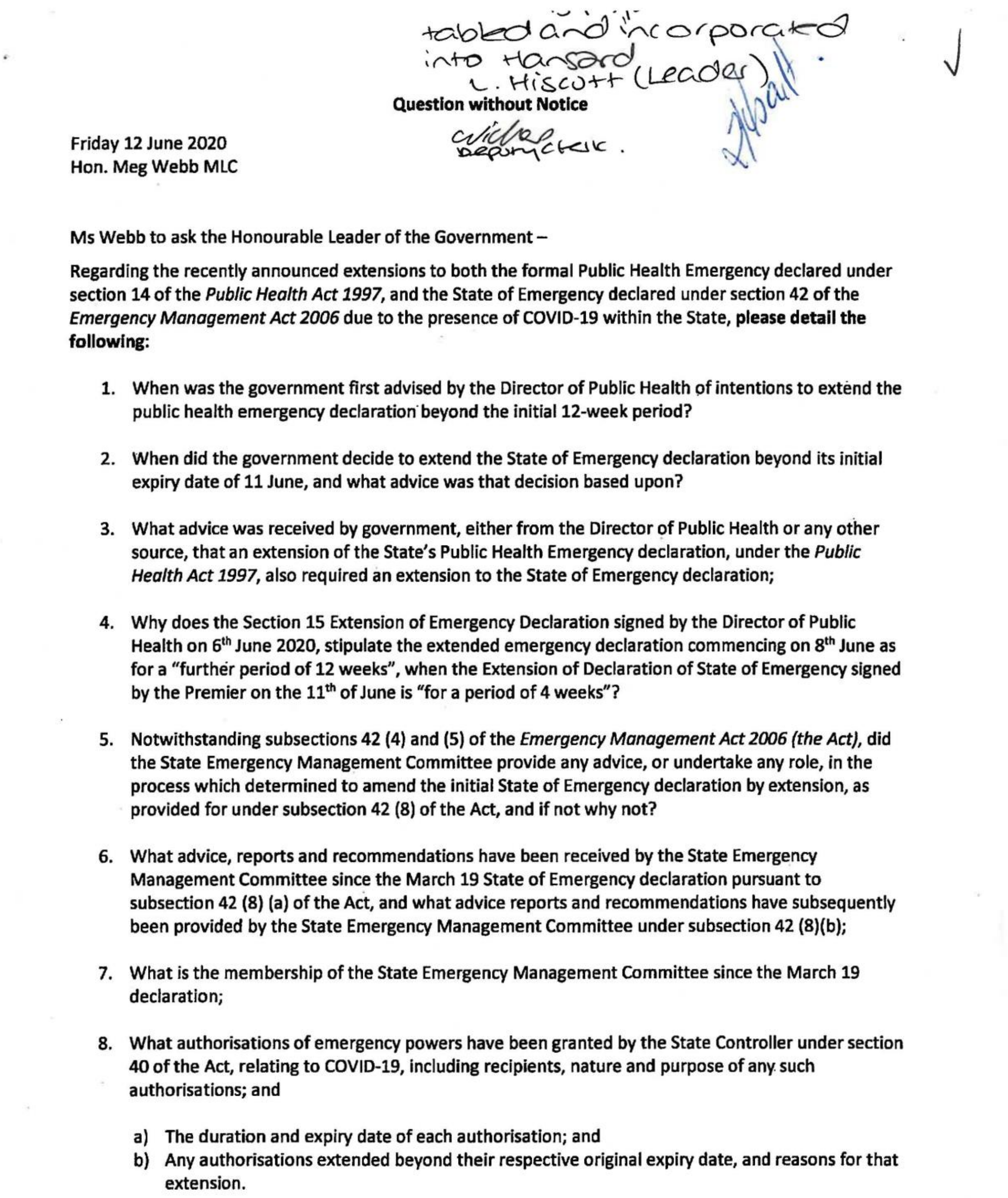
There are currently 28.72 FTE RN or Registered Midwife vacancies, 4.35 FTE EN vacancies, and 24.5 medical vacancies. This is in the context of more than 700 FTE who work at the hospital, and is at levels broadly consistent with previous years.

There has been a concerted effort across the THS to decrease the time to fill vacancies for nursing positions, with some success during 2019, although there has been impacts on recruitment more recently resulting from COVID-19.

end.

Sarah Courtney MP
Minister for Health

Appendix 2



tabled and incorporated
into Hansard
L. Hiscott (Leader).

Question without Notice

Deputy Clerk.

