LEGISLATIVE COUNCIL

Wednesday, 5 May 2021

The PRESIDENT (Hon. J.S.L. Dawkins) took the chair at 14:15 and read prayers.

The PRESIDENT: We acknowledge Aboriginal and Torres Strait Islander peoples as the traditional owners of this country throughout Australia, and their connection to the land and community. We pay our respects to them and their cultures, and to the elders both past and present.

Parliamentary Committees

LEGISLATIVE REVIEW COMMITTEE

The Hon. N.J. CENTOFANTI (14:17): I bring up the 35th report of the committee.

Report received.

The Hon. N.J. CENTOFANTI: I bring up the 36th report of the committee.

Report received and read.

Ministerial Statement

NATIONBUILDER

The Hon. R.I. LUCAS (Treasurer) (14:19): I lay on the table a copy of a ministerial statement made in another place today by the Deputy Premier on the subject of the use of NationBuilder by the state government.

HOMELESSNESS ALLIANCES

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:19): I seek leave to make a ministerial statement.

Leave granted.

The Hon. J.M.A. LENSINK: My ministerial statement is in relation to the South Australian homelessness alliances. South Australia's homelessness system is broken. That is what people with lived experience, who have struggled to get the help they need, have told us over and over. That is why I am delighted to report to the council today the outcome of the future directions for homelessness competitive tender, which will be delivering the most significant reform of South Australia's homelessness and domestic and family violence system in more than a decade.

Better services are on the way for South Australia's most vulnerable. On Friday 30 April, I announced the successful five alliances selected to deliver new high-quality services from 1 July. The alliance approach is based on innovative best practice models from international leaders in addressing homelessness and this government is proud to be introducing this approach in an Australian first.

The new alliances, Adelaide South, Adelaide North, Country South, Country North and Domestic and Family Violence, will deliver better services that intervene early to prevent people falling into homelessness and support people into safe, stable and long-term housing so they do not cycle in and out of homelessness.

Our existing homelessness system is comprised of individual program-based contracts in a system that is confusing for clients to navigate. As part of our consultation, people with lived experience of homelessness told us that the system was broken. One participant told us and I quote, 'It feels like the system is designed to make you crack. It is a full-time job accessing services and support.' Others told us that they currently 'felt trapped in a cycle of short-term accommodation, [and] homelessness'.

Responding to this feedback, the new system of five alliances will ensure providers work together at a system and geographical level to deliver integrated services. It will be easier for people to access the services they need and prevent them from having to retell their story to multiple providers or from being turned away completely, resulting in better outcomes for vulnerable South Australians.

Through the consultation, we were told we need a system that 'really listens and is able to shape services around individual needs and goals, rather than providing a narrow service response'. Our reforms will deliver just that. Contracts will be more flexible to allow alliances to tailor services to meet individual client needs, including supporting them to remain connected to their communities in safe and appropriate accommodation.

Alliances are also able to make changes to their service model over time to respond to client feedback rather than having a fixed and limited service offering prescribed in their contract. Most importantly, the reforms will deliver a system that is focused on long-term outcomes rather than short-term outputs. The alliances will shift the focus to outcomes, breaking the cycle of homelessness for good. While reform can be challenging, we unashamedly want the best services for vulnerable South Australians.

Let me be clear, there will be no reduction in funding to homelessness services. In fact, the funding for homelessness and domestic and family violence services has increased from $65.5 million in 2017-18, under the last term of the former Labor government, to $72.4 million in 2021-22.

However, we need to spend this funding more effectively. We spend almost $200,000 a day and yet people are still cycling in and out of the system. We can do better for our vulnerable South Australians and for taxpayers and we will. Our reforms will shift the focus toward more prevention and early intervention services, making the system more efficient and effective.

We are working with all providers to ensure a smooth transition and, most importantly, that clients receive high-quality support throughout the transition and beyond. At-risk South Australians, including women experiencing domestic violence, will continue to receive support and access to emergency and crisis accommodation.

As a government, we could have kept the status quo, continuing to spend $200,000 a day on homelessness services, being complicit, as previous Labor governments were, and not truly addressing homelessness in this state. Instead, we have chosen to undertake transformational reform that will ensure greater long-term outcomes for vulnerable South Australians.

Question Time

PATHOLOGY SERVICES

The Hon. K.J. MAHER (Leader of the Opposition) (14:24): My question is to the Minister for Health and Wellbeing regarding pathology.

1. How does the minister explain that a sample taken from a convicted murderer became contaminated with methylamphetamine at SA Pathology, which resulted in an alleged parole breach and major distress to the family of the murder victim?

2. After refusing to apologise to victims of ambulance ramping and hospital overcrowding yesterday, will the minister apologise to the family of the murder victim over this bungle?

Members interjecting:

The PRESIDENT: Order!

The Hon. S.G. WADE (Minister for Health and Wellbeing) (14:25): I thank the honourable member for his question, in spite of the fact that, yet again, he is defying you by continuing to insert comment, and not only comment but comment from a previous day. In relation to the matter, I am advised that SA Pathology issued a false positive result on a urine sample received from the Department for Correctional Services.

Once the false positive result was identified, SA Pathology immediately sent an amended report to the Department for Correctional Services to advise of the findings. SA Pathology is currently retesting all samples that were processed at the same time as the sample in question to verify their results. A formal review to establish the cause of the false positive result is underway. Of course, the government regrets any impacts on people as a result of the false positive.

PATHOLOGY SERVICES

The Hon. K.J. MAHER (Leader of the Opposition) (14:26): Supplementary arising from the answer: to the best of his knowledge, when was the minister first informed of this false positive result?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (14:26): Earlier today.

PATHOLOGY SERVICES

The Hon. K.J. MAHER (Leader of the Opposition) (14:26): Further supplementary: the minister in his answer outlined that there is a range of samples that are being retested. How many samples could potentially be affected?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (14:26): I am happy to take that question on notice.

PATHOLOGY SERVICES

The Hon. K.J. MAHER (Leader of the Opposition) (14:26): Final supplementary: can the minister outline how often such samples are wrongly contaminated?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (14:26): I am happy to take that question on notice.

CRISIS ACCOMMODATION

The Hon. C.M. SCRIVEN (14:27): I seek leave to make a brief explanation before asking a question of the Minister for Human Services regarding crisis accommodation.

Leave granted.

The Hon. C.M. SCRIVEN: The ABC reported yesterday that 67 crisis accommodation beds for homeless people in the Adelaide CBD are facing closure on 1 July, in the middle of winter, as a result of the minister's new homelessness service system. The ABC report said:

> St Vincent De Paul Society SA chief executive officer Louise Frost said a redirection of government funding to different providers meant it would have to close its city crisis accommodation beds for men by July 1. 'So that's 47 men every night who come to us because they're experiencing homelessness.'

Catherine House provides shelter for women facing complex mental health and trauma, and the ABC reported yesterday:

> General manager Julie Duncan said the service's loss of $1.2 million in government funding would negatively impact its crisis and emergency accommodation program, which offered 20 beds, 24 hours a day, along with case management services and outreach support.

My questions to the minister are: how does the minister justify what will be the closure of 67 homeless crisis beds in the CBD, including the only crisis beds for women, right in the middle of winter?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:28): I thank the honourable member for her question. If I could first respond to the last question in the suite of questions she asked: there are other crisis accommodation beds throughout the state that are available, so the—

The Hon. C.M. Scriven: CBD was the question.

The Hon. J.M.A. LENSINK: —assertion that they are the only ones available—

The Hon. C.M. Scriven: None in the CBD.

The Hon. J.M.A. LENSINK: —is not correct.

The PRESIDENT: The honourable deputy leader asked the question; she might like to listen to the answer.

The Hon. J.M.A. LENSINK: In terms of the reforms going forward, clearly we had five alliances, which—

The Hon. I.K. Hunter: In the middle of winter.

The Hon. J.M.A. LENSINK: There were five alliances which—

The PRESIDENT: The Hon. Mr Hunter, order!

The Hon. I.K. Hunter: You are closing beds in the middle of winter.

The PRESIDENT: Order! The minister has the call.

The Hon. J.M.A. LENSINK: Thank you, Mr President. There are five alliances that we were seeking; four of those were uncontested. The Adelaide South region was the only one that was contested. The new alliance leadership has reached out to all of the services to see how they could fit into the scheme going forward. As part of the tender process, all existing services that are being offered currently were required to demonstrate how they were able to continue to be provided through the new alliance model, and the successful tenderer was able to demonstrate that.

What we do know about some of the city-based services is that people do come into the city because that's where that particular service is. We also believe that people should be receiving services closer to where they come from so that they can remain connected to those existing supports in their community if that's what they choose. My message, clearly, to any of the services that weren't part of that successful bid is to engage with the alliance that won the tender to see how those services could fit going forward, and I understand that those discussions have been taking place already.

CRISIS ACCOMMODATION

The Hon. C.M. SCRIVEN (14:30): Supplementary: is the minister saying that the city crisis accommodation beds will not close?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:30): What I am saying is that there are negotiations going forward, and the winning alliance has stated—I think they have stated publicly as well—that the number of beds going forward will be maintained, but the exact location of that is yet to be determined, particularly when there are negotiations taking place. I am not going to insert myself into that process by making them—

The Hon. I.K. Hunter: No, you're just the minister; you're just the one who makes the decisions—

The PRESIDENT: Order!

The Hon. I.K. Hunter: —you're not going to insert yourself in the process at all!

The PRESIDENT: Order, the Hon. Mr Hunter!

The Hon. J.M.A. LENSINK: By way of one of the Labor member's interjections, I probably should explain a little bit—

The Hon. I.K. Hunter: This is an outrage. Beds closing in the middle of winter. Who has thought this up?

The PRESIDENT: Order, the Hon. Mr Hunter!

The Hon. I.K. Hunter interjecting:

The PRESIDENT: The Hon. Mr Hunter is out of order.

The Hon. J.M.A. LENSINK: —about how the model will operate. Under the old model, we had the existing services.

Members interjecting:

The PRESIDENT: Order!

The Hon. J.M.A. LENSINK: They were all prescribed about what service type—

Members interjecting:

The PRESIDENT: Order!

The Hon. J.M.A. LENSINK: —cohort, and so we have had this system that hasn't had a good look at for 10 years, which can't move funding around to where it's needed most. If you are prescribed to provide a particular service type to a particular cohort you can't shift that funding, yet when there are things that are going on in the community, such as if there is a surge in domestic and family violence, then we can't shift that funding around.

Instead of taking the individual command control approach with the non-government sector, we have said to them we want to give them the power to determine these things. The money was pooled together. The alliance tenders were released and assessed, and we are looking for a collective approach, something I thought the Labor Party thought they were all over. It's a collective approach—

Members interjecting:

The PRESIDENT: Order! The minister will be heard in silence.

The Hon. J.M.A. LENSINK: It is a collective approach, where the organisations have their own governance structure to determine changes to needs as they arise in the community.

CRISIS ACCOMMODATION

The Hon. C.M. SCRIVEN (14:33): Can the minister tell the chamber where people will go when these premises are converted to boarding houses or other uses?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:33): I think there is a fair amount of assumption in the honourable member's question. I think we ought to allow the providers to have their discussions without pre-determining what will happen going forward.

