June 2021

The Uniting Church in Australia
QUEENSLAND SYNOD

Moderator
Rev Andrew Gunton

The Secretary
Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Secretary,

The Uniting Church in Australia Queensland Synod (Queensland Synod) welcomes the opportunity to provide feedback to the Health and Environment Committee on the Voluntary Assisted Dying Bill 2021. The Queensland Synod and its service delivery agencies, UnitingCare Queensland and Wesley Mission Queensland, are making a response that brings together our views and experiences.

Whether voluntary assisted dying should be legalised in Queensland and its legal framework are significant questions for the Parliament to consider. While we do not support the legalisation of voluntary assisted dying, if it is legislated, the Queensland Synod advocates for safeguards that protect the most vulnerable in our community.

The Queensland Synod, UnitingCare Queensland and Wesley Mission Queensland would welcome future opportunities to discuss this submission further.

Should you require any further information, I can be contacted on 07 3377 9705.

Yours sincerely,

Rev. Andrew Gunton
Moderator, Uniting Church in Australia Queensland Synod

Supported by:

Craig Barke
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Voluntary Assisted Dying Bill 2021: Uniting Church in Queensland Submission

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Introduction

Synod

The Uniting Church is committed to working towards a society characterised by love, compassion, justice, inclusion and reconciliation so that all people, at every stage of life, can experience 'life in all its fullness' (John 10:10). Our faith calls us to the preferential care for the most marginalised in society. Moreover, the Christian vision for a flourishing society includes valuing and promoting the compassionate service and love of the most vulnerable in society based on the sanctity of all life. The experience of sickness, pain and suffering, especially at the end-of-life, is a vulnerable and fragile experience. As the Church, we are called to participate in and witness to God's mission of compassionate care for the sick, the dying, the poor in spirit, people with a disability, the aged, and those who are experiencing brokenness and forsakenness.

UnitingCare Queensland

UnitingCare Queensland (UnitingCare) is the health and community services arm of the Uniting Church in Australia in Queensland. We are committed to delivering quality health, aged care, disability and community services as one of the largest charities in Australia. UnitingCare provides person-centred care and support services to thousands of vulnerable individuals and persons in need every day of the year enabling our clients to live life in all its fullness whatever their circumstances.

Blue Care

For more than 65 years Blue Care has been committed to empowering individuals to live life their way. Today our people make more than three million visits to Queenslanders each year, providing the same holistic care, service and companionship that has been our hallmark since our establishment. Blue Care puts customers and their loved ones first, and this focus on individuals has helped us become one of Queensland's largest and most trusted providers of in-home care, residential aged care and independent and supported retirement living. We provide services from Thursday Island to Coolangatta and as far west as Mt Isa and Charleville. Through all our services, we provide care to more than 75,000 people a year – over 71, 000 community care clients are provided with services in their home and over 5,000 residential and respite clients are provided services in 47 residential aged care facilities. This includes palliative care services provided in community and residential aged care settings across Queensland. These are funded by a variety of sources, including contracted services on behalf of Queensland Hospital and Health Services, such as the Wynnum-Manly Palliative Care Unit. We also provide palliative support to many of the people we serve every year.

UnitingCare Hospitals

UnitingCare is one of the largest private hospital groups in Queensland and provides a comprehensive range of private medical services. We operate a palliative care unit at The Wesley Hospital in Brisbane and a smaller inpatient service at St Andrew's War Memorial Hospital. The Wesley Palliative Care Service is a multidisciplinary, holistic and inclusive service which values the human spirit in overcoming the burden of advanced incurable illness, regardless of the underlying cause. This unit has 17 beds and is supported by a team of medical specialists and registrars, experienced palliative nursing staff, dieticians, physiotherapists, occupational therapists, nurse counsellors and chaplains.

Wesley Mission Queensland

Wesley Mission Queensland was established in 1907 to provide nursing care to the homeless and was the first provider of residential aged care in Queensland. Today we operate 13 aged care communities that provide a home, care and support for over 1,000 residents.

The organisation has grown significantly in recent years, particularly in the mental health, disability and respite care sector and now supports more than 100,000 people in Queensland each year and 4,000 members of the Deaf community across Australia through the National Auslan Interpreter Booking Service.

Wesley Mission Queensland also provides two hospice services: Hopewell Hospice on the Gold Coast and Queensland's only children's hospice, Hummingbird House. Wesley Mission Queensland's core purpose is to walk alongside people in need, offering care and compassion and promoting choice, independence and community wellbeing.

Aged Care

All of Wesley Mission Queensland's aged care homes, embrace the Eden Alternative™ philosophy of care, which is dedicated to promoting quality of life for elders and creating homes that are filled with laughter, family, beautiful spaces, gardens, animals and music and, most importantly strong and warm relationships between residents, staff, volunteers and families. Our nursing staff provide responsive and flexible care, including palliative care, tailored to each resident's changing needs. We work with our multidisciplinary team to provide medical, social, emotional, spiritual and practical support for residents, families and friends.

Current Synod Position on Voluntary Assisted Dying

The Synod position statement on voluntary assisted dying, approved at the 2019 Synod meeting, is as follows:

The Uniting Church in Australia – Queensland Synod seeks to witness to the God given dignity and worth of every human life. We are committed to 'All that Jesus began to do and teach' (Acts 1.1) by working towards a society characterised by love, compassion, justice, inclusion and reconciliation so that all people, at every stage of life, can experience 'life in all its fullness' (John 10:10). We seek to witness to God's good gift of creation and the intrinsic worth and dignity of all people in every circumstance that is grounded in a reality that is untouched by the circumstances of our lives or death.