Friday 12 June 2020
Hon. Meg Webb MLC

Ms Webb to ask the Honourable Leader of the Government –

Regarding the recently announced extensions to both the formal Public Health Emergency declared under section 14 of the *Public Health Act 1997*, and the State of Emergency declared under section 42 of the *Emergency Management Act 2006* due to the presence of COVID-19 within the State, please detail the following:

1. **When was the government first advised by the Director of Public Health of intentions to extend the public health emergency declaration beyond the initial 12-week period?**
2. **When did the government decide to extend the State of Emergency declaration beyond its initial expiry date of 11 June, and what advice was that decision based upon?**
3. **What advice was received by government, either from the Director of Public Health or any other source, that an extension of the State's Public Health Emergency declaration, under the *Public Health Act 1997*, also required an extension to the State of Emergency declaration;**
4. **Why does the Section 15 Extension of Emergency Declaration signed by the Director of Public Health on 6th June 2020, stipulate the extended emergency declaration commencing on 8th June as for a "further period of 12 weeks", when the Extension of Declaration of State of Emergency signed by the Premier on the 11th of June is "for a period of 4 weeks"?**
5. **Notwithstanding subsections 42 (4) and (5) of the *Emergency Management Act 2006 (the Act)*, did the State Emergency Management Committee provide any advice, or undertake any role, in the process which determined to amend the initial State of Emergency declaration by extension, as provided for under subsection 42 (8) of the Act, and if not why not?**
6. **What advice, reports and recommendations have been received by the State Emergency Management Committee since the March 19 State of Emergency declaration pursuant to subsection 42 (8) (a) of the Act, and what advice reports and recommendations have subsequently been provided by the State Emergency Management Committee under subsection 42 (8)(b);**
7. **What is the membership of the State Emergency Management Committee since the March 19 declaration;**
8. **What authorisations of emergency powers have been granted by the State Controller under section 40 of the Act, relating to COVID-19, including recipients, nature and purpose of any such authorisations; and**
   a) **The duration and expiry date of each authorisation; and**
   b) **Any authorisations extended beyond their respective original expiry date, and reasons for that extension.**

Answers:

1 As required by the *Public Health Act 1997,* the State Commander was advised by the Director of Public Health of his intention to declare an extension of the (Public Health) Emergency Declaration on 6 June 2020.

2 The Premier issued an extension to the initial State of Emergency in response to the presence of COVID-19 in Tasmania on 11 June 2020. The Premier's declaration of the extension followed advice from the State Controller that there were reasonable grounds to extend the State of Emergency for a period of four weeks.

On 6 June 2020, the Director of Public Health had extended the initial public health emergency for a further period of 12 weeks. The rationale for the extension was that there was an ongoing need for restrictions to be in place to continue to effectively manage the risk of COVID-19 to the Tasmanian population.

At that point in time, the Tasmanian Government was beginning to ease restrictions. To ensure a cautious response and responsible management of the pandemic situation, there was a need to build in time to monitor and evaluate the impacts of the easing of restrictions between the different stages.

Although there were few confirmed active COVID-19 cases remaining in Tasmania at the time, with the easing of restrictions and increased mixing of people, it was anticipated that the State Controller may have been required to exercise the special emergency powers, which can only be exercised during a State of Emergency, to respond to another outbreak or cluster of cases.

As the restrictions imposed by the Directions issued by the Director of Public Health under the *Public Health Act 1997* were eased, it was anticipated that some form of restrictions would continue to be necessary into the coming months. At that time, decisions were under consideration for Stage Three of easing restrictions, which was due to begin at the end of June 2020. Given the significant increase in the number of people permitted to gather, an increase from a maximum of 80 both indoors and outdoors, to 250 indoors and 500 outdoors, the State Controller advised that an extension to the State of Emergency, was necessary to manage the risk of COVID-19.

Public Health Services provided its support to extend the State of Emergency for a period of four weeks, to ensure effective management and ongoing review of the border restrictions.

Since the initial extension on 11 June 2020 for a period of four weeks, the Premier announced the extension of the State of Emergency on 8 July 2020, until 31 August 2020.

3 The *Public Health Act 1997* requires the Director of Public Health to revoke an Emergency Declaration as soon as practicable after they are satisfied that the situation no longer requires it to be in force. The available national and international evidence indicates that to protect Tasmanians it is likely a Public Health Emergency declaration and appropriate Directions for the circumstances may be required for at least the next 6 months.