The PRESIDENT: Final supplementary.

CRISIS ACCOMMODATION

The Hon. C.M. SCRIVEN (14:33): Does the minister take responsibility for anyone who is literally left out in the cold because of these changes?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:33): Again, I think the honourable member is making a huge assumption. We believe that these services are going to improve—

Members interjecting:

The PRESIDENT: Order!

The Hon. J.M.A. LENSINK: —going forward—

Members interjecting:

The PRESIDENT: Order!

The Hon. J.M.A. LENSINK: —and that people will get a much better response as they need it.

HOMELESSNESS ALLIANCES

The Hon. E.S. BOURKE (14:33): My question is to the Minister for Human Services regarding human services. After taking more than three years to announce homelessness reforms, why has the sector been given just seven weeks to establish services, hire staff and, most importantly, prevent vulnerable homeless people falling through the cracks as their existing supports stop operating?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:34): I thank the honourable member for identifying the fact that it has taken us some time to reach these reforms. The reason for that is because we wanted to get it right. We have done a huge amount of consultation. Can I also just point out that this wasn't some bright idea that I thought up in the middle of the night or anyone in the department did. This was something the sector came to us with. They said to us that this is working really well in other jurisdictions, and it is a really important way to look at the way we fund and operate services.

The Hon. C.M. Scriven: So seven weeks is enough, is it? Enough to get ready?

The PRESIDENT: The deputy leader is out of order.

The Hon. J.M.A. LENSINK: So there's been no secrets about this process. It's been open and transparent. We provided additional time for the tenderers to put their particular bids in, and as part of that we said to them that they needed to have a transition plan, and that was tested through the panel process. So the transition plan is the part which guides how clients will be transitioned to new providers, if that is the case. I might say that in four of the alliances that is going to be a very minimal, if any, process. It's just the one alliance where we had two tenders, so the successful tenderer was required to have a transition plan, which is in place and which they are working towards.

HOMELESSNESS ALLIANCES

The Hon. E.S. BOURKE (14:35): Supplementary: if the minister claims that so much effort has been put into the plan, why only seven weeks to transition?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:36): The transition plans were required to be submitted as part of the tender panel so that they were tested against those criteria. We believe that a lot of these services will be successfully managed through the process, and we are working towards a much improved system as soon as possible.

HOMELESSNESS ALLIANCES

The Hon. E.S. BOURKE (14:36): Supplementary: can the minister guarantee that no-one will fall through the cracks, because the organisations will be ready to roll in seven weeks' time?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:36): Well, people fall through the cracks now, quite frankly, and that is because we have disparate services that do not operate cohesively. So the plan going forward is that people will not have to continue to navigate the system. There are people who I have spoken to and who have been reported through the consultation process who haven't been able to get into a service. I know one chap who knocked on the door of one service provider, which said, 'You don't fit our cohort, so we can't help you.' I mean, how absurd is that? This is a man without a communication device, without ID. He was turned away.

We need to ensure we have a much better system, so I am confident that going forward more people will receive a service than ever before. They will get the services they need when they ask for it, and they are not going to have to find their way through a complicated web of services to get assistance.

SA AMBULANCE SERVICE

The Hon. D.G.E. HOOD (14:37): Can the Treasurer outline the details of the settlement deal on ambulance services as announced today?

The Hon. R.I. LUCAS (Treasurer) (14:37): I am sure all members, irrespective of their political colour and persuasion, will be delighted to learn that there has been a settlement deal reached between government negotiators and the Ambulance Employees Association in relation to the ongoing dispute on ambulance services in South Australia.

Mr President, as you will recall, the parties did start a long way apart. The association—the union—was demanding 300 extra ambulance officers and no reform at all to be instituted. We are delighted that both sides, in the interests of patient safety and staff safety within our public hospitals, were prepared to compromise, and instead of 300 additional full-time staff there will be 74 additional full-time staff, of which 24 will be in four country locations, the other 50 in metropolitan locations.

The funding will be made available immediately for those. Staff will obviously have to be trained. The union accepts that that is indeed the case—they should be properly trained—and they will commence work as soon as they are properly trained.

Importantly, as part of the industrial negotiation undertaken under a mediator in the Employment Tribunal, the union has agreed now to comprehensive roster reform. In particular, the new reform models will be agreed by 30 June—so in less than two months—this year, and the important phrase or clause that the union has signed off on together with the government is 'it will shift the balance towards an increased reliance on other existing shorter shift arrangements'.

One of the dilemmas at the moment is that more than 90 per cent of our shifts are on the long and tiring 12-hour shifts. The government's position has been, whilst retaining the option of 12-hour shifts, that there be an increased reliance on shorter shifts: eight, 10 and a new 10½-hour shift arrangement. The union has agreed that the existing arrangements that any shift of a length greater than 10 hours would have two meal breaks, and the union has agreed that the new 10½-hour shift would only have one meal break as part of their willingness to compromise in this particular settlement deal.

I repeat again that the words from the mediator, signed by both sides, are 'shift the balance towards an increased reliance on other existing shorter shift arrangements'. I note that claims that the only people who will take on shorter shifts will be the extra 74 staff and not the existing 1,500 or 1,600 staff isn't an accurate reflection of what has been agreed between the parties and signed off by the independent mediator. I repeat again that 12-hour shifts will remain an option and an important option, but there will be an increased reliance and a shift in the balance towards shorter shifts: eight, 10 and 10½-hour shifts as part of the settlement arrangement.

The government indicated in terms of settlement that it was willing to further compromise on meal break reform. Both sides have agreed to improved crib performance discussions, which will commence no later than 14 May this year, but it's fair to say the details of that are still to be negotiated. The government's position on that is clear and I won't restate that here. The union still has a strong position opposing key elements of the government's discussion, but they have committed to improved crib performance reform discussions, commencing no later than 14 May.

The final key detail of the settlement arrangement has been, again, dot point 4 of the signed agreement under Deputy President Gilchrist, that the AEA agrees to cease all industrial action in South Australia. Clearly, the only tangible signs of industrial action in the community were union members taking it upon themselves to chalk ambulances. Clearly, the signed agreement requires and will require the removal of those chalk messages on government property, which is the ambulances.

As occurred in relation to firefighters, who took it upon themselves to mount signs in stations but also to mount signs on public property (that is, fire engines), they were directed to take those down. If it's required, ambulance officers will be directed to remove signs from government property. The simple fact is that no-one has the right to write their own messages on government property.

If they want to write chalked messages on their own cars and drive them around Adelaide, that's up to them, that's their property, but the taxpayers actually own the ambulances or the fire engines and no-one has the authority to write whatever it is they wish on taxpayer-owned government property such as ambulances. The clear message from the signed agreement is that all industrial action will be ceased and that particular aspect of the deal will be enforced, if it is so required.

SA AMBULANCE SERVICE

The Hon. J.E. HANSON (14:43): Supplementary: does the Treasurer guarantee that this alleged agreement will mean an ambulance will be available to respond immediately to high-priority incidents going forward?

The Hon. R.I. LUCAS (Treasurer) (14:43): The ambulance association and the government have agreed that this will be an important element of improving services. But the government's position has always been that the addition of additional ambulances and ambulance officers will not solve ramping in and of itself. What is required there is what the government is already doing in a variety of other areas: spending more than $100 million across public hospitals and increasing the number of treatment bays in emergency departments—Flinders Medical Centre, Lyell McEwin, I think it is, and others, where we are spending more than $100 million on improvement.

One of the unfortunate ironies of the situation at the moment is that the mere process of actually spending money on increasing the number of treatment bays at Flinders has created problems at Flinders because we have a construction site down there. The fact that we are fixing the problems we have inherited from the past is obviously taking some time. The money is there and it is being spent but whilst that construction site is in process it adds to the challenges to the system that the Minister for Health has expanded upon in recent days and weeks as well.

The other issues that the Minister for Health is already spending money on—state and commonwealth governments are looking at—is how do we keep people who shouldn't be in emergency departments out of emergency departments? The recent opening, within the last three or four weeks, of the—I won't get the exact title right—crisis centre in the CBD is specifically designed for mental health patients who shouldn't be in emergency departments and gives them an alternative treatment option in the CBD to keep them out of emergency departments.

The government responsibility is that we have to do a range of other things, and the minister and the department are, and part of the solution can be additional ambulance officers, but if you don't fix the problems that we have inherited in relation to the number of treatment bays and keeping people out of emergency departments, the mere addition of the number of ambulance officers and ambulances will not solve the problem because there will still be this blockage within the emergency departments.

We accept that it is part of the solution and that is why we have settled on 74 additional ambulance officers instead of the 300 that the union was demanding. We think it is a good settlement deal in the interests of both patients and staff within our public hospitals in South Australia, and we welcome the settlement which has been announced today.

BULLYING

The Hon. F. PANGALLO (14:46): I seek leave to make a brief explanation before asking the Treasurer a question about workplace harassment and bullying.

Leave granted.

The Hon. F. PANGALLO: This week, I received some very disturbing figures from the Commissioner for Public Sector Employment about the number of workers compensation claims for work-related harassment and/or workplace bullying across the whole of government. I was surprised to see the number of claims made by staff within the Department of Treasury and Finance. Out of the 27 government agencies named, the department had the equal seventh worst record, only behind super departments like the Department for Education, SA Health and SAPOL. Education was by far the worst for complaints and subsequent payouts.

Between 2015 and 2020, 18 claims were made by the Department of Treasury and Finance for a total payout of $1,417,168, with an average payout of $78,731.55. My question to the Treasurer is: what action, disciplinary or otherwise, is the government taking to address this endemic problem in the Public Service, particularly after the commissioner, Erma Ranieri, told public servants recently there would be zero tolerance for this conduct—whatever zero tolerance means.

Are you concerned by those figures and, with 18 claims in your department alone, what are you and the Under Treasurer, Chief Executive of the Department of Treasury and Finance, David Reynolds, doing to tackle the issue of work-related harassment and/or workplace bullying in your department?

The Hon. R.I. LUCAS (Treasurer) (14:48): The honourable member is right to say that I am sure he, myself and all members don't support any workplace harassment or bullying, whether it occurs within the Treasury department or anywhere in the public sector or, indeed, in the private sector or, frankly, in the parliament or even in parliamentary offices.

The sad fact of life is that bullying and/or harassment occurs in every workplace type throughout not only the state but throughout the nation. The member quotes that Treasury is the seventh worst, evidently. I am not sure how many are in the total. There are probably 15 or 20 agencies or something, I suspect, depending on how many of the smaller ones they incorporate in those. My department, as with all other departments, can do much better.

One of the areas that has been the subject of much debate over recent years and was the subject of much, I guess, disputation was SafeWork SA. It was the subject of an ICAC inquiry. New management has been incorporated into there in recent times, and there have been some ongoing issues that were inherited, frankly, in that department, as former staff members did not suit the culture of what had to be done in terms of the new approach for SafeWork SA. There were a small number of complaints there.

In the Treasury department itself, there were a small number of complaints. It is a much bigger department in terms of numbers. We have inherited from other departments in recent years. Shared Services SA has come into the Treasury department and procurement services are now part of the state Treasury department. We have certainly incorporated other sections of departments and agencies in recent years, as new responsibilities have been added to the Treasury department.

