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THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

VOLUNTARY ASSISTED DYING BILL 2023

REVISED EXPLANATORY STATEMENT

Presented by
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VOLUNTARY ASSISTED DYING BILL 2023

This explanatory statement relates to the Voluntary Assisted Dying Bill 2023 (**the Bill**) as presented to the ACT Legislative Assembly.

The statement is to be read in conjunction with the Bill. It is not a complete description but provides information about the intent of the provisions in the Bill.

It has been prepared to assist the reader. It does not form part of the Bill, has not been endorsed by the Legislative Assembly and is not to be taken as providing a definitive interpretation of the meaning of a provision.

The Bill is a Significant Bill. Significant Bills are bills that have been assessed as likely to have significant engagement of human rights and require more detailed reasoning in relation to compatibility with the *Human Rights Act 2004*.

BACKGROUND

The ACT Government believes all Canberrans should have end of life choices that align with their rights, preferences and values. Canberrans should have access to quality health care, including end of life care, when they need it.

However, we know that even with the best end of life care, some individuals with an advanced condition, illness or disease experience suffering near the end of their lives. Eligible individuals should be able to make informed choices about the end of their lives, with the support of health practitioners. To promote the autonomy and dignity of those people, the ACT Government is committed to legalising and regulating access to voluntary assisted dying, as all states in Australia have done, and as supported by a majority of Australians.[1]

Voluntary assisted dying (**VAD**) refers to a medical process that gives an eligible individual the option to end their suffering by choosing to die through the administration of an approved substance. VAD is not a choice between life or death, it is an additional choice that can be made by an eligible individual about the circumstances of their death.

Further, VAD is not considered to be a replacement for, or alternative to, effective palliative care. Palliative care is a holistic approach that aims to optimise the quality

[1] Australia Institute (2022) Polling – Territory rights and voluntary assisted dying, available at: https://australiainstitute.org.au/report/polling-research-territory-rights-and-voluntary-assisted-dying/.

of life of people, and their families, with an active, progressive and advanced disease and who is expected to die. Palliative care helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness.[2].

The ACT Government has long advocated for the ability of the ACT to introduce VAD. In 1997, Federal Parliament placed a ban on the Territories making laws about this important matter. On 1 December 2022, the *Restoring Territory Rights Act 2022* (Cth) was passed by Federal Parliament to lift that ban, enabling the Legislative Assembly to introduce this Bill to establish a legislative framework for VAD in the ACT, following community consultation.

OVERVIEW OF THE BILL

As ACT law currently stands, the self-administration of a substance to end one's own life is suicide. Any individual, including health practitioners, who assist that process of self-administration may commit the offence of aiding or abetting suicide or attempted suicide under section 17 of the *Crimes Act 1900* (ACT). Depending on the circumstances, an individual who administers the substance at the person's request may commit the offence of murder or manslaughter.

The Bill changes the law to ensure that, in defined circumstances and with strong safeguards, it is lawful for an authorised practitioner to assist an eligible individual to access an approved substance as an additional end of life choice.

The Bill's objects are to:

a. give individuals who are suffering and dying the option of requesting the assistance of health practitioners to end their lives; and

b. establish a process for individuals to exercise the option to request assistance to end their lives if they have been assessed as meeting the requirements under the Bill;

c. establish mechanisms to ensure that VAD is accessed only by individuals who want to exercise the option to request assistance to end their lives; and have been assessed as meeting the requirements under the Bill to access VAD; and

d. protect individuals from coercion and exploitation; and

[2] Palliative Care Australia (2023). "What is Palliative Care?", accessed 28 October 2023, available at: https://palliativecare.org.au/resource/what-is-palliative-care/

e. provide protection for health practitioners who choose to assist, or not assist, individuals to exercise the option of ending their lives in accordance with this Bill; and

f. provide for the monitoring and enforcement of compliance with this Bill.

The Bill achieves this by establishing a framework for VAD in the ACT, the key features of which include:

- clear eligibility requirements to ensure VAD is only available to adults with decision-making capacity who are dying and suffering intolerably, and acting voluntarily;
- a thorough process for requesting, and being assessed as eligible, to access VAD;
- clearly defined roles, requirements, protections and training for all health practitioners who wish to be involved in VAD;
- minimum standards that must be followed by individuals and facility operators that are unwilling or unable to assist with VAD, including conscientious objectors;
- strict requirements and safeguards for prescription, management, administration and disposal of an approved substance;
- the establishment of an independent oversight body to monitor and report on the operation of the Bill, record data, and exercise other oversight functions;
- criminal offences for non-compliance with the Bill; and
- other matters to support the operation of the scheme.

Further detail on how the Bill achieves its objectives is set out in the human rights analysis and the clause notes below.

The Bill draws from the legislation and experiences in other Australian states, noting that they are at different stages of implementing access to VAD and that each jurisdiction has its own unique characteristics.

As in other Australian jurisdictions, the Bill will be complemented by a suite of policy and guidance as part of the implementation process. As demonstrated by other Australian jurisdictions, establishing and operationalising VAD with appropriate safeguards and processes is crucial to ensure health system readiness and workforce capability to deliver VAD once the laws come into effect. Part of

implementation will be the establishment of system-wide care and referral pathways for VAD including a Care Navigator Service and centralised pharmacy service.

CONSULTATION ON THE PROPOSED APPROACH

In developing the Bill, the Government consulted with the public, key stakeholders, subject matter experts, and other Australian jurisdictions.

Public consultation through the ACT Government's YourSay webpage and targeted roundtables and meetings was undertaken from 7 February to 6 April 2023. The ACT Government's consultation sought views on how VAD should work in the ACT.

The consultation posed questions around who should have access to VAD, what process a person should follow to access VAD, what role health professionals and facilities should play, and how VAD could be monitored to ensure that safeguards are operating effectively.

To deliver an inclusive and accessible consultation, the ACT Government worked closely with the ACT Office for Disability, Disability Reference Group, Office for Aboriginal and Torres Strait Islander Affairs, and Aboriginal and Torres Strait Islander Elected Body. Consultation drew upon lived experience within the health system, and the Government also worked closely with organisations representing a wide variety of health consumers in the ACT.

During consultation, the YourSay Conversations website provided the community with information including a detailed Discussion Paper containing 36 questions for comment, a series of shorter Discussion Guides translated into Easy English and five common languages for the ACT community, and an invitation for people to have their say. The Discussion Paper was also available in ACT libraries, and by mail on request.

The consultation received 366 'short answer' submissions from individuals and 106 formal submissions received from organisations and individuals. In addition, 2,937 Canberrans who were part of the ACT Government's YourSay Panel completed a survey on VAD.

More than 30 meetings with stakeholders were held, including eight roundtables and workshops with key organisations representing health professionals, health consumers, health and aged care providers, disability, mental health, and First Nations communities. Meetings were held with the Disability Reference Group, Ministerial Council on Ageing, Multicultural Advisory Council, Youth Advisory Council, LGBTIQ+ Advisory Council, and members of the Aboriginal and Torres Strait Islander Elected Body to hear from Canberrans with lived experience. The Government also consulted closely with a Clinical Reference Group of health professionals and leaders from the ACT Health Directorate and Canberra Health Services, and held a workshop on clinical considerations attended by over 150 health professionals at Canberra Health Services.

The starting point for consultation was that VAD in the ACT would be informed by the 'Australian model' for VAD. The Australian model refers to the general approach

taken in Victoria, Western Australia, Queensland, South Australia, Tasmania, and New South Wales. Overall, most contributors supported the ACT adopting the main features of the Australian model:

- Strict eligibility requirements, including that a person must be suffering unbearably from a terminal illness, disease or condition;
- Thorough request process: three requests, including one in writing, with accessibility options, witnessed by independent witnesses;
- Provision of support and information through a government-run Care Navigator Service and centralised pharmacy service;
- Two health professionals, who meet training and eligibility requirements to independently assess a person's eligibility, at least one of whom is responsible for ensuring the person is informed and supported regarding all of their end of life and care options;
- Strict requirements for prescription, management and administration of an approved substance with criminal offences for mismanagement;
- Health professionals and health services may object to being actively involved in facilitating VAD, as long as they do not hinder access; and
- An independent oversight body monitors and reports on the operation of the Bill, records data, and exercises other oversight functions.

There was strong support for some aspects of the Australian model. However, the need for some adjustments to this model were also identified, to build on the experiences of other jurisdictions and meet the unique needs of the ACT.

Targeted feedback on a consultation draft of the Bill was sought from ACT Policing, ACT Human Rights Commission, ACT Courts and Tribunal, ACT Corrective Services, Access Canberra, Capital Health Network, ACT Law Society, ACT Bar Association, Aboriginal Legal Service NSW/ACT, Legal Aid ACT, and the Aged and Community Care Providers Association. Targeted consultation was also undertaken with ACT Disability, Aged and Carer Advocacy Service, Australia, Health Care Consumers' Association, Carers ACT and Women With Disabilities ACT.

CONSISTENCY WITH HUMAN RIGHTS

During the development of the Bill, due regard was given to its compatibility with human rights as set out in the *Human Rights Act 2004* (ACT) (**HRA**).

An assessment of the Bill against section 28 of the HRA is provided below. Section 28 provides that human rights are subject only to reasonable limits set by laws that can be demonstrably justified in a free and democratic society.

Rights engaged

The Bill engages the following sections of the HRA:

- Section 8 – Recognition and equality before the law (promoted and limited)
- Section 9 – Right to life (promoted and limited)
- Section 11 – Right to protection of the family and children (promoted and limited)
- Section 12 – Right to privacy and reputation (promoted and limited)
- Section 14 – Right to freedom of thought, conscience, religion and belief (promoted and limited)
- Section 18 – Right to liberty and security of a person (limited)
- Section 22 – Rights in criminal proceedings (limited)

Rights promoted

Access to VAD: Right to life, right to privacy

1. Right to life

Section 9 of the HRA provides that everyone has a right to life and no-one may be arbitrarily deprived of life. In the words of the United Nations Committee on Human Rights: 'the right to life has crucial importance both for individuals and for society as a whole. It is most precious for its own sake as a right that inheres in every human being, but it also constitutes a fundamental right, the effective protection of which is the prerequisite for the enjoyment of all other human rights and the content of which can be informed by other human rights.'[3]

The right to life comprises three distinct but overlapping obligations on government: an obligation not to arbitrarily take life; an obligation to safeguard life in specific circumstances; and an obligation to undertake proper and effective investigations into certain deaths. This Bill primarily engages the first obligation: to not support the arbitrary deprivation of life. Arbitrariness includes elements of inappropriateness,

[3] UN Human Rights Committee (HRC), *General comment no. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35, accessed 28 October 2023, available at: https://www.refworld.org/docid/5e5e75e04.html, [2].

injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity and proportionality.[4]

An important starting point is that VAD is not inherently incompatible with the right to life. The right to life does not impose on individuals a duty to live,[5] nor impose on governments 'a duty in every case to take steps to keep a terminally ill patient alive by all means for an indefinite period.'[6] Although the State has a positive obligation to protect human life, death is not always a negation of that right. How a person chooses to pass the final moments of their life is 'part of the act of living'.[7]

The United Nations Committee on Human Rights has stated that governments may allow health professionals 'to provide medical treatment or the medical means to facilitate the termination of life of afflicted adults, such as the terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity', as long they 'ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patients, with a view to protecting patients from pressure and abuse'.[8]

The Bill aims to promote the right to life in two key ways:

- By enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity'.[9] The right to enjoy a life with dignity is a core element of the right to life.[10] Courts overseas have recognised that 'the rights to dignity and to life are entwined. The right to life is more than existence – it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished.'[11] By providing a choice to not endure intolerable end of life suffering, the Bill promotes this aspect of the right to life.

- By putting in place safeguards so that an individual's life may not be ended arbitrarily, particularly involuntarily. Involuntary euthanasia represents an egregious, and criminal, breach of the right to life. In particular, failing to protect

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[4] Above n 3, [12].

[5] *Carter v Canada (Attorney-General)* [2015] 1 SCR 331, 367 [63].

[6] *Shortland v Northland Health Ltd* [1998] 1 NZLR 433; *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235. See also *Auckland Health Care Services Ltd v L* [1998] 1 NZFLR 74.

[7] *Pretty v United Kingdom* (2002) 35 EHRR 1, 37 [64]; *R (Purdy) v DPP* [2009] UKHL 45; [2009] 3 WLR 403, 416 [36], 424 [60].

[8] Above n 3, [9].

[9] Above n 3, [3], [9].

[10] Above n 3, [3].

[11] *S v Makwanyane* [1995] ZACC 3; [1995] 3 SA 391, 506 [327]; *Stransham-Ford v Minister for Justice and Correctional Services* [2015] ZAGPPHC 230; [2015] 4 SA 50, 60 [22]; *Searles v Attorney-General (NZ)* [2015] NZHC 1239; [2015] 3 NZLR 556, 574 [66].

vulnerable individuals may threaten their autonomy to choose to continue to live. The Bill promotes the right to life by ensuring that VAD as an additional end of life choice cannot become available to an individual unless they are acting voluntarily, without coercion, and with decision-making capacity; and by providing dozens of other safeguards to ensure no life can be taken arbitrarily.

2. Right to privacy

The Bill also promotes the right to privacy, by upholding individual autonomy to make choices about their own body, their life and their own death. The right to privacy protects notions of individual existence and autonomy that '[do] not touch upon the sphere of liberty and privacy of others'.[12] The right to privacy gives rise to 'a right to one's own body',[13] recognising that human beings have agency and self-determination in all aspects of their life, including to decide how and when to die.[14]

Right to equality and non-discrimination: flexibility for VAD requests

The Bill promotes the right to the right to equality and non-discrimination, by ensuring that an individual who wishes to access VAD has support to access it:

- as far as possible, allowing for decisions to be communicated in 'whatever way [the individual] can' – clause 12(1)(f);
- allowing for an individual's first and final request for VAD to be made in writing, orally, or by communicating in any other way the individual can – clause 13 and 32;
- acknowledging that an individual is capable of making a decision if they are capable of making the decision with adequate and appropriate support, and requiring that all practicable steps must be taken to support the individual to make decisions about VAD – clause 12(3), 16 and 23.
- acknowledging that capacity is fluid – clause 12(3)(e).

Provisions such as these ensure that an individual is not precluded from accessing VAD simply because they have a disability or condition which involves fluctuating

[12] Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (NP Engel, 2nd rev. ed, 2005), 385.

[13] Above n 12, 389.

[14] *Haas v Switzerland* [2011] ECHR 2422; (2011) 52 EHRR 33, 1184 [51]; *Koch v Germany* [2012] ECHR 1621; (2012) 56 EHRR 6, 207 [46], 208 [51]; *Gross v Switzerland* [2013] ECHR 429; (2013) 58 EHRR 197, 211 [60].

decision-making capacity, or which affects their ability to communicate without support.

This is particularly important in the context of VAD. Many individuals seeking to access VAD may, due to the advanced progression of their condition, have lost the ability to speak or write. Others may be taking medication that affects their decision-making capacity from time to time. Providing safeguarded yet flexible avenues for accessing VAD promotes the right to equality and non-discrimination.

Right to equality and non-discrimination, right to life, right to privacy: no timeframe to death requirement

Unlike other Australian jurisdictions, the Bill imposes no eligibility requirement that the individual's relevant conditions must be expected to cause their death with 6 or 12 months to access VAD (**the 'timeframe to death requirement'**).

This is intended to promote the right to equality and non-discrimination under section 8 of the HRA by enabling individuals to choose to access VAD if they meet all eligibility requirements, regardless of how soon their condition is expected to cause their death. In practice, this reduces the Bill's ability to discriminate between individuals based on the nature of their condition and prognosis. In turn, promoting the right to equality and non-discrimination regardless of timeframe to death also facilitates the enjoyment of the rights promoted by access to VAD discussed above.

These rights-promoting purposes of excluding a timeframe to death requirement are supported by evidence:

- **Arbitrary outcomes:** Timeframe to death requirements can operate arbitrarily, in that there may be very little to distinguish between the intolerable suffering of a person who is expected to die within the specified time limit, and those with similar conditions whose prognosis is slightly longer. This is exacerbated by the fact that different health professionals may assess timeframes to death in different ways, with different outcomes. The HRA requires that any limitations on human rights arising from the Bill are reasonable and justifiable, rather than arbitrary. The timeframe to death requirement in Queensland, another Australian human rights jurisdiction, has been criticised as disproportionate and arbitrary when considering the severe impact of timeframe restrictions on individuals and the existing limitation that persons without a terminal illness cannot access VAD.[15]

[15] Willmott, Lindy & White, Ben (2017) "Assisted dying in Australia: A values-based model for reform" In Petersen, K & Freckelton, I (Eds.) *Tensions and traumas in health law.* The Federation Press, Australia, 503.

- **Limits access to VAD:** A timeframe to death requirement risks preventing people who would be otherwise be eligible from accessing VAD, if the delay until death is approaching means that they are no longer well enough to navigate the assessment process.[16] The requirement would mean that individuals are unable to begin the VAD process at a time that suits their circumstances. For example, the ACT Government's consultation heard from health professionals that the Bill must allow enough time for people to go through the process and make a decision while people still have decision-making capacity, and that if the timeframe to death requirement is too restrictive that can becomes a problem.

- **Estimating timeframe to death can be inaccurate:** There is growing evidence that estimating a timeframe to death is inherently uncertain and imprecise.[17] According to a survey of members of the Australian and New Zealand Society for Geriatric Medicine in response to the (then) newly enacted Victorian VAD law, one third of respondents did not feel comfortable estimating a patient's prognosis, despite 95% having experience treating patients with terminal diagnoses.[18] Research has found that prognostic tools have greater accuracy predicting shorter prognoses, such as weeks to months, rather than 6 months, and clinicians may opt out of participating in VAD because they feel unable to make precise prognostic judgements.[19] The variability across Australian jurisdictions in wording about the level of certainty a doctor must have, or the 'standard of proof' that they must apply, in determining whether death will occur within that specified time demonstrates the uncertainty in this area. For example, judgements about timeframe death to be made on what is 'expected' (Victoria) or estimated to occur on 'the balance of probabilities' (Western Australia). These challenges were echoed by many health professionals during the ACT Government's public consultation.

- **Exacerbating suffering:** Timeframe to death requirements can create a situation where terminally ill individuals are intolerably suffering, but are forced to continue to suffer until they are close enough to death to meet the timeframe requirement.[20] For example, individuals with a terminal illness who are suffering intolerably but are not expected to die within the timeframe may

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[16] White at al, 'Who is Eligible for Voluntary Assisted Dying? Nine Medical Conditions Assessed Against Five Legal Frameworks' (2022) 45 *UNSW Law Journal,* 1.

[17] Nahm, S.H., Stockler, M.R. and Kiely, B.E. (2022), "Voluntary assisted dying: estimating life expectancy to determine eligibility" *Med J Aust*, 217: 178-179. https://doi.org/10.5694/mja2.51648.

[18] Treleaven et al, 'A review of the utility of prognostic tools in predicting 6-month mortality in cancer patients, conducted in the context of voluntary assisted dying' (2023) 1 *Internal Medicine Journal* 18.

[19] Ibid.

[20] White at al, 'Comparative and Critical analysis of key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks' (2021) 44 *UNSW Law Journal* 4.

be forced to consider the cruel choice between continuing to intolerably suffer until they meet the timeframe, or ending their own life outside of the VAD framework.[21] This was reflected by the ACT Government's consultation with individuals with lived experience. This outcome would directly contradict the objects of the Bill.

- **No support for a six month timeframe:** There is particularly strong evidence that a six month timeframe to death requirement would not be consistent with the Bill's objectives. Australian VAD advisory bodies have found that a six month timeframe to death requirement should not be adopted, as it is an 'arbitrary time limit based on factors that are not applicable to the Victorian context'.[22] The ACT Government's consultation also heard strong support to not include a six month timeframe to death requirement. Contributors were concerned that a short timeframe would, in practice, require an individual to continue to suffer until they are close to death, and within that six month window may die or lose decision-making capacity before they can access VAD.

- **Supported in public consultation**: Overall, the ACT Government's public consultation on VAD demonstrated that most contributors with views on this matter felt that VAD in the ACT should not be restricted by a timeframe to death requirement.

- **Consistency with majority of VAD jurisdictions**: Not having a timeframe to death requirement in the ACT is consistent with the approach in the Netherlands, Belgium, Switzerland, Canada, Colombia, Spain and Luxembourg.[23]

It is arguable that a timeframe to death requirement is necessary to 'maintain the principle that [VAD] is not a choice between life and death but a choice for those who are in the process of dying and wish to choose the time and circumstances of their death'.[24] Some contributors to the ACT Government's consultation supported the

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[21] Braun, 'When ill is not ill enough – timeframe until expected death restrictions in Australian Voluntary Assisted Dying laws and human rights compatibility' (2022) 28 *Australian Journal of Human Rights* 1.

[22] Parliament of Victoria, Legislative Council, Legal and Social Issues Committee, *Inquiry into end of life choices: final report,* Session 2014-16, no. 174, 223, available at: https://vgls.sdp.sirsidynix.net.au/client/search/asset/1288816. That Committee, as well as Victoria's Ministerial Advisory Panel on VAD, responsible for considering Australia's first VAD law, found that such a requirement was introduced in Oregon (and subsequently other US states) because that is when funding for hospice care was available in that jurisdiction – a factor that is irrelevant in Australia. See Ministerial Advisory Panel on Voluntary Assisted Dying, *Final Report*, Department of Health and Human Services, July 2017, 72 available at: https://www.health.vic.gov.au/publications/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report.

[23] Above n 18.

[24] Above n 21.

inclusion of a 12 month timeframe to death requirement on the basis of ensuring the option was only available for people towards the end of their lives, as well as to provide clarity to health practitioners and consumers.

However, the Bill's careful combination of eligibility requirements and safeguards ensures that this purpose is achieved through less rights-restrictive means than imposing a timeframe to death requirement. A key safeguard is the eligibility requirements that a person's condition be expected to cause their death, causes intolerable suffering, and is advanced and progressive. This means that VAD will still only be available to those who are in the advanced stage of illness, or the final part of a person's life where quality of life becomes unacceptable and where treatment (if available) is no longer effective. Requiring that a person's condition is both advanced and terminal provides flexibility for an assessing health professional, while ensuring that VAD is only an option for those near the end of life who wish for an end to intolerable suffering.

Prominent Australian VAD academics have found that not only do time-based approaches have a number of undesirable outcomes but are largely redundant given other, determinative, eligibility requirements which work together to provide strong safeguards.[25] White and Willmott's research found that removing timeframes would have no impact on restricting the medical conditions that would permit access to VAD because the requirement for a person's medical condition to be 'advanced' similarly constrains access to VAD.[26]

Right to privacy and reputation: ACAT hearings held in private

Clause 125 of the Bill provides that a hearing of an application for review of a reviewable decision by ACAT must take place in private, unless ACAT makes an order allowing stated people to be present. This promotes the right to privacy and reputation as it protects personal and health information from being disclosed in public. Where a person does not wish their hearing to be private, a request could be made to ACAT for the hearing to be open to certain people or the public.

Right to freedom of thought, conscience, religion and belief: provision for conscientious objection

Part 6 of the Bill provides that health practitioners and health service providers may conscientiously object to assisting with VAD. This includes acting as a practitioner for

[25] Above n 16.
[26] Ibid.

an individual, providing VAD advice to an individual or other practitioners, participating in VAD assessment and administrative processes, supplying an approved substance and being present when an approved substance is administered.