4 The *Public Health Act 1997* requires the Director of Public Health to advise the State Controller of their intention to declare an extension of the (Public Health) Emergency Declaration. The State Controller may take this into consideration during their independent consideration of the appropriateness of the extension of a State of Emergency.

5 The SEMC is not a decision-making body, and as such, did not formally consider the question of whether a State of Emergency should be declared or whether it should be amended or extended. The extensions of the State of Emergency were recommendations by the State Controller to the Premier and took into account the advice from the Director of Public Health, information provided at the meetings listed above and guidance from the COVID-19 State Emergency Co-ordination Centre (SECC) which was subsequently expanded to the full State Control Centre (SCC).

6 In addition to the SEMC meetings, members of the SEMC have been provided advice and reports on the COVID19 response from the State Control Centre (SCC) through a variety of forums.

7 SEMC members are listed below.

4.1 Chair: State Emergency Management Controller (Commissioner of Police and Head of Agency, Department of Police, Fire and Emergency Management (DPFEM)) is appointed per sections 8 (4) and 10 (1) of the Act and is responsible for directing the conduct of SEMC functions and powers.
4.2 Executive Officer: Director, State Emergency Service (DPFEM), appointed as per the Emergency Management Act 2006 to provide administrative and secretariat services.

4.3 Members:

- Deputy Commissioner of Police (DPFEM) (Deputy Chair)
- Secretary, Department of Premier and Cabinet (DPAC)
- Secretary, Department of Health (DoH)
- Secretary Department of Primary Industries, Parks, Water and Environment (DPIPWE)
- Secretary, Department of State Growth (State Growth)
- Secretary Department of Justice (DoJ)
- Secretary, Department of Education (DoE)
- Secretary, Department of Treasury and Finance (Treasury)
- Secretary, Department of Communities Tasmania (Communities Tasmania)
- Deputy Secretary, DPAC (State Recovery Advisor)
- Chief Officer, Tasmania Fire Service (TFS) (DPFEM)
- Director of Public Health (DoH)
- Chief Executive, Ambulance Tasmania (DoH)
- Director, State Emergency Service (DPFEM)
- Chief Executive Officer, Local Government Association of Tasmania (LGAT)
- Regional Emergency Management Controllers
- Chairs of SEMC Sub-Committees
- any other person holding a position or office determined by the State Controller; and

- any other persons the State Emergency Management Controller considers appropriate (such persons are to be appointed in writing by the State Emergency Management Controller for the period specified in the instrument of appointment).

8 The State Controller has issued a number of authorisations of the exercise of the emergency powers under Section 40 of the *Emergency Management Act 2006* (the Act), including to himself, to Biosecurity Tasmania Officers and to Tasmania Police Officers.

The reasons for extending these authorisations beyond their original expiry dates is to ensure operational continuity. For example, an extension of the authorisation of the emergency powers to declare all Biosecurity Tasmania as authorised officers for the purpose of the Act was essential to ensure they can continue to perform key functions at Tasmania's borders to manage the risks associated with the arrival of people into the State.

The details of these authorisations and any extensions are outlined in the attached table.

Table the table.

Section 40 – Authorisations by State Controller for of the use of Emergency Powers (Schedule 1)

Executed Date	Authorisation	Additional Comments
21-Mar-20	Authorisation of all Schedule 1 Emergency Powers: All members of Tasmania Police to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Minister notified on 21 March 2020. Taken to be 12 weeks with the amendments. Extended on 12 June 2020.
23-Mar-20	Authorisation of all Schedule 1 Emergency Powers: State Controller.	Minister notified on 23 March 2020. Taken to be 12 weeks with the amendments. Extended on 12 June 2020.
29-Mar-20	Authorisation of Schedule 1 Emergency Powers: Biosecurity Tasmania to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Extended on 19 June 2020 to have effect from 20 June 2020 until 10 July 2020.
12-Jun-20	Extension Authorisation of all Schedule 1 Emergency Powers: State Controller.	Extended to 10 July 2020. Consent obtained from Minister prior to extension of authorisation.
12-Jun-20	Extension of Authorisation of all Schedule 1 Emergency Powers: All members of Tasmania Police to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Extended to 10 July 2020. Consent obtained from Minister prior to extension of authorisation.
19-Jun-20	Authorisation of Schedule 1 Emergency Powers (extension): Biosecurity Tasmania to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Extended to 10 July 2020. Consent obtained from Minister prior to extension of authorisation.
9-Jul-20	Extension of Authorisation of all Schedule 1 Emergency Powers: State Controller.	Extended to 31 August 2020. Consent obtained from Minister prior to extension of authorisation.
9-Jul-20	Extension of Authorisation of all Schedule 1 Emergency Powers: All members of Tasmania Police to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Extended to 31 August 2020. Consent obtained from Minister prior to extension of authorisation.
9-Jul-20	Authorisation of Schedule 1 Emergency Powers (extension): Biosecurity Tasmania to ensure compliance with directions of the Director of Public Heath under the *Public Health Act 1997*, and Directions of the State Controller.	Extended to 31 August 2020. Consent obtained from Minister prior to extension of authorisation.