I am not sure whether those numbers also incorporate the various bodies that report to me. I can check that. I have bodies like ReturnToWorkSA, Funds SA, Super SA, HomeStart and a variety of other boards and agencies that report to me. I am not sure whether, within those particular bodies, they are incorporated within the Treasury numbers as well.

In terms of what is being done, the Commissioner for Public Sector Employment, together with the chief executives, is leading the attempt to provide comprehensive support both to chief executives and senior managers in terms of how you manage disputes within the workplace, how you try to prevent bullying and harassment and provide training and education in terms of the responsibilities.

That is an ongoing challenge for not only for the commissioner but also chief executives in terms of managing differences of opinion and disputes within worksites, which some will claim will be bullying and harassment. Ultimately, in some cases it might be proved to be bullying and harassment. In other cases it will be shown to be performance management perhaps of unsatisfactory performance by a particular officer within the department, which they may well construe as bullying and harassment, whereas an independent assessment will find occasionally it is actually managing poor performance in the workplace.

All of those can be incorporated in the sorts of figures that the honourable member has talked about. He can rest assured that I, as the minister, and the commissioner have exactly the same goal as he has, I am sure, and that is to reduce to the extent that we can the extent of bullying and harassment within any worksite, including the public sector.

HOMELESSNESS ALLIANCES

The Hon. I. PNEVMATIKOS (14:52): I seek leave to make a brief explanation before asking a question of the Minister for Human Services regarding human services.

Leave granted.

The Hon. I. PNEVMATIKOS: Liberal members of parliament have now begun to send out set standard responses to people who want answers about the concerning homelessness reforms that have been implemented. We are informed that these reforms have occurred 'following extensive consultation and a competitive tender process'. Can the minister explain exactly how the competitive tender process worked in the four out of five regions where only one application was received?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:53): I thank the honourable member for her question. It gives me delight to provide a bit more detail to her in relation to the details of this particular process. I don't have the exact dates in front of me about when the tenders opened and closed, but we have been talking about this level of reform for some time.

I think we had some discussions last year in here, possibly around September—in fact, it might have been closer to November—when the Housing Authority had been running workshops with the sector to talk to them about the alliance model so that it was well understood about how it operates and how that could and should look in South Australia. The tenders then opened some time late last year and closed earlier this year.

The tenders were in a written form. They were provided to a tender panel, and the tender panel then went back to each of the bidders to talk to them in more detail to ensure that all of the elements that were in the request for tender were going to be met. That was to ensure that all of the services that people may need in their particular location are available to them rather than the current situation we have where we've got quite a fractured system where some people can get particular services depending on their circumstances or whether they are a young person or someone experiencing domestic and family violence.

Within each region the services that should be provided to all cohorts include intake and referral; supported accommodation; supported housing packages; support in case management, which covers a lot of things including early intervention, support for children, intensive tenancy support and a range of other things as well; community development and education; and workforce training and development. So the full range of services was required to be met by the alliances that were to be accepted, and the advice I have received is that has been met to the satisfaction of the tender panel.

HOMELESSNESS ALLIANCES

The Hon. I. PNEVMATIKOS (14:56): A supplementary: what portion of the overall $70 million-odd per annum had no competition or comparators?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:56): Of the $70 million, the five alliances total pool is about $50 million, and then the Adelaide South, which is the only contested one, is approximately $15 million. So it would be the other $35 million, which is across Adelaide North, the two country regions and the Domestic and Family Violence consortia. That total would be approximately $35 million, on my calculations.

The PRESIDENT: The Hon. Ms Pnevmatikos, another supplementary?

HOMELESSNESS ALLIANCES

The Hon. I. PNEVMATIKOS (14:56): How can the minister know that a successful applicant will provide better services or better value for money when there is no measuring stick, there is no comparator, to assess that?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:57): In response to the honourable member's supplementary, I would say that the things that we put in the tender are much more rigorous than the existing contracts. As I have already spoken about today, as part of that there needed to be a demonstration that the organisations could work collaboratively between them as well so that if, as I have referred to already today, a particular client walks into a service there is a no wrong door approach, which means that rather than that person being sent off somewhere else, or not given a service at all, that person will be picked up straightaway by the system and they won't have to find their way to the particular office to get the help they need.

So it's through the way the tenders were structured and the outcomes that we are looking at that we believe these services will be far more effective going forward.

DOMESTIC AND FAMILY VIOLENCE

The Hon. J.S. LEE (14:58): My question is to the Minister for Human Services regarding women's safety. Can the minister please provide an update to the council on how the Marshall Liberal government is investing in new responses to address domestic and family violence in South Australia?

The Hon. J.M.A. LENSINK (Minister for Human Services) (14:58): I thank the honourable member for her question. We do have in South Australia record funding for domestic and family violence services in the realm of some $21 million, particularly through the suite of reforms that we brought in as a new government. With the commonwealth funding, there was funding, which I think I have referred to previously, which was provided last year in a range of tranches. We have been able to support new services and some of those services include services for children who are experiencing domestic and family violence.

As we also know, through the reforms to the family support services, the Intensive Family Support, the old ERD, particularly through the consultation with the sector, there are a lot of very similar drivers for both domestic violence and for children who are at risk of entering the child protection system, so we are working towards making sure those systems are working much more closely together.

That aside, we are in the process of funding some new services, which includes safe and well kids, a program to wrap around children and adolescents who are experiencing domestic and family violence, so very much a focus on the child. We do know they can experience significant trauma through witnessing or being victims themselves. We also have a new Aboriginal children's therapeutic service, with half a million dollars to assist Aboriginal children and young people specifically to heal from the trauma of family violence.

In addition, there is $1.7 million for safe and secure housing, which is to assist women and children to move out of temporary crisis accommodation into safe, long-term accommodation, which is important for families to be able to reconnect into the community. Obviously, in a crisis service kids have their connection to their schools disrupted and to the communities that support them, so we want to make sure that people are exiting the system and are able to reconnect and get on with their lives.

RENTAL AFFORDABILITY

The Hon. R.A. SIMMS (15:01): I seek leave to make a brief explanation before addressing a question without notice to the Minister for Human Services on the topic of rental affordability for single people on income support.

Leave granted.

The Hon. R.A. SIMMS: Last week, Anglicare Australia released their 2021 rental affordability snapshot, which found that there was not a single rental property in South Australia that a single person on JobSeeker could afford—not a single one. The report also found that there were no affordable properties for those on Youth Allowance, with just 4 per cent of properties considered affordable for families with both parents on JobSeeker.

At the height of the pandemic, JobSeeker recipients were also entitled to a supplementary payment worth $550 a fortnight. With that now gone, and only a minor permanent increase to the JobSeeker payment—a meagre increase—it is clear that the rental affordability crisis gripping South Australia is even greater than before the pandemic.

My question to the minister is: what is the government doing to address this affordability crisis, and will the minister guarantee that no South Australian renter will be evicted into homelessness by extending the moratorium on evictions beyond the end of June?

The Hon. J.M.A. LENSINK (Minister for Human Services) (15:02): I acknowledge the honourable member and his first question in this place and acknowledge his long advocacy for people in these situations. If I can address the last issue first; that is, the issue of the ceasing of the arrangements through the residential tenancy laws, that primarily rests with the Attorney-General through her responsibilities. However, it is something, obviously, that the government is committed to as we pass through this COVID situation and our economy recovers. We are removing some of the restrictions that have been in place during this period.

My understanding of the SACAT process is that, for people who are experiencing financial difficulty, that is always something they take into consideration in any case, so people can make that representation. We also have a particular support service for them, which is a joint service, I think, with SYC and Uniting Communities called RentRight, and they provide advice to people through that situation. The South Australian government has long had a private rental assistance program, which can support people with bonds and rent in advance, so that program is available at all times.

Quite recently, I did go to the Uniting Communities Law Centre, which runs the new advocacy service we provide, which is a multidisciplinary service. They have legal advice and a whole range of things. One of the things that they mentioned to me at that stage is that some of the biggest advocacy that they do is with banks and with people who actually have mortgages, as this can be a particular problem that people run into difficulties with. They have been working quite closely with banks to make sure that people don't fall into the system.

I note through ministerials that I receive that often someone will write to me and raise a particular case and those are often resolved quite quickly. People who have a good track record in the rental system are more than likely to be able to continue to maintain their private rental.

For people who are on Centrelink benefits, there is commonwealth rental assistance, which can be quite generous for people with families. That can be quite a reasonable addition to their income that assists them through the private rental market as well as the programs that are available through state level.

RENTAL AFFORDABILITY

The Hon. R.A. SIMMS (15:05): A supplementary question: I note the minister's response, but will the minister give an undertaking that the government will extend the moratorium around ending evictions beyond the June deadline? The transitional arrangements expire at the end of June; will the minister give an undertaking that that's going to be continued?

The Hon. J.M.A. LENSINK (Minister for Human Services) (15:06): I can't do that because it's a government decision that that will cease, so that's been the decision that's been made.

INTERNATIONAL DAY OF THE MIDWIFE

The Hon. T.J. STEPHENS (15:06): I seek leave to make a brief explanation before asking the Minister for Health and Wellbeing a question about International Day of the Midwife.

Leave granted.

The Hon. T.J. STEPHENS: Last year, the World Health Organization announced that 2020 would be the International Year of the Nurse and the Midwife, before the pandemic hit. In recognition of their work over the past year, some jurisdictions have continued the recognition into 2021. In light of this particular recognition, will the minister update the council on this important celebration of midwives?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (15:07): I thank the honourable member for his question. It is indeed a worthy acknowledgement of the extraordinary contribution of nurses and midwives that some jurisdictions have made the international year into two years, with the International Year of the Nurse and the Midwife moving from 2020 to 2021. Of course, within those years, the milestone days are 5 May and 12 May: 5 May being the International Day of the Midwife and 12 May being the International Day of the Nurse.

Today, 5 May, the International Day of the Midwife, it is appropriate that we recognise this year's theme, which is International Day of the Midwife—Follow the Data: Invest in Midwives. As Minister for Health and Wellbeing, I very much appreciate the wisdom of this theme. As we strive to come out of the global pandemic, it is essential that health systems use data and evidence to design and renew their services.

In the case of midwifery, we know midwifery is a profession founded on respect for women and on a strong belief in the value of women bearing and raising children, our next generation. All the evidence points to supporting the need to support women to be empowered through the journey of pregnancy, labour, childbirth and early parenting. The more quality education, information and support women are given through all of these stages the better the outcomes will be for both mother and baby or babies.

Midwifery is a women-centred primary healthcare discipline founded on the relationship between a woman and her midwife and focuses on a woman's needs, her expectations and her aspirations. Midwives play a critical role in promoting healthy women, ensuring the health and wellbeing of women and babies and the family unit.

The contribution of South Australian midwives has been recognised through the SA Health awards. In the category of the Chief Executives Imitation Award, we actually had two finalists from midwifery-based initiatives. In the Yorke and Northern Local Health Network, the Midwifery Caseload Model of Care Pilot was a finalist. That program is based on the belief that pregnant women deserve the best evidence-based care, no matter where they live.