By allowing health practitioners and health service providers to act consistently with their personal convictions, the Bill promotes their right to freedom of thought, conscience, religion and belief. This also promotes one of the objects of the Bill which is to provide protection for health practitioners who choose to assist, or not assist, individuals to exercise the option of ending their lives.

A health practitioner or health service provider who conscientiously objects must provide referral information to the individual which, as discussed below, may also limit the right to freedom of thought, conscience, religion and belief.

Right to fair trial: protection from liability for assisting with VAD

The right to fair trial encompasses the right to fair hearing, which is concerned with procedural fairness, and equal access to proceedings.

This right is promoted by Part 9 of the Bill, which protects various categories of individuals from certain types of liability for undertaking functions in accordance with the Bill honestly and without recklessness. This includes protections from criminal liability for health practitioners who assist an eligible individual to lawfully access an approved substance.

Rights limited

Allowing access to VAD – right to life

1. Nature of the right and the limitation (s28(a) and (c))

The Bill engages the right to life by making it lawful for an individual to access a substance intended to cause death, and for certain individuals to assist another individual to die.

Section 9 of the HRA provides that everyone has a right to life and no-one may be arbitrarily deprived of life. In the words of the United Nations Committee on Human Rights: 'the right to life has crucial importance both for individuals and for society as a whole. It is most precious for its own sake as a right that inheres in every human being, but it also constitutes a fundamental right, the effective protection of which is the prerequisite for the enjoyment of all other human rights and the content of which can be informed by other human rights.'[27]

The right to life comprises three distinct but overlapping obligations on government: an obligation not to arbitrarily take life; an obligation to safeguard life in specific circumstances; and an obligation to undertake proper and effective investigations into certain deaths.

This Bill primarily engages the first obligation: to not support the arbitrary deprivation of life. Arbitrariness includes elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity and proportionality.[28]

An important starting point is that VAD is **not** inherently incompatible with the right to life. The United Nations Committee on Human Rights' has stated that governments may allow health professionals 'to provide medical treatment or the medical means to facilitate the termination of life of afflicted adults, such as the terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity', as long we they 'ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patients, with a view to protecting patients from pressure and abuse'.[29] Accordingly, the Bill seeks justifies the limitation on the right to life by ensuring the safeguards included are sufficient to prevent the arbitrary deprivation of life.

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[27] Above n 3, [2].

[28] Above n 3, [12].

[29] Above n 3, [9].

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[30] and by providing choices for a person about the circumstances of their death. This is discussed further in the 'rights promoted' section above.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

A person's right to life will be protected by establishing a safe and effective process for a person to access VAD. A person will be supported to make choices about their own body, their life and their own death while ensuring that vulnerable members of the community are protected from coercion and exploitation.

Evidence from Australia and overseas demonstrates that creating a safeguarded process to access VAD helps to achieve those purposes. Reliable evidence about VAD systems internationally and in Australia shows that VAD can be safely regulated.[31]

Evidence is emerging from Victoria – the longest-running VAD jurisdiction in Australia, whose Act was the starting point for developing this Bill – that lawful access to VAD is promoting the human rights of eligible individuals. For example, research indicates patient experiences of accessing the VAD Care Navigator Service 'made a very difficult situation more manageable' through 'care and compassion'.[32] Family members and loved ones report comfort from seeing a person 'relieved of suffering and being able to access a dignified end of life on their own terms'.[33] An individual who used an approved substance to die made the following remarks:[34]

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[30] Above n 3, [3], [9].

[31] White, Ben & Willmott, Lindy (2021) *Voluntary assisted dying research: a policy briefing*. Australian Centre for Health Law Research, Queensland University of Technology, available at: https://eprints.qut.edu.au/216870/8/Voluntary_assisted_dying_research_policy_briefing_NC.pdf 1.

[32] Above n 31, 2.

[33] Voluntary Assisted Dying Review Board (Victoria), *Annual Report: July 2022 to June 2023,* available at: https://www.safercare.vic.gov.au/sites/default/files/2023-08/VADRB%20Annual%20Report%202022-23.pdf, 1

[34] Above n 33, 24.

'Thank you for the opportunity to end my suffering on my own terms with dignity. I feel no pressure to use [the substance] and will remember you both, as my wife will, for your act of humanity and kindness.'

Overall, the Victorian VAD Board has reported that the true 'measure of success' of the operation of the Victorian law is 'providing relief from suffering':[35]

'Feedback from applicants, families, loved ones and others involved shows the benefits accrue to a far wider group. They include those who obtain comfort from the knowledge that they have an option for end of life treatment; or that they have the substance but may not use it; and for families and loved ones who witness the person's wishes fulfilled and autonomy respected.'

The Victorian experience has also demonstrated that even having access to a VAD process through legislation is having a positive palliative effect on the lives of individuals experiencing intolerable suffering:[36]

'[The] number of people accessing an approved substance does not represent the full beneficial impacts of the VAD program. There are, in addition, people who obtain the substance but choose not to use it, who receive comfort and relief from suffering by knowing that they have the option.'

4. Proportionality (s28 (e))

There is no reasonably available alternative which achieves the purpose of allowing VAD, but which imposes less harm to human rights. More onerous safeguards would create barriers to a person's reasonable access to VAD, and would therefore not achieve the purpose of the Bill nor impose a lesser burden on human rights. Alternatively, reducing the safeguards to access VAD would increase the risk that vulnerable members of the community may be subject to coercion and exploitation.

The systems and safeguards introduced by the Bill are comprehensive, and ensure as far as reasonably possible that any limitation on the right to life is justified. They have been developed and informed by research, evidence and community views on what is fair and appropriate.

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[35] Voluntary Assisted Dying Review Board (Victoria), *Report of operations: July 2021 to June 2022*, available at, p 1: https://www.safercare.vic.gov.au/sites/default/files/2022-09/Voluntary%20Assisted%20Dying%20Review%20Board%20Report%20of%20Operations%20July%202021-June%2022_FINAL.pdf, 1.

[36] Above n 33.

Relevant safeguards to ensure a person's right to life is not unreasonably limited and that a person is not arbitrarily deprived of life. These include:

- independence of health practitioners and witnesses;
- VAD is only available as an end of life option. Strong eligibility requirements to access VAD is established in the Bill including that a person must:
    - be suffering intolerably,
    - have an eligible condition that is advanced and progressive,
    - have decision-making capacity,
    - be acting voluntarily and without pressure or duress.
- guidance will be provided to health practitioners on interpretation of legislation in relation to eligibility;
- review of certain decisions on eligibility is available through ACAT;
- health practitioners must provide certain information to an eligible individual about the alternatives to VAD, to ensure they are aware of other end of life options that might be less rights-restricting;
- strong penalties for non-compliance with the Bill, including for inciting or coercing a person to access VAD or self-administration an approved substance;
- assisting someone's death will remain an offence unless it is undertaken in accordance with the Bill.

A less restrictive limitation on the right to life would be to retain the status quo and not have access to VAD in the ACT, however this would fail to achieve the Bill's legitimate purposes. Consultation demonstrated strong community and stakeholder support for the role of VAD as one of many end of life options for an eligible individual whose suffering is intolerable.

<u>Right to recognition and equality before the law, right of children to protection: restricting access to adults</u>

1. Nature of the right and the limitation (s28(a) and (c))

The Bill prohibits an individual aged under 18 years of age from accessing VAD, even if they meet all the other eligibility requirements. In practice, this limitation means that adults who meet the eligibility requirements will have a choice to end

intolerable suffering through VAD, but that young people similarly suffering and dying will be required to endure intolerable suffering, 'regardless of their maturity and regardless of their views on the matter'.[37]

This limits the right to equality and non-discrimination for a young person with decision-making capacity who meets all the other eligibility requirements and wishes to access VAD to end their intolerable end of life suffering. Section 8 of the HRA provides that everyone is entitled to enjoy their rights without discrimination of any kind, and that everyone is equal before the law and entitled to the equal protection of the law without discrimination. Section 8 of the HRA also provides that every person has a right to enjoy their other human rights without discrimination. That means that young people have a right to enjoy the human rights promoted through access to VAD – the right to life and right to privacy – without discrimination based on their age.

Because the Bill provides no way for a young person's views to be taken into account in relation to accessing VAD, the Bill also limits an aspect of a child's right to the protection they need because of being a child, recognised in section 11(2) of the HRA. Key to this right is that a young person's best interests must be a primary consideration in any decision that affects a young person.[38] In determining a young person's best interests, their views must be taken into account: '[a]ny decision that does not take into account the child's views or does not give their views due weight according to their age and maturity, does not respect the possibility for the child or children to influence the determination of their best interests.'[39]

2. Legitimate purpose (s28(b))

The legitimate purpose of limiting access to VAD to adults aged 18 years and over promotes the young person's right to life, particularly the right not to be arbitrarily deprived of life. It also promotes a young person's right to protection. That right requires the government to support parents to exercise responsibility for protecting their children.[40] Both rights are promoted by ensuring that a young person is not put in a position where they can freely decide to access medical assistance to end their own life.

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[37] See submission by Professor Colleen Cartwright: Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary assisted dying* (Report No 34, March 2020), 116 [8.2.1].

[38] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) ('CRC') art 3.

[39] Committee on the Rights of the Child, *General Comment No 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration* (art 3, para 1), UN Doc CRC/C/GC/14 (29 May 2013) 13 [53].

[40] UN Human Rights Committee, *General Comment No. 17: Article 24 (Rights of the child)* (1989) [6].

3. Rational connection between the limitation and the purpose (s28(d))

Any Bill introducing access to VAD for young people who meet the eligibility requirements would need to ensure that young people would be correctly assessed as having decision-making to decide to access VAD.

Extensive consultation with health professionals on the development of this Bill demonstrated significant policy complexities in determining the most appropriate, safeguarded and evidence-based mechanism for assessing decision-making capacity in young people in relation to VAD. No jurisdiction in Australia has developed such a mechanism. While the concept of Gillick competency is recognised for assessing capacity in young people's health decisions, its application in the context of VAD is untested. There are still gaps in the evidence regarding the capacity of minors to give voluntary and informed consent to VAD.[41] The ACT's Clinical Reference Group (CRG) raised concerns that working with young people was inherently complex, particularly in relation to assessing their decision-making capacity in the context of their emerging capacity and autonomy. Additional safeguards would be needed as there are complexities around treating and caring for terminally ill young people and the involvement of parents/guardians and families.

Further, as the ACT is a very small jurisdiction, specialist paediatric treatment and palliative care for young people with complex and terminal illnesses is often provided interstate by the Sydney Children's Hospital and Network. Clinicians in the CRG advised that in their experience, those young people resident in the ACT who might otherwise meet the eligibility requirements for VAD would generally receive treatment and care outside the ACT due to the limited availability and capacity of specialised paediatric care in the ACT.

In addition, it is estimated that there would generally be very limited demand for VAD in the ACT among young people, due to the very small numbers of young people that would meet the other eligibility requirements. If practitioners were not regularly providing the specific services associated with VAD for minors, this would limit the ACT's ability to provide quality health services in that context. Allowing access to VAD in those circumstances may unreasonably limit the rights of young people to protection.

It is therefore not yet possible for the ACT Government to ensure the quality and safety of the provision of highly specialised VAD services and safeguards for young people without significant further research and, from that, capacity-building and training for ACT VAD clinicians and the ACT health system.

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[41] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (Report No 79, May 2021), 148 [7.368]-[7.369].

Allowing access to VAD to young people at this time without workable safeguards, due to the complexities of developing a mechanism for assessing decision-making capacity in young people in relation to VAD and the particular circumstances of the paediatric healthcare system in the ACT, would unreasonably limit the rights of young people to protection. The Bill's exclusion of young people is therefore rationally connected to its objective to protect young people from harm.

4. Proportionality (s28 (e))

The approach in this Bill, to limit access to VAD for only adults aged 18 years and over, aligns with ACT Government's obligation to protect the rights of young people.

The ACT Government's consultation demonstrated some strong support for mature young people suffering intolerably to have the same end of life choices as adults. However, the consultation also demonstrated strong expectations that access for young people be subject to additional safeguards, particularly in assessing whether a young person has decision-making capacity for VAD. As outlined above, given the current underdevelopment of suitable safeguards, the blanket ban on young people accessing VAD is the only means reasonably available to achieve the Bill's purpose in line with the ACT community's expectations.

Currently, there is no other reasonably available means to achieve the Bill's legitimate purpose of protecting the rights of young people to life and protection. Accordingly, the limits imposed on human rights by the age restriction are necessary to achieve their purpose.

VAD is a fast-developing policy area, and there is much to be learned from the implementation of schemes in the ACT, other Australian jurisdictions, and overseas. In light of this, the Bill provides that the restriction of VAD to adults will be reviewed as soon as practicable after three years of operation of the Bill.

<u>Right to equality and right to privacy: restricting access to individuals with a relevant condition</u>

1. Nature of the right and the limitation (s28(a) and (c))

The Bill requires that one of the eligibility requirements to access VAD is that an individual must have been diagnosed with a condition that, either on its own or in combination with one or more other diagnosed conditions, is advanced, progressive and expected to cause death (**relevant conditions**).

The Bill may limit the right to equality and non-discrimination in section 8 of the HRA, because it sets eligibility requirements which excludes people with conditions that do

not meet this threshold, while those with a relevant condition can access VAD. This right provides that everyone is entitled to enjoy their rights without discrimination of any kind, and that everyone is equal before the law and entitled to the equal protection of the law without discrimination.

Similarly to the other eligibility requirements that limit human rights, this also limits the human rights that would have been promoted through access to VAD: the right to dignity, and the right to privacy.

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[42] and by providing choices for a person about the circumstances of their death.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

Clearly defining eligibility requirements to access VAD enhances end of life choices for certain people, and ensures that VAD is not an available option for others. The Bill provides that VAD is only be available for persons diagnosed with an eligible condition.

There is a rational connection between the use of eligibility requirements and the legitimate purpose. Establishing eligibility requirements, including that a person must have a condition is advanced, progressive and terminal and must have decision making capacity, will reduce the risks that a vulnerable person may access VAD when they are not at the end of life stage of their illness. A similar requirement operates in other Australian jurisdictions.

The limitation seeks to strike a balance between allowing an individual access to the scheme, with ensuring there are appropriate safeguards to protect vulnerable people from coercion and exploitation. The Queensland Law Reform Commission's report found that using a combination of eligibility requirements clarifies that VAD is an option only for people at the end of life who are suffering and dying, and strikes the

[42] Above n 3, [3], [9].

right balance between the fundamental value of human life and the values of individual autonomy and reduced suffering.[43]

The Bill maintains a distinction between VAD and assisted suicide. As outlined in the Queensland Law Reform Commission's report, 'voluntary assisted dying is not a choice between life and death but a choice for those who are dying to exercise some control over the timing and manner of their death.'[44]

This clause is intended to protect against abuse of the VAD model by limiting access to only those who are facing death, rather than allowing broader categories of individuals access to a life-ending substance.

4. Proportionality (s28 (e))

The approach chosen is the least restrictive means reasonably available to achieve the Bill's legitimate purpose.

While the Bill may exclude certain groups of people who are suffering from issues such as extreme pain, loss of autonomy, indignity, and mental anguish',[45] the Bill seeks to protect the inherent value of human life, and the need to protect vulnerable people. The sanctity of human life and the need to protect vulnerable people are sufficiently important[46] that they are capable of outweighing the impacts on the human rights of people who do not meet the requirement that a condition must be advanced, progressive and terminal.

An alternate approach would be to establish different eligibility requirements, such as that a person's condition is not expected to cause death. While this would provide greater personal autonomy, it would significantly reduce the protection offered to vulnerable people.

The model for VAD applied through this Bill and in other jurisdictions seeks to provide end of life choices to alleviate suffering at the end of their lives. Allowing VAD for people who are not at the end of life stages of their relevant condition would fundamentally change the nature of VAD, and is not the intended purpose of this Bill.

To ensure the eligibility requirements are applied in a consistent manner by health practitioners, detailed guidance will be provided for VAD health practitioners on the

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[43] Above n 41, [7.71].

[44] Above n 41, [7.146].

[45] Above n 41, [7.104].

[46] See for example *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431; [2018] 3 WLR 925, 970-1 [205]-[207]; *R (Conway) v Secretary of State for Justice* [2018] UKSC B1; [2019] 1 WLR 1125.

factors to consider when assessing whether a relevant condition is advanced, progressive, and expected to cause death.

Right to recognition and equality before the law, right to life, right to privacy: restricting access to individuals with decision-making capacity

1. Nature of the right and the limitation (s28(a) and (c))

The Bill provides that an individual must have decision-making capacity at key stages of the VAD process: the first assessment, consulting assessment, final assessment, and practitioner administration of the approved substance. The concept of decision-making capacity is defined at clause 12 of the Bill and further discussed in the clause notes below.

This limits the right to equality for individuals who cannot demonstrate decision-making capacity at key stages of the process. Similar to the other eligibility requirements that limit human rights, this also limits the human rights that would have been promoted through access to VAD: the right to dignity, and the right to privacy.

In practice, this will often mean that VAD will not be available to individuals who might meet all the other eligibility requirements, but lose decision-making capacity near their end of their life because of their relevant conditions or their treatment.

This can be a significant limitation in the context of VAD, because many terminal conditions, such as advanced dementia, impair an individual's decision-making capacity while the person is experiencing intolerable suffering. Many contributors to the ACT Government's public consultation pointed out that dementia causes intolerable suffering as well as being a leading cause of death in Australia, such that restricting VAD to people with decision-making capacity would exclude a large proportion of people near the end of their lives and require them to continue intolerably suffering without the additional end of life choice of VAD.

2. Legitimate purpose (s28(b))

Restricting access to individuals who have decision-making capacity serves two legitimate purposes.

Firstly, it seeks to promote the right to life by protecting individuals who have lost capacity from arbitrary deprivation of life. 'Arbitrariness' includes elements of

inappropriateness, injustice, lack of predictability, and due process of law as well as elements of reasonableness, necessity, and proportionality.[47]

Secondly, it seeks to ensure that health practitioners are protected from liability for ending the life of a person who did not have capacity to consent.

3. Rational connection between the limitation and the purpose (s28(d))

The Bill's blanket rule that individuals without capacity cannot access VAD will achieve the Bill's legitimate purposes. A blanket rule ensures no individual will slip through the cracks, particularly because at least two health practitioners must independently attest that an individual has decision-making capacity. Similar blanket rules in all Australian jurisdictions with VAD laws are operating effectively to protect individuals who have lost decision-making capacity from arbitrary deprivation of life.

The requirement that decision-making capacity is demonstrated at key points of the process is fundamental to ensuring a decision to access VAD is voluntary, reflective of the individual's wishes, and is not the product of undue influence or coercion. This is particularly important to safeguard the lives people with disabilities and other vulnerable people from abuse and exploitation. Without appropriate frameworks and safeguards (as discussed below), allowing for an individual's access to VAD to be made when the individual has lost capacity would present a significant risk of unjust, unpredictable, and inappropriate deprivation of life.

The ACT Government's public consultation heard concerns from some health professionals that a decision to administer an approved substance to an individual who lacks capacity is highly subjective, ethically challenging, and without precedent in current medical practice in the ACT. Health professionals shared the challenges posed by, among other things, potentially having to administer an approved substance to a person who has lost the capacity to understand and agree that this substance would end their life. The consultation also heard from VAD experts who considered this issue had not yet been sufficiently researched and considered in Australia, particularly as no Australian VAD laws currently deal with this matter.

Given these challenges, and the absence of an appropriately developed framework and safeguards for these decisions, the Bill's restrictions on access to only individuals with capacity seek to protect the rights of people who do not have decision-making capacity and protect health practitioners from unknown or unreasonable civil, criminal and professional consequences.

[47] Above n 3, [12].

4. Proportionality (s28 (e))

The Bill's blanket rule that individuals without capacity cannot access VAD is proportionate, given the need to protect the rights of people without decision making capacity and the lack of evidence about safeguards which could be put in place to enable people in this cohort access to VAD. Similar blanket rules in all Australian jurisdictions with VAD laws are operating effectively to protect individuals who have lost capacity from arbitrary deprivation of life.

The requirement that decision-making capacity is demonstrated at key points of the process is fundamental to ensuring that a decision to access VAD is voluntary, reflective of the individual's wishes, and is not the product of undue influence or coercion. This is particularly important to safeguard the lives people with disabilities and other vulnerable people from abuse and exploitation. Without appropriate frameworks and safeguards (as discussed below), allowing for an individual's access to VAD to be made when the individual has lost capacity would present a significant risk of unjust, unpredictable, and inappropriate deprivation of life.

An alternative approach would be to allow for requests for VAD through advance care or 'final consent waiver' documents, as in Canada.[48] Although it is possible in the ACT to request through advance care planning that health professionals passively withdraw life-sustaining treatment, there is no current mechanism available in the ACT to request that health professionals actively use a substance to cause an individual's death. Significant legal, ethical and clinical changes would be required to create an appropriate framework for these decisions. The scope and implications of such a change to the nature of advance care documents is broader than the scope of the present Bill.

Another alternative approach would be to allow for case-by-case assessments, perhaps by the Board or ACAT, to determine whether the individual should have access to VAD despite having lost capacity. This would be less rights-restrictive than the present blanket ban. However, in the absence of an appropriate framework for these decisions, this approach would fail to achieve the Bill's purpose of protecting individuals who have lost capacity from arbitrary deprivation of life, and ensuring

[48] Canadian law allows the final consent that is required immediately before substance administration can be waived in certain circumstances. A person whose natural death is reasonably foreseeable, who has been approved for VAD, and who has arranged for VAD to be provided on a certain day can enter into a written agreement consenting to substance administration if they lose capacity to consent. The substance can then be lawfully administered, unless the person refuses or resists. See Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada: Choice for Canadians*, February 2023, 44th Parliament, 1st Session, available at: https://www.parl.ca/Content/Committee/441/AMAD/Reports/RP12234766/amadrp02/amadrp02-e.pdf, 66.

health practitioners are protected from liability for ending an individual's life without consent.

The ACT Government has committed to considering access to VAD for people who have lost decision-making capacity in the future, once the VAD model has been in operation for three years. This is reflected in the Bill's requirement for a statutory review of the operation and effectiveness of the Bill to specifically consider whether an individual should be allowed access to VAD through advance care planning.

This commitment is in response to the views of many contributors to the ACT Government's consultation that felt strongly that a person should be able to request VAD through advance care planning, so that VAD could take place if a person assessed as eligible had lost capacity at the time of administration of the VAD substance (for example, because of advanced dementia).

The statutory review will provide an opportunity to review relevant legal, ethical and clinical developments in Australia and internationally that may enable robust safeguards to be put in place to facilitate access to VAD in the ACT through advance care planning in future.

Right to recognition and equality before the law: restricting access to ACT residents who have lived in the ACT for at least the previous 12 months

1. Nature of the right and the limitation (s28(a) and (c))

Section 8 of the HRA provides that everyone is entitled to enjoy their rights without discrimination of any kind, and that everyone is equal before the law and entitled to the equal protection of the law without discrimination. The Bill limits the right to recognition and equality before the law by providing that VAD may only be accessed by individuals who have residents of the ACT for 12 months or more, or those who can establish they have a substantial connection to the ACT. This may mean that current ACT residents who do not meet the residency requirements are not eligible to access VAD in the ACT, unless they obtain a residency exemption under clause 151 of the Bill.

2. Legitimate purpose (s28(b))

The purpose of the limitation is to ensure that access to VAD in the ACT is not unduly limited by overburdening the ACT health system with people seeking access to VAD. This could occur if people were to move to the ACT to seek VAD where they do not otherwise have a connection to the ACT.