In our compassionate care we seek to remain with people, in both lament and hope, bearing witness to God being with us in every circumstance of life.

In recognition of this, we do not support the legalisation of voluntary assisted dying in Queensland. If legalised, our facilities will not provide this as a service and our staff, in the course of their employment, will not participate in medical acts to end a life through voluntary assisted dying.

We recognise that in some situations, the experiences of end-of-life can cause significant distress for the person dying, their families and care staff. While we do not support voluntary assisted dying, if it is legalised, the Church is committed to offering a compassionate and pastoral response to people and families who choose this path.

We also recognise that there will be people, who in good conscience and in light of their faith in God, make a decision to undertake voluntary assisted dying.

A compassionate and pastoral response in the Synod agencies includes working with people and families who choose and access voluntary assisted dying to offer emotional, psychological and social support, spiritual and pastoral care, and minimising physical suffering. This response does not include medically participating in acts intended to end life through a voluntary assisted dying process.

That in the case of the legalisation of voluntary assisted dying in Queensland, to request Wesley Mission Queensland and UnitingCare to develop a policy and practice approach in light of the Synod's position and any legislative requirements.

Affirms the critical importance of high quality, well-resourced and accessible palliative and end-of-life care that responds to the physical, psycho-social and spiritual needs of people at the end-of-life. The Church undertakes the following actions:

I. Advocate for a well-resourced and flexible system that consistently meets people's needs and preferences for care;

II. Continue to provide high quality and accessible palliative care, responsive to the pastoral and spiritual needs of the people we serve, as central to our mission as the Church.

That in advocating to government regarding the Church's position, the Church strongly recommends provisions for conscientious objection, for both individuals and organisations, be included in any proposed legislation.

1. Eligibility Criteria

1.1 The Bill

10 Eligibility
(1) A person is eligible for access to voluntary assisted dying if—
(a) the person has been diagnosed with a disease, illness or medical condition that—
(i) is advanced, progressive and will cause death; and
(ii) is expected to cause death within 12 months; and
(iii) is causing suffering that the person considers to be intolerable; and

(b) the person has decision-making capacity in relation to voluntary assisted dying; and
(c) the person is acting voluntarily and without coercion; and
(d) the person is at least 18 years of age; and
(e) the person—
(i) is an Australian citizen; or
(ii) is a permanent resident of Australia; or
(iii) has been ordinarily resident in Australia for at least 3 years immediately before the person makes the first request; or
(iv) has been granted an Australian residency exemption by the chief executive under section 12; and
(f) the person—
(i) has been ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request; or
(ii) has been granted a Queensland residency exemption by the chief executive under section 12.
(2) In this section—
permanent resident means—
(a) the holder of a permanent visa as defined by the *Migration Act 1958* (Cwlth), section 30(1); or
(b) a New Zealand citizen who is the holder of a special category visa as defined by the *Migration Act 1958* (Cwlth), section 32.
suffering, caused by a disease, illness or medical condition, includes—
(a) physical or mental suffering; and
(b) suffering caused by treatment provided for the disease, illness or medical condition.
13 Disability or mental illness
(1) To remove any doubt, it is declared that a person with a disability or mental illness—
(a) may be eligible under section 10(1)(a); but
(b) is not eligible under section 10(1)(a) only because the person has the disability or mental illness.
(2) In this section—
eligible means eligible for access to voluntary assisted dying.
mental illness see the *Mental Health Act 2016*, section 10.

1.2 Synod Concerns

We recommend the inclusion of a specified timeline for expected death, and that this should not exceed six months. The Bill goes further than Victoria, Western Australia and Tasmania who all have a 6 months' timeframe in their eligibility criteria and 12 months for neurodegenerative conditions. The 6 months limit is an important safeguard for the Bill to ensure that only people at the end of life have access to voluntary assisted dying.

We recommend that the draft legislation remove the definition of mental suffering. In the Bill, a person can access voluntary assisted dying while having no physical symptoms, but only mental suffering related to the terminal diagnosis. The removal of mental suffering from the definition of suffering will make it clear that eligibility for voluntary assisted dying is limited to those with physical pain considered intolerable for the person, that cannot be relieved from high quality palliative care, and that is linked to the medical condition. This will be consistent with the intention that voluntary assisted dying is an option only for people at the end of life who are suffering and dying. In the Bill, whether the condition is causing intolerable suffering to the person is a subjective determination by

the person concerned. The inclusion of mental suffering opens this subjective determination to move beyond the stated intention of voluntary assisted dying. The Bill does not state that this suffering is to be enduring or constant.

Research indicates that the reasons for a person choosing to access voluntary assisted dying are multifaceted and complex, and not simply about physical pain. The most common reasons for people to request voluntary assisted dying are loss of autonomy and dignity and the inability to enjoy life and other activities. Research analysing people's views of voluntary assisted dying found that unbearable suffering relating to psycho-emotional factors such as hopelessness, feeling a burden, loss of interest or pleasure and loneliness were at least as significant as pain and other physical symptoms in motivating people to consider voluntary assisted dying. These issues are societal, psycho-emotional and spiritual rather than medical. They represent society's values and understanding of a range of issues such as autonomy, dignity, vulnerability, suffering and worth. We recommend that the legislation clearly focuses on unrelievable and intolerable physical suffering.

The Queensland Law Reform Commission's (2021) report, *A legal framework for voluntary assisted dying*, recommends that a definition of 'disability' be provided within the legislation, specifically 'a disability as defined in section 11 of the *Disability Services Act 2006'.* This definition in not included in the legislation. We recommend that this definition be inserted.