In 2019, a midwifery case load model of care was implemented in rural South Australia in the Yorke and Northern Local Health Network. The model provides continuity of care across five birthing sites, working collaboratively with maternal and neonatal care providers and promoting a sustainable midwifery workforce regionally. This resulted in high-level, efficient, evidence-based care closer to home for women and families in local communities.

The second finalist in the same category was the Midwifery Group Practice at the maternity unit at the Ceduna hospital in the Eyre and Far North Local Health Network. Faced with regular suspension of the Ceduna birthing services due to staffing resources, the Ceduna hospital elected to adopt a midwifery group practice model of care for local expectant mothers. Appropriate senior roles were implemented to ensure success of the local adaptation of the midwifery group practice and the professional support of enthusiastic midwifery graduates.

Ability to share care through the group model has immensely benefited service continuity, staff retention and community satisfaction. I can vouch for that because last week I went to Ceduna and met with those midwives. I met with Kath Bald, Sandy Byster, Yolande Doecke, Isabeal Murphy-Haines and Faith Kiamba. I also met with Aboriginal Maternal Infant Care worker Deb Miller. It was great to talk to these women and hear their passion to walk alongside women in the birthing and parenting journey.

The past 15 months have been particularly challenging for practices and midwives in this state with the restrictions that COVID-19 has brought to bear on many aspects of the health system. Many midwives have had to pivot to provide additional support during labour when only one support worker has been allowed in the delivery suite with a birthing mother and in the days afterwards when hospital visitors have often been restricted.

On the pregnancy journey, many midwives have had to provide care and antenatal classes via video or teleconference. All these adaptations have been necessary to keep women safe through their pregnancy, but they have also added to the challenge for midwives and pregnant women and their families throughout this time. On the International Day of the Midwife, it is a pleasure for me to acknowledge and thank South Australian midwives for all that they do to support women and their babies, their broader families and the community.

MENTAL HEALTH SERVICES

The Hon. J.E. HANSON (15:12): I seek leave to make a brief explanation before asking a question of the Minister for Human Services regarding mental health.

Leave granted.

The Hon. J.E. HANSON: The minister has referred today to extensive consultation on homelessness reforms and that any successful tenderer, as a result of those reforms, would require an ability to have a collaborative approach. My questions are: did the allegedly extensive consultation include the mental health system and, if so, who? Secondly, if so, what exactly was their response to the closure of 67 crisis beds when there is a huge crossover between homelessness and mental health?

The Hon. J.M.A. LENSINK (Minister for Human Services) (15:13): I thank the honourable member for his question. In terms of the role of mental health in the consultation phase, there were a range of workshops last year. I can't tell you off the top of my head which stakeholders were there from outside the homelessness and housing sector generally, so I would need to take that on notice. Certainly, we did a report on lived experience, which is one of the reports that informed the structure of the reforms, if you like. Obviously, there would be a number of people with lived experience of mental health who were consulted as part of that process.

I think it is important to point out that, in terms of the alliance tenderer that won the Southern Adelaide bid, one of the alliance partners is a mental health provider. That really does go to the point the honourable member made in his question, in that we do recognise that mental health is a significant driver for some people who experience homelessness.

That embedded expertise within that alliance partner is going to be quite innovative going forward in how those mental health services are delivered. I think it is something that is very exciting in terms of that particular successful alliance tenderer, and I think it will be a very interesting model that other jurisdictions will look at in terms of its success rate, which we expect to be very helpful.

MENTAL HEALTH SERVICES

The Hon. J.E. HANSON (15:15): Supplementary: who was the alliance partner and what exactly was their response to the closure of 67 crisis beds, given the huge crossover between homelessness and mental health?

The Hon. J.M.A. LENSINK (Minister for Human Services) (15:15): The name of that particular provider is Sonder, which I understand is a national organisation. I have already responded to questions from another honourable member in terms of those particular beds that have been identified, in that the successful tenderer in the alliance is negotiating with existing providers going forward and we think those negotiations ought to be treated respectfully for them to negotiate the best outcome for vulnerable South Australians.

MCGOWAN, DR C.

The Hon. C. BONAROS (15:16): I seek leave to make a brief explanation before asking the Minister for Health and Wellbeing a question about the alleged behaviour of SA Health CEO, Dr Chris McGowan.

Leave granted.

The Hon. C. BONAROS: At the outset, I would like to take the opportunity to clarify and indeed correct some comments I made in this place yesterday during a question to the minister. During that question, I asked the minister if he was aware of comments Dr McGowan made when he referred to what I believed was just one of the CEOs of SA Health's local health networks as a 'tea lady'. That reference was wrong and indeed, as I have since found out, is much worse than I originally believed.

Worse because I am advised now that the comment was directed at not one but all three CEOs of the LHNs: the Central Adelaide LHN CEO, Lesley Dwyer; the Southern Adelaide LHN CEO, Susan O'Neill; and the Northern Adelaide LHN CEO, Maree Geraghty, who just all happen to be females. Worse, because I am now advised that Dr McGowan didn't use the phrase 'tea lady' but rather used the words 'my three bank teller girls, the ones who are always very keen to take your money'.

I am told that those comments were made at a meeting he was hosting in front of the three CEOs of his senior executive team I have mentioned, as well as other SA Health staff. I am further advised that there was no reported laughter, and even if it was intended as a joke it was reported to me as completely and utterly inappropriate. I am also told by a person present at the meeting that Dr McGowan, as he always is when hosting such meetings, was trying to 'build a moat between himself and the minister, the LHNs and his continued strategy to shift blame'. My question to the minister is:

1. Are you aware of these comments being made by Dr McGowan? If not, will you undertake to make yourself aware of these comments?

2. Since I first raised issues in this place yesterday, have you sought clarification from Dr McGowan personally?

3. Do you believe such comments are appropriate?

4. Will you speak to Dr McGowan personally to seek clarification of the comments apparently made in front of an audience, in line with what I have just outlined?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (15:18): I thank the honourable member for her question. Certainly, I didn't need to go to Mr McGowan; he came to me to indicate that what the honourable member said in this house yesterday in relation to 'tea lady' was completely incorrect.

In relation to the latest piece of hearsay that the honourable member is bringing to this house, I am advised that at a meeting of local health network chief executive officers Dr McGowan used words to the effect of, 'It wasn't a bank teller who invented the automatic teller machine.' My understanding is that the chief executive was trying to make the point that people who are vested in business as usual tend not to see disruptive ways to improve outcomes. As we improve the health system in South Australia, we will need to find disruptive ways to improve outcomes, and that's what we expect of our leadership.

MCGOWAN, DR C.

The Hon. C. BONAROS (15:19): Supplementary: will the minister seek clarification as to whether Dr McGowan used the words 'my three bank teller girls, the ones who are always very keen to take your money'?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (15:19): I will certainly put that to Dr McGowan, but as the honourable member has rightly pointed out, she was incorrect yesterday. I am much more inclined to take the word of my chief executive than hearsay.

Members interjecting:

The Hon. S.G. WADE: Than hearsay.

Members interjecting:

The PRESIDENT: Order!

The Hon. S.G. WADE: I think if we are going to spend question time after question time having a series of hearsay—

Members interjecting:

The PRESIDENT: Order! The Leader of the Opposition is out of order and so is the Hon. Ms Bourke and the Opposition Whip.

The Hon. S.G. WADE: As I said, it is unbecoming of this chamber to fixate on hearsay reports of statements—

Members interjecting:

The PRESIDENT: Order! You are running out of your own question time.

The Hon. S.G. WADE: As I said in my answer to the honourable member, I will seek clarification whether the chief executive used the phrase that she gave. That is not a phrase that has been put to me before. I will put it to the chief executive.

The PRESIDENT: Final supplementary, the Hon. Ms Bonaros.

MCGOWAN, DR C.

The Hon. C. BONAROS (15:20): Will the minister undertake to provide minutes of the meeting where these comments were allegedly made or at least make himself aware of the minutes of that meeting?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (15:21): I will certainly make inquiries as to whether minutes of that meeting were kept.

MENTAL HEALTH SERVICES

The Hon. T.T. NGO (15:21): My question is to the Minister for Health and Wellbeing about health. Can the minister point to a single new measure to come out of last Wednesday's mental health meeting with Adjunct Professor Mendoza, and can the minister point to a single dollar of additional funding arising from last week's mental health meeting?

The Hon. S.G. WADE (Minister for Health and Wellbeing) (15:21): I thank the honourable member for his question, because it is really a good opportunity to highlight the constructive discussions that were held last week. Whilst there is much more to be delivered in terms of our Mental Health Services Plan, as I said yesterday, it is very pleasing for the government to be continuing to roll out the Mental Health Services Plan after a seven-year hiatus since the last plan by the previous government.

Last week's workshop was a key event for a broad range of stakeholders to come together to progress mental health reform. The Marshall Liberal government shares the passion of the group for mental health reform. While the workshop demonstrated significant support for the direction of the Mental Health Services Plan, it also heard the calls for action in the short term to respond to increased pressure in mental health services, emergency departments and ambulance services.

The government is in the process of finalising some short-term measures that will be announced shortly. It also will be continuing to do what it has been doing since the first day we were elected, which is to—

The Hon. I.K. Hunter interjecting:

The Hon. S.G. WADE: —steadily roll out initiatives in relation to mental health services. There is an echo in the chamber suggesting this government has done nothing in mental health services, so let me just mention a few.

The PRESIDENT: Order, the Hon. Mr Hunter!

The Hon. S.G. WADE: Just let me let me mention a few. What about the borderline personality disorder service—

Members interjecting:

The PRESIDENT: Order!

The Hon. S.G. WADE: —that the consumers were demanding for years and the former Labor government ignored it?

The Hon. I.K. Hunter interjecting:

The PRESIDENT: Order, the Hon. Mr Hunter!

The Hon. S.G. WADE: I would like to acknowledge the contribution of the Hon. Kelly Vincent and the Hon. Tammy Franks in advocating for a borderline personality disorder service.

The Hon. I.K. Hunter interjecting:

The PRESIDENT: Order, the Hon. Mr Hunter!

The Hon. S.G. WADE: We committed to that service, and it was delivered.

The Hon. T.A. Franks: And the Labor Party wouldn't even recognise borderline personality disorder.

The PRESIDENT: Order! The Hon Ms Franks is not helping.

The Hon. S.G. WADE: I've heard it said that the Labor Party wouldn't even recognise that borderline personality disorder—

The Hon. I.K. Hunter: You don't even know if the ambulances turn up on time or not. You don't even bother to ask the questions.

The PRESIDENT: Order! The Hon. Mr Hunter should dip back into his own memory.

The Hon. S.G. WADE: So we have done the borderline personality disorder service. What about that we have committed to a paediatric eating disorder service, and that is in the process of being rolled out.

Members interjecting:

The PRESIDENT: Order! The minister will continue in silence.

The Hon. S.G. WADE: So we have done the borderline personality disorder service, and we have talked about the paediatric eating disorder service. What about the urgent mental health care service, which was opened two months ago?

Members interjecting:

The PRESIDENT: The Hon. Mr Hunter is out of order.