3. Rational connection between the limitation and the purpose (s28(d))

As demonstrated VAD laws in other Australian states, residency requirements help to ensure that individuals who have lived in the ACT for at least 12 months or have a substantial connection to the ACT have priority in accessing VAD.

Access to VAD under the Bill relies on timely access to qualified health professionals and, for many people, time spent under the care of a facility operator such as a palliative care hospice. Only a small number of health professionals and facility operators in the ACT have the experience, qualifications and will to assist with VAD. Without some restriction on the amount of people who seek to use those services in the ACT, it is possible that those services will be unable to meet demand.

Accordingly, limiting VAD access to people who have lived in the ACT for at least 12 months seeks to recognise 'the priority that residents of the legislating jurisdiction should expect to have in a system that depends on limited resources and a finite number of qualified persons to assess eligibility and to administer medication'.[49]

4. Proportionality (s28 (e))

The Bill strikes a fair balance between the need to protect the ACT health system from being unable to meet demand for ACT, and the need to enable access to VAD for individuals who should reasonably expect it.

This approach includes several safeguards to minimise the limitations on the right to equality:

i. Providing a simple 12 month residency requirement enables straightforward assessment of eligibility by a coordinating practitioner, and clear community understanding of VAD eligibility.
ii. Requiring the directorate to assess whether a person has a substantial connection to the ACT recognises that this is a more holistic assessment. Guidance will be issued to the directorate to support delegates to make decisions in a consistent and transparent manner.

iii. Decisions about residency requirements by a coordinating practitioner or the directorate are reviewable by the Tribunal (see Schedule 1 and 2), which promotes an individual's ability to seek redress if they disagree with the assessment.

In addition, the Bill provides that the Director-General must, on application, grant an exemption from the residency requirement if satisfied that the individual has a 'substantial connection to the ACT'. Examples in the Bill include an individual who

[49] Above n 41, [7.437].

lives close to the border and works or receives medical treatment, an Aboriginal individual with a substantial connection to the ACT who wishes to die on Country, and an individual who has lived in the ACT for less than 12 months but has been diagnosed with their relevant condition after moving to the ACT. The meaning of substantial connection is intended to be interpreted beneficially, allowing for case-by-case consideration of all the relevant circumstances. In assessing whether an individual has a 'substantial connection to the ACT', the decision maker would need to have regard to the human rights of a person living in the ACT, in accordance with s 40B of the HRA. The decision to grant an exemption is reviewable by ACAT.

The inclusion of the residency exemption where a person can demonstrate a substantial connection is to ensure that non-ACT residents who rely on health and palliative care in the ACT are not unreasonably limited from accessing VAD.

Many regional NSW residents – particularly those living very close to the ACT border – access health and palliative care in the ACT and visit the ACT regularly for appointments. Denying access to these individuals 'may have harsh, and possibly unintended, consequences for individuals who have a substantial connection…and who might be thought to be deserving of access to the scheme.'[50] Consultation strongly supported the ACT taking steps to ensure that individuals who rely on health care in the ACT, but do not reside here, should have access to VAD in the ACT.

This approach to achieving the legitimate purpose is less restrictive on rights than the approach in Victoria, South Australia, Tasmania, and Western Australia. These states restrict access to individuals who have lived in that state for at least 12 months, without providing for access available for individuals with a substantial connection to that state. The approach in the Bill recognises that conferring a discretionary power on the directorate to allow access to VAD for individuals with a substantial connection to the ACT is justified on compassionate grounds.

This approach to achieving the legitimate purpose is also less restrictive on rights than other Australian states, that additionally require a person to be an Australian citizen or permanent resident. Consultation and research revealed very little support for mirroring such a requirement in the ACT, with concern about the potential for this to result in unfair outcomes for refugees, New Zealanders, and other individuals.

While non-residents of the ACT may not be able to access VAD in the ACT, VAD is legally available in all the Australian jurisdictions, other than the Northern Territory.

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[50] Above n 41, [7.456].

Obligations on conscientious objectors – right to freedom of thought, conscience, religion and belief

1. Nature of the right and the limitation (s28(a) and (c))

Part 6 of the Bill recognises that health practitioners and health service providers may conscientiously object to assisting with VAD. By allowing health practitioners and health service providers to act consistently with their personal convictions, this promotes the right to freedom of thought, conscience, religion and belief – whether theistic, non-theistic or atheistic.[51]

However, the Bill requires conscientious objectors to:

- tell an individual seeking VAD that other health practitioners, health service providers or services may be able to assist the individual; and

- giving the individual information about the Care Navigator Service , which can provide the individual with information about another health practitioner, health service provider or service who may be able to assist the individual.

Requiring that a health practitioners and health service provider take certain action that may conflict with their freedom of thought, conscience, religion and belief may limit that right.

As noted above, the Bill promotes the right to freedom of thought, conscience, religion and belief by providing that health practitioners and health service providers may conscientiously object to assisting with VAD, subject to mandatory referral and information requirements.

Restrictions on the freedom of religion are only permissible if limitations are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.[52]

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[53] and by providing choices for a person about the circumstances of their death.

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[51] UN Human Rights Committee (HRC), *CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion)*, 30 July 1993, CCPR/C/21/Rev.1/Add.4, [1]-[2], available at: https://www.refworld.org/docid/453883fb22.html [accessed 4 August 2023].

[52] Above n 51, [8].

[53] Above n 3, [3], [9].

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

Health practitioners and health service providers are a key gateway for starting and continuing a conversation about VAD under the Bill. If they were permitted to refuse to engage in any discussion or provide any information about VAD, eligible individuals could find it harder to access VAD which would interfere with the policy intent of the Bill.

The objective of Part 6 is to ensure an eligible individual has access to VAD if they choose to, irrespective of the moral, ethical and religious beliefs of their health practitioners and health service providers. Eligible individuals 'should not bear the burden of managing the consequences of physicians' religious objections'.[54]

In doing so, Part 6 seeks to balance a conscientious objector's rights to freedom of belief, with an eligible individual's fundamental rights and freedoms to choose VAD. It aims to ensure access to VAD, while respecting that some health practitioners and health service providers may be morally, ethically or spiritually opposed to VAD.

The limitation supports the objectives of the Bill including giving eligible individuals who are suffering and dying the option of requesting assistance to end their lives, and ensuring there are processes for eligible individuals to exercise the option.

There is a clear connection between the proposed enforcement provisions and the legitimate purpose. This limitation allows health practitioners and health service providers to opt out of VAD entirely, provided they inform the individual about options to discuss VAD with other practitioners. This will ensure eligible individuals are informed on the options available.

This is broadly consistent with regulation of conscientious objection is provided for in Australian codes of conduct and ethical standards for doctors, nurses, pharmacists and other health practitioners.[55] These standards require health practitioners to

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[54] *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393; (2019) 147 OR (3d) 444, [185].

[55] Above n 41, [14.6], citing MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia*

ensure that a patient has alternative care options or that their access to care is not impeded, including by providing information to enable a patient to obtain services elsewhere.[56] Consistency with existing professional standards demonstrates that Part 6 is well suited to achieving its objectives.

4. Proportionality (s28 (e))

The limitations on the right to right to freedom of thought, conscience, religion and belief are considered proportionate, given the need to ensure eligible individuals are fully informed to choose an end of life choices that aligns with their rights, preferences and values.

Health practitioners and health service providers are a key gateway for starting and continuing a conversation about VAD under the Bill. If they were permitted to refuse to engage in any discussion or provide any information about VAD, eligible individuals could find it harder to access VAD which would interfere with the policy intent of the Bill.

This approach is the least rights-restrictive means reasonably available to achieve the objective. It recognises that the right to make a conscientious objection is subject to other individuals' rights, and mitigates the impacts on conscientious objectors' rights in several ways:

i. The Bill contains a broad right to conscientiously object to being actively involved in any part of the VAD process;
ii. The only aspect of VAD that objectors cannot opt out of is the requirement to provide information, which is the least intensive and involved part of the process;
iii. No person is required to participate in VAD at all – only health practitioners who opt in to assist with VAD are actively involved in the VAD process.

An alternative approach considered was to allow conscientious objection without any obligations on health practitioners and health service providers to inform the individual that they have options to discuss VAD with other practitioners. While this would be a lesser restriction on the right to freedom of thought, conscience, religion and belief, this would likely fail to achieve the legitimate aim of balancing this right with the rights of individuals seeking a lawful health service. The impact would be

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(October 2020) [3.4.6]–[3.4.7]; AMA, *Code of Ethics* (2016) [2.1.13], [4.2.3]; AMA, *Position Statement: Conscientious Objection* (2019) [1.2][1.3], [2.2]–[2.3]; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (March 2018) [4.4](b); Australian Nursing & Midwifery Federation, *Policy: Conscientious Objection* (November 2017) [1]–[2], [4]; Australian Nursing & Midwifery Federation, *Position Statement: Voluntary assisted dying* (November 2019) [12](a); Pharmacy Board of Australia, *Code of Conduct for Pharmacists* (March 2014) [2.4](f), (g); Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (February 2017) 12, 18.

[56] Ibid.

greater still where an eligible individual is dependent on a health practitioner with a conscientious objection to VAD. This is particularly the case given there appears to be high rates of conscientious objection to VAD among health practitioners,[57] on whom eligible individuals are 'exceptionally dependent'.

Another alternative option considered was to require health practitioners and health service providers to provide information about VAD in guidelines, rather than in legislation. However, experts have observed that the absence of a legislative requirement to refer might 'impede access' to a lawful option, which would 'compromise the realisation of other important policy goals: respect for autonomous choices, alleviation of suffering and the provision of high-quality care'.[58]

Further, it should be noted that the clause does not limit freedom of opinion, an absolute right that cannot be justifiably limited. The clause does not limit the right of health practitioners and health service providers to hold opinions based in religion or conscience.

Right to freedom of religion, conscience, belief and thought – obligations on facility operators

1. Nature of the right and the limitation (s28(a) and (c) Human Rights Act 2004)

Part 7 of the Bill requires a facility operator in certain circumstances to:

- facilitate the provision of information about VAD;
- facilitate access to a relevant person who can assist with VAD, either at the facility or if that is not reasonably practicable, via transfer to another place;
- have and make available a policy on how it will comply with these requirements; and
- not withdraw or refuse to provide care services if a person is likely to wish to access VAD.

A facility operator is defined in clause 96 of the Bill as the 'entity' that is responsible for the management of a facility. 'Entity' is defined in the *Legislation Act 2001* to include an individual or a corporation.

Section 14 of the *Human Rights Act 2004* provides that everyone has the right to freedom of thought, conscience and religion. This right includes the freedom to have or to adopt a religion or belief of a person's choice, the freedom to demonstrate that religion or belief in worship, observance, practice and teaching (whether in public or private), and freedom from coercion that would limit these freedoms. This includes

[57] Sifris, R (2022) *Conscientious Objection in Australia: A Comparison between Abortion and Voluntary Assisted Dying* (2022) 29 Journal of Law and Medicine 1079, 1087.

[58] White et al, 'Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417, 444.

beliefs that are theistic, non-theistic or atheistic.[59] Restrictions on the freedom of religion are only permissible if limitations are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.[60]

To the extent that Part 7 applies to an individual, these obligations may limit the right to freedom of religion and belief in two ways:

- An individual who is responsible for the management of a facility (for example, a duty manager) is a 'facility operator', so is required to take certain actions to personally comply with Part 7 and ensure the facility complies with Part 7. If those actions conflict with their beliefs or religion, Part 7 may limit their right to freedom of religion.
- An individual who works in a facility but who is not responsible for its management (for example, a receptionist) might be directed to take certain actions by the facility operator, so that the facility operator can comply with its obligations under Part 7. If those actions conflict with their beliefs or religion, Part 7 may limit their right to freedom of religion.

To the extent that Part 7 applies to organisations (such as corporations, unincorporated bodies and not-for-profits), there is no engagement with any human rights: the *Human Rights Act 2004* only protects the human rights of individuals, not organisations.[61]

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[62] and by providing choices for a person about the circumstances of their death.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

The objective of Part 7 is to ensure a resident of a facility, such as a hospital, hospice, nursing home or residential aged care, has reasonable access to VAD if they choose to, irrespective of the moral, ethical and religious beliefs of that facility, its management and other staff.

3. Rational connection between the limitation and the purpose (s28(d))

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[59] UN Human Rights Committee (HRC), *CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion)*, 30 July 1993, CCPR/C/21/Rev.1/Add.4, [1]-[2], available at: https://www.refworld.org/docid/453883fb22.html [accessed 4 August 2023].
[60] Above n 51, [8].
[61] Human Rights Act 2004 (ACT), s 6.
[62] Above n 3, [3], [9].

Part 7 seeks to address the severe distress and suffering, as well as human rights limitations, caused by restricting lawful access to VAD. This was reflected as an important feature of the scheme in the ACT Government's public consultation, which heard strong concerns from the community and expert stakeholders about the challenges individuals have experienced in other jurisdictions accessing VAD in faith-based health services that oppose voluntary assisted dying, and the distress caused if they needed to be transferred to other premises to access VAD.

Part 7 is likely to be effective in achieving this objective because it compels facility operators to take action that prioritises lawful access to information about VAD and to people who can assist with VAD. An individual who is responsible for the management of a facility will be required to take actions to ensure the obligations under Part 7 are discharged. An individual who works in a facility but who is not responsible for its management might also be directed to take certain actions by the facility operator, so that the facility operator can comply with its obligations under Part 7. A facility operator will need to make choices about their operations and structure, including through policies and practices, to meet their legal obligations.

The effectiveness of Part 7 is even more likely in a regulatory context where facility operators will be aware of their obligations through engagement with government and there are penalties for non-compliance. These penalties will only apply to facility operators.

Emerging evidence demonstrates that where a jurisdiction chooses not to compel individuals to take these actions, unnecessary suffering results, contradicting the purpose of VAD legislation. Evidence in Victoria, for example, includes that facility operators have refused to allow a VAD substance into a facility, not allowed outside health professionals to undertake eligibility assessments at a facility, and prevented staff from discussing VAD at all.[63] In some cases, objections by facility operators resulted in forced transfers out of facilities to access VAD, causing additional pain, suffering and distress for eligible individuals and caregivers. In other cases, facility operators have precluded access to voluntary assisted dying because a transfer was not available or physically possible.

Evidence shows that failure to allow access to VAD in facilities also undermines some of the crucial factors in the voluntary assisted dying scheme from the perspective of the individual, including choice and control in the dying process, receiving integrated end-of-life care, and a pain free death which supports dignity and emotional well-being.[64] This in turn can impact the complexity of grief experienced by family and carers,[65] which was raised as a significant concern in the ACT Government's public consultation.

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[63] White et al, "The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions" 24 BMC Medical Ethics 22 (2023).

[64] Emily Meier et al, 'Defining a good death (successful dying): literature review and a call for research and public dialogue (MAID) – a qualitative study 24 *American Journal of Geriatric Psychiatry* 4 (2022).

[65] Narges Hashemi et al, "Quality of bereavement for caregivers of patients who died by medical assistance in dying at home and the factors impacting their experience: a qualitative study" 24 *Journal of Palliative Medicine* 9 (2021).

While the evidence does not distinguish between the actions of a facility itself, and the actions of individuals responsible for managing a facility, it is clear that decisions by individuals responsible for managing a facility inform a facility's culture, policies and procedures, and day-to-day management. It is for this reason that Part 7 imposes obligations on the individuals who are responsible for managing a facility.

Accordingly, Part 7 of the Bill adopts an approach that seeks to strike a balance between the rights of the individual seeking access to voluntary assisted dying and the interests of individuals responsible for managing a facility and their staff.[66] It aims to ensure access to VAD, while respecting that some facilities, their management and staff may be morally, ethically or spiritually opposed to VAD. If those rights and interests conflict, Part 7's intention is to require that individual facility operators and their staff accommodate the rights of the individual seeking access to voluntary assisted dying by upholding the obligations set out in Part 7. If individual facility operators and their staff were permitted to restrict or hinder access to VAD, this would interfere with the policy intent of the Bill.

4. Proportionality (s28 (e))

Given the Bill's purpose to ensure that individuals, including residents of facilities, are fully informed and able to make end of life choices that align with their rights, preferences and values, any limitations on the right to freedom of thought, conscience, religion and belief of an individual responsible for the management of a facility are considered proportionate. In addition, the Bill does not impose individual obligations on other staff members working in a facility but not responsible for its management, but places an onus on facility operators to meet obligations.

A less rights-restricting approach to reconciling this conflict of rights is in place in Victoria, Western Australia and Tasmania. In those jurisdictions, facility operators have no legislative obligations to facilitate access, and conduct is regulated through guidance. In Victoria, the longest-standing voluntary assisted dying jurisdiction in Australia, this approach has been found to be "not effective in achieving the objectives of respecting institutional positions while promoting patient access" and "appears to have allowed existing power, resource, and information asymmetry to prioritise institutions' positions over patient choice.[67] Accordingly, a different approach was needed to reconcile the interests of individuals and faith-based health service providers, to prevent eligible people, and their friends, family and carers, from experiencing unnecessary suffering.

The human rights limitations on health practitioners and health service providers are mitigated by Part 6 of the Bill. This part explicitly allows conscientious objection in certain circumstances:

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[66] See Waller, K, Del Villar, K, Willmott, L and White, B, "Voluntary Assisted Dying in Australia : A Comparative and Critical Analysis of State Laws" *University of New South Wales Law Journal*, Vol. 46, No. 4 (2023), available at SSRN: https://ssrn.com/abstract=4394798, p 38.

[67] White, B, Jeanneret, R., Close, E. *et al.* "The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perception.

- The Bill contains a broad right to conscientiously object to being actively involved in any part of the VAD process;
- The only aspect of VAD that objectors cannot opt out of is the requirement to provide information, which is the least intensive and involved part of the process;
- No person is required to participate in VAD at all; only health practitioners who opt in to assist with VAD are actively involved in the VAD process.

The human rights limitations on other individuals who are not protected by Part 6 – such as receptionists and other non-clinical staff – are mitigated by the fact that they will not ordinarily be required to have personal significant dealings with an individual about their wish to access VAD. Any objections to participating in actions required under Part 7 will need to be handled by the facility operators and may be covered by a facility's policies and procedures.

The penalties for non-compliance with Part 7 are reasonable and proportionate. Lower penalties attach to individual non-compliance, with higher penalties for corporations. The offences themselves are nuanced and build in various tests for reasonableness and practicability. The offences only attach to individuals who are responsible for the management of a facility, reflecting the high degree of accountability expected from these roles.

Further, it should be noted that the clause does not limit freedom of opinion, an absolute right that cannot be justifiably limited. The clause does not limit the right of health practitioners and health service providers to hold opinions based in religion or conscience.

Right to privacy and reputation: powers of inspectors

1. Nature of the right and the limitation (s28(a) and (c))

Clause 150 of the Bill applies the enforcement functions of Chapter 7 of the *Medicines, Poisons and Therapeutic Goods Act 2008* to the Bill, including:

- powers of medicines and poisons inspectors to enter premises and seize things;
- provisions relating to the issue of warrants to enter premises and powers that can be exercised under a warrant; and
- provisions providing for the taking and analysis of sample of substances.

The Bill also provides inspectors with a power to require a person to state their name and home address if the inspector believes on reasonable grounds that the person is committing or has just committed an offence against the Voluntary Assisted Dying Act.

Accordingly, this Bill provides the legal authority for the enforcement of the offences under VAD legislation to be achieved through a comprehensive range of inspection and seizure powers including the power for inspectors to enter premises. The functions of an inspector under the *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) (**MPTG Act**) will be extended to the investigation and enforcement of compliance with the Bill. For example, an inspector may be required to enter a place to ensure an approved substance is being stored in accordance with the VAD legislation.

In this way, the Bill may limit the right to privacy and reputation. Section 12 (a) of the HRA provides that everyone has the right to not have their privacy interfered with unlawfully or arbitrarily. The right to privacy under section 12 of the HRA protects people in the ACT from 'unlawful' interference with their privacy. This means that no interference can take place except in cases authorised by law.

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[68] and by providing choices for a person about the circumstances of their death.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

The purpose of this limitation is to support the objective of the Bill including to establish mechanisms to ensure that VAD is accessed only by individuals who want to exercise the option to request assistance to end their lives; and have been assessed as being eligible to request assistance to end their lives, to protect individuals from coercion and exploitation and provide for the monitoring and enforcement of compliance with this Bill.

There is a clear connection between the proposed enforcement provisions and the legitimate purpose.

The inclusion of enforcement provisions will support the ACT VAD scheme to operate in accordance with the legal framework as intended. This includes the power

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[68] Above n 3, [3], [9].

for inspectors to enter premises to ensure compliance, and for a magistrate to issue a warrant if satisfied there are reasonable grounds for suspecting there is a particular thing or activity connected with an offence against the Bill.

The scheme requires medical practitioners to undertake appropriate record-keeping and reporting to the Board throughout the VAD process. This provides a safeguard for both people seeking access to VAD and participating medical practitioners. The inclusion of enforcement provisions will provide an ongoing system of checks to ensure compliance with the scheme.

4. Proportionality (s28 (e))

This Bill does not authorise arbitrary interferences with privacy. The limitations on the right to privacy and reputation are considered proportionate to the legitimate purpose, given the need to maintain the integrity of VAD in the ACT.

The Bill embeds wide-ranging safeguards on the power of inspectors. The Bill will allow an inspector to enter premises, however this is limited to entry at a reasonable time when the premise is open to the public (for commercial premises only), at any time with owner consent, to carry out a search warrant or at any time where an inspector believes on reasonable grounds that the circumstances are so serious and urgent. These provisions provide appropriate safeguards to limitations on the right to privacy as they only allow inspectors to enter residential premises with consent or in circumstances where entry would be required for serious and urgent circumstances or as authorised by a warrant due to reasonable grounds for suspicion of connection with an offence against the Bill.

An inspector's powers are also limited in that the MPTG Act sets out specific activities that an inspector may undertake on a premise. While the Bill also enables inspectors to seize things, the Bill includes safeguards that limit the exercise of this power.

The Bill includes safeguards on the use of these powers including requirements for inspectors to produce identity cards and tell the occupier certain things when seeking consent to enter premises, a requirement that a receipt and access are provided to seized things and that a thing seized must be returned to its owner, or reasonable compensation paid for the loss of the thing in state circumstances, and that inspectors must take all reasonable steps to ensure that they cause as little inconvenience, detriment and damage as practicable.

The use of enforcement powers will be subject to independent oversight by the VAD Board.

These powers are considered necessary to ensure that inspectors are able to monitor compliance with the legislation, similarly to powers of inspectors under ACT other regulatory schemes and other Australian VAD laws. This is one of many safeguards to ensure that the community is protected from improper dealings with an approved substance, outside of the lawful VAD scheme. For example, the powers of inspectors will ensure that an approved substance can be removed from premises where vulnerable people or young children might have unlawful access to the substance.

There is not considered to be any less restrictive means to achieve the outcome sought, which is ensuring compliance with the ACT VAD scheme.

Right to privacy and reputation: requirement to disclose/collect personal information

1. Nature of the right and the limitation (s28(a) and (c))

Section 12 of the HRA provides that a person has the right not have his or her privacy, family, home or correspondence interfered with unlawfully or arbitrarily.