1.3 Recommendation 1

Eligibility criteria
Recommendation 1
That the following amendments are made to Sections 10 and 13 (suggested changes are highlighted in red):

10 Eligibility
(1) A person is eligible for access to voluntary assisted dying if—
(a) the person has been diagnosed with a disease, illness or medical condition that—
(i) is advanced, progressive and will cause death; and
(ii) is expected to cause death within weeks or months, not exceeding six months;
(iii) is causing physical suffering that is unrelievable and that the person considers to be intolerable;
(b) the person has decision-making capacity in relation to voluntary assisted dying; and
(c) the person is acting voluntarily and without coercion; and
(d) the person is at least 18 years of age; and
(e) the person—
(i) is an Australian citizen; or
(ii) is a permanent resident of Australia; or
(iii) has been ordinarily resident in Australia for at least 3 years immediately before the person makes the first request; or
(iv) has been granted an Australian residency exemption by the chief executive under section 12; and
(f) the person—
(i) has been ordinarily resident in Queensland for at least 12 months immediately before the person makes the first request; or
(ii) has been granted a Queensland residency exemption by the chief executive under section 12.

(2) In this section—
permanent resident means—
(a) the holder of a permanent visa as defined by the *Migration Act 1958* (Cwlth), section 30(1); or
(b) a New Zealand citizen who is the holder of a special category visa as defined by the *Migration Act 1958* (Cwlth), section 32.
suffering, caused by a disease, illness or medical condition, includes—
(a) physical suffering; and
(b) suffering caused by treatment provided for the disease, illness or medical condition.
13 Disability or mental illness
(1) To remove any doubt, it is declared that a person with a disability or mental illness—
(a) may be eligible under section 10(1)(a); but
(b) is not eligible under section 10(1)(a) only because the person has the disability or mental illness.
(2) In this section—
eligible means eligible for access to voluntary assisted dying.
disability see the *Disability Services Act 2006*, section 11.
mental illness see the *Mental Health Act 2016*, section 10.

2. Process: Final Request

2.1 The Bill

43 When final request may be made
(1) The final request may not be made—
(a) before the end of the designated period, except as provided in subsection (2); and
(b) in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.
(2) The final request may be made before the end of the designated period if—
(a) in the opinion of the coordinating practitioner, the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period; and
(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the person as expressed in the consulting assessment.
(3) In this section—
designated period means the period of 9 days from and including the day on which the person made the first request.

2.2 Synod Concerns

The most significant area of concern is the designated period of nine days, and to be able to access voluntary assisted dying after only two days if the relevant exemptions apply. If these exemptions are to be included, the designated period should be extended to a more reasonable timeframe of 14 days or more. This would build on the safeguard that a request be an enduring request and would still allow for exceptional circumstances such as those outlined in the Bill.

This will give space for people to have as many opportunities as possible to consider their decision, to reflect deeply upon their decision, to receive palliative care and process the complex array of emotions and grief experienced by the individual, and their families and friends. This will also be an additional safeguard from external pressure to rush the process.

Research indicates that there is a significant gap between those who are prescribed the relevant substance for voluntary assisted dying and those who take it. It is not uncommon for people to change their mind at different stages of the process. It is therefore critical for an adequate waiting time, without this being too long for people experiencing unrelievable suffering. We do not support a provision for a reduced timeframe because of the likelihood of death before the timeframe is completed or because of the risk of losing decision-making capacity.

State legislation in the United States generally provides a waiting period of 15 – 20 days between the first and final request. In many of those jurisdictions, an additional waiting period of 48 hours applies between the final request and when the substance is prescribed. The rationale for minimum time frame is that it is an assessment period, not a reflection period, and it helps to ensure that practitioners spend sufficient time exploring the various dimensions of the person's request.

In terms of an exemption for a person likely to lose capacity, it was concluded in Victoria that reducing the waiting period due to an imminent loss of decision-making capacity would be inappropriate:

Concern about an imminent loss of decision-making capacity may pressure a person to make the decision to request voluntary assisted dying quickly, without fully considering their options and the possibility of continued enjoyment of life (Queensland Law Reform Commission, 2021, A legal framework for voluntary assisted dying).

The Synod agrees with the Victorian stance, that the minimum time frame of two days if an exemption applies, conflicts with the safeguard that a request be enduring. In terms of an exemption for a person likely to die before the designated period of nine days, palliative care and treatment would be made available in this time period, therefore removing the need for access to voluntary assisted dying.

2.3 Recommendation 2

When final request may be made
Recommendation 2
That the following amendments are made to Section 43 (suggested changes are highlighted in red):

43 When final request may be made
(1) The final request may not be made—
(a) before the end of the designated period, except as provided in subsection (2); and
(b) in any case, until the day after the day on which the consulting assessment that assessed the person as meeting the requirements of a consulting assessment was completed.
(2) The final request may be made before the end of the designated period if—
(a) in the opinion of the coordinating practitioner, the person is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period;

and
(b) the opinion of the coordinating practitioner is consistent with the opinion of the consulting practitioner for the person as expressed in the consulting assessment.
(3) In this section—
designated period means the period of 14 days from and including the day on which the person made the first request.

3. Initiating A Discussion About Voluntary Assisted Dying

3.1 The Bill

7 Health care worker not to initiate discussion about voluntary assisted dying
(1) A health care worker must not, in the course of providing a health service or personal care service to a person—
(a) initiate discussion with the person that is in substance about voluntary assisted dying; or
(b) in substance, suggest voluntary assisted dying to the person.
(2) However, despite subsection (1), a medical practitioner or nurse practitioner may do a thing mentioned in subsection (1)(a) or (b) if, at the same time, the practitioner also informs the person about—
(a) the treatment options available to the person and the likely outcomes of that treatment; and
(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.
(3) Nothing in subsection (1) prevents a health care worker from providing information about voluntary assisted dying to a person at the person's request.
(4) In this section—
health care worker means—
(a) a registered health practitioner; or
(b) another person who provides a health service or personal care service.