The Hon. S.G. WADE: An exemplary contemporary service to provide urgent care for people with mental health. So those who say that we have done nothing in mental health—

The Hon. I.K. Hunter: What are the outcomes? Tell us!

The PRESIDENT: Order!

The Hon. I.K. Hunter: That was the question!

The PRESIDENT: Order! You might like to listen to the answer.

The Hon. S.G. WADE: The fact of the matter is, this government has continued to implement mental health reform even in the absence of a plan that the former government left empty, left vacant for seven years. We kept developing reform.

The Hon. I.K. Hunter: What was this outcome?

The PRESIDENT: Order!

The Hon. S.G. WADE: In November 2019, we released the Mental Health Services Plan. We have been diligently implementing it. The workshop last week was a great opportunity to take stock. What was very clear from the workshop is that people wanted to continue on the pathway laid down by—

Members interjecting:

The PRESIDENT: Order!

The Hon. S.G. WADE: —the Mental Health Services Plan. There is certainly a lot of work to be done to implement it. We are committed to work with the consumers, carers and clinicians to deliver the outcomes they need.

Matters of Interest

REGIONAL SOUTH AUSTRALIA

The Hon. T.J. STEPHENS (15:25): I rise today to speak on the Marshall Liberal government's commitment to the growth and future prosperity of regional South Australia. For the past three years, the Marshall Liberal government has put the people of South Australia first, building the foundations for a sustainable and beneficial future. Funding has been provided for many sectors across South Australia, such as agriculture, forestry, fisheries and regions, and provided relief support for those impacted by bushfires, drought and COVID-19 restrictions.

The Marshall Liberal government has already delivered key support measure changes to the agriculture sector in South Australia, such as:

- $21 million for drought support;
- $25 million in bushfire assistance and recovery activities;
- $7½ million for the Red Meat and Wool Growth Program; and
- $3.6 million in wine development grants.

Additional funding for rural financial counselling services has been provided and implemented for the fire danger season. Grants and support packages are invested into the agriculture sector to assist local farmers and businesses from devastating bushfires and/or drought throughout the summer seasons.

The forestry sector has also been affected throughout the summer periods of 2020 and 2021. Bushfires destroyed significant landmasses and native habitats. The Marshall Liberal government has already processed many support packages following the Kangaroo Island, Cudlee Creek, Cherry Gardens and Clarendon, and South-East bushfires, but other initiatives have also been instigated, including:

- the establishment of the Forestry Advisory Council;
- $2 million for the Timberlink cross-laminated facility in Tarpeena; and

- $1.1 million for bushfire prevention in the South-East.

Within the fisheries sector, significant investment since coming into government has delivered many beneficial outcomes to protect the future of marine life and to continue a sustainable strategy to ensure clean and healthy coastlines. Examples include:

- $24.5 million for marine scale fish reform;
- $16 million investment in the South Australian Research and Development Institute's West Beach Fisheries Science Centre;
- $1.6 million oyster lease fee relief; and
- the lobster fishery management plan.

South Australian snapper stocks have been running dangerously low in the Spencer Gulf and Gulf St Vincent. A restocking program has witnessed the release of 150,000 fingerlings into Gulf St Vincent early in 2021 and another 150,000 fingerlings were recently released into the Spencer Gulf. This restocking program is a commitment from the Marshall Liberal government, which has injected $500,000 to help support the snapper industry from recovering low numbers in our gulf waters.

Our regions are a key driver of the South Australian economy and will be critical to a speedy recovery following the lifting of COVID-19 restrictions. The Marshall Liberal government is fast-tracking $25 million of the Regional Growth Fund 2020-21 to create 1,500 regional jobs and deliver critical economic stimulus.

As interstate borders closed, locals could not travel interstate, which encouraged the Marshall Liberal government to create a promotion that has allowed locals to explore South Australia like never before. The Great State Voucher scheme is yet another example of support not only to the regions but to South Australia's tourism sector across the entire state, helping to create jobs and boost our economy.

Round 1 and round 2 created more than 60,000 bookings worth more than $31 million, getting people staying overnight in the CBD and regions, spending in our restaurants, cafes and bars. This resulted in the highest occupancy levels in 12 months in regional South Australia, and a direct economic injection into the visitor economy. Round 3 has just closed and a further round 4 has been announced.

More recently, further commitments include the $5.4 million Wine Export Recovery Plan, to increase wine exports into the United States, the United Kingdom, Canada and other international markets, thus reducing reliance on China, and the $1.08 billion energy agreement with the federal Liberal government, of which the Marshall Liberal government will fund $422 million. Whilst providing cost-saving benefits to consumers across our whole state, the investment in major projects will be undertaken in the regions, including boosts to gas production, further work on the interconnector between South Australia and New South Wales, and the development of a hydrogen industry.

The Essential Services Commission has determined that the average household has saved $269 from their electricity bills since the Marshall Liberal government came into government. Recent proposed initiatives are expected to realise a further $100 saving. The $105 million Road Safety Program, of which the Marshall Liberal government will fund 20 per cent, involves upgrades to regional roads across the state to create jobs but, importantly, will provide safer roads for South Australians.

In conclusion, the Marshall Liberal government, since coming into government, has been and continues to focus on investing extensive resources into new industries, creating jobs, growing the regions and backing local businesses.

MYANMAR MILITARY COUP

The Hon. T.T. NGO (15:30): I rise today to speak out against the violent and brutal actions of the military dictatorship in Myanmar. Following the landslide victory in the November 2020 general election by the National League for Democracy, led by Aung San Suu Kyi, Myanmar's new parliament was to meet on 1 February 2021 to be sworn in as the elected government.

Led by Army general Min Aung Hlaing, Myanmar's military, known as the Tatmadaw, took control of Myanmar and detained politicians and civil society leaders, including the democratically elected Aung San Suu Kyi and President U Win Myint. The Tatmadaw claimed the election fraudulent and rejected the outcome despite international observers saying there is no evidence of fraud. Since the military coup, we have seen reports of devastating violence in the streets and the climbing toll of lives lost as the voices of Myanmar's citizens cry out against this dictator military, a military using deadly and indiscriminate force against its own people who are protesting the unseating of their elected government.

On 2 May, the Assistance Association for Political Prisoners recorded at least 765 people had been killed. I am told the Myanmar's military continues to use brutal and violent methods to quell protesters. At least 4,609 people are under detention and 1,396 have been issued arrest warrants. Myanmar people have remained defiant and continue to protest the dictatorship on their streets. I am told the Tatmadaw have stamped down on media trying to report on the military's violence and crimes. It has also cut out internet access and mobile data nationally preventing the Myanmar people from communicating with each other and the world.

On 16 April, Myanmar's ousted parliamentarians, anti-coup protest leaders and representatives of ethnic minorities of the Buddhist majority formed the National Unity Government (NUG) with the commitment to end military rule and build a federal democracy.

The people of Myanmar in Australia and around the world are calling for the protection of their people and seek help from the international community. The Myanmar people do not want further losses of their brothers and sisters in Myanmar. They really want action, very strong action that can stop the brutal acts of the Tatmadaw.

Myanmar's ambassador to the United Nations, Mr Kyaw Moe Tun addressed the UN General Assembly recently and urged the world body to use 'any means necessary to take action against the Myanmar military' to restore democracy in his country. Mr Kyaw Moe Tun urged all countries to strongly condemn the coup, to refuse to recognise the military regime and to ask military leaders to respect the November elections. He said:

> It is time for the military to immediately relinquish power and release those detained.
>
> We will continue to fight for a government which is, of the people, by the people, for the people.
>
> I appeal to the international community to help us in whatever way they can. Many of us inside the country, especially those young, young people who are on the streets, they are helpless. And not only them, but all of us—all people of Myanmar—also feel helpless.
>
> …Our democracy was just a nascent democracy and then the military came in to set it back 40 or 50 years. Democracy should prevail. Democracy must prevail.

I support Mr Kyaw Moe Tun's and his people's cries for help. I also support them in urging South-East Asian leaders and countries like the US, Canada and Australia to work with the newly formed anti-coup unity government in Myanmar to restore democracy, putting an end to the illegal military takeover.

Ayay Taw Pone—Aung Ya Mye (meaning 'Uprising—we shall win')

Ayay Taw Pone—Aung Ya Mye.

Ayay Taw Pone—Aung Ya Mye.

WHYALLA

The Hon. J.A. DARLEY (15:35): Today, I rise to speak about Whyalla. Whyalla's future has been in the spotlight throughout 2021. Speculation regarding the finances of GFG Alliance has made global headlines, but Whyalla is an incredibly resilient community that will not be distracted from their focus on realising their exciting potential. Despite GFG's financial situation—caused by the collapse of a main financier, and not mismanagement of assets—its Whyalla operations are in the strongest position in years, an important aspect that has been missing in much of the recent media hype.

Local GFG representatives regularly brief the council, Chamber of Commerce and other key stakeholders. Recent briefings have highlighted record rates of production, strong product demand

and a very positive attitude from employees, despite the external speculation. The operators are now profitable. Only 12 months ago, there were significant losses year on year, so the local team has done an outstanding job turning things around.

This very positive news, combined with the COVID-19 pandemic highlighting to our nation the critical importance of domestic manufacturing, gives the community confidence in GFG's future in Whyalla. As well as GFG's local success, major developments in Whyalla add to the excitement around the city:

1. A brand-new, world-class jetty—supported by state funding—that is attracting record tourist numbers and global acclaim.

2. A new $100 million state high school set for completion later this year.

3. The federally funded $12.1 million upgrade of the airport, improving security and better positioning Whyalla to capitalise on fly-in fly-out opportunities and the short 45-minute flight from Adelaide.

4. The Cuttlefish Coast Sanctuary Tourism and Environmental Management Project, with $2.1 million in state funding, which will create a huge boost in regional tourism.

5. Major construction projects of a new Aldi store and ElectraNet electricity infrastructure upgrade, totalling nearly $300 million.

6. These above activities have created a rental market boom and rise in median house prices.

These are exciting achievements creating a genuine optimism about Whyalla's future. However, it remains critical that Whyalla continues to receive extensive support from state and federal governments to complement and diversify the existing economy, easing the ongoing reliance on the steel industry. Key priorities include:

1. Whyalla as a hydrogen hub, with the city ideally placed to deliver and cater for world-class hydrogen production.

2. GFG's green steel transformation vision.

3. Promotion of industry, utilising the Whyalla Port for export opportunities.

4. State, Whyalla city council and local stakeholder collaboration on the potential uses of the future surplus state government high school sites, ensuring maximum benefits for the community and the state. The collaboration needs to take into account the city's Foreshore Master Plan process and the need to create temporary workers' accommodation to address the current housing shortage.

5. Maximising education opportunities from UniSA and TAFE Whyalla campuses.

6. Attraction and retention of skilled workers and their families through the Upper Spencer Gulf's 'Housing' and 'Image and Liveability' strategies.

Identifying and prioritising defence-related opportunities from the adjacent Cultana defence base. Whyalla remains positive about its future, but much will depend on critical ongoing state and federal support. The state government demonstrated confidence in the future of Whyalla through its significant investment in the new high school. It is now imperative that governments continue this level of support, ensuring that these investments realise and foster a growing, diversified workforce and economy for Whyalla, the region and South Australia for decades to come.