The Bill engages the right to privacy and reputation as a person is required to provide or obtain personal information, sensitive information and health information. This includes:

- Clauses 15, 18, 21, 22, 29, 30, 33 and 34 - A health practitioner must record information about a person's first request, first assessment, consulting assessment, second request, final request, and final assessment, and provide that information to the Board;

- Clauses 26 and 36 - An eligible individual, a health practitioner, a contact person, and a witness must provide certain identifying information to the Board;

- Clause 43 - A health practitioner must record certain information in an individual's health record;

- Clauses 37, 38, 44, 46 and 47- Transfer of functions must be recorded in an individual's health record; and

- Clauses 42 - Administration decision and revocation must be recorded in an individual's health record.

Further, the Bill empowers the Board to refer issues identified by the Board in relation to VAD to other entities, which may involve the transfer of an individual's information from one entity to another.

These clauses limit the right of a person to not have his or her privacy, family, home or correspondence interfered with unlawfully or arbitrarily, under section 12 of the HRA.

The right encompasses the idea that individuals should have a separate area of autonomous development, interaction and liberty, free from excessive government intervention and unsolicited intrusion by other individuals. Making access to VAD contingent on disclosing private information arguably limits this right.

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[69] and by providing choices for a person about the circumstances of their death.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

The Bill requires collection of information as a rational means of achieving its legitimate purpose.

The collection of personal information ensures that vulnerable individuals are protected from coercion and exploitation through appropriate monitoring and enforcement of compliance with VAD legislation. These requirements promote and ensure compliance with the legal framework and accurate record keeping.

Without access to personal information, the VAD Board and Directorate would not be able to fulfil its functions providing critical oversight of the scheme. This would result in VAD operating in the ACT without scrutiny and without the ability to contact and evaluate the individuals involved in the VAD process.

4. Proportionality (s28 (e))

The right to privacy only protects against arbitrary and unlawful interferences with privacy. Interference with privacy that is neither arbitrary nor unlawful will not limit the right.

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[69] Above n 3, [3], [9].

Because the impacts on privacy are proportionate, they are not arbitrary. They are clearly defined, legislated, and are 'opt in' – only the individuals and health practitioners who have chosen to participate in the VAD scheme are required to provide personal. Accordingly, any limitation on the right to privacy is justified.

Information sharing under the Bill is governed by existing legislation, including the Health Records (Privacy and Access) Act 1997 and the Information Privacy Act 2004. The Health Records (Privacy and Access) Act 1997 in particular contains a number of safeguards on the collection, use and disclosure of health records and serious penalties apply where this information is not used as permitted under ACT legislation.

Rights in criminal proceedings: strict liability offences

1. Nature of the right and the limitation (s28(a) and (c))

Section 22 (1) of the HRA provides that everyone charged with a criminal offence has the right to be presumed innocent until proven guilty according to law.

The Bill limits this right by introducing strict liability offences which support the effectiveness of the VAD framework. Strict liability offences engage and limit the right to be presumed innocent until proven guilty because they allow for the imposition of criminal liability without the need to prove fault.

The Bill's 34 strict liability offences are listed at **Appendix 1** to this explanatory statement. They seek to regulate various compliance requirements under the Bill. This includes requirements to give the Board reports and notification of key events, to give an individual contact details of the Care Navigator Service, and to give an individual access to a facility operator's policy on VAD within required timeframes. There are also strict liability offences that apply to a contact person who fails to notify the Board that they have given an approved substance to the individual, to another person, or to an approved disposer.

These offences all carry a maximum penalty of 20 penalty units, other than clause 99(2) which is 30 penalty units.

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with

dignity' and 'die with dignity',[70] and by providing choices for a person about the circumstances of their death.

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

The intention of the strict liability offences introduced by this Bill is to support an effective regulatory scheme and deter unauthorised behaviour.

3. Rational connection between the limitation and the purpose (s28(d))

The strict liability offences are to support the objectives of the Bill. Appropriate regulatory actions are essential to build community confidence in the safeguards of the ACT VAD framework.

Strict liability offences typically arise in a regulatory context where for reasons such as public safety and ensuring that regulatory schemes are complied with, strict criminal penalties are required. A defendant can reasonably be expected, because of their involvement with the regulated activity, to know what the requirements of the law are, and as such the mental, or fault, element can justifiably be excluded.

The inclusion of strict liability offences in the Bill is necessary to deter individuals from engaging in activities that are inconsistent with the objects of the Bill, and the obligations placed on authorised practitioners in carrying out functions under the Bill. There is a high expectation that authorised practitioners will exercise appropriate skill and care when providing professional services. It is important that this standard is enforced through appropriate offences and penalties to protect the community and deter unsafe behaviours.

In particular, the strict liability offences attaching to a contact person who fails to notify the Board that they have given an approved substance to the individual, to another person, or to an approved disposer seek to recognise the serious responsibilities taken on by a contact person in handling a substance that is designed to kill a person. They are intended as a strong deterrent from mishandling an approved substance, and a reflection of the fact that even an inadvertent or mistaken mishandling of an approved substance could have lethal consequences.

[70] Above n 3, [3], [9].

The purpose of the specific penalties attributable to these offences is to provide an appropriate disincentive to individuals from undertaking the actions subject to the offence provisions.

4. Proportionality (s28 (e))

The limitations on the right to liberty and security of person and rights in criminal proceedings are considered proportionate to the legitimate purpose, given the need to maintain an effective regulatory scheme and deter unauthorised behaviour in order to protect vulnerable members of the community from coercion and exploitation.

The consequences of health practitioners not complying with the reporting and notification requirements are sufficiently important to warrant a strong deterrent for non-compliance. Those consequences include individuals having access to VAD, and potentially dying, with no independent oversight. Without prompt reporting and notification from health practitioners, the Board would have no visibility of whether practitioners are complying with the Bill and no ability to monitor access to VAD in real time. This can limit the Board's ability to carry out its functions. It would also increases risk of lowering community confidence in the safeguards built into the VAD scheme.

It is also reasonable and proportionate to apply strict liability for offences with short time periods for compliance. For example, the requirement for a practitioner to lodge a report within two working days. Prompt compliance with the Bill's requirements enables an individual and other practitioners to have confidence that the strict requirements of the scheme are being complied with by all practitioners involved, when seeking to move to the next stage of the process. This confidence is important particularly because of the strong penalties attaching to non-compliance with the Bill. Prompt compliance with reporting requirements also enables the Board to monitor a VAD process in 'real time', which in Western Australia has seen highly successful interventions by the Board in individual processes to support compliance.

In any case, the provisions attaching to health practitioners require practitioners to do things within 'working days', meaning days when that practitioner is working. This is a deliberately less rights-restricting approach than requiring practitioners to comply outside of their work hours, to reflect the significant burden these provisions place on practitioners.

Strict liability offences typically arise in a regulatory context where, for reasons such as public safety and ensuring that regulatory schemes are complied with, criminal penalties are required. A defendant can reasonably be expected, because of their involvement with the regulated activity, to know what the requirements of the law are, and as such the mental, or fault, element can justifiably be excluded.

The Bill has an 18 month implementation period, during which time there will be further consultation by government with health practitioners. Practitioners will be well aware of their obligations under VAD legislation as they are required to undertake training before being authorised to undertake VAD activities. This is particularly the case for VAD because it is a practitioner's personal choice to opt in to VAD training and assist with VAD, so the cohort of practitioners affected by the strict liability offences are highly engaged about their responsibilities.

A similar justification can be made in relation to contact persons. A contact person willingly opts in to assisting a person with handling the approved substance, and in doing so chooses to participate in a regulatory scheme with strict safeguards. Clause 50 requires the coordinating practitioner to inform the contact person of their obligations under the Bill, as well as the support services available to assist the contact person to comply. This will include the Care Navigator Service, which can provide tailored information and support to a contact person to help them understand how to handle an approved substance and when to report to the Board.

Accordingly, the risk of an inadvertent breach of these offences is considered to be low. In any case, the defence of reasonable mistake of fact is available for a strict liability offence. If a person is under a mistaken but reasonable belief about certain facts; and the conduct would not have constituted an offence if those facts existed, then the person will have a defence to a charge. This protects health practitioners and other persons who, for example, mistakenly but reasonably believed that they had submitted a report to the Board.

Existing penalties and offences for health professional malpractice or non-compliance will continue to operate alongside an ACT VAD scheme. For example, malpractice in relation to VAD could contravene AHPRA codes of conduct and attract penalties such as suspension of registration. However, these are not specifically aimed to ensuring that practitioners comply with the unique requirements of the Bill.

The penalties for these offences are within the normal range for strict liability offences and are in accordance with the ACT Government's *Guide to Framing Offences*, lending to the proportionality of this provision. The maximum penalties attached to the offences reflect the seriousness of the offence relative to other offences in the Bill and other offences of a similar nature in the ACT and other Australian jurisdictions. They also reflect the level of responsibility the person committing the offence has for the conduct that will result in the offence being committed, and the potential serious consequences that can arise for individuals and the community where there is non-compliance with the provisions.

Right to liberty and security of person: imprisonment offences

1. Nature of the right and the limitation (s28(a) and (c))

The right to liberty under the HRA prohibits the arbitrary and unlawful deprivation of liberty. Deprivation of liberty through arrest or detention, must not only be lawful, in accordance with pre-established legal procedures, but must not be 'arbitrary'. Detention may be 'arbitrary' if it is unreasonable, unjust, inappropriate or disproportionate in all the circumstances of the case or not in accordance with due process.

The Bill provides that the following offences carry a maximum penalty of imprisonment:

- Clause 40 - Inducing making or revocation of request for access to VAD - Maximum penalty: imprisonment for 7 years.
- Clause 49 - Inducing making or revocation of administrative decision - Maximum penalty: imprisonment for 7 years.
- Clause 70 - Unauthorised administration of approved substance - Maximum penalty: imprisonment for 7 years.
- Clause 71 - Inducing self-administration of approved substance - Maximum penalty: imprisonment for 7 years.
- Clause 93 - Acting as coordinating practitioner, consulting practitioner or administering practitioner when requirements to act not met - Maximum penalty: 100 penalty units, imprisonment for 12 months or both.
- Clause 157 - Use or divulge protected information - Maximum penalty: 50 penalty units, imprisonment for 6 months or both.
- Clause 140 – Contravention of ACAT non-publication orders - Maximum penalty: 50 penalty units, imprisonment for 6 months or both.

2. Legitimate purpose (s28(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[71] and by providing choices for a person about the circumstances of their death.

[71] Above n 3, [3], [9].

VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

3. Rational connection between the limitation and the purpose (s28(d))

Imprisonment terms are included in specific provisions of the Bill to reflect the serious nature of the conduct captured by the offences, deter this conduct and provide adequate regulatory powers in support of enforcement.
Offences attracting penalties of imprisonment in the Bill are generally comparable to similar offence provisions, where those exist in VAD laws in other Australian jurisdictions. The maximum terms of imprisonment in the Bill tend to be similar or less. For example:

- For unauthorised administration of an approved substance, the Bill imposes a maximum term of 7 years' imprisonment, where Queensland imposes 14 years and Victoria and NSW impose life imprisonment;

- For inciting the making of a request to access VAD, or self-administration of an approved substance, the Bill imposes a maximum term of 7 years' imprisonment, the same as Queensland and New South Wales; with Victoria imposing a maximum of 5 years' imprisonment.

Further, maximum terms of imprisonment are used in the ACT in other health regulatory contexts where non-compliance could have serious or deadly consequences. For example, the *Health Act 1993* (ACT) imposes a maximum penalty of 5 years' imprisonment for unauthorised supply or administration of abortifacient and unauthorised surgical abortion, and six months imprisonment for divulging protected information. The *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) imposes a maximum penalty of 5 years' imprisonment for supplying a declared substance, and one year's imprisonment for providing a false prescription. This demonstrates the proportionality of imposing serious penalties in other serious health related contexts.

4. Proportionality (s28 (e))

Imprisonment is an appropriate maximum penalty to apply to the most serious conduct contemplated by the Bill. In weighing up the appropriateness of these penalties, consideration was given to the penalties applicable in other jurisdictions and the seriousness of the behaviour captured.

The offences in clauses 40, 49, 70, 71, 115, 116 and 117 concern matters of life and death. They criminalise conduct that could result in the unlawful death of a person outside the circumstances permitted by this Bill. It is imperative that the serious nature of such offences is reflected in serious penalties. It is also important to

impose serious penalties because the relevant conduct may not reach the high threshold of murder or manslaughter, but still involve the endangerment of an individual's life.

The offences in clauses 140 and 157 concern unauthorised disclosure of information gathered under the Bill. That information might include an individual's health conditions, symptoms and prognosis, their most intimate wishes for their final days, or details about the end of life care plans. In circumstances where an individual is already intolerably suffering and dying, unauthorised release of such sensitive information could significantly impact the individual and their family, friends and carers. It could also erode confidence in the VAD scheme and in ACAT.

The proposed terms of imprisonment are a maximum term only. Courts have discretion not to apply a term of imprisonment, or to apply a lesser term. The maximum term is expected to only apply to the most serious incidents. Although a lesser term of imprisonment may be considered a less restrictive means to address this behaviour, considering the serious harm the offence can entail, any lesser maximum term of imprisonment is not considered appropriate.

Right to a fair trial: ACAT hearings in private

1. Nature of the right and the limitation (ss 28(2)(a) and (c))

Part 10 and 11 of the Bill provide for review of certain decisions made under the Bill by the ACT Civil and Administrative Tribunal (ACAT).

Clause 139 provides that the ACAT hearing of an application for review of a reviewable decision must take place in private. This limits the right to a public hearing protected by section 21(1) of the HRA.

That right recognises, among other things, that everyone has the right to have 'rights and obligations recognised by law' – including civil and administrative matters – decided by a competent, independent and impartial tribunal after a fair and public hearing.

While public hearings are generally fundamental to the transparency and accountability of courts, some exceptions to the principle of open justice are permitted. The press and public may be excluded from all or part of a hearing:
to protect morals, public order or national security in a democratic society; or
if the interest of the private lives of the parties require the exclusion; or
if, and to the extent that, the exclusion is strictly necessary, in special circumstances of the case, because publicity would otherwise prejudice the interests of justice.

2. Legitimate purpose (s 28(2)(b))

The purpose of introducing VAD is to promote the human rights of individuals who are suffering and dying by enabling an eligible individual to both 'enjoy a life with dignity' and 'die with dignity',[72] and by providing choices for a person about the circumstances of their death.
VAD aims to provide a safe, effective, and accessible process where an eligible individual chooses to access VAD in the ACT. The Bill seeks to strike the right balance between the fundamental value of human life and the values of individual autonomy in order to reduce suffering.

The purpose of the limitation on the right to a public hearing is to promote an individual's right to privacy, dignity and autonomy under section 12 of the HRA.

3. Rational connection between the limitation and the purpose (s 28(2)(d))

Requiring a hearing to be private will ensure that the sensitive details of an individual's medical treatment, decision-making capacity, terminal condition, and other personal information will be protected from access by members of the public and the press. This directly promotes the individual's right to privacy.

The Queensland Law Reform Commission's report acknowledged the need to 'the private and potentially sensitive nature of the subject matter'. The ACT Government's consultation demonstrated that VAD is a deeply personal matter, the nature of which is unique to each individual and their carers, families and carers.

4. Proportionality (s 28(2)(e))

The requirement for private hearings is an appropriate balance between the conflicting right to a public hearing and the right to privacy. The only reasonably available alternative is a public hearing, but this would not guarantee protections of the right to privacy in the same way as clause 139 does.

It is important to note that privacy does not equal secrecy. Clause 139 does not exclude all members of the public as a blanket rule. ACAT will still retain its power to make directions, on its own initiative or on the application of a party, about the persons who may attend a hearing. In the context of VAD, it is possible that this might include an individual's carers, family, friends and health professionals if desired by the individual.

ACAT will retain its discretion to publish written decisions. ACAT's discretion to publish written decisions is limited principles of open justice and other factors. Presiding Members may decide to restrict publication or anonymise names, after

[72] Above n 3, [3], [9].

considering the sensitivity of the matter. Any limitations on the right to a fair trial arising from this discretion are reasonable and proportionate, taking into account ACAT's responsibility to weigh the competing interests of the parties in deciding whether to publish decisions.

CLAUSE NOTES

Part 1 Preliminary

Part 1 comprises clauses 1 to 5 dealing with formal matters including commencement and key definitions for the purposes of the Bill.

Clause 1 Name of Act

This clause provides that the name of this Bill is the *Voluntary Assisted Dying Act 2023*.

Clause 2 Commencement

This clause provides for the commencement of the Bill 18 months after its notification day. The 18 month period between notification and commencement is to enable research, development and delivery of functions to support the effective and safeguarded implementation of the Bill.

This includes the development of processes and guidelines for access to VAD and oversight; the establishment of a pharmacy service and Care Navigator Service; development of care pathways; governance arrangements for the Board and secretariat; capacity-building for health practitioner participation; development of regulations and guidelines; education and training programs for health practitioners and stakeholders; and development of public communications for consumers, carers, stakeholders and community.

Clause 3 Dictionary

This clause is a formal provision identifying the dictionary and explaining conventions used to define words and terms for the purposes of the Bill.

Clause 4 Notes

This clause is a formal provision explaining the status of notes in the Bill.

Clause 5 Offences against Act—application of Criminal Code etc

This clause clarifies that other legislation applies to offences against this Bill including the *Criminal Code 2002* (ACT), which applies to all offences against the Bill, and the *Legislation Act 2001* (ACT), which deals with the meaning of offence penalties that are expressed in penalty units.

Part 2 Objects, principles and important concepts

Part 2 comprises clauses 6 to 12 setting out the objects of the Bill and principles to be applied when exercising functions under the Bill.

Clause 6 Objects of Act

This clause sets out the purpose of the Bill.

Clause 7 Principles of Act

This clause sets out principles that are to be taken into account by a person in exercising a function under the Bill.

Clause 8 Voluntary assisted dying not suicide

This clause prescribes that a death as the result of the administration of an approved substance in accordance with this Bill is not considered suicide, for the purposes of:

- a territory law; or
- a contract, deed or other instrument entered into in the ACT or governed by a territory law.

This clause also provides that, for the same purposes, a death as a result of the administration of an approved substance in accordance with this Bill is taken to be a death caused by the person's relevant condition. This is relevant to clause 78(2)(a), which requires that in a written notice of the death and cause of death of an individual, a medical practitioner must state that the individual's cause of death was their relevant condition, not VAD.

This clause seeks to clarify that:

- assisting with VAD in accordance with the Bill does not constitute the crime of assisting suicide under ACT law, including under section 17 of the *Crimes Act 1900* (ACT);
- section 18 of the *Crimes Act 1900* (ACT) – which makes is lawful for a person to use reasonable force to prevent suicide – would not apply in the context of VAD;
- a VAD death is not to be considered suicide in the context of an individual's life insurance, superannuation, death certificates, or other relevant matters in an ACT law, contract, deed or other instrument; and
- data gathered about VAD deaths is not combined with data about suicides.

Clause 9 No obligation to continue with request to access voluntary assisted dying

This clause clarifies that individual may, at any time, decide not to take any further steps in a VAD request and assessment process, and that they do not need to start a new request if they later decide to take further steps in relation to the request.

In practice, this means that if an individual decides to pause their VAD request and assessment process for any reason, they can restart it without having to undertake new requests or assessments. The purpose is to ensure an individual need not undergo unnecessary bureaucratic hurdles or delays in continuing the VAD process at a time of their choosing.

Clause 10 When individual may access voluntary assisted dying

The purpose of this clause is to illustrate how various clauses of the Bill work together to allow an individual to access VAD.

This clause clarifies that an individual may access VAD only after the individual has:

- completed the request and assessment process in accordance with Part 3, including that the individual has been assessed as meeting the eligibility requirements by both a coordinating practitioner and consulting practitioner; and
- made an administration decision in accordance with Division 4.1; and
- if the individual has made a self-administration decision, the individual's contact person appointment has taken effect in accordance with Division 4.2.

Clause 11 Meaning of *eligibility requirements*

This clause sets the eligibility requirements to access VAD. Clause 11(1) provides that an individual meets the eligibility requirements if:

a) they are an adult; and

b) they have been diagnosed with a condition that, either on its own or in combination with one or more other diagnosed conditions, is advanced, progressive and expected to cause death (the ***relevant conditions***); and

c) they are suffering intolerably in relation to the relevant conditions, as defined by clause 11(3); and

d) they have decision-making capacity in relation to VAD; and

e) their decision to access VAD is made voluntarily and without coercion; and

f) they have—

a. lived in the ACT for at least the previous 12 months; or

b. been granted an exemption under clause 151.

Clause 11(2) clarifies that a disability, mental disorder or mental illness alone is not a relevant condition. This is to ensure that no individual with a disability, mental disorder or mental illness has access to VAD unless they meet all the eligibility requirements and choose to access VAD in accordance with the Bill. This is an important signal and safeguard to protect individuals with disability from stigmatisation and harm arising from assumptions about their disability and their willingness to access VAD.

Clause 11(3) and (4) further define key concepts in the eligibility requirements, including:

- that an individual's relevant conditions are 'advanced' if the individual's functioning and quality of life have declined; and any treatments that are available and acceptable to the individual lose any beneficial impact; and the individual is in the last stages of their life;

- that an individual's condition is 'progressive' if their condition is deteriorating and will continue to deteriorate;

- that the meaning of 'suffering intolerably' is subjective, denotes persistent suffering, includes physical and mental suffering, and includes suffering not only caused by the relevant conditions but any combination of the relevant conditions, other conditions, and treatments received. 'Suffering intolerably' can also include anticipation or expectation, based on medical advice, of suffering caused by any combination of these matters. The persistent suffering a person is experiencing must be in their opinion intolerable. This is a deliberately broad definition designed to recognise the nuances and complexities of end of life suffering, including that intolerable suffering can be caused by more than just the symptoms of a person's relevant conditions.

Clause 12 Meaning of *decision-making capacity*

This clause defines decision-making capacity for the purpose of the Bill. This is particularly relevant to:

- Clause 11(1)(d), which provides that one of the eligibility requirements to access VAD is that the individual has decision-making capacity in relation to VAD.

- Clause 16 and 23, which requires the coordinating practitioner and consulting practitioner to be satisfied that the individual meets the eligibility requirements for the purpose of the first assessment and consulting assessment.

- Clause 35, which requires the coordinating practitioner to be satisfied whether the individual meets the final assessment requirements, including that the individual has decision-making capacity.

- Clause 63(3), which requires that the administering practitioner must not administer the approved substance to the individual unless satisfied, immediately before administering the substance, that the individual has decision-making capacity;

- clause 77(3), which requires the administering practitioner to prepare an administration certificate certifying that fact; and

- Part 10, which provides that the Tribunal can review the decision by a coordinating practitioner or consulting practitioner as to whether or not an individual has decision-making capacity.

Clause 12(2) provides that an individual must be assumed to have decision-making capacity in relation to VAD, unless it is established that they do not.

Clause 12(3) sets out principles relevant to a decision about whether an individual has decision-making capacity. These are designed to assist practitioners to recognise that an individual's support needs, fluctuating capacity, capacity in relation to other matters, and other relevant matters are not determinative of whether an individual has capacity in relation to VAD. In practice, the intent is that an individual is supported to make decisions about VAD and that their capacity to do so is assessed holistically.

Part 3 Request and assessment process for access to voluntary assisted dying

Part 3 comprises clauses 13 to 40. This part sets out the process an individual must follow to access VAD.

Division 3.1 First request, coordinating practitioner and first assessment

Clause 13 Making first request

This clause describes how the VAD request and assessment process commences with an individual's first request to a health practitioner.

It requires that a first request must be clear and unambiguous, and made personally by the individual.

It also clarifies that a first request may be made in writing or orally, or by communicating in any other way the individual can. This is intended to recognise that

people who are intolerably suffering and dying may need support to communicate their wishes.