3.2 Synod Concerns

This is a positive outcome in line with the Synod's position for the prohibition on a health care worker, who provides a health care service or personal care service to a person, to initiate discussion about voluntary assisted dying to that person. However, there are concerns with the details of this section of the Bill.

First, the exemption that a health care worker can provide information about voluntary assisted dying to a person at the person's request. This is problematic, as the definition of *health care worker* includes 'a person who provides a health service or personal care service'. Any worker who provides a health service or personal care service, other than a health care practitioner, incudes workers who do not have the required knowledge and training to discuss voluntary assisted dying. This exemption does not also mandate that the person be informed of treatment options available to the person and the likely outcomes of that treatment, and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment. In addition, health care workers who provide personal care services, such as support workers in disability services, do not have any professional registration requirements, such as adhering to a Code of Conduct, associated professional conduct regulation, and oversight by a professional body.

Second, providing exemptions from this prohibition on initiating discussion to medical practitioners and nurse practitioners, if they also inform the person of treatment options available to the person and the likely outcomes of that treatment, and the palliative care and treatment options available to the person and the likely outcomes of that care and treatment. The Queensland Synod's position is that the power dynamic of a health practitioner and patient relationship needs to be considered, as there is the potential for coercion and subtle pressure being applied by any initiation of a conversation about voluntary assisted dying, with a vulnerable person, within the context of a therapeutic relationship.

As the Queensland Law Reform Commission's (2021) *A legal framework for voluntary assisted dying* reports:

> *In Canada, Roger Foley has recorded multiple conversations where medical professionals suggest euthanasia to him over his frequent refusals and objections. It stands to reason many others do not covertly record these conversations or may simply give in to the pressure and the authority that physicians represent.*

We recommend an approach similar to the *Voluntary Assisted Dying Act 2017* (Vic) that prohibits a health practitioner (health care worker and medical practitioner) from initiating or suggesting voluntary assisted dying. Any discussion about voluntary assisted dying should be initiated by the person. The prohibition on initiating of conversations by health practitioners is an important safeguard.

3.3 Recommendation 3

Health care worker not to initiate discussion about voluntary assisted dying
Recommendation 3
That the following amendments are made to Section 7 (suggested changes are highlighted in red):

7 Health care worker not to initiate discussion about voluntary assisted dying
(1) A health care worker and a medical practitioner or nurse practitioner must not, in the course of providing a health service or personal care service to a person—
(a) initiate discussion with the person that is in substance about voluntary assisted dying; or
(b) in substance, suggest voluntary assisted dying to the person.
(2) A medical practitioner or nurse practitioner may provide information about voluntary assisted dying to a person at the person's request if, at the same time, the practitioner also informs the person about—
(a) the treatment options available to the person and the likely outcomes of that treatment; and
(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

4. Witness to Self-administration

4.1 The Bill

52 Self-administration—authorisations
(1) This section applies if the person makes a self-administration decision.
(2) The coordinating practitioner for the person is authorised to prescribe a voluntary assisted dying substance for the person that is of a sufficient dose to cause death.
(3) Subsection (2) is subject to section 59(6).
(4) The authorised supplier who is given the prescription for the person is authorised to—
(a) possess the voluntary assisted dying substance for the purpose of preparing it and supplying it to a person mentioned in paragraph (c); and
(b) prepare the substance; and
(c) supply the substance to the person, the contact person for the person or an agent of the person.
(5) The person is authorised to—
(a) receive the voluntary assisted dying substance from the authorised supplier, the contact person for the person or an agent of the person; and
(b) possess the substance for the purpose of preparing and self-administering it; and
(c) prepare the substance; and
(d) self-administer the substance.
(6) An agent of the person is authorised to—
(a) receive the voluntary assisted dying substance from an authorised supplier; and
(b) possess the substance for the purpose of supplying it to the person; and
(c) supply the substance to the person.
(7) Another person, requested by the person to prepare the voluntary assisted dying substance for the person, is authorised to—
(a) possess the substance for the purpose of preparing it; and
(b) prepare the substance; and
(c) supply the substance to the person.
Note—
See section 61 for the authorisation of a contact person in the case of a self-administration decision.
53 Practitioner administration—authorisations
(1) This section applies if the person makes a practitioner administration decision.
(2) The coordinating practitioner for the person is authorised to prescribe a voluntary assisted dying substance for the person that is of sufficient dose to cause death.
(3) Subsection (2) is subject to section 59(6).
(4) The authorised supplier who is given the prescription for the person is authorised to—
(a) possess the voluntary assisted dying substance for the purpose of preparing it and supplying it to the administering practitioner for the person; and
(b) prepare the substance; and
(c) supply the substance to the administering practitioner for the person.

(5) The administering practitioner for the person is authorised to—
(a) receive the voluntary assisted dying substance from an authorised supplier; and
(b) possess the substance for the purpose of preparing it and administering it to the person; and
(c) prepare the substance.
(6) The administering practitioner for the person is authorised to administer the voluntary assisted dying substance to the person, in the presence of an eligible witness, if the administering practitioner is satisfied at the time of administration that—
(a) the person has decision-making capacity in relation to voluntary assisted dying; and
(b) the person is acting voluntarily and without coercion.

54 Witness to administration of voluntary assisted dying substance

(1) Another person (the ***witness***) is eligible to witness the administration of a voluntary assisted dying substance to the person if the witness is at least 18 years of age.
(2) The witness must certify in the practitioner administration form for the person that—
(a) the person appeared to be acting voluntarily and without coercion; and
(b) the administering practitioner for the person administered the substance to the person in the presence of the witness.