COVID-19

The Hon. N.J. CENTOFANTI (15:40): As COVID-19 has spread across the globe, almost every country has been left to grapple with extraordinary challenges. Borders have been slammed shut, economies have ground to a halt, health system capacities have been tested and unfortunately lives have been and continue to be lost. Whilst we have been extremely fortunate in Australia, we have not been immune to the challenges and tragedies of COVID-19. South Australia has recorded 730 cases, four deaths, and encounters the prospect that these numbers could continue to rise.

There is no doubt that since the first Australian COVID-19 cases were detected in late January 2020 the lives of South Australians have dramatically changed. As a government we have fought COVID-19 on two fronts. Firstly, the health and safety of South Australians has been the primary concern of this state government. Restrictions of different kinds have been placed at various times for months to ensure we protect the South Australian community.

The second part of the battle against COVID-19 is how to best support jobs, workers, businesses and the economy. The restrictions have undoubtedly been tough on employees and employers. That is why the state and federal Liberal governments have unlocked record economic stimulus, infrastructure projects and tax cuts. These measures have been designed to support employment opportunities for South Australians and to provide relief to the hip pocket.

When observing the terrible tragedy occurring overseas, I am proud of each and every South Australian for playing their part in keeping our state safe. I am also proud of our government's collaborative approach with the federal government, South Australian Health and South Australia Police to manage the COVID-19 outbreak. Difficult times may still lie ahead of us, but we have shown that South Australia can cope with the complex challenges involved with the pandemic.

South Australia's ongoing management of COVID-19 has involved many organisations and individuals who have done an outstanding job. As they continue their work contributing to South Australians' COVID-19 efforts, I believe this is a timely opportunity to thank them for their dedication. Frontline workers, medical professionals, SA Pathology, SA Health and SA Police have all been crucial to keeping South Australians safe during 2020 and now into 2021.

These organisations and individuals deserve our continued gratitude. However, I would like to take this opportunity to particularly thank the men and women of South Australia Police. The government's response to COVID-19 has given SA Police a unique set of responsibilities. As our communities face evolving restrictions, SA Police were at the forefront of enforcing these measures. The gravity and burden of the changing responsibilities on SA Police over the past 12 months could not have been foreshadowed or planned for.

Despite how quickly COVID-19 has changed our community, SA Police have been able to swiftly respond. One of the greatest changes to occur in South Australia and around our nation has been the closure of state borders. We have not seen states and territories limit and deny movement within Australia in this fashion since Federation. Border closures have now become an unfortunate reality of slowing the spread of COVID-19.

The South Australian-Victorian border was our most affected border, which required SA Police to enforce travel restrictions at entry and exit points. For months police officers from around the state worked to man our border with Victoria on top of their vital, everyday duty in their communities. Border restrictions were extremely difficult for the affected communities, such as those in the Riverland and Mallee and in the South-East, but the work by SA Police in enforcing travel restrictions was crucial to reducing the risk to South Australia during the height of COVID-19 transmission.

Our South Australian police have been required to enforce restrictions on community movement as well as oversee the inception of COVID marshals, COVID-safe plans and patron limits on businesses. I know our police force are extremely grateful for the South Australian community's response to the restrictions. It has made their job much easier; however, these men and women have still spent countless time away from their families ensuring the job gets done and we will be forever grateful to them for this.

So I wish to thank our police for how they approach this challenging time in our community. Thank you to each and every police officer, all of whom have ably assisted in absorbing the additional volume of work required due to the COVID-19 outbreak. Your dedication and efforts have not gone unnoticed. I look forward to all South Australians continuing to work together to ensure our state remains safe and healthy.

HUTT ST CENTRE

The Hon. R.A. SIMMS (15:44): The matter I rise to speak on this afternoon is one of real importance to South Australians who care about the most vulnerable in our community, that is, the decision to cut funding for the Hutt St Centre and Catherine House. I am deeply concerned about the implications of these cuts. I acknowledge the minister's comments earlier and the statement that they have made regarding the shifting of money, but the reality is that this is a reduction in funding for the Hutt St Centre and for Catherine House, both of which are vital services in our community.

When one considers the Hutt St Centre, I know that there are many people in our community who rely on that service and have been using it for years. Quite frankly, another service provider will struggle to offer that same level of service because they do not necessarily have the same relationships with the people involved in the community, and that is my concern with this cut.

Let us consider the implications of this. What has been proposed is a $2.4 million cut from both the Hutt St Centre and Catherine House, so that is $1.2 million each, and that could result in the loss of 31 jobs; that is, 31 jobs in sectors that are vital, that are supporting the most vulnerable people in our community in the middle of the worst economic crisis in a generation and in the middle of a one-in-100-year pandemic.

The Hutt St Centre could lose 12 staff and Catherine House, South Australia's only specialist homelessness service for women, could lose up to 19 jobs, so 31 jobs are at risk at this time. If we consider the impact that the Hutt St Centre and Catherine House have, it is very clear that this has a significant implication for vulnerable people in our state.

The Hutt St Centre serves up to 40,000 meals and offers social work and support services to nearly 2,000 people. The facilities they offer include showers, laundry facilities, visiting health professionals, an aged-care living program for their older clients and recreational activities. We know that 200 people experience homelessness each day in our state.

Catherine House is South Australia's only homelessness and recovery service for women exclusively, and 59 women are provided with safe and secure accommodation every night of the year. Again, 55,936 meals and snacks were provided during the year, and 480 essential personal product packs were provided to clients. This is an important service, and it is not one that we can afford to lose.

I also acknowledge that this has been a really challenging 12 months for the Hutt St Centre in particular. Last year, they were subject to a pointless review, led by the failed Team Adelaide faction in Town Hall, in particular by Alex Hyde, who is a staffer to Nicolle Flint. That review created a huge amount of discomfort for the Hutt St Centre, a lot of uncertainty for them during this time of crisis, and I am very disappointed that they are now being subject to more uncertainty in the middle of this crisis.

I urge the government to reconsider, to go back to the drawing board and to look at what can be done to ensure that the Hutt St Centre and Catherine House are guaranteed their funding in the future so that they do not have to lay off staff and so that they do not have to cut the vital services that we know so many South Australians rely on.

COVID-19

The Hon. R.P. WORTLEY (15:49): As we gain some relief and satisfaction that South Australia has done well in getting on top of the coronavirus pandemic, we have been reminded in recent weeks that many places around the world continue to do it hard and lose lives on a scale that is hard to image.

The images and the numbers coming out of India tell us that this pandemic is not going away and a lot more needs to be done to bring it under control. If India, a nation with almost 20 per cent of the world's population, is being brought to its knees BY COVID-19, then we are all in trouble in this global village. If this pandemic and all the lockdowns and restrictions has taught us anything, it is that we are all in this together and the world has become smaller.

We no longer have the luxury of turning away from the bad news happening overseas and saying that it does not affect us here. The world needs to get together and help out countries like India, which is facing an unimaginable crisis. If we expect to get on top of the pandemic and return to something like normal life, we must support India or we will never rid this world of the coronavirus.

The news out of India is getting worse every day. In February, India was losing about 95 people a day. Latest figures show that numbers have exploded beyond anything we could have imagined to more than 3,000 a day. Last Thursday, 3,645 people lost their lives to the pandemic in a single day. India has over 20 million COVID cases and the nation recently passed the shocking figure of 200,000 deaths.

When I made notes for this speech last week, the highest number of cases recorded in a day was around 250,000. Over the weekend, that number hit a frightening new high of 400,000 people. The country is just not able to cope. Mass cremations are being conducted to avoid the risk of infection spreading. In the capital of Delhi, one in three people being tested for COVID-19 is returning a positive result, while cities like Kolkata and Chandrapur are recording almost 50 per cent infection rates.

I have heard distressing stories from friends of mine in the strong Indian community within South Australia of people losing family and friends to COVID. The virus has a virulent strain that struck swiftly and brutally across the Indian nation. We are hearing new stories of a failing health system, with oxygen shortages not just in regional areas but in the capital of Delhi. India is understandably experiencing social and political unrest, as people desperately seek medical aid that is not always available. On that front, I believe it is up to the more fortunate countries and wealthier countries to come to the aid of those in India.

The federal government has enjoyed bipartisan support during the COVID pandemic, but has failed on a number of fronts. Our vaccination program is too slow. The United Kingdom, with a population of less than 70 million, has given a jab to around 50 million of its people, more than 70 per cent of the population. Australia, with a population of 25 million, has only given a jab to two million people, around 8 per cent of the population.

It has failed to implement an effective quarantine process for travellers from overseas. Thousands of Australian citizens are desperate to come home and this government has done very little to assist them to get back to their country. The government has failed to protect Australian citizens around the world, in particular in India, and should be ashamed of the measures announced recently that prevent our citizens coming home from India, making it a criminal act with a penalty of five years' gaol and/or a fine of $66,000 just for wanting to come home to the safety of their homeland. According to the AMA, this is a clear indication that the federal government's quarantine program has failed.

Australia needs to join, if not lead, other First World countries and nations in providing support to India by way of vaccinations and a wide range of health care. It is in the interests of the whole world to ensure that a massive country like India, and a great friend of Australia, does not succumb to COVID-19. The sooner India is on the road to recovery, the less the threat to the rest of the world.

Just as importantly, we have to remember that each of these astronomical numbers is a person with a family, and with support from countries like Australia perhaps we can help ensure that many lives are saved while we bring COVID-19 under control.

COVID-19

The Hon. J.S. LEE (15:54): I rise today with a heavy heart to speak about the devastating second wave of the coronavirus currently unfolding in India. India, sadly, has become the second country in the world, after the United States, to tally more than 20 million total infections when the government announced 357,000 new cases yesterday, and over 220,000 people have died from the disease thus far.

The Premier of South Australia, the Hon. Steven Marshall, made a compassionate ministerial statement in parliament yesterday. Since learning about the terrible human tragedy in India, we have reached out to the Indian community in South Australia. On behalf of the South Australian government, we express our sympathy to everyone in India and community members in South Australia to let them know that we are thinking of them and their families and that we stand in solidarity with the Indian community and will continue to support the Indian community during this difficult, sad and challenging time.

Watching the COVID crisis in India unfolding and seeing images of cremation, overcrowded hospitals, overwhelmed frontline emergency and medical professionals and desperate families across various news media has been truly heartbreaking. We can only imagine how stressful and upsetting events in India are for communities here and in India, with many having lost family and friends while others are growing more anxious about the health, safety and wellbeing of loved ones.

Throughout the pandemic, I have spoken in this place about the incredible resilience, compassionate community spirit and proactive leadership shown by our multicultural community leaders and organisations in response to the COVID pandemic. I would like to commend our Indian community organisations, which have been working in collaboration with government agencies and the not-for-profit sector throughout the pandemic. In addition, these generous organisations have also conducted fundraising activities for those who are facing multiple hardships as they are impacted by the COVID crisis.