Clause 14 Health practitioner must accept or refuse to accept first request

Clause 14(1) requires that within two working days of the first request, a health practitioner must accept or refuse the first request and tell the individual about that decision. A 'working day' is defined in the Dictionary as a day that the health practitioner is working.

Clause 14(4) provides that if the health practitioner accepts the first request, they become the individual's coordinating practitioner. The individual's coordinating practitioner is the individual's key contact throughout the VAD process. The coordinating practitioner's responsibilities include undertaking the first assessment (see clause 16), referring the individual for a consulting assessment (see clause 19), undertaking the final assessment (see clause 35), prescribing, handling and in some circumstances administering the approved substance (see Part 4), and complying with record-keeping and notification requirements.

Clause 14(2)(a) sets out that a health practitioner must only accept a first request if they meet the coordinating practitioner requirements under clause 92. This ensures that a health practitioner can only become an individual's coordinating practitioner if they have completed mandatory VAD training and qualification requirements. This is designed to ensure that the VAD process is assisted only by health practitioners who are suitably qualified and skilled.

Clause 14(2)(b) clarifies that a health practitioner may refuse to accept a first request if they are unable or unwilling to exercise the functions of a coordinating practitioner, including if they have a conscientious objection (see clause 94).

Clause 14(3) requires that:

- if the health practitioner accepts the first request, the health practitioner must give the individual any information prescribed by regulation. This is intended to ensure the individual receives the information they need to make informed end of life choices; or

- if the health practitioner refuses to accept the first request for any reason, the health practitioner must tell the individual that other health practitioners may be able to assist, and give the individual information about another health practitioner who they believe is likely to be able to assist the individual with their request or the Care Navigator Service. This is to ensure that a refusal to accept a first request does not hinder an individual's access to VAD.

Clause 15 Recording first request in individual's health record

This clause requires a health practitioner to record certain information about the first request in the individual's health record.

The Bill adopts the definition of health record from the *Health Records (Privacy and Access) Act 1997* (ACT): 'any record, or any part of a record (a) held by a health service provider and containing personal information; or (b) containing personal health information.'

Clause 16 Coordinating practitioner to undertake first assessment

This clause requires the coordinating practitioner to undertake a first assessment to decide whether the individual meets the eligibility requirements, as long as the coordinating practitioner is satisfied that the individual understands the information given to them under clause 14(3)(a). Clause 16(3) sets out principles to be taken into account in deciding whether an individual understands that information.

Clause 16(4) also empowers the coordinating practitioner to take into account any relevant information about the individual that has been prepared by another person who has the appropriate skills and training to provide the information. This includes any advice given by another practitioner under clause 17. This is designed to ensure the coordinating practitioner is fully informed in making their assessment, particularly because the coordinating practitioner may not have worked with the individual before.

Clause 17 Referral for advice about eligibility requirements

This clause applies if a coordinating practitioner is unable to decide whether the individual meets an eligibility requirement.

Clause 17(1) requires the coordinating practitioner to refer the individual to another person who has the appropriate skills and training to provide advice about whether the individual meets the eligibility requirement.

Clause 17(2) requires that a referral must not be made to a person who the coordinating practitioner knows or believes is a family member of the individual, or who may benefit from the individual's death or from assisting the individual to access VAD. This is to reduce the risk of an actual or perceived conflict of interest arising from the referral.

Clause 18 Notifying individual and board about outcome of first assessment

This clause requires that after deciding whether an individual meets the eligibility requirements, the coordinating practitioner must within two working days:

- Prepare a first assessment report and give it to the Board; and

- Tell the individual about the decision and give the individual a copy of the first assessment report.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to give the Board a copy of the first assessment report within the timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to incentivise strict adherence to reporting requirements, because these are a key safeguard for monitoring compliance with, and operation of, the Bill.

Clause 19 Referral for consulting assessment

This clause requires that if an individual's coordinating practitioner decides that the individual meets the eligibility requirements, within two working days the coordinating practitioner must refer the individual to another health practitioner (the first referral practitioner) for a consulting assessment. Where the first referral practitioner does not accept the referral, the coordinating practitioner must take reasonable steps to find another health practitioner who will accept the referral. Where another health practitioner cannot be found, the coordinating practitioner must refer the individual to the Care Navigator Service.

Division 3.2 Consulting referral, consulting practitioner and consulting assessment

Clause 20 Health practitioner must accept or refuse to accept consulting assessment referral

This clause sets out the process and requirements for a practitioner accepting or refusing a referral to become an individual's consulting practitioner.

Clause 20(1) requires that within two working days after a health practitioner receives a referral under clause 19 or 26, the practitioner must—

- decide to accept or refuse to accept the referral; and
- tell the individual's coordinating practitioner about the decision.

Clause 20(2) requires that the health practitioner must refuse to accept the referral if they do not meet the consulting practitioner requirements under clause 92.

Clause 20(2) clarifies that a health practitioner may refuse to accept a referral if they are unable or unwilling to exercise the functions of a consulting practitioner, including if they have a conscientious objection (see clause 94).

Clause 20(3) provides that as soon as practicable after the health practitioner tells the coordinating practitioner about their decision, the coordinating practitioner must tell the individual about the decision and tell the health practitioner that they have told the individual.

Clause 21 Recording referral in individual's health record

This clause requires a health practitioner to record certain information about the referral in the individual's health record.

The Bill adopts the definition of health record from the *Health Records (Privacy and Access) Act 1997* (ACT): 'any record, or any part of a record (a) held by a health service provider and containing personal information; or (b) containing personal health information.'

Clause 22 Notifying board about decision to accept or refuse to accept referral

Clause 22(1) requires that within two working days after the coordinating practitioner tells the individual about the health practitioner's decision to accept or refuse the referral, the health practitioner must give the Board written notice of the decision.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to incentivise strict adherence to reporting requirements, because these are a key safeguard for monitoring compliance with and operation of the Bill.

Clauses 22(4) and (5) provide that if the health practitioner accepts the referral:

- they become the consulting practitioner for the individual at the time that they give notice to the Board; and
- they must give the individual any information prescribed by regulation.

Clause 23 Consulting practitioner to undertake consulting assessment

This clause requires the consulting practitioner to undertake a consulting assessment to decide whether the individual meets the eligibility requirements, as long as the consulting practitioner is satisfied that the individual understands the information given to them under clause 22(5). Clause 23(2) sets out principles that

must be taken into account in deciding whether an individual understands that information.

The purpose of the consulting assessment is to provide a second, independent determination of the individual's eligibility to access VAD. This important safeguard ensures two qualified professionals agree that the individual is eligible.

This clause also empowers the consulting practitioner to take into account any relevant information about the individual that has been prepared by another person who has the appropriate skills and training to provide the information. This includes any advice given by another person under clause 24. This is designed to ensure the consulting practitioner is fully informed in making their assessment, particularly because the consulting practitioner may not have worked with the individual before.

Clause 24 Referral for advice about eligibility requirements

Similarly to clause 17, this clause applies if a consulting practitioner is unable to decide whether the individual meets an eligibility requirement.

Clause 24(1) requires the consulting practitioner to refer the individual to another person who has the appropriate skills and training to provide advice about whether the individual meets the eligibility requirement.

Clause 24(2) requires that a referral must not be made to a person who the consulting practitioner knows or believes is a family member of the individual, or who may benefit from the individual's death or from assisting the individual to access VAD. This is to reduce the risk of an actual or perceived conflict of interest arising from the referral.

Clause 25 Notifying individual, coordinating practitioner and board about outcome of consulting assessment

This clause requires that after deciding whether an individual meets the eligibility requirements, the consulting practitioner must within two working days:

- Prepare a consulting assessment report and provide it to the Board and the coordinating practitioner; and

- As soon as practicable, tell the individual about the decision and give the individual a copy of the consulting assessment report.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to give a copy of the consulting assessment report to the Board is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to

incentivise strict adherence to reporting requirements, because these are a key safeguard for monitoring compliance with, and operation of, the Bill.

Clause 26 Referral for further consulting assessment

This clause applies if an individual's consulting practitioner decides that the individual does not meet the eligibility requirements. It clarifies that the coordinating practitioner may refer the individual to another health practitioner for a further consulting assessment. In practice, a further consulting assessment would follow the same process as the original consulting assessment and replace the original consulting assessment.

Division 3.3 Second request

Clause 27 Making second request

This clause sets out that after both the coordinating practitioner and consulting practitioner have decided the individual meets the eligibility requirements, the individual may make a second request for VAD to their coordinating practitioner.

Unlike the first and final requests, the second request must be formalised in writing, signed by the individual.

Clause 27(3) and (4) provide that if the individual is unable to sign the request – for example, because they have lost mobility in their hands – another person (an agent) may sign at the individual's request. This is an important accessibility feature that recognises some individuals choosing to access VAD may have limited ability to write.

This clause contains safeguards to reduce the risk of actual or perceived conflicts of interest, and ensure that agents and witnesses are not in a position of undue influence over the individual:

- Clause 27(4)(b) requires the agent to be an adult who is neither a witness nor the coordinating nor consulting practitioner, and to sign in the presence of the individual.

- The second request must be signed by the individual in the presence of two eligible witnesses. A witness is eligible if they are an adult, and if they do not know or believe that they will benefit from the individual's death or their access to VAD. In addition, the witness must not own or manage a facility where the individual lives or is being treated, and must not be the individual's coordinating practitioner or consulting practitioner.

This clause requires that the second request must state that the request is made voluntarily and without coercion, and that the individual understands the nature and effect of the request. If an interpreter was used, the interpreter must certify on the

second request that the interpreter provided a true and correct translation of any material translated.

Clause 28 Certification of witness

This clause prescribes the role of witnesses to the second request, and provides added safeguards to ensure the second request is made voluntarily.

This clause requires each witness referred to in clause 27 to certify that the second request was signed voluntarily and without coercion, and in the presence of the witness. Alternatively, if the request was signed by an agent, the witnesses must certify that the individual appeared to ask, voluntarily and without coercion, the agent to sign the request, and the request was signed by the agent.

This clause also requires the witnesses to certify that they are not knowingly an ineligible witness, as defined in clause 27(6).

Clause 29 Recording second request in individual's health record

This clause requires a health practitioner to record certain information about the second request in the individual's health record.

The Bill adopts the definition of health record from the *Health Records (Privacy and Access) Act 1997* (ACT): 'any record, or any part of a record (a) held by a health service provider and containing personal information; or (b) containing personal health information.'

Clause 30 Notifying board about second request

This clause requires that within two working days after the day the coordinating practitioner receives the second request, the practitioner must give the Board a copy.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to comply with this clause is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to incentivise strict adherence to reporting requirements, because these are a key safeguard for monitoring compliance with and operation of the Bill.

Division 3.4 Final request and final assessment

Clause 31 Meaning of final assessment requirements

This clause sets out that an individual meets the final assessment requirements if the individual—

(a) has decision-making capacity in relation to VAD; and

(b) the individual's decision to access VAD is made voluntarily and without coercion.

The coordinating practitioner must be satisfied that the individual meets these final assessment requirements to move to the next stage of the process.

There is no requirement for the coordinating practitioner to assess at this stage whether the individual meets the other eligibility requirements in clause 11. This is because those other requirements (age, residency, relevant conditions, and intolerable suffering) are unlikely to fluctuate in the same way as an individual's capacity and voluntary decision-making may fluctuate throughout the VAD request and assessment process.

Clause 32 Making final request

This clause describes the process for an individual to make a final request to their coordinating practitioner.

It requires that a final request must be clear and unambiguous, and made personally by the individual.

It also clarifies that a final request may be made in writing or orally, or by communicating in any other way the individual can. This is intended to recognise that people who are suffering and dying may need support to communicate their wishes.

Clause 33 Recording final request in individual's health record

This clause requires the coordinating practitioner to record certain information about the final request in the individual's health record.

The Bill adopts the definition of health record from the *Health Records (Privacy and Access) Act 1997* (ACT): 'any record, or any part of a record (a) held by a health service provider and containing personal information; or (b) containing personal health information.'

Clause 34 Notifying board about final request

This clause requires that within two working days after the day the coordinating practitioner receives the final request, the practitioner must give the Board a copy of the final request report.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to give the Board a copy of the final request report is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to incentivise strict

adherence to reporting requirements, because these are a key safeguard for monitoring compliance with and operation of the Bill.

Clause 35 Coordinating practitioner to undertake final assessment

This clause requires the coordinating practitioner to undertake a final assessment to decide whether the individual meets the final assessment requirements, as defined in clause 31.

Clause 36 Notifying individual and board about outcome of final assessment

This clause requires that as soon as practicable after deciding whether an individual meets the final assessment requirements, the coordinating practitioner must tell the individual.

This clause also requires that within two working days, the coordinating practitioner must give a copy of the final assessment report to the Board and the individual.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Failure to give a copy of the final assessment report is a strict liability offence, the maximum penalty for which is 20 penalty units. This is to incentivise strict adherence to reporting requirements, because these are a key safeguard for monitoring compliance with and operation of the Bill.

Division 3.5 Transfer of coordinating practitioner functions

This division applies where there is a need to transfer the role of coordinating practitioner to another practitioner. In practice, this could occur if the coordinating practitioner is unwilling or unable to continue acting as the individual's coordinating practitioner for any reason (clause 37), or if the individual wishes to proceed with a different person as their coordinating practitioner (clause 38).

This division is designed to ensure that in such a situation, the individual does not need to restart the VAD request and assessment process, or find a new coordinating practitioner. Instead, a smooth transition can take place so that another qualified practitioner becomes the new coordinating practitioner, and any assessments already undertaken by the original coordinating practitioner remain valid.

Clause 37 Transfer request made by coordinating practitioner

This clause sets out the process for a coordinating practitioner (the ***original practitioner***) to request that another health practitioner (the ***other practitioner***) become the coordinating practitioner for the individual (a ***transfer request***), including that the request may only take place if the individual consents.

Clause 37(3) requires the other practitioner to tell the original practitioner whether they accept or refuse the request within two working days.

Clause 37(4) requires the other practitioner to refuse to accept the transfer request if they do not meet the coordinating practitioner requirements under clause 92. It also provides that the other practitioner may refuse if they are unable or unwilling to exercise the functions of a coordinating practitioner, including if they have a conscientious objection.

Clause 37(5) requires that if the other practitioner accepts the transfer, the original practitioner must tell the individual, and record the acceptance in the individual's health record.

It also requires the original practitioner to give the Board written notice as soon as practicable but not later than two working days after telling the individual about the acceptance, and tell the other practitioner about this as soon as practicable after giving notice. Non-compliance with the Board notification requirement is a strict liability offence, the maximum penalty for which is 20 penalty units.

Requiring practitioners to comply with the Bill within certain timeframes such as these is intended to reduce administrative delays in the individual being able to progress to the next stage of the process.

Clause 37(7) provides that when the original practitioner gives the Board notice of the transfer, the other practitioner becomes the individual's coordinating practitioner.

Clauses 37(8) provides that if the original practitioner is unable to transfer their functions after taking reasonable steps to do so, they must refer the individual to the Care Navigator Service. This is to ensure the individual has access to support in finding a new coordinating practitioner, so that their access to VAD is not hindered.

Clause 38 Transfer request made by individual

If an individual's coordinating practitioner is unwilling or unable to transfer their functions under clause 37 (for example, they are uncontactable or have died), clause 38 sets out a process for the transfer to take place at the individual's request. It provides for a similar process and requirements as clause 37.

Clause 39 Decisions of previous coordinating practitioner remain valid despite transfer of coordinating practitioner functions

This clause provides that if a health practitioner accepts a transfer request under clause 37 or 38, any previous first assessment or final assessment undertaken by the original practitioner continues to have effect.

This means that an individual is not required to undergo repeat assessments if the functions of their coordinating practitioner transfer to another practitioner. This is designed to reduce bureaucratic hurdles to an eligible individual accessing VAD if they choose to.

Division 3.6 Miscellaneous

Clause 40 Inducing making or revocation of request for access to voluntary assisted dying

Clause 40(1) provides an offence where a person dishonestly or by coercion, induces an individual into making a request for access to VAD. The maximum penalty for this offence is imprisonment for seven years.

Clause 40(2) provides an offence where a person dishonestly or by coercion, induces an individual into revoking a request for access to VAD. The maximum penalty for this offence is 100 penalty units.

'Dishonest' is defined as where the person's conduct is dishonest according to the standards of ordinary people; and the person knows that the conduct is dishonest according to those standards.

A key feature of the scheme is that VAD must be voluntary, and the inclusion of these offences will reduce the risk of potential coercion or exploitation. While it is considered important to include an offence for both inducing and revoking a request, the conduct of inducing a request is considered more serious warrants a stronger penalty as a deterrent.

Part 4 Accessing voluntary assisted dying and death

Part 4 comprises clauses 41 to 80. This part sets out the process for accessing VAD and death, including regulation of the administration of an approved substance, appointment of administrating practitioner and contact person (if required), dealing with approved substances, and notifications of death.

Division 4.1 Administration decision

Clause 41 Application—div 4.1

This clause provides that Division 4.1 only applies once an individual has made a final request to access VAD, and the individual's coordinating practitioner has prepared a final assessment report for the individual under clause 36(2). This

ensures an approved substance is not administered until the requirements of the request and assessment process have been complied with.

Clause 42 Making administration decision

This clause sets out the requirements for making an administration decision, if the individual wishes to proceed with the VAD process. An administration decision is a prerequisite to prescribing, supplying and administering the VAD substance.

There is no default method of administration of an approved substance. An individual may decide to self-administer an approved substance (a self-administration decision) or have it administered to them by a health practitioner (a practitioner administration decision). Many individuals near death may have lost the ability to self-administer an approved substance, so may need to opt for practitioner administration.

This clause provides that an administration decision must be clear and unambiguous and made by the individual personally. The individual may make an administration decision in writing, verbally or by another means of communication available to the individual. The decision may be made following consultation with the individual's coordinating practitioner.

The individual's coordinating practitioner must record the decision in the individual's health record and give the Board written notice of the decision within two working days of the decision. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 43 Changing administration decision

This clause provides that an individual who has made a self-administration decision under clause 42 may at any time change their decision to a practitioner administration decision, and vice versa. This might happen, for example, if an individual who has made a self-administration decision loses the physical ability to self-administer an approved substance.

This decision must be clear and unambiguous and made by the individual personally. The individual may make an administration decision in writing, verbally or by another means of communication available to the individual. The decision may be made following consultation the individual's coordinating practitioner.

The individual's coordinating practitioner must record the decision in the individual's health record and give the Board written notice of the decision within two working days of the decision. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Where an individual elects to change from a practitioner administration to a self-administration decision, the individual must appoint a contact person under clause 51.

Where an individual elects to change from a self-administration to a practitioner administration decision, the contact person's appointment ends. This is because an individual is not required to have a contact person for practitioner administration.

Clause 44 Administering practitioner

This clause applies where an individual has made a practitioner administration decision.

It provides a process for an individual to ask their coordinating practitioner or another eligible health practitioner (the requested practitioner) to act as their administering practitioner. An administering practitioner is someone who is authorised to deal with and administer the approved substance to an individual.

This clause provides that the requested practitioner must not act as the administrating practitioner if they do not meet the administering practitioner requirements under clause 92.

Where the requested practitioner agrees to act as the administering practitioner, the practitioner must tell the individual and give the Board written notice of their decision within two working days. Failure to comply is a strict liability offence, the maximum penalty for which is 20 penalty units.

Where the requested practitioner does not agree to act as the administering practitioner, they must direct the individual to another practitioner or the Care Navigator Service. This is to ensure that a refusal to accept the request does not hinder an individual's access to VAD.

The practitioner must record details of the request, their decision and the steps taken to direct the individual to another practitioner or the Care Navigator Service in the individual's health record.

Clause 45 Revocation of administration decision

This clause sets out the process for an individual to revoke a self-administration or practitioner administration decision at any time. This may occur in writing or orally, or by communicating in any other way the individual can and must be clear and unambiguous, and made personally by the individual.

The revocation of an administration decision does not prevent the individual from making a new administration decision at a later time.

The individual's administering practitioner or coordinating practitioner must record the administration decision in the individual's health record, advise the person's coordinating practitioner of the decision and give the Board written notice of the decision within two working days of the decision. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 46 Transfer of administering practitioner functions—transfer request made by administering practitioner

This clause sets out the process for transferring the functions of an administering practitioner, where the transfer is initiated by the administering practitioner. Where a practitioner is unable or unwilling to act as the administering practitioner, they may ask another health practitioner to become the individual's administering practitioner. Consent must be obtained from the individual prior to making the transfer request.

The other health practitioner must accept or refuse the role within two working days. An individual must not act as the administrating practitioner if they do not meet the administering practitioner requirements under clause 92.

If the transfer is accepted, the original practitioner must tell the individual the transfer has occurred and advise the other health practitioner's name and contact details, record the request in the individual's health record, give written notice to the Board within two working days and tell the other health practitioner that the Board has been notified. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Once notice has been provided to the Board, the other health practitioner becomes the individual's new administering practitioner.

If the original practitioner is unable to transfer their role, they must refer the individual to the Care Navigator Service. This is to ensure that a refusal to accept the request does not hinder an individual's access to VAD.

Clause 47 Transfer of administering practitioner functions—transfer request made by individual

This clause sets out the process for transferring the functions of an administering practitioner, where the transfer is initiated by the individual and an administering practitioner is unable or unwilling to transfer their functions under clause 46. This might happen, for example, where an individual wishes to use a different person as their administering practitioner, or if the administering practitioner is not contactable. An individual may ask another health practitioner to become their administering practitioner.

The other health practitioner must accept or refuse the role within two working days. An individual must not act as the administrating practitioner if they do not meet the administering practitioner requirements under clause 92.

If the transfer is accepted, the new health practitioner must tell the individual's original administering practitioner they have accepted the role, record the request in the individual's health record, give written notice to the Board within two working days and tell the original administering practitioner that the Board has been notified.

Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Once notice has been provided to the Board, the health practitioner becomes the individual's new administering practitioner.

If the practitioner refuses to accept the transfer of the role, they must refer the individual to the Care Navigator Service. This is to ensure that a refusal to accept the request does not hinder an individual's access to VAD.

Clause 48 Coordinating practitioner functions do not transfer on transfer of administering practitioner functions

This clause clarifies that if an individual's original administering practitioner was also their coordinating practitioner, the original administering practitioner remains the coordinating practitioner despite the appointment of a new administering practitioner under clause 46 or 47.

Clause 49 Offence—inducing making or revocation of administration decision

Clause 49(1) provides an offence where a person dishonestly or by coercion, induces an individual into making an administration decision. The maximum penalty for this offence is imprisonment for seven years.

Clause 49(2) provides an offence where a person dishonestly or by coercion, induces an individual into revoking an administration decision. The maximum penalty for this offence 100 penalty units.

A definition of 'dishonest' is provided.

A key feature of the scheme is that VAD must be voluntary, and the inclusion of these offences will reduce the risk of potential coercion or exploitation. While it is considered important to include an offence for both inducing and revoking an administration decision, the conduct of inducing a request is considered more serious and a stronger penalty is warranted to act as a deterrent.

Division 4.2 Contact person

Clause 50 Application—div 4.2

This clause provides that division 4.2 applies if an individual has made a self-administration decision. This makes clear that an individual who has made a self-administration decision must appoint a contact person.

The contact person is appointed to help an individual with administrative matters, but also to ensure Board and relevant persons have established someone to take responsibility for certain matters once the person dies. The contact person is responsible for obtaining the approved substance if the person applying for VAD is unable to, returning any unused approved substance, notifying the Board when a person dies, and liaising with the Board as required.