97 Administration of voluntary assisted dying substance

(1) This section applies if—
(a) the person has made an administration decision; and
(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have an administering practitioner administer a voluntary assisted dying substance to the person; and
(c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.
(2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must—
(a) if the person has made a practitioner administration decision—
(i) allow reasonable access to the person at the facility by the administering practitioner for the person to administer a voluntary assisted dying substance to the person; and
(ii) allow reasonable access to the person at the facility by an eligible witness to the administration of the voluntary assisted dying substance by the administering practitioner for the person; or
(b) if the person has made a self-administration decision—not hinder access by the person to a voluntary assisted dying substance.
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.
(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—

• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the place to which the person is proposed to be transferred is available to receive the person.

4.2 Synod Concerns

There are concerns with the details of this section of the Bill. Section 53, which outlines the requirements for self-administration of the voluntary assisted dying substance, does not have the requirements for an eligible witness, as provided for in sections 53 and 54 which outline requirements for practitioner administration of the voluntary assisted dying substance. We recommend amending the relevant sections, including section 97, to include the requirement for an eligible witness to be present in the case of self-administration of the dying substance. This would assist to ensure the person self-administering the voluntary assisted dying substance has another person present in case the self-administration process goes wrong and the person self-administering requires urgent medical assistance to avoid prolonged and/or suffering in the dying process.

4.3 Recommendation 4

Witness to Self-administration
Recommendation 4
That the following amendments are made to Sections 52, 54 and 97 (suggested changes are highlighted in red):

52 Self-administration—authorisations
(1) This section applies if the person makes a self-administration decision.
(2) The coordinating practitioner for the person is authorised to prescribe a voluntary assisted dying substance for the person that is of a sufficient dose to cause death.
(3) Subsection (2) is subject to section 59(6).
(4) The authorised supplier who is given the prescription for the person is authorised to—
(a) possess the voluntary assisted dying substance for the purpose of preparing it and supplying it to a person mentioned in paragraph (c); and
(b) prepare the substance; and
(c) supply the substance to the person, the contact person for the person or an agent of the person.
(5) The person is authorised to—
(a) receive the voluntary assisted dying substance from the authorised supplier, the contact person for the person or an agent of the person; and
(b) possess the substance for the purpose of preparing and self-administering it; and
(c) prepare the substance; and
(d) self-administer the substance, in the presence of an eligible witness.

(6) An agent of the person is authorised to—
(a) receive the voluntary assisted dying substance from an authorised supplier; and
(b) possess the substance for the purpose of supplying it to the person; and
(c) supply the substance to the person.
(7) Another person, requested by the person to prepare the voluntary assisted dying substance for the person, is authorised to—
(a) possess the substance for the purpose of preparing it; and
(b) prepare the substance; and
(c) supply the substance to the person.
Note—
See section 61 for the authorisation of a contact person in the case of a self-administration decision.

54 Witness to administration of voluntary assisted dying substance

(1) Another person (the ***witness***) is eligible to witness the self-administration or the administration of a voluntary assisted dying substance to the person if the witness is at least 18 years of age.
(2) The witness must certify for the administration of a voluntary assisted dying substance in the practitioner administration form for the person that—
(a) the person appeared to be acting voluntarily and without coercion; and
(b) the administering practitioner for the person administered the substance to the person in the presence of the witness.

97 Administration of voluntary assisted dying substance

(1) This section applies if—
(a) the person has made an administration decision; and
(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have an administering practitioner administer a voluntary assisted dying substance to the person; and
(c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.
(2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must—
(a) if the person has made a practitioner administration decision—
(i) allow reasonable access to the person at the facility by the administering practitioner for the person to administer a voluntary assisted dying substance to the person; and
(ii) allow reasonable access to the person at the facility by an eligible witness to the administration of the voluntary assisted dying substance by the administering practitioner for the person; or
(b) if the person has made a self-administration decision—not hinder access by the person to a voluntary assisted dying substance and allow reasonable access to the person at the facility by an eligible witness to the self-administration of the voluntary assisted dying substance by the person.
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.

(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the place to which the person is proposed to be transferred is available to receive the person.

5. Individual Conscientious Objection

5.1 The Bill

84 Registered health practitioner with conscientious objection
(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—
(a) provide information to another person about voluntary assisted dying;
(b) participate in the request and assessment process;
(c) participate in an administration decision;
(d) prescribe, supply or administer a voluntary assisted dying substance;
(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.
(2) A registered health practitioner who, because of a conscientious objection, refuses to do a thing mentioned in subsection (1) for a person seeking information or assistance about voluntary assisted dying, must—
(a) inform the person that other health practitioners, health service providers or services may be able to assist the person; and
(b) give the person—
(i) information about a health practitioner, health service provider or service who, in the practitioner's belief, is likely to be able to assist the person; or
(ii) the details of an official voluntary assisted dying care navigator service that is able to provide the person with information (including name and contact details) about a health practitioner, health service provider or service who may be able to assist the person.

5.2 Synod Concerns

The Bill states that a health practitioner may decline to provide or participate in a lawful treatment or procedure because it conflicts with the individual's personal beliefs, values or moral concerns. The Human Rights Act recognises an individual's right to 'freedom of thought, conscience, religion and belief'. Overall, this is a positive outcome in line with the Synod's position. The most significant area

of concern is the obligation to provide information about voluntary assisted dying. Given that it will be highly unlikely that a person would not be aware of where to find information about voluntary assisted dying in Qld, if this is arranged by the State through a navigator service, then this obligation will be an unnecessary burden on the individual who holds a conscientious objection.