I wish to take this opportunity to thank a number of community leaders, including Dr Sridhar Nannapaneni, SAMEAC member; Mr Rajendra Pandey from Vishva Hindu Parishad of Australia; Mr Amarjit Grewal from the Indian Australian Association of South Australia; Mr Sandy More from United Indians of South Australia; Mr Daljeet Bakshi from the Australian Sikh Support volunteers group and Desi Australia; Mrs Usha Rajagopalan from the Hindu Society of South Australia; and their committees, along with many other individuals who have raised concerns and shared important information with me in recent times.

I acknowledge their compassionate work and valuable feedback and thank them for their strong advocacy and continuing efforts and willingness to work closely with our state and federal governments. I look forward to meeting tomorrow with the Indian Consul General, Mr Manish Gupta, and also Mr Amarjit Grewal and the IAASA team to discuss how we can work together to best support the Indian community in South Australia during this difficult time.

As the Premier outlined yesterday in his ministerial statement, the government of South Australia stands shoulder to shoulder with the Indian community during this incredibly difficult and emotional time. The Department of the Premier and Cabinet is working closely with SA Health to see how we can best support the efforts to fight the crisis in India. SA Health is looking at what supplies of oxygen, PPE and consumables we can donate, and we are talking to the Australian government to work out the logistics on how to get the supplies safely to where they are needed most.

As honourable members would be aware, the Prime Minister announced last week that the federal government is also sending an initial humanitarian support package to India. This package includes 500 ventilators and other medical supplies and PPE, such as surgical gowns, face masks, goggles, gloves and face shields, with more aid to follow.

Let us keep all the communities that are impacted by the deadly disease in our thoughts and prayers. I wholeheartedly support the ministerial statement by the Premier and want to reassure the Indian community that our South Australian government is working closely in monitoring the situation in India and working with the commonwealth government to continue to support the Indian community during this sad and troubling time.

Motions

MILISITS, MR VILMOS

Adjourned debate on motion of Hon. F. Pangallo:

That this house—

1. Acknowledges the passing of Vilmos Milisits OAM;
2. Acknowledges his outstanding contribution to South Australia and Australian businesses;
3. Acknowledges the international success of his bakery business, Vili's;
4. Recognises his generosity and support for many individuals, charities, clubs and businesses; and
5. Conveys its sincerest condolences to his wife, Rosemary, their children and their extended families.

(Continued from 31 March 2021.)

The Hon. F. PANGALLO (16:01): I rise to speak on the motion in my name, acknowledging the passing of the much celebrated and respected South Australian Vilmos Milisits OAM. The first part of this speech is dedicated to his illustrious life and accomplishments. The second deals with the untold story, how in his time of greatest need the medical establishment and system dealt him the cruellest of blows and failed him.

Vili Milisits was many things to the countless people who came to know and admire him. Above all, he was a great and loyal South Australian who loved this country more than his own place of birth. As he would often declare, he was Hungarian by birth, Australian by choice. Vili was simply an irrepressible and irresistible character, a generous, philanthropic man, larger than life and full of love for the things most important to him.

At the top of the list was his family: Rosemary, his devoted wife and business partner of 53 years; their two children, Simon and Alison; and their grandchildren, Joshua, Laura, Luke, Ethan and Katelyn. His extended family must also include the hundreds of his staff. And, of course, he was extremely proud of his eponymous baking empire at Mile End, which stretches across Australia and the globe into 23 countries.

Vili's is a most remarkable success story, worthy of a book and a movie. The young refugee migrant with gritty determination and an insatiable work ethic began at the very bottom of the business food chain with bold dreams and ambition to rise to the very top and be the very best at what he did.

Vili amassed a long list of impressive awards and achievements in his lifetime. He mentored thousands of economics students, was on numerous state bank advisory boards and was an adviser to the Reserve Bank. He did it all without a formal education, leaving school at 14 to take up a pastry chef apprenticeship out of necessity, to help support his family when his father, Istvan, fell ill. He was a maths wizard, who took great delight in bragging how he could do costings calculations for his family baking business in his head.

Climbing mountains seemed easy for Vili, because of his burning desire and ambition to conquer any obstacle in his way to achieving success. With a firm conviction in his eyes, Vili would say, 'We wanted our kids to have what we didn't have. We have built them a business that will last three or four generations.' He would recount his own personal journey, wrought with the suffering, loss and despair of his large family's displacement after the 1956 Hungarian uprising. They eventually found their way to Adelaide, where 16 of them lived under one small roof.

It is why he easily identified with refugees and their struggles against racial discrimination in making a new life for themselves and in a foreign land with a completely different culture. Vili did not judge them, providing job opportunities at his Mile End headquarters. There are now more than 34 different nationalities on the payroll. For 22 years he was in a refugee employment scheme run by the Salvation Army and the Catholic Church. He helped by employing Vietnamese people who arrived on the second boat in Darwin in 1978 and continued with escapees from Communism and the Balkan war until 1989 and then detainees from Baxter detention centre who were sent from the Adelaide Mosque until 1999.

Through the federal government employment program he provided jobs and friendship, settlement advice, help with obtaining housing and interest-free loans. Five per cent of his workers are special needs people whom, he declared, never took sickies, because for them having a job was heaven sent.

Vili had a disdain for slackers but always had time for those prepared to pull their weight. When sizing someone for a position, Vili could be blunt and to the point, 'Do you want a job, or do you want to work?' In Vili's world, there was a distinct difference. Even though he was the head honcho, Vili was far removed from being the rich, aloof boss. He remained grounded and laboured hard with them, shoulder to shoulder. He explained his work practice and ethic like this:

> If you can inspire self-pride and self-satisfaction in what they do, they will appreciate what they have and what they can do. You need to have an affinity with your workers. Put yourself in their position. I have been there. I understand.

Next door to his sprawling family baking business in Manchester Street is the omnipresent reminder of Vili and Rosemary's own humble beginnings: the ramshackle house where they started it all, making homemade pasties by hand half a century ago. They would start at 10 at night and finish at four in the afternoon the next day, with only four or five hours sleep. 'I would fall asleep putting my socks on,' Vili joked.

The house, complete with the old stove, ovens and equipment they used, will never be demolished. It is a nostalgic aide-mémoire of his and Rosemary's tireless toil, a museum of sorts. In a fabulous feature piece by Craig Cook in *The Advertiser* a couple of years ago, Vili remarked:

> Rosemary and I wake at 4.30am every day and we roll out of bed with laughter thinking of all the bullshit that's happened in our life…But we know we've got a lot to be thankful for—life in Australia is good, very good and when something is this good, you stick with it.

Until ailing health started to slow him down in 2019, 90-hour weeks were the norm. He would be at work before sunrise every day, pulling pies, pasties, sausage rolls and cakes out of ovens. The factory produces an incredible 100,000 products daily. Anything that is not sold goes straight to homeless shelters like the Hutt St Centre, such is their magnanimous generosity.

After the baking was done for the day you would often find flour-dusted Vili, dressed in uniform—white pants, navy polo with that distinctive emblem and the hairnet—in his wildly popular Cafe de Vili's, slaving over his fryers, making his specialty for his customers: golden crisp chips, cooked to perfection. The secret, he confided in me, was cooking each batch at three different temperatures.

Vili was innovative, with new styles and flavours for a basic Aussie staple. There are now a lot of pies in the range to choose from, compared with his rivals. His personal favourite was the green peppercorn pie. One of the best tributes for our king of pies came from legendary satirist Barry Humphries who quipped, 'At least there is a decent pie in the sky now.'

Vili was particularly proud that he sourced all the ingredients for his products exclusively from South Australian producers. That kind of loyalty saved the Wintulich's Smallgoods company in Gawler from closure and restored it to profitability. Wintulich's chairman, Matthew Peart, paid credit to Vili's managerial skills and gregarious personality, saying they benefited greatly from their 25-year partnership. 'A partnership and a fellow you can only describe as the real deal,' wrote Mr Peart.

Vili's trademark flaky pasties were the real deal of a meal, too. 'Meat with six veg,' he would chortle. Potato, carrots, turnips, swedes, onions, plus the coup de grâce in his recipe, trombone. Shortly before he passed, Vili confided another of his cooking tips. After he discovered trombone was a magic ingredient, he shored up a deal with an Adelaide Hills grower to buy their entire crop each season to ensure his supply.

It was not always about price for Vili; it was about quality and supporting his home state. There were no compromises, although he was known to drive a hard bargain and staunchly defended the high standard of his products. 'If it hasn't got a V, it ain't me' was one of his clever advertising slogans. A few years ago, when I was reporting with *Today Tonight*, a furious Vili rang me with a story about how some unscrupulous bakeries and delis in the north-western suburbs were passing off their inferior pies, pasties and cakes as his by selling them in his own marked bags that had been obtained by devious means.

During my investigation, we tested several samples of pies against Vili's. The results were not unexpected, but shocking nonetheless. The knockoffs barely contained meat of any description, but certainly there was none of the claimed beef to be found. 'I hate liars and thieves,' Vili thundered when he saw the lab results. He even employed a tray detective to chase down the distinctive plastic trays from thieving bakeries—something that was costing him $100,000 a year.

He also loved to fight for what was right. 'I always win when I know I'm right,' he grinned and laughed with that distinctive cackle. Two years ago, Coles arrogantly dumped Vili's because he sought to increase his prices by a modest 5 per cent to cover his own cost increases created by the drought. The grocery giant paid the price alright: they suffered a severe customer backlash. They were forced to quickly reverse the decision.

Only a few weeks before he passed away, Vili was telling me how upset he was after being ditched by the South Australian fuel outlets On the Run. He had refused to discount his prices just so they could make a bigger profit on selling his products. Instead, On the Run brought in an inferior budget-priced pie from interstate, along with cut sandwiches, flown in frozen. Vili declared, 'I'd rather shut my doors and go broke.'

His biggest V for victory and 'up you' salute was reserved for SA Health. In 2012, the then chief medical executive, Dr Kevin Buckett, without a shred of evidence, falsely fingered Vili's custard berliners as being responsible for a widespread salmonella outbreak in the community. It struck right at the heart of what Vili stood for. That was SA Health's first and biggest mistake. The second was failing to check that the business was a partnership, not a corporation, so Vili and Rosemary could sue for defamation.

The South Australian government tried to deep-pocket them all the way to the High Court, but Vili prevailed in a seven-year fight to clear their name, winning substantial damages and costs. Despite the win, the futile bureaucratic attempt to destroy his brand and reputation continued to rile him to the end. I quote:

> We had major international export licences to protect, and we have invested a lot in systems and expensive equipment to make sure this sort of thing can't happen.

And it did not, he fumed. Further:

> They picked on the wrong bloke and thought they could get away with it. All they had to do was say sorry, but they wouldn't and we made them pay the price for their lies.

Vili was a good talker. My intended short visits to his home, particularly over the past year, would often stretch into a couple of hours of lively and entertaining discussions. You could not help but be mesmerised by him and his wit, his take on life, business and his extremely dim view of politics and politicians. Nothing was sacred. Political correctness was just never going to be in Vili's vocabulary. There will never be another like him, and he will be greatly missed.

This now brings me to the most disturbing, disgraceful, upsetting and traumatic developments in the final months of Vili's life that I must now share, and I do so with the full consent of those closest to him. Had Vili not been subjected to an act of sheer medical incompetence and what I and others closest to him could only conclude was tacit age discrimination, he may have still been with us today.