Clause 51 Appointment of contact person

This clause sets out the requirements for a person to act as the contact person. To be eligible for appointment a person must be an adult and willing to perform the role. An individual may appoint their coordinating practitioner, their consulting practitioner, another health professional or any other eligible individual, including family members or a Care Navigator Service employee, to the role.

The appointment must be in writing, prepared by the person or another adult on their behalf, and must include any matters set by regulation.

Written notice of the appointment must be provided by the individual's coordinating practitioner to the Board within two working days. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 52 Coordinating practitioner must give information to contact person

This clause provides that the individual's coordinating practitioner must give certain information to contact person within two days of the Board being notified of the appointment. This includes information outlining the functions of a contact person and the support services available to assist the contact person to comply with their obligations.

Clause 53 Ending contact person appointment

This clause sets out the process for ending the appointment of a contact person. This can be initiated by the individual or the contact person in writing. Where the appointment ends, the individual must advise this to their coordinating practitioner, and then make another appointment. Written notice of the end of the appointment must be provided by the individual's coordinating practitioner to the Board within two working days. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 54 Effect of revocation of administration decision on contact person appointment

This clause provides that the appointment of a contact person ends where a self-administration decision is revoked or changed to a practitioner administration decision.

Division 4.3 Dealing with approved substances

Clause 55 Definitions—div 4.3

This clause provides definitions for ‘prescribe’ and ‘prescription’, and defines ‘possess’, ‘supply’, ‘purchase order’, ‘requisition’, and ‘standing order’ by reference to the *Medicines, Poisons and Therapeutic Goods Act 2008*.

Clause 56 Approved substances

This clause provides that the Director-General may approve a medicine for use under this Bill for the purposes of causing an individual’s death.

An administrative mechanism will be established to ensure that coordinating practitioners are given information about what substances may be prescribed. Given the nature of the approved substances, it is not considered appropriate that they be publicly notified through a disallowable or notifiable instrument.

This clause provides a signpost definition for ‘medicine’ by reference to the *Medicines, Poisons and Therapeutic Goods Act 2008*.

Clause 57 Approved suppliers and disposers

This clause provides that the Director-General may approve a health practitioner to supply or dispose of an approved substance under this Bill, if the practitioner meets the eligibility requirements prescribed by regulation.

Eligibility requirements for approved suppliers and disposers may be prescribed by regulation. Approval is made through a notifiable instrument. This clause will ensure that only suitable persons handle and dispose of approved substances. Authorised suppliers and disposers will act as an essential check and balance on the VAD process.

Clause 58 Prescribing approved substances—first prescription

This clause provides that an individual’s coordinating practitioner may prescribe one or more approved substances that, either alone or in combination, are of a sufficient dose to cause the death of the individual.

Where the individual has made a self-administration decision, they must have appointed a contact person prior to the coordinating practitioner prescribing the substance. Where the individual has made a practitioner administration decision, the individual must have an administering practitioner prior to the coordinating practitioner prescribing the substance. For both types of administrative decisions, the individual’s coordinating practitioner must have given the individual any information prescribed by regulation prior to prescribing the substance.

Written notice of the prescription must be provided by the individual’s coordinating practitioner to the Board within two working days after prescribing an approved

substance. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

This requirement will support the safe management of the substance by ensuring all instances of supply are recorded and assisting the Board in its monitoring and review role.

Clause 59 Prescribing approved substances—subsequent prescription

This clause allows for additional prescriptions to be issued where the individual's coordinating practitioner is satisfied that it is appropriate to issue another prescription, and the individual's coordinating practitioner has undertaken a further final assessment to decide again that the individual meets the final assessment requirements.

As required under clause 58, where the individual has made a self-administration decision, they must have appointed a contact person prior to prescribing the substance. Where the individual has made a practitioner administration decision, the individual must have an administering practitioner. For both types of administrative decisions, the individual's coordinating practitioner must have been given any information prescribed by regulations prior to prescribing the substance.

Written notice of the prescription must be provided by the individual's coordinating practitioner to the Board within two working days. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

This requirement will support the safe management of the substance by ensuring all instances of supply are recorded and assisting the Board in its monitoring and review role.

Clause 60 Possessing, preparing and supplying approved substances—approved suppliers

This clause provides that an approved supplier may possess and prepare an approved substance on receipt of a prescription. The supplier must be satisfied about the authenticity of the prescription, and of the identity of the coordinating practitioner and the person who the substance is being supplied to. The substance must be labelled in accordance with any requirements set by regulation, and meet any other requirements set by regulation.

An approved supplier must not supply an approved substance that is a controlled medicine (as defined in the *Medicines, Poisons and Therapeutic Goods Act 2008*, section 11(2)) if the prescription was issued more than six months ago. For any other approved substance, the prescription must have been issued within the past 12 months.

An approved supplier must not supply a subsequent supply of an approved substance unless satisfied that the previously supplied substance has been given to

an approved disposer or reported as lost or stolen in accordance with section 39 of the *Medicines, Poisons and Therapeutic Goods Act 2008*.

The Director-General and Board must be notified of the supply within two working days, and a written record of the supply must be kept by the approved supplier for two years. Failure to meet these obligations is a strict liability offence, the maximum penalty for which is 20 penalty units.

This requirement will support the safe management of the substance by ensuring all instances of supply are recorded and assisting the Board in its monitoring and review role.

Clause 61 Receiving, possessing, preparing and administering approved substances—individuals and other people

This clause provides what may happen to an approved substance where the individual has made a self-administration decision, and the substance has been prescribed by the individual's coordinating practitioner.

Clause 61(2) provides what an individual is authorised to do with an approved substance. Clause 61(3) provides what a contact person is authorised to do with an approved substance. This is to ensure the approved substance is only in the possession of authorised individuals.

Written notice must be provided by the individual's contact person to the Board and Director-General within two business days of the substance being given to the individual. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units. This supports the safe management of the substance by ensuring all instances of possession of the substance are recorded to assist the Board in its monitoring and review role.

Clause 61(6) allows for the individual to ask another adult to assist in preparing the approved substance for the individual. The adult preparing the substance must not administer the approved substance. The administration of an approved substance by an unauthorised person is an offence under clause 70 of the Bill.

Definitions of 'give' and 'receive' are provided for this clause.

Clause 62 Giving approved substances to administering practitioner after change of administration decision—individuals

This clause provides that where an individual changes their administration decision to practitioner administration from self-administration, the individual must give the approved substance to their administering practitioner as soon as practicable after the health practitioner becomes their administering practitioner.

Written notice must be provided by the administering practitioner to the Board and Director-General within two working days of receipt of the approved substance by

the practitioner. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 63 Receiving, possessing and administering approved substances— administering practitioner

This clause provides what an individual's administering practitioner may do with an approved substance and how the substance may be received, possessed and administered.

Clause 63(3) provides that an administrating practitioner may only administer the approved substance to the individual where satisfied, immediately before administering the substance, that the individual has decision-making capacity in relation to VAD and is acting voluntarily and without coercion. The administration of an approved substance by an unauthorised person is an offence under clause 70 of the Bill.

The administrating practitioner may receive the substance where an individual has changed their decision from self-administration to practitioner administration.

Where the administrating practitioner's functions are transferred and the original administrating practitioner is in possession of the substance, they must give the substance to the new administrating practitioner or an approved disposer.

Written notice must be provided by the administering practitioner to the Board and Director-General within two working days of the original administering practitioner giving the approved substance to the new administering practitioner. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

This supports the safe management of the substance by ensuring all instances of possession of the substance are recorded to assist the Board in its monitoring and review role.

Clause 64 Giving, receiving and possessing approved substances— change in contact person

This clause sets out what must happen to an approved substance where the contact person's appointment ends and the contact person is in possession of the substance. This might happen if the contact person role changes from one person to another, late in the VAD process.

Within 14 days after day the contact person appointment ends, the individual may ask the original contact person to give the approved substance to them or the new contact person.

The substance must be provided by the original contact person within two days of this request. Failure to do so is an offence, the maximum penalty for which is 100 penalty units. This is not intended to be a strict liability offence. The higher penalty reflects the need to ensure the substance is provided to the individual or their new contact person quickly to reduce the risk that an unauthorised person comes into possession of the substance and to ensure a person's ability to access VAD is not unnecessarily delayed.

Written notice must be provided by the original contact person to the Board and Director-General within two working days after the original contact person gives an approved substance to another person. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

This supports the safe management of the substance by ensuring all instances of possession of the substance are recorded to assist the Board in its monitoring and review role.

Clause 65 Giving approved substances to approved disposer if individual dies or contact person appointment ends— contact person

This clause sets out what must happen to an approved substance if an individual dies or a contact person appointment ends, and the contact person is in possession of the substance and is not required to return it under clause 64.

The contact person must give the approved substance to an approved disposer as soon as practicable, but not later than 14 days after the individual dies or the contact person appointment ends. Failure to do so is an offence, the maximum penalty for which is 100 penalty units. There is a need to ensure the substance is disposed of quickly to reduce the risk that an unauthorised person comes into possession of the substance. This does not apply where an individual has directed the contact person to give the substance to them or the new contact person under clause 64.

The approved disposer must notify the Board on the return of the substance under clause 68.

Clause 66 Giving approved substances to approved disposer— administering practitioner

This clause sets out what must happen when an individual revokes their practitioner administration decision, dies or the administrating practitioner does not consider the substance suitable for administration, and the administering practitioner is in possession of the substance. The administering practitioner must give the approved substance to an approved disposer. Failure to comply with this requirement is an offence, the maximum penalty of which is 100 penalty units.

Unlike the requirements for a contact person, no timeframe is provided for the return of the substance. While it is expected this would occur as soon as practicable, given

the administering practitioner is a health professional it is not considered necessary to impose a statutory timeframe to return the substance.

The approved disposer must notify the Board and Director-General on the return of the substance under clause 68.

Clause 67 Giving expired approved substances to approved disposer

This clause sets out what must happen when an approved substance has been supplied and is not used before it expires, and it is in possession of the individual or another person.

Clause 67(2) requires that the individual or other person must give the approved substance to an approved disposer as soon as practicable but not later than 14 days after the day they become aware that the substance has expired. Failure to do so is an offence, the maximum penalty for which is 100 penalty units. This recognises the serious and unpredictable consequences of an approved substance being used after it has expired, and the need to deter such usage.

Clause 68 Disposal of approved substances by approved disposer

This clause sets out the requirements where an approved disposer receives an approved substance from a person.

Written notice must be provided to the Board and Director-General by the approved disposer within two working days after the approved substance is given to the approved disposer. Failure to notify the Board is a strict liability offence, the maximum penalty for which is 20 penalty units.

The approved disposer must then dispose of the approved substance as soon as practicable in accordance with any disposal requirements prescribed by regulation.

The approved disposer must then, within seven days of the disposal, give the Director-General written notice of the disposal, and must prepare a disposal record and provide it to the Board. This record must be kept by the approved disposer for two years. Failure to provide the Board with a disposal record within the timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units.

This clause supports the safe management of the substance by ensuring all instances of possession and disposal of the substance are recorded to assist the Board in its monitoring and review role.

Clause 69 Storage of approved substances

This clause provides that requirements for storage of an approved substance may be set through regulation. This will ensure safe storage of the substance so that unauthorised access to an approved substance is limited as far as possible.

Clause 70 Offence—unauthorised administration of approved substance

This clause provides an offence where a person administers an approved substance to an individual and is not authorised to administer the approved substance to the individual under clause 63.

The maximum penalty for this offence is imprisonment for seven years.

Other existing offences in the *Criminal Code 2002* are provided for unlawful killing and aiding suicide. These will continue to apply to the unauthorised administration of an approved substance. This offence covers a range of potential conduct including where a person administers a substance but is not qualified to do so, either knowingly or inadvertently. It would also cover behaviour where a person knowingly or recklessly acts outside the scheme. For example, where the administering practitioner knows the individual has not made or has withdrawn their request to access VAD, or where the individual does not have the required decision-making capacity.

Clause 71 Offence—inducing self-administration of approved substance

This clause provides that a person commits an offence if the person, dishonestly or by coercion, induces an individual into self-administering an approved substance.

The maximum penalty for this offence is imprisonment for seven years.

A signpost definition of ‘dishonest’ is provided.

A key feature of the scheme is that VAD must be voluntary, and the inclusion of this offence will reduce the risk of potential coercion or exploitation.

Division 4.4 Notifications about death

Clause 72 Application—div 4.4

This clause provides that Division 4.4 applies if an individual dies while an administration decision is in effect for them.

Clause 73 Contact person to tell coordinating practitioner about death

This clause requires a contact person to tell the coordinating practitioner about the death of an individual, of any cause, within two business days after the contact person becomes aware of the death. This is to ensure the coordinating practitioner can fulfill all their obligations under the Bill that arise after an individual’s death.

Clause 74 Coordinating practitioner to notify board and director-general about death

This clause provides that the coordinating practitioner must notify the Board and Director-General about the death of an individual, of any cause, within two working days of the coordinating practitioner becomes aware of the individual's death. Failure to notify the Board within the required timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units.

Notification of the Board is an important mechanism to ensure the Board can perform its functions and provide full oversight of the VAD scheme in the ACT.

Clause 75 Administering practitioner to notify board, coordinating practitioner and director-general about death

This clause provides that the administering practitioner must notify the Board, coordinating practitioner and Director-General about the death of an individual within two working days of becoming aware of the death. This does not apply where the administering practitioner is individual's coordinating practitioner or has given notification under clause 76.

Failure to notify the Board within the required timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units.

Notification of the Board is an important mechanism to ensure the Board can provide full oversight of the VAD scheme in the ACT.

Clause 76 Administration certificate

This clause provides that where an individual dies following the administration of an approved substance by their administering practitioner, written notice of the death must be given by the administering practitioner to the Director-General within two working days.

The administering practitioner must prepare an administration certificate providing that the individual made an administrative decision to have the approved substance administered, and that immediately before administering the substance, the administering practitioner was satisfied that the individual had decision-making capacity in relation to VAD and the individual was acting voluntarily and without coercion.

Failure to notify the Board within the required timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 77 Notice of death if individual dies following administration of an approved substance

This clause applies where a health practitioner is required to give the registrar-general written notice of the death and cause of death of an individual under section 35 of the *Births, Deaths and Marriages Registration Act 1997* (BDMR Act), and they know or reasonably believe that the individual died after an approved substance was administered by or to the individual under this Bill.

Clause 77(2) requires that the practitioner must state that the individual's cause of death was the individual's relevant condition. The notice must not include any reference to VAD as the cause of death.

This is to ensure that consistent with other jurisdictions, that a person's underlying condition, rather than VAD, is recorded as the cause of death on the death certificate issued by the registrar-general for births, deaths and marriages. This is to promote the individual's right to privacy and avoid any unintended implications relating to insurance or other personal matters arising after an individual's death.

Clause 77(3) requires the health practitioner to give the registrar-general written notice that the individual's 'manner of death' was the administration of an approved substance under this Bill. The intention of this is to ensure authorise the collection of data on VAD deaths under the Bill.

As provided in schedule 3 of this Bill, the new section 42(2A) of the BDMR Act prevents an individual's manner of death for VAD from being released to any person by the registrar-general, other than under clause 118.

Clause 78 Health practitioner to notify board about death

This clause provides that within two working days after a health practitioner becomes aware of the individual's death, the health practitioner must give the Board and Director-General written notice of the death. This clause is intended to cover health practitioners who are required to give notification of a death under clause 77, but not required to give notice under clauses 74, 75 or 76 of the Bill.

Failure to notify the Board within the required timeframe is a strict liability offence, the maximum penalty for which is 20 penalty units.

Clause 79 Board may request information from coordinating practitioner or contact person

This clause provides that the Board may request information from a contact person and coordinating practitioner in relation to the individual's death, after the coordinating practitioner gives the Board notice of the death. Clause 79(3) sets out procedural fairness requirements for the Board's request.

The Board is responsible for oversight of the VAD scheme in the ACT. A robust oversight mechanism will ensure transparency and accountability and enable compliance with the legislation.

In undertaking their functions, it may be necessary for the Board to obtain further information on the individual's death. Given the importance of the Board being fully informed, a strict liability offence is established where the contact person or coordinating practitioner does not comply with the Board's request. The maximum penalty for this offence is 20 penalty units.

Division 4.5 Miscellaneous

Clause 80 Director-general must keep register about supply, possession and disposal of approved substances

This clause requires the Director-General to keep a register of approved substances that includes the information prescribed by regulation, and any other information the Director-General considers appropriate. On request by the Board, the Director-General may give information in the register to the Board if the Director-General is satisfied that the information is relevant to the exercise of the Board's functions.

This clause provides an additional safeguard by tracking approved substances that are prescribed in the ACT, and allowing for the Board to access information about those substances to exercise its functions.

Part 5 Requirements for coordinating practitioners, consulting practitioners and administering practitioners

Part 5 comprises clauses 81 to 93. This part sets the eligibility requirements for an individual to act as a coordinating practitioner, consulting practitioner and administering practitioner.

Division 5.1 General

Clause 81 Definitions—pt 5

This clause provides definitions of a 'authorised administering practitioner', 'authorised consulting practitioner' and 'authorised coordinating practitioner'.

Clause 82 Meaning of authorised practitioner—div 5.2

This clause provides that in this Division, an authorised practitioner means an 'authorised administering practitioner', 'authorised consulting practitioner' and 'authorised coordinating practitioner'.

Clause 83 Application for authorisation

This clause provides that a health practitioner may apply in writing to the Director-General for authorisation to become one or more of an administering practitioner, consulting practitioner and coordinating practitioner. A regulation may prescribe information to be included in the application.

Authorisation of practitioners will ensure the individual has the necessary knowledge, clinical skills and professional attributes to perform the role.

Clause 84 Eligibility for authorisation

This clause provides that a health practitioner is eligible for authorisation where they meet the requirements prescribed by regulation.

The setting of the eligibility requirements through a regulation is necessary to provide flexibility to introduce new obligations where this is deemed appropriate. Similarly, it may become apparent that previous requirements are unnecessarily limiting the pool of health practitioners available to assist with VAD. In this instance, the Government could review and adjust the requirements without the need for this matter to be considered by the Legislative Assembly. However, the regulations would still be disallowable by the Legislative Assembly, which provided appropriate oversight and consideration.

Clause 85 Director-general may require more information

This clause provides that the Director-General may request further information in writing as reasonably needed to decide the application. Where information is not provided, the Director-General may refuse to consider the application further.

As with all regulatory oversight, there may be instances where further information is required to make an informed decision. An information request would be limited to matters relevant to the application. An individual provides the information at their own discretion, and may decide not to provide further information, knowing it may affect their application.

Clause 86 Change of information must be provided

This clause provides the applicant must give the Director-General notice of where the information provided in their application changes. This is to ensure that authorisation is not provided where a person is not eligible.

Clause 87 Deciding applications

This clause provides that the Director-General must make a decision to authorise or refuse to authorise a health practitioner on application by that health practitioner.

Clause 88 Authorisation conditions

This clause provides that an authorised practitioner's authorisation is subject to any condition that the Director-General or that is prescribed by regulation.

This clause also provides that before imposing any conditions, the Director-General must provide notice of the proposed condition and the reasons it is propose, and allow the practitioner 28 days to respond. The Director-General must consider the response in deciding whether to impose the conditions. This establishes natural justice and will allow the practitioner to provide input to the decision.

Clause 89 Notifying director-general about change in eligibility for authorisation

This clause provides that an authorised practitioner must give the Director-General written notice about changes to their name, contact details, eligibility to be an authorised practitioner, or any other event or circumstance prescribed by regulation within 14 days of becoming aware of it. This is to ensure that records are kept up to date and to allow the Director-General to assess whether change impacts on the practitioner's eligibility to be authorised.

Clause 90 Revocation of authorisation

This clause provides that the Director-General may revoke a practitioner's authorisation if satisfied that the practitioner is no longer eligible to be authorised, or where the practitioner requests that their authorisation be revoked.

Clause 91 Register of authorised practitioners

This clause requires the Director-General to establish a register of authorised practitioners.

It also requires the Director-General to give a copy of the register to Board and the Care Navigator Service. Access to the register will allow the Board to have oversight of the practitioners delivering VAD in the ACT. The Care Navigator Service will use the register to direct individuals seeking VAD to health practitioners that offer VAD services.

It is not intended that the register will be available publicly due to the sensitive nature of the information contained in the register.

Division 5.3 Requirements for coordinating practitioners, consulting practitioners and administering practitioners

Clause 92 Requirements for acting as coordinating practitioner, consulting practitioner or administering practitioner

This clause sets out the requirements for acting as coordinating practitioner, consulting practitioner or administering practitioner.

In addition to the requirement to be authorised by the Director-General under division 5.1, a practitioner must not have a personal interest in relation to the individual.

For this clause, a practitioner has a 'personal interest' in relation to an individual if the practitioner is a family member of the person, or may benefit financially or in any other material way from the person's death or access to VAD. These requirements are consistent with existing professional obligations and ensure there is no real or perceived conflict of interest between the practitioner and the person requesting access to VAD.

Clause 92(3) provides that the coordinating practitioner and the consulting practitioner for an individual must not both be nurse practitioners. This ensures at least one practitioner is a medical practitioner, and that a mix of skills and expertise is available in assessing the individual's suitability for VAD.

Clause 93 Acting as coordinating practitioner, consulting practitioner or administering practitioner when requirements to act not met

This clause provides an offence where a person acts as a coordinating practitioner, consulting practitioner or administering practitioner for an individual, and does not meet the requirements in clause 92.

The maximum penalty for this offence is 100 penalty units, imprisonment for 12 months or both.

The authorisation of appropriately trained, qualified and experienced health practitioners to perform roles under the ACT VAD scheme is a key safeguard of the scheme. The various safeguards imbedded into the ACT scheme provide adequate protections to people who are seeking VAD and the practitioners delivering VAD services. For example, under the Bill health practitioners assess an individual's eligibility to access the scheme. If a person does not hold the relevant expertise, this could result in vulnerable individuals accessing VAD when they do not meet the eligibility requirements.

Under the Bill it is clear that a person must be authorised to act in the role of a coordinating practitioner, consulting practitioner or administering practitioner. Public education will support the knowledge and understanding of the scheme and its obligations.

Part 6 Conscientious objections—health practitioners and health service providers

Part 6 comprises clauses 94 to 95. This part sets out obligations for health practitioners and health service providers, where they have a conscientious objection to VAD.

Clause 94 Conscientious objection by health practitioner or health service provider

This clause recognises that a health practitioner or health service provider may have a conscientious objection to VAD, and refuse to participate in certain aspects of the VAD process, as long as they give the individual written contact details for the Care Navigator Service within two working days.

This clause seeks to strike a balance between the rights of the individual seeking access to VAD and the rights of others to freedom of thought, conscience, religion and belief. If those rights conflict, this Part's intention is to require that the rights of the individual seeking access to VAD prevail.

Failure to comply with this clause is a strict liability offence, with a maximum penalty of 20 penalty units. This is to deter non-compliance and protect individuals seeking to access VAD from barriers to lawful access.

A health practitioner is defined in the *Legislation Act 2001* (ACT) as a person registered under the *Health Practitioner Regulation National Law* (ACT) to practise a health profession (other than as a student). A health profession includes medicine, nursing, occupational therapy, pharmacy, physiotherapy, and psychology.