5.3 Recommendation 5

Registered health practitioner with conscientious objection
Recommendation 5
That the following amendments are made to Section 84: removing 2 (b) i and ii, while maintaining 2(a).

84 Registered health practitioner with conscientious objection
(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—
(a) provide information to another person about voluntary assisted dying;
(b) participate in the request and assessment process;
(c) participate in an administration decision;
(d) prescribe, supply or administer a voluntary assisted dying substance;
(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.
(2) A registered health practitioner who, because of a conscientious objection, refuses to do a thing mentioned in subsection (1) for a person seeking information or assistance about voluntary assisted dying, must—
(a) inform the person that other health practitioners, health service providers or services may be able to assist the person.

6. Institutional Conscientious Objection

6.1 The Bill

Different considerations apply to different stages of the voluntary assisted dying process. For the purposes of this submission, we have divided the different stages into the following areas:

- access to information;
- a first request or further request and an eligibility assessment;
- the administration decision and administration of the substance;
- public information about non-availability of voluntary assisted dying.

Stage 1: Access to Information

90 Access to information about voluntary assisted dying
(1) This section applies if—
(a) a person is receiving relevant services from a relevant entity at a facility; and
(b) the person asks the entity for information about voluntary assisted dying; and
(c) the entity does not provide at the facility, to persons to whom relevant services are provided, the information(c) the entity does not provide at the facility, to persons to whom relevant services are provided, the information that has been requested.

(2) The relevant entity and any other entity that owns or occupies the facility—
(a) must not hinder the person's access at the facility to information about voluntary assisted dying; and
(b) must allow reasonable access to the person at the facility by each person who—
(i) is a registered health practitioner or a member or employee of an official voluntary assisted dying care navigator service; and
(ii) is seeking the access to provide the requested information to the person about voluntary assisted dying.

Stage 2: Requests and Assessments

The relevant entity must allow reasonable access to a medical practitioner, witnesses and other relevant people at each stage of the request and assessment process regardless of its publicly stated position as a non-participating entity. This includes reasonable steps to transfer the person if the assessment cannot be undertaken at the facility due to a medical practitioner not being able to attend etc.

There is a differentiation between permanent and non-permanent residents. Transfer is allowable for non-permanent residents unless the transfer is deemed unreasonable for the reasons of it is likely to cause serious harm to the person or adversely affect the person's access to voluntary assisted dying and other criteria including likely to incur financial costs. The same process is repeated for the first assessment and consulting assessment. An example is section 92.

92 First requests and final requests
(1) This section applies if—
(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a ***relevant request***); and
(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.
(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a medical practitioner—
(a) whose presence is requested by the person; and
(b) who—
(i) for a first request—is eligible to act as a coordinating practitioner; or
(ii) for a final request—is the coordinating practitioner for the person.
(3) If the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made to—
(a) the requested medical practitioner; or
(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

Stage 3: Administration Decision and Administration

Section 96-97 of the Bill deals with the administration of voluntary assisted dying substance after the successful completion of the assessment process. This includes self-administration and practitioner administration of the substance.

96 Administration decisions

(1) This section applies if—

(a) the person has made a final request; and

(b) the person or the person's agent advises the relevant entity that the person wishes to make an administration decision; and

(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to a person's coordinating practitioner to enable an administration decision to be made.

(2) If the person is a permanent resident at the facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person to consult with and advise the person in making the administration decision; and

(b) if the coordinating practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of—

(i) the coordinating practitioner; or

(ii) another medical practitioner who is eligible and willing to act as the coordinating practitioner for the person.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of, the coordinating practitioner for the person; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person.

(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person;

Examples of serious harm—

• significant pain

• a significant deterioration in the person's condition

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;

Examples of adverse effects—

• the transfer would likely result in a loss of decision-making capacity of the person

• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;

(d) whether the place to which the person is proposed to be transferred is available to receive the person;

(e) whether the person would incur financial loss or costs because of the transfer.

97 Administration of voluntary assisted dying substance

(1) This section applies if—

(a) the person has made an administration decision; and
(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have an administering practitioner administer a voluntary assisted dying substance to the person; and
(c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.
(2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must—
(a) if the person has made a practitioner administration decision—
(i) allow reasonable access to the person at the facility by the administering practitioner for the person to administer a voluntary assisted dying substance to the person; and
(ii) allow reasonable access to the person at the facility by an eligible witness to the administration of the voluntary assisted dying substance by the administering practitioner for the person; or
(b) if the person has made a self-administration decision—not hinder access by the person to a voluntary assisted dying substance.
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.
(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the place to which the person is proposed to be transferred is available to receive the person.

Stage 4: Public information about Non-availability of Voluntary Assisted Dying

98 Relevant entities to inform public of non-availability of voluntary assisted dying
(1) This section applies to a relevant entity that does not provide, at a facility at which the entity provides relevant services, services associated with voluntary assisted dying, such as access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

(2) The relevant entity must publish information about the fact the entity does not provide those services at the facility.
(3) The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the facility, or may in future receive the services of the entity at the facility, become aware of the information.

6.2 Synod Concerns

The provisions in the Bill regarding entities providing reasonable access to the information, request, and assessments for a person considering voluntary assisted dying, as well as providing public information about non-availability of voluntary assisted dying, are consistent with the Synod's position. These are reasonable expectations for entities, balancing compassionate care and the rights of entities who hold a conscientious objection. There is a need to clarify what is meant by *must take reasonable steps to facilitate the transfer* for non-permanent residents, if this is required. The Synod submission to the QLRC recommended *reasonable steps to support the transfer* of the person. The latter emphasises the obligation and resourcing of transfer to be borne by the State and/or the individual, rather than an entity that maintains a conscientious objection.