Consent was sought from the Minister for Police, Fire and Emergency Management for authorisations, or extensions, on the exercise of Emergency Powers under the EM Act in accordance with section 40(6)(b) of EM Act.

Appendix 3

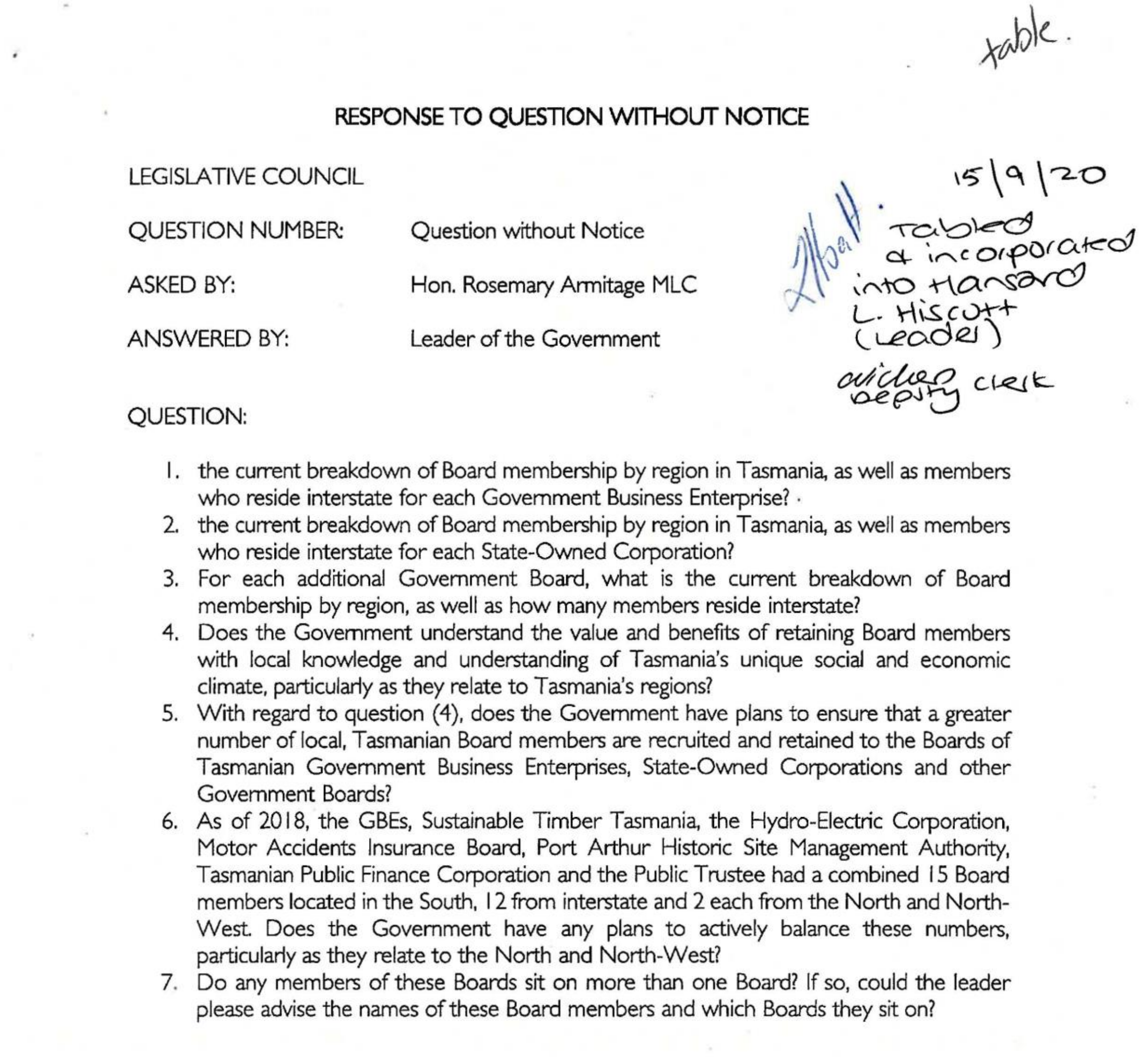


table.