A health service provider is defined in clause 94(5) as a person who:

- is a health service provider for section 5 of the *Health Act 1993* (ACT). This means a health practitioner or other person who provides a health service. A health service is further defined as a service provided to a service user for any of the following purposes:
    - assessing, recording, maintaining or improving the physical, mental or emotional health, comfort or wellbeing of the service user;
    - diagnosing, treating or preventing an illness, disability, disorder or condition of the service user.
- Is prescribed by regulation as a health service provider.

Clause 95 Giving individual contact details for approved care navigator service

This clause applies if a health practitioner or health service provider refuses to do a thing mentioned in clause 94 in relation to an individual.

Within two working days after the day the request is made, the health practitioner or health service provider must give the individual, in writing, the contact details for the Care Navigator Service.

This is intended to ensure that the individual's access to VAD is not hindered by the health practitioner or health service provider's objection to VAD.

It is a strict liability offence for a facility operator to not comply with this clause, with a maximum penalty of 20 penalty units.

Part 7 Obligations of facility operators

Part 7 comprises clauses 96 to 104. This Part seeks to strike a balance between the rights of the individual seeking access to VAD and the interests of facility operators, particularly those that operate a facility in accordance with an ethos or faith that opposes VAD. If those rights and interests conflict, this Part's intention is to require that the rights of the individual seeking access to VAD be accommodated.

This Part provides three obligations for facility operators arising under certain circumstances: giving an individual the contact details for the Care Navigator Service, granting access to a relevant person at the facility unless not reasonably practicable, and facilitating the transfer of an individual to another place to see a relevant person unless the transfer is unreasonable in the circumstances.

Corporations who commit an offence under Part 7 will pay higher penalties than if an individual commits an offence under Part 7. This is because section 133 of the *Legislation Act 2001* (ACT) provides that the penalty unit amount under ACT laws is higher for corporations than for individuals.

Division 7.1 General

Clause 96 Definitions—pt 7

This clause sets out definitions of key terms used in this Part: 'care service', 'facility', 'facility operator', and 'resident of a facility'.

'Care service' means a health service, aged care service or personal care service, which are further defined in clause 96(2).

A 'facility' is defined in clause 96 as a place (other than an individual's private residence) where a 'care service' is provided to a resident of the facility. This includes including a hospital; a hospice; and a nursing home, hostel, respite facility, or other facility where accommodation, nursing or personal care is provided to individuals who, because of infirmity, illness, disease, incapacity or disability, have a need for accommodation, nursing or personal care.

A ‘resident’, of a facility, means an individual who is staying at the facility on a temporary or permanent basis to receive accommodation, nursing or personal care. This includes someone staying at a facility for a short time. The obligations in Divisions 7.2 and 7.3 are designed to protect and facilitate access to VAD for residents of a facility who may wish to access VAD.

This clause also defines ‘facility operator’ as the entity that is responsible for the management of a facility. The obligations in Divisions 7.2 and 7.3 attach to a facility operator. At law, the concept of vicarious liability means that the acts or omissions of a facility operator include the acts or omissions of the facility operator’s agents, including their employees, contractors and owners.

Division 7.2 Information and access obligations

Clause 97 Application–div 7.2

Clause 97(1) provides that Division 7.2 applies if an individual is a resident of a facility and a relevant person as defined under clause 98 is not available to the individual at the facility. This clarifies that a facility is only required to grant access or facilitate a transfer under this division where the individual would not already have access to the relevant person that can assist them with access to VAD. This clarifies that the purpose of this Division is to provide access to VAD where it might otherwise be hindered.

Clause 98 Definitions – div 7.2

Clause 98(1) sets out definitions of key terms used in this Division.

‘Deciding practitioner’, for a decision about the transfer of an individual, means the individual’s coordinating practitioner; or in any case, a treating doctor of the individual.

‘Relevant person’ means:

- for information about VAD—any person who can provide the information; and
- for a request to access VAD—a person who is necessary for the exercise of a function under Part 3 or Part 4 of the Bill in relation to an individual’s request for access to VAD (for example, a coordinating practitioner, a witness, or a contact person, depending on the nature of the individual’s request).

Clause 99 Giving individual contact details for approved care navigator service

This clause applies if the individual, or their agent, tells the facility operator, orally or in writing, that the individual wants information about or access to VAD.

Within two working days after the day the request is made, the facility operator must give the individual, in writing, the contact details for the Care Navigator Service.

This is intended to ensure that the individual's access to VAD is not hindered by the facility operator, or by being a resident of a facility. This is particularly important in the context of VAD where an individual may have limited mobility or be required to stay at the facility due to their relevant condition.

It is a strict liability offence for a facility operator to not comply with this clause, with a maximum penalty of 30 penalty units.

Clause 100 Giving individual reasonable access to relevant people

This clause applies if the individual, or their agent, tells the facility operator, orally or in writing, that the individual wants information about or access to VAD.

Clause 100(2) requires the facility operator to allow a 'relevant person' to have reasonable access to the individual at the facility, with the individual's consent.

'Reasonable access' is not defined in the Bill. Whether access to the individual at the facility is 'reasonable' depends on all the circumstances.

This clause provides that a facility operator is not required to comply with clause 100(2) if the facility operator decides that it is not reasonably practicable to do so. 'Reasonably practicable' is a legal concept that is context dependent and depends on all the circumstances. Deciding whether something is reasonably practicable requires consideration of:

- what can be done – that is, what is possible in the circumstances to allow access; and
- whether it is reasonable in the circumstances to do all that is possible.

In other words, if access is practicable, it must be allowed unless in all the circumstances doing so would be unreasonable.

It is an offence for a facility operator to not comply with this clause, with a maximum penalty of 100 penalty units.

Clause 156 of the Bill empowers the Director-General to make guidelines or this Bill, including in relation to a facility operator's obligations under clause 99(2).

Clause 101 Facilitating transfer of individual

This clause only applies if, under clause 100, the facility operator decides that it is not reasonably practicable for a relevant person to have access to an individual at the facility, and the individual asks to be transferred to and from another place to see the relevant person.

Clause 101(2) requires that the facility operator must ask the individual's deciding practitioner, as defined in clause 98, to decide whether the transfer is reasonable in the circumstances.

Clause 101(3) lists factors that the deciding practitioner must take into account when deciding whether a transfer is reasonable in the circumstances:

- whether the transfer would be likely to cause serious harm to the individual, adversely affect the individual's access to VAD, or cause undue delay or prolonged suffering in accessing VAD;

- whether the place where it is proposed the individual would be transferred to is available to receive the individual;

- whether the individual would incur a financial loss or cost because of the transfer.

Clause 101(4) requires that, if the deciding practitioner decides the transfer is reasonable and if the individual consents, the facility operator must facilitate the transfer as soon as reasonably practicable. This is to ensure that if relevant persons cannot access an individual at a facility in relation to VAD, the individual's access to VAD is not hindered and is facilitated through transfer to a place where they can access VAD. Clause 101(4) makes it an offence for a facility operator to fail to do so. The maximum penalty is 100 penalty units.

Clause 101(5) requires that if the facility operator does not facilitate the transfer of the individual as required under clause 101(4), the operator must give the Board written notice stating the reasons for this, and the steps taken by the operator to try to transfer the individual. Non-compliance with this clause is a strict liability offence with a maximum penalty of 20 penalty units.

Clause 102 Making access to relevant person reasonably practicable

This clause applies if it is both:

- Not reasonably practicable for a relevant person to access the individual at the facility under clause 100; and

- Not reasonable to transfer the individual to another place under clause 101.

This clause requires the facility operator must take reasonable steps to make it reasonably practicable for the relevant person to have access to the individual at the facility. What steps are reasonable will depend on all the circumstances.

The intent of this clause is to ensure that no individual's access to VAD is hindered if they are a resident at a facility. It fills the gap that may be created if access by a relevant person at the facility is not reasonably practicable, but the individual is too unwell to be transferred elsewhere.

It is an offence for a facility operator to not comply with this clause, with a maximum penalty of 100 penalty units.

Division 7.3 Other obligations

Clause 103 Facility operator must have policy

This clause is designed to ensure that individuals who may wish to access VAD are informed about the processes and considerations for accessing VAD if they are, or become, a resident of a facility. This seeks to empower an individual to make informed end of life choices.

Clause 103(1) requires a facility operator to have a policy that sets out how the operator will comply with its obligations under Division 7.2, plus any additional requirements prescribed by regulation.

Clause 103(2) requires the facility operator to publish its policy in a way that is likely to come to the attention of a resident, or an individual who may wish to become a resident in the future. Examples include including the policy in a brochure about the facility operator, including the policy on the facility operator's website, and displaying the policy on signs at the facility.

Clause 103(3) requires that, on request by a person, the facility operator must make its policy available to the person within two working days.

Non-compliance with any part of this clause is a strict liability offence, with a maximum penalty of 20 penalty units.

Clause 104 Facility operator must not withdraw or refuse to provide care service

This clause makes it an offence for a facility operator to withdraw a care service from, or refuse to provide a care service to, an individual only because the operator knows that:

- the individual or their agent has asked, or is likely to ask, for information about VAD; or
- the individual has made, or is likely to make, a request to access VAD.

The maximum penalty is 100 penalty units.

The intention is to ensure that a facility cannot withdraw or deny a care service on the basis that an individual wants, or may want, information about or access to VAD. This is designed to prevent facility operators from hindering lawful access to VAD and promote the rights of individuals.

Part 8 Voluntary assisted dying oversight board

Part 8 comprises clauses 105 to 122. This part establishes the Voluntary Assisted Dying Oversight Board (the Board). The Board is a key safeguard for the ACT VAD scheme. The Board is an important oversight mechanism to monitor compliance, recommend improvements to the scheme and provide for the safe and transparent operation of VAD legislation.

Division 8.1 Establishment of board

Clause 105 Establishment of board

This clause provides that the Board is established.

Division 8.2 Membership of board

Clause 106 Members of board

This clause provides the number of members to be appointed to the Board. The Board will consist of at least four and not more than seven members, which includes the Chair and Deputy Chair (if one is appointed).

Clause 107 Appointment of members

This clause provides that the Minster may appoint a person as a member of the Board where the Minister is satisfied that the person:

- has knowledge and expertise in one or more relevant area outlined in clause 107(5); or
- is likely to make a valuable contribution to the Board because of their experience, knowledge and skills.

Clause 107(2) requires that the Board's membership must:

- include people with a range of experience, knowledge and skills relevant to the work of the Board;
- takes into account the social, cultural and geographic characteristics of the ACT community and people who work or receive medical treatment in the ACT; and
- not made up by a majority of members who are public employees.

Specifying the matters the Minister must consider in appointing members of the Board will ensure membership is suitably mixed, and the Board is not dominated by persons from a single profession.

Clause 107(1) provides a person may not be appointed as a member if the person:

- is, or has been bankrupt or personally insolvent; and
- has been convicted or found guilty of an indictable offence.

Clause 107(3) and (4) provide that members are appointed for a maximum of three years on conditions stated in the appointment, subject to any determination under the *Remuneration Tribunal Act 1995*.

Clause 108 Appointment of chair

This clause provides that the Minister must appoint a member of the Board to be chair of the Board. The chair is appointed for a maximum of three years on conditions stated in the appointment, subject to any determination under the *Remuneration Tribunal Act 1995*. The functions of the chair are set out in clause 115.

Clause 109 Appointment of deputy chair

This clause provides that the Minister may appoint a member of the Board to be deputy chair of the Board. The deputy chair is appointed for a maximum of three years on conditions stated in the appointment, subject to any determination under the *Remuneration Tribunal Act 1995*. The functions of the deputy chair are set out in clause 115.

Clause 110 Ending member appointments

This clause sets out the ways a Board member's appointment may end during the term of their appointment (including the chair and deputy chair). This is an important safeguard to ensure that members of the Board remain appropriate to hold their position.

Clause 111 Honesty, care and diligence of board members

This clause provides that a Board member must exercise their functions with the honesty, care and diligence required to be exercised by a director of a corporation in relation to the affairs of the corporation.

This will provide the community with confidence that the Board is exercising its functions appropriately. A member's appointment to the Board may end under clause 110 where they do not exercise their functions in this manner.

Clause 112 Conflicts of interest by board members

This clause provides that a Board member must take all reasonable steps to avoid being placed in a position where a conflict of interest arises during the exercise of the member's functions. This will provide the community with confidence that the Board is exercising its functions appropriately. A member's appointment to the Board may end under clause 110 where they do not exercise their functions in this manner.

Clause 113 Disclosure of interests by board members

This clause provides that a Board member must disclose where they have a conflict of interest with a matter being discussed. The member must disclose the nature of the interest at a meeting, as soon as practicable after the relevant facts come to the member's knowledge. The disclosure must be recorded in the Board's minutes, unless determined otherwise by the Board. The member must not be present when the Board considers the matter and they may not contribute to a decision on the matter.

Division 8.3 Functions of board and members

Clause 114 Functions of board

This clause sets out the functions of the Board. Clause 114(2) provides that in exercising its functions, the Board must act independently and in the public interest, and is not subject to the direction and control of any person, except as provided by this Bill or another territory law.

Clause 115 Functions of chair and deputy chair

This clause sets out the functions of chair and deputy chair.

Clause 116 Ministerial directions

This clause provides that the Minister may give directions to the Board about the exercise of its functions under this Bill, and the Board must comply with a direction.

This is not intended to reduce the independent nature of the Board, but rather allow the Minister to direct the Board to investigate or consider a matter that the Minister considers requires their expertise.

Clause 116(2) provides that a direction cannot be about the exercise of a function in relation to a particular person. This means the Minister cannot direct the Board to take certain actions in relation to a particular person.

To provide public confidence that this power will be used appropriately, the Bill requires that any direction be notified through a notifiable instrument. This will allow members of the public to scrutinise the use of this power.

Clause 117 Decisions of board

This clause provides that a decision of the Board is valid if at least 3 members vote, and the question is decided by majority of those votes. It also clarifies that each member has one vote, but the chair has a casting vote if votes are equal.

Division 8.4 Miscellaneous

Clause 118 Board may request information from registrar-general

This clause provides that if the Board has been notified about an individual's death, the Board may ask the registrar-general for information recorded in the ACT's deaths register about the individual's death.

This clause will provide authority for the Board to access data on VAD deaths that is held in the register maintained under section 39 of the BDMR Act. This will support the functions of the Board by allowing the Board to cross check and interrogate data held by the Registrar-General.

This clause provides an exception to the consequential amendments to the BDMR Act in Part 13 of the Bill, which provide that the registrar-general cannot release information about an individual's manner of death.

Clause 119 Delegation by board

This clause provides that the Board may delegate its functions under this Bill or another territory law to a public servant. This will allow the Board to access any additional expertise needed to perform its role and functions.

Clause 120 Director-general to give support to board

This clause provides that the Director-General must provide administrative support and facilities to the Board. This could include secretarial support, meeting rooms or any other support to assist the Board in performing its functions.

Clause 121 Arrangements for board staff and facilities

This clause provides that the Board may arrange with the head of service to use the services of a public servant or territory facilities. This will allow the Board to access additional expertise needed to perform its role and functions (for example, staff employed outside of the directorate of the Director-General).

Clause 122 Annual reporting of board

This clause provides that the Board must prepare an annual report under the *Annual Reports (Government Agencies) Act 2004*. This will ensure accountability and transparency on the Board's role in monitoring and promoting compliance with the legislation.

Part 9 Protection from liability

Part 9 comprises clause 123 to 130. This Part provides people who engage lawfully, honestly and without recklessness with the requirements of the Bill with a range of protections from criminal and civil liability. Protections from liability have been included in the Bill to provide clarity and certainty for those who may act under, or interact with, the Bill.

Clause 123 Meaning of *conduct*—pt 9

This clause provides that for Part 9, 'conduct' means an act or omission to do an act.

Clause 124 Board members and people assisting board

This clause provides that no civil liability is attached to a person who engages honestly and without recklessness:

- in the exercise of a function of the Board under this Bill or another territory law, or
- in the reasonable belief that their conduct was in the exercise of a function of the Board under this Bill or another territory law.

Clause 124(2) provides that any liability that would, apart from this clause, attach to that person instead attaches to the Territory.

Clause 125 People assisting access to voluntary assisted dying or witnessing administration of approved substance

This clause provides that a person is not criminally liable only because the person, honestly and without recklessness:

- engages in conduct that assists an individual to access, or request access to, VAD in accordance with this Bill; or
- is present when an approved substance is administered by or to an individual under this Bill.

Clause 126 People engaging in conduct under Act

This clause provides that a person is not civilly or criminally liable for conduct engaged in honestly and without recklessness under this Bill, or in the reasonable belief that the conduct was engaged in under this Bill.

Clause 127 Protection from liability for certain offences against Crimes Act 1900

This clause is included to remove any doubt that a person who engages in conduct mentioned in clauses 125 or 126 does not commit an offence against section 12

(Murder), section 15 (Manslaughter) or section 17 (Suicide—aiding etc) of the *Crimes Act 1900 (ACT).* This clause is designed to clarify that lawfully assisting with VAD should not be a crime.

Clause 128 Health practitioners and ambulance service members

This clause applies where a health practitioner or ambulance service member, honestly and without recklessness, does not administer life sustaining treatment to an individual in the reasonable belief that the individual has not requested the administration of life sustaining treatment and is dying after self-administering or being administered with an approved substance in accordance with this Bill.

It provides that they are not criminally or civilly liable for not administering life sustaining treatment to the individual.

To remove any doubt, clause 128(3) clarifies that they also do not commit an offence against section 12 (Murder), section 15 (Manslaughter) or section 17 (Suicide—aiding etc) of the *Crimes Act 1900 (ACT).*

This protection is provided to address concerns that a health practitioner or ambulance officer might be liable for failing to provide aid or assistance to someone who is dying because of administration of a VAD substance in accordance with the Bill.

A definition of ‘health practitioner’ and ‘member’ is provided for this clause.

Clause 129 Onus of proof if party to proceeding alleges person liable for conduct

This provision clarifies that if a party alleges that clause 125(a), 126 or 127 do not prevent a finding of liability against a person, that party bears the onus of proving that the person did not engage in the conduct in the circumstances mentioned in the relevant clause.

Clause 130 Provisions of part do not affect complaints or referrals

This clause clarifies that nothing in clause 125, 126 or 127 prevents the making of a notification under the *Health Practitioner Regulation National Law* (ACT), the making of a complaint under the *Human Rights Commission Act 2005*, or the referral of an issue by the Board to the human rights commission under clause 114(1)(c). This is to clarify that these existing regulatory and oversight frameworks continue to apply in the VAD context despite Part 9.

Part 10 Review of coordinating practitioner, consulting practitioner and administering practitioner decisions

Part 10 comprises clauses 131 to 146. Part 10 provides the ACT Civil and Administrative Tribunal (ACAT) with a new jurisdiction to review decisions made about whether an individual has decision-making capacity, is acting voluntarily and without coercion, and has lived in the ACT for at least the previous 12 months.

This seeks to provide individuals seeking access to VAD, and their friends, families and carers, with access to justice and procedural fairness. It also seeks to provide an additional safeguard to assess eligibility if an individual's eligibility to access VAD is in question.

Division 10.1 General

Clause 131 Definitions—pt 10

This clause defines key terms used in Part 10: 'affected person', 'decision-maker', 'registrar', and 'reviewable decision'.

'Affected person' means the individual about whom a reviewable decision was made; or any other person who has a sufficient and genuine interest in the rights of that individual in relation to VAD.

'Registrar' means the ACAT registrar appointed under the *ACT Civil and Administrative Tribunal Act 2008*.

'Reviewable decision' and 'decision-maker' are defined in the table below (extracted from Schedule 1 to the Bill):

column 1 **item**	**column 2** **clause**	**column 3** **reviewable decision**	**column 4** **decision-maker**
1	16 (1)	decision about whether individual meets the eligibility requirement that they have decision-making capacity in relation to voluntary assisted dying	individual's coordinating practitioner
2	16 (1)	decision about whether individual meets the eligibility requirement that their decision to access voluntary assisted dying is made voluntarily and without coercion	individual's coordinating practitioner
3	16 (1)	decision about whether individual meets the eligibility requirement that they have lived in the ACT for at least the previous 12 months	individual's coordinating practitioner
4	23 (1)	decision about whether individual meets the eligibility requirement that they have decision-making capacity in relation to voluntary assisted dying	individual's consulting practitioner

5	23 (1)	decision about whether individual meets the eligibility requirement that their decision to access voluntary assisted dying is made voluntarily and without coercion	individual's consulting practitioner
6	23 (1)	decision about whether individual meets the eligibility requirement that they have lived in the ACT for at least the previous 12 months	individual's consulting practitioner
7	35	decision about whether individual meets the final assessment requirement that they have decision-making capacity in relation to voluntary assisted dying	individual's coordinating practitioner
8	35	decision about whether individual meets the final assessment requirement that their decision to access voluntary assisted dying is made voluntarily and without coercion	individual's coordinating practitioner
9	59 (1) (f) (i)	decision about whether individual meets the final assessment requirement that they have decision-making capacity in relation to voluntary assisted dying	individual's coordinating practitioner
10	59 (1) (f) (i)	decision about whether individual meets the final assessment requirement that their decision to access voluntary assisted dying is made voluntarily and without coercion	individual's coordinating practitioner

Division 10.2 Reviewable decision notices and applications for review of reviewable decision

Clause 132 Reviewable decision notices

This clause provides that if a decision-maker makes a reviewable decision in relation to an individual, the decision-maker must give the individual a notice that includes any information prescribed by regulation. It also clarifies that a failure to comply with this requirement does not affect the validity of the decision.

This seeks to ensure that an individual is aware of their review rights under Part 10 at key stages of the VAD process.

Clause 133 Making application for review of reviewable decision

This clause provides that an affected person for a reviewable decision may apply to the ACAT for review of the decision.

Clause 133(2) provides that this must occur not later than five days after the latest of the day that the individual is given a copy of the first assessment report, consulting assessment report, final assessment report, or the day the affected person becomes aware of the reviewable decision. This timeframe is shorter than the typical 28-day timeframe for many ACAT matters. This is because time is of the essence in reviewing whether or not an individual can access VAD. This clause seeks to avoid unnecessary delays that would prolong the individual's intolerable suffering.

In any case, ACAT has the power to extend this timeframe under section 151C of the *Legislation Act 2001* (ACT), even after the timeframe has elapsed.

Clause 134 Parties to application for review

This clause provides that the individual and the coordinating practitioner are parties to an application for review, along with the applicant and the decision-maker. This is to ensure ACAT has access to relevant people and information in undertaking its review.

Clause 135 Application for review suspends process for accessing voluntary assisted dying

This clause provides that once an application is made under this Part, the individual cannot proceed with the VAD process or accessing the approved substance until the application is finalised or withdrawn. This is to ensure that the individual's eligibility to access VAD is determined before the individual can take the next step in the VAD process.

Clause 136 Registrar must give notice of application for review

This clause provides that within two days after an application is made, the registrar must give a copy of the application to each party, the consulting practitioner (if appointed), the Board, and any other person the ACAT directs a copy of the application be given to. This is to promote procedural fairness for those persons, and ensure the Board is informed about matters that may be relevant to the exercise of its functions.

Clause 137 Application for review taken to be withdrawn if individual dies

This clause provides that if an individual dies after an application is made, the application is taken to be withdrawn. Clause 137(3) also provides that in these circumstances, the registrar must, as soon as practicable after becoming aware of the individual's death, give notice of the withdrawal to any person who was given notice of the application for review under clause 137; and any other person the ACAT directs a copy of the notice be given to.