The criteria for whether it is reasonable to transfer non-permanent residents for administration of voluntary assisted dying includes regard to *(c) whether the place to which the person is proposed to be transferred is available to receive the person*. There may be circumstances where the lack of resources and availability for a suitable facility result in an obligation being placed on entities not to transfer a non-permanent resident for administration of voluntary assisted dying.

Ethically, there is a significant difference between an assessment process and an act that will cause death. Put simply, administration of the substance causes death in an intentional way; the assessment process does not cause death. This is ethically quite different from any other current legal end of life practices. In cases where it is deemed not reasonable to transfer a person, then a compassionate position, consistent with the Synod's position, is to obligate the entity to allow self-administration or practitioner-administration in their facility. A compassionate and pastoral response in the Synod agencies includes working with people and families who choose and access voluntary assisted dying to offer emotional, psychological and social support, spiritual and pastoral care, and minimising physical suffering. This response does not include medically participating in acts intended to end life through a voluntary assisted dying process.

In addition, the rights of other permanent residents in a facility or service needs to be considered. A Commonwealth Government approved aged care provider must be able to demonstrate that it meets the Aged Care Quality Standards. This includes the standard 'Consumer dignity and choice'. The Aged Care Quality and Safety Commission states that 'No two consumers' lived experiences are the same. What is respectful or dignified for one consumer might not be for another'. In relation to choice, the Aged Care Quality and Safety Commission also states: 'There may also be situations where consumers won't be able to have unlimited choice, such as if their choice negatively effects other people. In these situations, it's expected that the organisation will take reasonable steps to find alternatives that can help meet the consumer's needs and preferences (Aged Care Quality and Safety Commission, Standard 1. Consumer dignity and choice (25 May 2021) https://www.agedcarequality.gov.au/providers/standards/standard-1).

The Aged Care Quality Standards are supported by the Charter of Aged Care Rights, enshrined in the *User Rights Principles 2014* (Cth). The Charter of Aged Care rights also includes rights relating to a resident's choice. This is particularly relevant when a person may wish to self-administer or

practitioner-administered voluntary assisted dying substance in their home, a room in a facility or service. Under the current provisions of the draft Bill, the other residents will not be given a choice over whether they wish this activity to be undertaken in their place of residence. An aged care facility is also a residence of a community. It may have negative effects on other permanent residents, such as emotional distress and be against their cultural and/or spiritual beliefs. Staff at a facility or service may also be negatively affected.

Where it is reasonable for a person to be transferred, and an entity holds a conscientious objection (and this information is given to the resident prior to entering the facility), then we argue that the entity should not be obligated to allow self-administration or practitioner administration. This would give entities more scope in developing a policy and practice approach for a variety of contexts, taking into account the unique culture of each service. In cases where it is reasonable for a transfer for administration of voluntary assisted dying, then this is a resource and process issue. The State should provide access to dedicated facilities to undertake administration of the voluntary assisted dying substance.

We are aware of the potential problem of limited access to medical practitioners and any voluntary assisted dying services in rural and remote Queensland. There may be cases that will result in not transferring the person on compassionate grounds based on geographical locations without meeting other criteria listed above in the reasonable to transfer section. The Synod position statement is clear in continuing to offer compassionate support to the people we serve.

We support the inclusion of where a person requests access to voluntary assisted dying and is residing or being cared for in a facility or service of an entity that holds a conscientious objection, the entity must: (a) inform the person of the entity's objection to providing access to voluntary assisted dying within its facility or service; (b) not impede the transfer of the care or residence of the person to another entity; (c) take reasonable steps to support the transfer of care with a view of minimising suffering of the person seeking access to voluntary assisted dying.

6.3 Recommendations 6-8

Access to Information, Requests and Assessments, Administration Decision and Administration Recommendation 6
That the following amendments are made to sections 92-96 (suggested changes are highlighted in red):

92 First requests and final requests
(1) This section applies if—
(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a *relevant request*); and
(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.
(2) The relevant entity and any other entity that owns or occupies the facility must take reasonable steps to support the access to the person at the facility by a medical practitioner—
(a) whose presence is requested by the person; and
(b) who—
(i) for a first request—is eligible to act as a coordinating practitioner; or
(ii) for a final request—is the coordinating practitioner for the person.

(3) If the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's relevant request may be made to—
(a) the requested medical practitioner; or
(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

93 Second requests

(1) This section applies if—
(a) the person or the person's agent advises the relevant entity that the person wishes to make a second request; and
(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.
(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by—
(a) the coordinating practitioner for the person; and
(b) 2 persons who are eligible to witness the signing of a second request by the person.
(3) If the coordinating practitioner is not available to attend, the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's second request may be made to—
(a) the coordinating practitioner; or
(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

94 First assessments

(1) This section applies if—
(a) the person has made a first request; and
(b) the person or the person's agent advises the relevant entity that the person wishes to undergo a first assessment; and
(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.
(2) If the person is a permanent resident at the facility—
(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and
(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's assessment may be carried out by—
(i) the relevant practitioner; or
(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's assessment may be carried out by a relevant practitioner for the person; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
(d) whether the place to which the person is proposed to be transferred is available to receive the person;
~~(e) whether the person would incur financial loss or costs because of the transfer.~~
(5) In this section—
relevant practitioner, for a person, means—
(a) the coordinating practitioner for the person; or
(b) a registered health practitioner to whom the coordinating practitioner for the person has referred a matter under section 21.
95 Consulting assessments
(1) This section applies if—
(a) the person has undergone a first assessment; and
(b) the person or the person's agent advises the relevant entity that the person wishes to undergo a consulting assessment; and
(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.
(2) If the person is a permanent resident at the facility—
(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and
(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's assessment may be carried out by—
(i) the relevant practitioner; or
(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's assessment may be carried out by a relevant practitioner for the person; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or

occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.
(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
(d) whether the place to which the person is proposed to be transferred is available to receive the person;
~~(e) whether the person would incur financial loss or costs because of the transfer.~~
(5) In this section—
relevant practitioner, for a person, means—
(a) the consulting practitioner for the person; or
(b) a registered health practitioner to whom the consulting practitioner for the person has referred a matter under section 32.
96 Administration decisions
(1) This section applies if—
(a) the person has made a final request; and
(b) the person or the person's agent advises the relevant entity that the person wishes to make an administration decision; and
(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to a person's coordinating practitioner to enable an administration decision to be made.
(2) If the person is a permanent resident at the facility—
(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person to consult with and advise the person in making the administration decision; and
(b) if the coordinating practitioner is not available to attend—the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of—
(i) the coordinating practitioner; or
(ii) another medical practitioner who is eligible and willing to act as the coordinating practitioner for the person.
(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to support the transfer of the person to and from a place where the person's administration decision may be made in consultation with, and on the advice of, the coordinating practitioner for the person; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating practitioner for the person.
(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
(d) whether the place to which the person is proposed to be transferred is available to receive the person;
~~(e) whether the person would incur financial loss or costs because of the transfer.~~

Recommendation 7
That the following amendments are made to Section 97:
Removing (4) (c) *whether the place to which the person is proposed to be transferred is available to receive the person.*
Recommendation 8
That the following amendments are made to Section 97 (suggested changes are highlighted in red):

97 Administration of voluntary assisted dying substance
(1) This section applies if—
(a) the person has made an administration decision; and
(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have an administering practitioner administer a voluntary assisted dying substance to the person; and
(c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.
(2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility—

(a) the relevant entity must take reasonable steps to support the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.
(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person
(3) If the person is not a permanent resident at the facility—
(a) the relevant entity must take reasonable steps to support the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance; or
(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances.
(4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
(a) whether the transfer would be likely to cause serious harm to the person;
Examples of serious harm—
• significant pain
• a significant deterioration in the person's condition
(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
Examples of adverse effects—
• the transfer would likely result in a loss of decision-making capacity of the person
• pain relief or medication for the transfer would likely result in a loss of decision-making capacity of the person

7. Cultural and First Peoples Perspective

7.1 The Bill

5 Principles
The principles that underpin this Act are—
(a) human life is of fundamental importance; and

(b) every person has inherent dignity and should be treated equally and with compassion and respect; and
(c) a person's autonomy, including autonomy in relation to end of life choices, should be respected; and
(d) every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life; and
(e) access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland; and
(f) a person should be supported in making informed decisions about end of life choices; and
(g) a person who is vulnerable should be protected from coercion and exploitation; and
(h) a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected.

7.2 Synod Concerns

Section 5 of the Bill contains the principles of voluntary assisted dying, specifically 5(h) states that *a person's freedom of thought, conscience, religion and belief and enjoyment of their culture should be respected***.** There has been a lack of consideration for First Nations communities about the cultural appropriateness of voluntary assisted dying and the various processes detailed in the Bill. There is a need for consultation with First Nations communities to hear their perspective on voluntary assisted dying and to be informed about the cultural impact of the Bill.

7.3 Recommendation 9

First Nations Perspective
Recommendation 9
That a dedicated consultation with First Nations communities be undertaken to inform and develop culturally appropriate processes for voluntary assisted dying in the Bill.
That the Principles outlined in section 5 of the Bill includes specific reference to considerations for First Nations peoples.

8. Offence of revoking request for voluntary assisted dying

8.1 The Bill

141 Inducing a person to request, or revoke request for, voluntary assisted dying
(1) A person must not, dishonestly or by coercion, induce another person to make, or revoke, a request for access to voluntary assisted dying.
Maximum penalty—7 years imprisonment.
(2) An offence against subsection (1) is a misdemeanour.
(3) In this section—
request for access to voluntary assisted dying means—
(a) a first request; or
(b) a second request; or
(c) a final request; or
(d) an administration decision.

8.2 Synod Concerns

Section 141 of the Bill outlines an offence for inducing a person to request or revoke a request for access to voluntary assisted dying. Page 546 of the Queensland Law Reform Commission's (2021) report*, A legal framework for voluntary assisted dying*, states that this provision was taken from section 61 of the *Powers of Attorney Act 199*8 (Qld), which makes it an offence for a person to 'dishonestly induce' a person to make or revoke an enduring document. We are concerned that this may be a technical error in the writing of the Bill which will have the consequences of making it an offence for spiritual advisors, such as a Minister of religion or chaplain, and psychological advisors, such as counsellors and therapists, to provide advice opposing voluntary assisted dying. There is no other explanation for the inclusion of 'or revoke a request for' in the Final Report to justify its inclusion and no other legislation in Australia includes such a reference.

8.3 Recommendation 10

Offence of revoking request for voluntary assisted dying

Recommendation 10

That the wording 'or revoke' is removed from Section 141 (suggested changes are highlighted in red):

141 Inducing a person to request, or revoke request for, voluntary assisted dying
(1) A person must not, dishonestly or by coercion, induce another person to make~~, or revoke,~~ a request for access to voluntary assisted dying.
Maximum penalty—7 years imprisonment.
(2) An offence against subsection (1) is a misdemeanour.
(3) In this section—
request for access to voluntary assisted dying means—
(a) a first request; or
(b) a second request; or
(c) a final request; or
(d) an administration decision.