RESPONSE TO QUESTION WITHOUT NOTICE

LEGISLATIVE COUNCIL

15/9/20
Tabled
& incorporated
into Hansard
L. Hiscott
(Leader)
deputy clerk

QUESTION NUMBER:	Question without Notice
ASKED BY:	Hon. Rosemary Armitage MLC
ANSWERED BY:	Leader of the Government

QUESTION:

1. the current breakdown of Board membership by region in Tasmania, as well as members who reside interstate for each Government Business Enterprise?
2. the current breakdown of Board membership by region in Tasmania, as well as members who reside interstate for each State-Owned Corporation?
3. For each additional Government Board, what is the current breakdown of Board membership by region, as well as how many members reside interstate?
4. Does the Government understand the value and benefits of retaining Board members with local knowledge and understanding of Tasmania's unique social and economic climate, particularly as they relate to Tasmania's regions?
5. With regard to question (4), does the Government have plans to ensure that a greater number of local, Tasmanian Board members are recruited and retained to the Boards of Tasmanian Government Business Enterprises, State-Owned Corporations and other Government Boards?
6. As of 2018, the GBEs, Sustainable Timber Tasmania, the Hydro-Electric Corporation, Motor Accidents Insurance Board, Port Arthur Historic Site Management Authority, Tasmanian Public Finance Corporation and the Public Trustee had a combined 15 Board members located in the South, 12 from interstate and 2 each from the North and North-West. Does the Government have any plans to actively balance these numbers, particularly as they relate to the North and North-West?
7. Do any members of these Boards sit on more than one Board? If so, could the leader please advise the names of these Board members and which Boards they sit on?

ANSWER:

1. The following table provides the breakdown of Board membership by region as at 26 August 2020 for each Government business:

Government Business Enterprise	Southern Tasmania	Northern Tasmania	North-West Tasmania	Interstate	Total
Hydro Tasmania	1	1	0	4	6
MAIB	2	1	1	1	5
PAHSMA	4	0	0	2	6
Public Trustee	2	1	1	1	5
STT	3	1	0	2	6
Tascorp	1	0	0	3	4
TOTAL	**13**	**4**	**2**	**13**	**32**

2. The following table provides the breakdown of Board membership by region as at 26 August 2020 for each State-Owned Corporation:

State-Owned Company	Southern Tasmania	Northern Tasmania	North-West Tasmania	Interstate	Total
Aurora Energy	2	0	1	2	5
Metro Tasmania	2	0	1	2	5
Tas Irrigation	1	3	0	1	5
TasNetworks	4	1	0	1	6
TasPorts	3	1	0	1	5
TasRacing	4	2	0	1	7
TasRail	1	1	0	3	5
TT-Line	4	0	0	3	7
TOTAL	**21**	**8**	**2**	**14**	**45**

3. The Women on Boards Database holds data for 101 Government boards and committees (excluding GBEs ad SOCs) as at 30 June 2020.

   Of the 101 boards and committees, there are 830 filled positions on Government boards and committees. Of these:

   - 594 reside in the South
   - 66 reside in the North-West
   - 140 reside in the North; and
   - 30 reside interstate.

   Please note that:

   - As some members sit on multiple Government boards and committees, they are being counted more than once in the above data.
   - There are currently 24 vacant positions across the 101 boards and committees.

4. As outlined in the *Guidelines for Tasmanian Government Businesses: Board Appointments* (Guidelines), an active approach to Board composition and renewal is required to ensure a balance of skills and experience that match the needs and direction of each Government business.

   The Guidelines stipulate that the director selection and appointment process for Tasmanian Government businesses is to be undertaken within the parameters of several key principles, one of which is diversity.

5. The selection process has been developed to recognise the importance of diversity in Board membership and the need to maintain a constant and on-going pool of qualified candidates. This ensures a balance of skills and experience, including geographical background, are identified and considered throughout the selection process.

6. The Treasurer and Portfolio Ministers actively monitor diversity of Government business Board compositions.

7. There are four people on multiple Government business boards:

Director Name		
Samantha Hogg	Hydro Tasmania	Tas Irrigation
Michael Dontschuk	MAIB	Public Trustee
Tracy Matthews	Public Trustee	TasPorts
Helen Galloway	Tasracing	TT-Line

APPROVED / NOT APPROVED

Hon Peter Gutwein
Premier
Treasurer

Date: 10.9.20