Division 10.3 Procedural matters

Clause 138 Coordinating practitioner and consulting practitioner must provide documents to ACAT

This clause applies if the registrar gives an individual's coordinating practitioner or consulting practitioner a copy of an application for review under clause 136. It seeks to assist ACAT to make a decision informed by all relevant information. This may in turn increase the efficiency of the review process, reducing the duration of the individual's intolerable suffering.

Clause 138(1) requires the registrar to give the coordinating practitioner or consulting practitioner a written notice that states that the practitioner must give the ACAT any documents in their possession or control and relevant to the decision being reviewed.

Clause 138(2) requires the practitioner to comply not later than two days after the day the registrar gives the notice under clause 138(1).

Clause 139 Hearings must take place in private

This clause requires the hearing of an application for review of a reviewable decision to take place in private. This is to protect the privacy and dignity of the individual subject to the application, given the personal and health information being reviewed by ACAT.

However, this clause also empowers ACAT to make an order allowing stated people to be present at the hearing if appropriate.

This clause imposes reasonable and justifiable limits the right to a fair trial. This is discussed in the human rights analysis section of this Explanatory Statement.

Clause 140 Non-publication orders

Clause 140(1) empowers make an order prohibiting or restricting:

- the publication of evidence given at the hearing or matters contained in documents filed in or received as evidence for the hearing;
- the disclosure to some or all of the parties evidence given at the hearing or matters contained in documents filed in or received as evidence for the hearing.

Clause 140(2) makes it an offence to contravene such an order, with a maximum penalty of 50 penalty units, imprisonment for 6 months or both.

Like clause 139, this is designed to protect the privacy and dignity of the individual subject to the application, given the personal and health information being reviewed by ACAT.

Clause 141 Members constituting ACAT

This clause clarifies that for a proceeding under this part, the ACAT may be made up of a presidential member alone, but not a non-presidential member alone.

Division 10.4 Decisions of ACAT

Clause 142 Orders following review of reviewable decision

Clause 142(1) sets out the orders ACAT must make if it reviews a reviewable decision. In summary, ACAT must make orders that the individual does or does not meet the eligibility requirement that was the subject of the reviewable decision.

Clause 142(2) provides that an order takes effect on the day that it is made, or on the day stated on the order.

Clause 143 Effect of ACAT decision that individual meets relevant requirement

This clause applies if, under clause 142, ACAT makes an order that the individual does meet the eligibility requirement in question. It provides that the order is taken to be the decision of the decision-maker for the reviewable decision. In other words, ACAT's decision replaces the decision of the decision-maker. In practice, this means that the VAD process is no longer paused and can continue (assuming the individual meets all the eligibility requirements and wishes to continue).

Clause 144 Effect of ACAT decision that individual does not meet relevant requirement

This clause applies if, under clause 142, ACAT makes an order that the individual does not meet the eligibility requirement in question. It provides that the VAD process must stop for the individual.

Clause 145 Registrar must give decision to individual's consulting practitioner if consulting practitioner not party

This clause clarifies that if the consulting practitioner is not a party, the registrar must give the consulting practitioner a copy of the final order as soon as practicable after ACAT makes the order.

Clause 146 Coordinating practitioner must give copy of ACAT decision to board

This clause applies if the ACAT makes a final order in relation to the application (including any appeal); and the registrar gives the individual's coordinating practitioner a copy of the final order made by the ACAT.

It requires that within two working days after the day the registrar gives the coordinating practitioner a copy of the final order, the coordinating practitioner must give the Board a copy of the order.

Non-compliance is a strict liability offence, with a maximum penalty of 20 penalty units.

This seeks to ensure the Board is kept informed promptly of matters that may be relevant to the exercise of its functions.

Part 11 Notification and review of other decisions

Part 11 comprises clauses 147 to 149. Its purpose is to provide for review of the decision of the Director-General to grant a residency exemption to an individual under clause 151(1) of the Bill. This is to promote procedural fairness and access to justice for an individual who has been deemed ineligible to access VAD in the ACT.

Its purpose is also to provide for review of the decision of the Director-General to refuse to authorise, or revoke authorisation, of a practitioner to be a coordinating practitioner, consulting practitioner or administering practitioner under clause 87 and 90. This is to promote procedural fairness and access to justice for an individual who sought to be authorised to assist with VAD.

Clause 147 Definitions—pt 12

This clause defines ‘affected person’ and ‘reviewable decision’ in accordance with the table in Schedule 2, copied below:

column 1 item	column 2 section	column 3 reviewable decision	column 4 affected person
1	87 (b)	refuse to authorise person to be coordinating practitioner, consulting practitioner or administering practitioner	applicant for authorisation
2	90 (a)	revoke authorisation because authorised practitioner no longer eligible for authorisation	authorised practitioner
3	151 (1)	refuse to grant residency exemption	applicant for exemption

Clause 148 Reviewable decision notices

This clause provides that if the Director-General makes a reviewable decision, the Director-General must give a reviewable decision notice to each affected person. This is to promote access to justice and procedural fairness.

Clause 149 Applications for review

This clause provides that an affected person may apply to the ACAT for a review of a reviewable decision. This would take place in ACAT's administrative review jurisdiction.

Part 12 Miscellaneous

Part 12 comprises clauses 150 to 159. It contains miscellaneous provisions that are important to ensuring the effectiveness of the Bill.

Clause 150 Exercise of enforcement powers under Medicines, Poisons and Therapeutic Goods Act 2008

Clause 150 provides that a medicines and poisons inspector may exercise their powers under the MPTG Act for the purpose of investigating, monitoring and enforcing compliance with a relevant provision of this Bill.

Chapter 7 of the MPTG Act creates medicines and poisons inspectors, and grants them powers including to apply for warrants, enter premises, seize things, destroy unsafe things, and take samples. A medicines and poisons inspector can be a police officer or another person appointed under the MPTG Act.

This clause ensures the ACT's existing regulatory regime to protect public health and safety by minimising misuse of regulated substances applies in the context of approved substances. This is an important safeguard to ensure misuse of an approved substance is discouraged and can be enforced through existing powers.

Clause 151 Residency exemptions

This clause provides that the Director-General must, on application, grant an individual an exemption from the 12 month residency requirement mentioned in clause 11(1)(f)(i) if satisfied that the individual has a 'substantial connection to the ACT'.

This clause includes the following examples of a 'substantial connection to the ACT':

- an individual who has lived in a place close to the ACT border for at least the previous 12 months and who works in the ACT or receives medical treatment in the ACT;
- an individual who has moved to the ACT so that family, friends or carers who live in the ACT can provide care and support to the individual;
- an individual who previously lived in the ACT and whose family, friends or carers live in the ACT;

- an Aboriginal or Torres Strait Islander individual who has substantial connections with the ACT community and wishes to die on Country;

- an individual who has lived in the ACT for less than 12 months but who was diagnosed with a condition mentioned in s 11 (1) (b) after moving to the ACT.

The term carer in these examples is taken to have the meaning as provided under the *Carers Recognition Act 2021.*

This clause seeks to strike a fair balance between the need to protect the ACT health system from being unable to meet demand for ACT, and the need to enable access to VAD in the ACT for individuals who should reasonably expect it.

The Director-General will be responsible for assessing applications by individuals for an exemption. Under Part 11, this decision is reviewable by ACAT.

Clause 152 Requirements for authorised practitioners and other health professionals when initiating conversations about voluntary assisted dying

This clause requires that if certain health professionals initiate a conversation about VAD with an individual, they must ensure certain information is provided to that individual. This is designed to help an individual make informed end of life choices, and reduce the risk of coercion or undue influence by health professionals.

Clause 152(1) requires that a medical practitioner or nurse practitioner who considers that they have the expertise to appropriately discuss treatment and palliative care options with the individual must take reasonable steps to ensure the individual knows:

- the treatment options available to the person and their likely outcomes; and

- the palliative care options available to the person and their likely outcomes.

Clause 152(2) requires all other registered health practitioners, social workers and counsellors, as well as any medical practitioners and nurse practitioners who do not meet the expertise requirements in clause 152(1), may only initiate a discussion about VAD if they ensure that the individual knows:

- that they have treatment and palliative care options available; and

- that the person should discuss the options with their treating doctor.

To avoid doubt, nothing in this clause prohibits any person, including health professionals, from initiating a discussion about VAD, however it does establish minimum requirements for health professionals who initiate these conversations. Health professions must also consider their scope of practice when initiating conversations on VAD.

Clause 153 Interpreters

This clause seeks to ensure that if an individual uses an interpreter in relation to VAD, the interpreter's role must be sufficiently independent and not give rise to any actual or perceived conflicts of interest.

Clause 153(1) requires that an interpreter must not be an individual's family member, must not know or believe that they will benefit from the individual's death or access to VAD, must not own or be responsible for managing a facility where the individual is a resident, and must not be directly involved in providing a health service, aged care service or personal care service to the individual (as defined in Part 7).

Clause 153(2) provides that, despite subclause (1), the Director-General may authorise an interpreter to provide interpretation services for an individual if the Director-General is satisfied that no other interpreter is reasonably available; or there are exceptional circumstances for the authorisation.

Clause 154 Technical error does not invalidate processes

This clause provides that reports, records and other notices will not be invalid merely because of a minor or technical error, clerical error or defect, or a failure by a relevant practitioner to comply with requirements within the stated time.

This seeks to ensure that an individual's access to VAD is not disrupted by minor administrative errors. It is not intended to excuse non-compliance with the Bill's requirements and objects.

Clause 155 Approved care navigator service

This clause provides that the Director-General may approve, by notifiable instrument, one entity to be the VAD Care Navigator Service for this Bill. It provides that the purpose of the Care Navigator Service is to provide support, assistance and information to people relating to VAD.

Clause 156 Director-general may make guidelines

This clause provides that the Director-General may make guidelines for this Bill, and that these guidelines must be consistent with the objects and principles of the Bill. It also provides that a guideline is a disallowable instrument, and that a person must comply with a guideline that applies to them.

Clause 157 Use or divulge protected information

This clause provides that a person commits an offence if the person uses or, divulges protected information, and they are reckless to whether the information is protected, and the information could be divulged to someone else, will be guilty of an offence. Divulge includes communicate and publish. The maximum penalty that can be applied is 50 penalty units, imprisonment for six months, or both.

Clause 157(3) provides authority for when information can be used or divulged. This includes:

- under this Bill or another law applying in the ACT; or
- in relation to the exercise of a function by a person under this Bill or another law applying in the ACT; or
- in a court proceeding; or
- using or divulging of protected information about a person with the person's consent.

Definitions of 'court', 'divulge', 'produce', 'protected information' and 'use' are included.

This offence has been included due to the personal information and personal health information that is collected under the Bill.

Clause 158 Regulation-making power

This clause is a formal provision that allows the Executive to make regulations for this Bill.

Clause 159 Review of Act

Clause 159(1) requires the Minister to review the operation and effectiveness of this Bill as soon as practicable 3 years after the Bill commences (**first review**); and then every 5 years after the first review of this Bill is presented to the Legislative Assembly.

Clause 159(2) requires that the first review must include a review in relation to:

- whether an individual should be allowed access to VAD under this Act if the individual:
- is a child with decision-making capacity in relation to VAD;
- seeks to access VAD through advanced care planning;
- has not lived in the ACT for at least the previous 12 months, and is not eligible for an exemption under clause 151.

The meaning of child is defined under the *Legislation Act 2001* as an individual who is under 18 years old.

Clause 159(3) requires the Minister to present a report of the review to the Legislative Assembly.

By ensuring a thorough, formal review of the operation and effectiveness of the Bill, this clause provides an additional safeguard to monitor whether the Bill is achieving its objects.

Part 13 Consequential amendments

Clause 160 Legislation amended—sch 3

This clause is a formal provision to note that the Bill amends the legislation mentioned in schedule 3.

Schedule 1 Reviewable decisions— coordinating practitioner, consulting practitioner and administering practitioner decisions

Schedule 1 sets out the decisions that are reviewable by the ACT Civil and Administrative Tribunal (ACAT) under this Bill in relation to decisions by a coordinating practitioner, consulting practitioner and administering practitioner and the eligible and interested entities for each review.

Schedule 2 Reviewable decisions— other decisions

Schedule 2 sets out the other decisions that are reviewable by the ACT Civil and Administrative Tribunal (ACAT) under this Bill, and the eligible and interested entities for each review.

Schedule 3 Consequential amendments

Part 3.1 Births, Deaths and Marriages Registration Act 1997This clause inserts a new section 42(2A) into the BDMR Act.

Section 42 of the BDMR Act regulates the circumstances in which a person may have access to the register of births, deaths and marriages. The new section 42(2A) provides that the registrar-general must **not** give the access to any part of the register, or any information in the register, that would disclose a person's manner of death, or that a manner of death was recorded for a deceased person. This seeks to protect the privacy of an individual who has died in accordance with the Bill, whose manner of death will be collected by the registrar under clause 74(3) but is not to be disclosed to any other person.

This clause also inserts a new section 45(2A) into the BDMR Act. Section 45(1)(a) requires that on completing a search of the births, deaths and marriages register, the registrar-general must issue a certificate certifying the particulars contained in the register. In doing so, section 44 requires that the registrar-general must, as far as practicable, protect a person to whom the entry in the register relates from unreasonable intrusion into the person's privacy.

The new section 45(2A) provides that: ‘For subsection (1)(a), if an entry in the register relates to a death and a manner of death is recorded, the entry is taken not to include the manner of death.’ The effect of this is that a death certificate issued by the registrar-general must not include the individual’s manner of death, such as VAD. This seeks to protect the individual’s privacy by ensuring that their access to VAD is not disclosed on their death certificate. This also seeks to avoid any complexities arising in relation to the individual’s estate, superannuation, insurances or other matters that may be affected by the individual’s access to VAD.

This clause also makes technical amendments to section 45(1) of the BDMR Act.

The note clarifies that clause 118 of the Bill, which allows the Board to request information about an individual’s manner of death, applies despite the new section 42(2A) and 45(2A) of the BDMR Act.

Part 3.2 Births, Deaths and Marriages Registration Regulation 1998

This clause inserts a new section 12(e) into the *Births, Deaths and Marriages Registration Regulation 1998* (ACT) (**BDMR Regulation**).

Section 38(1) of the BDMR Act provides that the registrar-general must register a death by an entry in the register about the death that includes the particulars prescribed by regulation.

For the purpose of section 38(1), section 12 of the BDMR Regulation prescribes that several particulars must be included in the entry in the register, including the individual’s name, last home address, whether or not the death was reported to the coroner, the place and manner of the disposal of the remains of the deceased, and the matters listed in section 9(a) to (o) of the BDMR Regulation.

The new section 12(e) provides that if the registrar-general is given notice that the manner of death was VAD (under clause 74(3) of the Bill), the manner of death must be included in the entry in the register. The effect of this is that the registrar-general is obliged to make a record of each VAD death. This is designed to provide a source of data so that VAD deaths can be monitored in accordance with the Bill, subject to the privacy protections in the BDMR Act.

Part 3.3 Coroners Act 1997

This clause inserts a new section 13(1A) into the *Coroners Act 1997*.

Section 13(1) of the *Coroners Act 1997* sets out the circumstances in which the Coroner must hold an inquest into a death, including when a death is suspicious, accidental, or due to an operation or procedure.

The new section 13(1A) provides that for subsection 13(1)(a) to (h) of the *Coroners Act 1997*, the death of a person who has self-administered, or been administered, an approved substance in accordance with the Bill is not a death into which the coroner must hold an inquest only because the death happened in accordance with the Bill.

This is to clarify, for the avoidance of doubt, that a VAD death that happened in accordance with the Bill must not be the subject of a mandatory coronial inquest, unless the death falls into the coroner's existing jurisdiction. This is both to ensure that the grieving family, friends and carers of an individual who accesses VAD are not required to go through the coronial process without due cause, and also to ensure the Coroner's Court is not unintentionally bound by legislation to hold an inquest into every VAD death.

Examples of a death into which the coroner must hold an inquest because the death would fall within the coroner's existing jurisdiction include:

- the death of a person who has self-administered, or been administered, an approved substance in accordance with the Bill, where the death was also suspicious; or

- the death of a person who has self-administered, or been administered, an approved substance in accordance with the Bill, where the death occurred in circumstances that, in the opinion of the Attorney General, should be better ascertained.

This clause also introduces a new section 13(1B) into the *Coroners Act 1997.* This section establishes an exception to the rule set out in new section 13(1A): for subsection 13(1)(i) (a death in care or custody), the death of a person who has self-administered, or been administered, an approved substance in accordance with the Bill is not a death into which the coroner must hold an inquest. Care and custody are defined in the *Coroners Act 1997*.

This seeks to ensure a VAD death in care or custody is not a death into which the coroner must hold an inquest. This recognises the distinct, voluntary nature of a VAD death in care or custody, compared with other deaths in care or custody which warrant an examination of the circumstances of the death. This does not affect the coroner's existing jurisdiction to hold an inquest in section 13(1)(a) to (h) of the *Coroners Act 1997*, for example if there was a VAD death in custody that was suspicious.

These new sections do not seek to grant any discretion to the coroner in respect of VAD deaths. It will remain the responsibility of police, doctors and other relevant persons to involve the coroner if they consider a VAD death falls within the coroner's jurisdiction.

Part 3.4 Guardianship and Management of Property Act 1991

This clause inserts a new section 7B(f) into the *Guardianship and Management of Property Act 1991* (ACT). Section 7B provides that certain powers listed in that section may not be given to a guardian specified.

The new section 7B(f) adds 'request access to, revoke a request to access, or access voluntary assisted dying' to the list of powers that may not be given to a guardian. This seeks to clarify, for the avoidance of doubt, the Bill's intent that only an individual with decision-making capacity may request VAD, and must do so personally rather than through a guardian.

Part 3.5 Powers of Attorney Act 2006

This clause inserts a new section 37(da) to the *Powers of Attorney Act 2006* (ACT).

Section 35(b) of the *Powers of Attorney Act 2006* provides that a principal cannot authorise the attorney to exercise power in relation to special health care matters.

The new section 37(da) adds 'requesting access to, revoking a request to access, or accessing voluntary assisted dying' to the list of 'special health care matters' defined in section 37. This seeks to clarify, for the avoidance of doubt, the Bill's intent that only an individual with decision-making capacity may request VAD, and must do so personally rather than through an attorney.

Dictionary

The Dictionary defines key terms used in the Bill.

Appendix 1 to the Explanatory Statement: List of strict liability offences

18(1)(b)	Coordinating practitioner must give the Board a copy of the first assessment report within two working days after the day they decide whether the individual meets the eligibility requirements
22(2)	Within two working days after the day the health practitioner tells the individual about their decision to accept or refuse to accept the referral, the health practitioner must give the Board written notice of their decision.
25(1)(c)(i)	Within two working days after the day the consulting practitioner decides whether the individual meets the eligibility requirements, the consulting practitioner must give a copy of the consulting assessment report to the Board.
30(1)	Within two working days after the day an individual's coordinating practitioner receives a second request, the coordinating practitioner must give the Board a copy of the request
34(1)(b)	Within two working days after the day an individual makes a final request, the individual's coordinating practitioner must give the Board a copy of the final request report.
36(4)(a)	The coordinating practitioner must give a copy of the final assessment report to the Board within two working days after the day they decide that the individual meets the final assessment requirements.
37(5)(c)	Where another health practitioner accepts a request for transfer of functions, the original practitioner must give the Board written notice of the request acceptance as soon as practicable but within two working days.
38(5)(b)	If another health practitioner accepts a request for transfer of functions requested by the individual, the original practitioner must give the Board written notice of the request acceptance as soon as practicable but within two working days.
42(4)(b)	The individual's coordinating practitioner must give the Board written notice of the decision within four business days after the day the individual tells their coordinating practitioner about the administration decision.
43(4)(b)	The individual's coordinating practitioner must give the Board written notice of the change of decision within four business days after the day the individual tells their coordinating practitioner about the change of administration decision.
44(5)	If the requested practitioner agrees to act as the individual's administering practitioner, the practitioner must give the Board written notice of their decision within four business days after the day they tell the individual about their decision.
45(4)(c)	If the individual revokes an administration decision under subsection (1) (b), their administering practitioner must give the Board written notice of the revocation within two working days after the day the individual tells the administering practitioner about the revocation.
46(5)(c)	If the other health practitioner accepts the request by the original administering practitioner to transfer administering practitioner functions, the original practitioner must give the Board written notice of the request acceptance as soon as practicable, but not later than two working days after the day the original practitioner tells the individual.
47(5)(c)	If the health practitioner accepts the request by the individual to transfer administering practitioner functions, the health practitioner must give the Board written notice of the transfer within two working days after the health practitioner tells the individual that they accept the request.
51(6)	The individual's coordinating practitioner must give the Board a copy of the appointment of the contact person within two working days after the day the coordinating practitioner receives the appointment.
53(4)	Within two working days after the day the individual tells their coordinating practitioner about the contact person appointment ending, the coordinating practitioner must give the Board written notice about the appointment ending.

58(4)	The individual's coordinating practitioner must, within two working days after prescribing an approved substance under subsection (1), give the Board written notice of the prescription.
59(4)	The individual's coordinating practitioner must, within two working days after prescribing an approved substance under subsection (2), give the Board written notice of a subsequent prescription.
60(5)(c)	If an approved supplier supplies an approved substance under subsection (2) (b), the supplier must give the Board a copy of the supply record within two working days after the day they supply the approved substance.
61(4)(a)	Within 2 business days after the day the contact person gives an approved substance to the individual under subsection (3) (c), the contact person must give the Board written notice that they gave the substance to the individual.
62(3)	Within two working days after the day an individual gives an approved substance to their administering practitioner under subsection (2), the administering practitioner must give the Board written notice that they received the substance from the individual.
63(6)	Within two working days after the day the original administering practitioner gives an approved substance to the new practitioner under subsection (5) (a), the original administering practitioner must give the Board written notice that they gave the substance to the new administering practitioner
64(5)	Within 2 business days after the day the original contact person gives an approved substance to another person under subsection (2), the original contact person must give the Board written notice that they gave the substance to the other person.
68(2)	Within 2 working days after the day the disposer receives the approved substance from a person under subsection (1), the approved disposer must give the Board written notice that they have received the substance.
74(2)(a)	Where an individual dies, within two working days after the day the coordinating practitioner becomes aware of the individual's death, the coordinating practitioner must give the Board written notice of the death.
75(2)(a)(i)	Within two working days after the day the administering practitioner becomes aware of the individual's death, the administering practitioner must—if the administering practitioner is not the individual's coordinating practitioner—tell the coordinating practitioner about the death.
76(4)	The administering practitioner must give the Board a copy of the administration certificate within two working days after the day the administering practitioner administers the approved substance to the individual
78(2)(a)	Within two working days after the day the health practitioner becomes aware of the individual's death, the health practitioner must give the Board written notice of the death.
79(5)	The coordinating practitioner or contact person must comply with a request by the Board for information.
95	A health practitioner or health service provider commits an offence if the health practitioner or health service provider conscientiously objects to assisting with VAD and fails to give the individual, in writing, the contact details for the approved care navigator service within two working days after the day they refuse to do the thing.
99(2)	Within two working days after the day an individual tells a facility operator they want information about or access to VAD, the facility operator must give the individual, in writing, the contact details for the approved care navigator service.
101(5)	If the facility operator does not facilitate the transfer of the individual under subsection (2), the operator must give the Board written notice stating (a) the reasons why the individual was not transferred to and from the place; and (b) the steps taken by the operator to try to transfer the individual.
103(3)	On request by a person, the facility operator must make its policy available to the person.

146(2)	Within two working days after the day the registrar gives the coordinating practitioner a copy of the final order, the coordinating practitioner must give the Board a copy of the order.