Tara Cheyne MLA
Minister for the Arts, Culture and the Creative Economy
Minister for City Services
Minister for Government Services and Regulatory Reform
Minister for Human Rights

Member for Ginninderra

Our ref: PRO23/4847

Peter Cain MLA
Chair
Standing Committee on Justice and Community Safety (Legislative Scrutiny Role)
ACT Legislative Assembly
By email: scrutiny@parliament.act.gov.au

14 December 2023

Dear Mr Cain Peter

I am writing in response to the Standing Committee on Justice and Community Safety (Legislative Scrutiny Role) Scrutiny Report 37 of November 2023, regarding the Voluntary Assisted Dying Bill 2023 (**Bill**). The Bill was presented to the Legislative Assembly on 31 October 2023.

This letter responds to the Committee's request for further information about the Bill. I have consulted with the Minister for Health in preparing this letter.

Further information on whether it is intended that a breach of subclause 64(3) be a strict liability offence, and if so, why any limitation on the presumption of innocence by that subclause is considered necessary

Clause 64(3) of the Bill requires that if an individual asks the original contact person to give the approved substance to the individual or the new contact person, the original contact person must comply within two days. As stated in the Bill's Explanatory Statement, this is not intended to be a strict liability offence. I intend to make government amendments to clause 64(6) to clarify that clause 64(3) is not a strict liability offence.

Why Part 7 of the Bill should be considered a reasonable limit on the right to freedom of thought,conscience, religion and belief in section 14 of the HRA, and that consideration be given to amending the explanatory statement to include this information

Part 7 of the Bill imposes obligations on facility operators in relation to voluntary assisted dying. A facility operator is defined in clause 96 as the entity that is responsible for the management of a facility.[1]

The *Human Rights Act 2004* (ACT) protects the human rights of individuals. These protections do not extent to entities such as corporations and not-for-profit organisations.[2] That said, corporations and organisations are comprised of individuals who will be tasked with ensuring an entity upholds its obligations. Further, the meaning of 'entity' includes an unincorporated body and a person (including an individual or a corporation)[3] – meaning that an individual who is responsible for the management of a facility will be bound by the obligations in Part 7.

To address the Committee's concerns, I intend to table a revised Explanatory Statement justification along the following lines, explaining how Part 7 limits the right to freedom of thought, conscience, religion and belief:

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 beliefs that are theistic, non-theistic or atheistic.[4]

---

[1] 'Facility' is defined at clause 96 of the Bill as a place (other than an individual's private residence) where a care service is provided to a resident of the facility, including a hospital; a hospice; 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; and a residential aged care facility.

[2] Human Rights Act 2004 (ACT), s 6.

[3] See *Legislation Act 2001* (ACT), Dictionary.

[4] 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].

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.[5]

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.[6]

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',[7] 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))

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

---

[5] Above n 51, [8].
[6] Human Rights Act 2004 (ACT), s 6.
[7] Above n 3, [3], [9].

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. [8] In some cases, objections by facility operators resulted in forced transfers out of facilities to access VAD, causing additional pain, suffering and stress 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.[9] This in turn can impact the complexity of grief experienced by family and carers,[10] which was raised as a significant concern in the ACT Government's public consultation.

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.

---

[8] 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).

[9] 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).

[10] 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).

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. [11] 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.[12] 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:

- 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

[11] 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.

[12] 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' perceptions" *BMC Med Ethics* 24, 22 (2023), available at: https://doi.org/10.1186/s12910-023-00902-3p, p 11.

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.

In relation to clause 17 and 24, what safeguards are in place to ensure the coordinating assessment and consulting assessment are suitably independent

Clause 17 and 24 of the Bill respectively provide that if a coordinating practitioner or consulting practitioner is unable to decide whether the individual meets an eligibility requirement, the practitioner must refer the individual to another person (**third party**) who has the appropriate skills and training to provide advice about whether the individual meets the eligibility requirement.

There are several safeguards to ensure that the coordinating assessment and consulting assessment are suitably independent from each other:

- Clause 16 and 23 require the coordinating practitioner and consulting practitioner respectively, and separately, to decide whether the individual meets the eligibility requirements.
- Under clause 16, the coordinating practitioner only makes a referral to a consulting practitioner once the coordinating assessment is complete. That means the consulting practitioner plays no role in the first assessment by the coordinating practitioner.
- Clause 23(4) explicitly requires that the consulting practitioner's consulting assessment and related decisions must be 'made independently of' the coordinating practitioner.
- Coordinating practitioners and consulting practitioners are bound by existing professional rules that require them to manage and mitigate conflicts of interest, and act in the best interests of their patients.[13]

[13] See for example *AMA Guidelines for Doctors on Managing Conflicts of Interest in Medicine 2018*, available at: https://www.ama.com.au/sites/default/files/documents/AMA_Guidelines_for_Doctors_on_Managing_Conflicts_of_Interest_in_Medicine_2018.pdf; *Good medical practice: a code of conduct for doctors in Australia*, chapter 10.12, available at: https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx; *Code of Conduct for Nurses 2018*, chapter 4.4, available at: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx.

Where a co-ordinating practitioner or consulting practitioner refers a matter to a third party, sections 17 and 24 also include safeguards to ensure that a third party is not a family member of the individual or likely to benefit from the individuals' death (financially or in some other material way).

During extensive consultation, research, cross-jurisdictional analysis and policy development, there was no basis identified for including further independence requirements in the ACT's framework for voluntary assisted dying. Consistent with all other Australian jurisdictions:

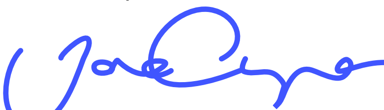
- There is no requirement that the third party be authorised in the same way that a coordinating practitioner, consulting practitioner, or administering practitioner must be authorised under Part 5 of the Bill. Unlike those practitioners, the third party is not responsible for holistically assessing whether an individual can access voluntary assisted dying, supporting the individual through the process, upholding reporting and qualification obligations, or undertaking voluntary assisted dying training. Although advice provided by a third party may inform a decision, the third party has no decision-making role in relation to a persons' eligibility to access voluntary assisted dying. Accordingly, there is no policy justification for requiring the third party to be authorised by the director-general.

- There is no requirement that the third party not be closely associated with other practitioners involved. In a small jurisdiction like the ACT, with an even smaller pool of health professionals who may wish to assist with voluntary assisted dying, it would be impractical for health professionals to establish that they are not closely associated with each other.

- There is no requirement that the coordinating practitioner and consulting practitioner may not both refer to the same third party for advice. For similar reasons as set out above, there are sufficient safeguards to ensure that practitioners manage and mitigate conflicts of interest as far as possible in a small jurisdiction. It may be that there is only one suitable professional in the ACT to provide, for example, third party advice on whether an individual has capacity in the context of their particular relevant condition.

Thank you for your consideration of the Bill. I trust the information above is of assistance to the Committee.

Sincerely



Tara Cheyne MLA
Minister for Human Rights