It is a view that would be widely supported by Vili's personal medical team, comprising skilled professionals and carers, including Rosemary, his wife, Pauline Clune, his dedicated and highly experienced nurse and carer, family members and his many friends, who were dismayed and flabbergasted by a series of crushing setbacks and delays which befell Vili. He, too, found it hard to comprehend what was happening to him as he was left languishing and then rejected for life-saving transplant surgery.

Before outlining the devastating and distressing events that betrayed and ultimately failed Vili, I must very strongly emphasise that they totally exclude and do not in any way apply to Sydney's wonderful, caring and accomplished transplant unit at St Vincent's Hospital, headed by chief surgeon Paul Jansz and thoracic specialist Dr Monique Malouf. They were his last hope, and the opportunity only arrived in late March, some seven months almost to the day after Melbourne's Alfred Hospital declined to put him on their transplant list, a decision it made based largely on a now discredited medical assessment with unfounded assumptions.

While the lung transplant itself was a success, Vili succumbed to complications arising from his already frail state. Things may have turned out much differently had Vili been given the chance much earlier, as was hoped. Vili had idiopathic pulmonary fibrosis, a progressive condition where the lungs were unable to adequately supply oxygen to the body. Left untreated, it is fatal, and the only effective treatment was going to be a lung transplant.

For more than a year, Vili was at home on permanent oxygen. Every day was vital, yet he remained optimistic and in good spirits that his turn would eventually come. Vili had an insatiable lust for life and he was not ready to go—not by a long shot. Vili had undergone an extensive medical assessment process at the Royal Adelaide Hospital in preparation for being listed for a lung transplant to be performed at the Alfred Hospital.

On 4 June last year, things looked bright following an assessment by Dr Helen Whitford, a consultant from the Alfred's respiratory and lung transplant service. In a letter to Professor Mark Holmes, the head of South Australia's lung transplant service at the Royal Adelaide Hospital, Dr Whitford found that overall Vili was an excellent candidate for transplantation. I now seek leave to table that letter.

Leave granted.

The Hon. F. PANGALLO: Apart from a query about possible minor heart surgery, Dr Whitford was otherwise positive about his prospects. 'Otherwise I think we should move ahead very quickly, as he has a limited window of opportunity for transplant,' Dr Whitford wrote in an obvious expression of the urgency. This was early June 2020. The clock is ticking down for Vili Milisits.

Part of the protocol required Vili to also have a neuropsychological assessment. Professor Holmes then referred Vili to Andrew Rothwell, of Rothwell Neuropsychology, who saw Vili at his practice on 29 June 2020. Mr Rothwell's subsequent report was sent directly to Professor Holmes. The contents were so bewildering, they defied belief. I now seek leave to table Mr Rothwell's report.

Leave granted.

The Hon. F. PANGALLO: In summary, here is what Mr Rothwell concluded:

- Vili's cognitive and intellectual capacity was so impaired that his IQ was 84;
- Vili's memory was so vague that Mr Rothwell doubted Vili was actually capable of still running his business and assumed this was being done by his managers;
- the likelihood that Vili had Alzheimer's disease, or being six times likely to have it, and;
- the assessment was not invalidated by Vili's existing health problems, and he presumed that Vili's oxygen levels were reasonable.

The report was absurd, insulting, inaccurate and contained unsubstantiated observations and assumptions. Mr Rothwell had not checked Vili's oxygen level over the two-hour test. He simply took a guess or assumed it was okay. In fact, by the time he had arrived for the mentally gruelling test, Vili's oxygen level was so low and he was already quite exhausted. Therefore, you would expect his cognitive responses would have to be affected.

An IQ reading of 84 put Mr Milisits in the category of an imbecile—just think Forrest Gump or Chauncey Gardiner. I and so many others who dealt and met with Vili around this time and afterwards can attest that he was very cogent and still as sharp as a razor. As for possible Alzheimer's or that he was not capable of running his business, this was more ludicrous guesswork by Mr Rothwell. Vili recalled being quite anxious because so much was riding on the tests that he had difficulty with some of the puzzles Mr Rothwell asked him to do. 'Frank, I'm not a puzzles man. I am a dollars and cents man. Give me figures and I will show you what I can do,' he said.

However, that assessment was to be devastating and soul destroying. From being told he was an excellent candidate, Professor Holmes then had to break the sombre news from the Alfred that Vili would not be placed onto its transplant list because it now considered the chance of getting a good transplant outcome was risky and low. 'Rothwell signed my death warrant. Do they want me to go away and accept that I will die?' a dejected Vili told me at the time.

Dr James Asimakopoulos, one of Vili's doctors and a long-time friend, described the report as outrageous—perhaps an understatement. He wrote to me, expressing his disgust at Vili's treatment. I now seek leave to table Dr Asimakopoulos's letter.

Leave granted.

The Hon. F. PANGALLO: Dr John Langrehr, a world-renowned expert on the topic of cognitive test designs, brain functioning and thinking processes, and author of 25 books on the topic, which have been translated into four languages, also expressed doubts about the validity of Mr Rothwell's methodology. He expressed concern that Vili was subjected to cognitive testing under less than ideal testing conditions. Here is part of what he had to say in an email dated 21 August 2020. I quote:

> There are many important aspects of cognitive ability that are not measured by a pencil and paper test. The items are limited to correct answer, or lower order thinking which can be given a mark. Management and higher order or multiple answer thinking processes are not considered in testing but they are in real life.
>
> I think it is only fair that Vili be offered a retest to check the reliability of the test results. I am sure that if the tests were given in a relaxed setting at his home or business and that he was privy to the types of questions that would be in the tests his results would be quite different. I also wonder about the culture fairness of the tests knowing Vili's background.

I seek leave to table that email.

Leave granted.

The Hon. F. PANGALLO: A leading psychiatrist whose name I will not disclose also reviewed the Rothwell report and was scathing of his method. He said Mr Rothwell should not have made some of the assumptions that he did, such as Vili not being in a mental state to run his business. Let me quote some of what this psychiatrist said:

> I think that is a bit sloppy when so much is at stake. The assessment needs to be comprehensive, particularly given what is at stake.

By that, he means that Mr Rothwell was dealing with a man's fate. Allow me to continue:

> I get concerned at times that some doctors make diagnoses without dotting every i and crossing every t, particularly when diagnosing dementia in young people or when dementia may be in its early stages.
>
> The neuropsychologist is making assumptions about whether people are propping him up. He shouldn't guess. He should know!!!!!!!

That ends with seven exclamation marks. Vili was, of course, still very much in charge of his many business interests, taking phone calls, meeting and talking with staff each day and testing new products. He was also personally piecing together a $20 million business expansion deal—not bad for a dimwit. Bill Muirhead, the Agent-General for South Australia in the UK, wrote in an email to Vili's daughter, Alison, on 2 October 2020, and I quote:

> I had a long conversation from London this morning with Vili. I must say in my opinion he was very clear and also well aware of the business discussions that we have been having. He knew exactly who I was and also even had his normal sense of humour. I find it incomprehensible and insulting he could have been diagnosed with a low IQ and dementia. In fact, that was very far from the reality. Rosemary was on the call and we discussed his situation regarding a lung transplant. Apart from urging you to appeal this bizarre physiologist's report I would try and have it overturned independently and get him back on the transplant list in Australia. I am not medical but the alternative of flying to America seems the last resort.

I seek leave to table that email from Bill Muirhead.

Leave granted.

The Hon. F. PANGALLO: Vili's management staff also signed sworn statements rejecting Mr Rothwell's assertion they were making decisions for him. I now seek to table 14 of those sworn statements.

Leave granted.

The Hon. F. PANGALLO: There was to be one last almighty effort to get Alfred to review its decision, or get another hospital that does transplants to consider Vili's predicament. PET and MRI scams arranged by Dr Asimakopolous in August showed no abnormalities in his body or brain—nothing to suggest there was an onset of Alzheimer's or dementia, as hypothesised by Mr Rothwell. Mr President, I now seek leave to table those test reports, along with a letter from Vili's respiratory specialist, Dr Andrew Scroop.

Leave granted.

The Hon. F. PANGALLO: In the meantime, Dr Scroop arranged for more tests to be carried out by clinical neuropsychologists Dr Colin Field and Dr Anthony Walsh. They discredited Rothwell's report, finding that Vili performed to expectations and showed no signs of any progressive cognitive or intellectual impairment. In other words, Vili did not display any signs of being an idiot who was losing his marbles. I now seek leave to table the report by Dr Field and Dr Walsh.

Leave granted.

The Hon. F. PANGALLO: Unfortunately for Vili, and despite the new clinical assessments, the Alfred was not going to budge and change its decision. In a letter to Professor Mark Holmes in late October, Professor Gregory Snell, the medical head of the lung transplant service at the Alfred and chair of the lung transplantation advisory committee on the Transplantation Society of Australia and New Zealand, said that the entire team of 43 transplant staff had again decided that a lung transplant was not the appropriate approach for this man. I seek leave to table that letter from Professor Gregory Snell.

Leave granted.

The Hon. F. PANGALLO: Professor Snell did not say what another appropriate approach might be, although they did offer to pass on documentation to another transplant unit elsewhere. However, based on Alfred's firm rejection, what were the chances that another Australian transplant unit would take him?

A sympathetic Professor Holmes did not hold out much hope either for Vili, telling him that the Alfred was the only unit in the country that does transplants on people aged 70, that it was the only hospital in the world that pushed the boundaries by doing transplants on people aged 70. In fact, at least two hospitals in the United States have performed transplants on patients up to the age of 78. But travelling to a COVID-ravaged country was out of the question, even though Vili had plans and was prepared to do it.

Vili was 72. Even though they would never openly admit it, the inference was clear: Vili's age also had to be a driving factor, although Vili's lung specialist, Dr Andrew Scoop, was confident that his patient would be up to the ordeal. With time running short and his lung condition worsening by the day, Vili was not in any frame of mind to fly the while flag, go into palliative care and die. He expressly told me he still had a lot of living to do.

After being rejected by Brisbane's unit, St Vincent's indicated they were prepared to assess him. Then, as he was preparing to fly to Sydney, another cruel setback. A serious blood infection put him into hospital and he needed to recover from that first before he could board a medi-flight, holding up the process even more. Time was running out.

A resolute Vili courageously said that he was prepared to have the transplant surgery, even if it meant he would not survive. I will quote him, 'All I want is the chance to get a lung. If I don't make it, at least I will know they tried.' St Vincent's gave him that chance. Vili and his family were extremely grateful for their quick and decisive action when he arrived and the care and compassion that followed. By all accounts, the lung transplant was successful. Vili battled for three days before his weary body gave out.

It was a double tragedy for the Milisits family. Only 48 hours before his surgery, Vili was informed that his older sister Olga had just died. Nine months had elapsed from the time Vili was flatly rejected by the Alfred Hospital to his surgery at St Vincent's. For someone with a rapidly worsening condition, that is an eternity.

In our chats on the phone and in his home, a disillusioned Vili felt he had been cheated by a discriminating health system. Vili never expected anything from this country because it gave him so much, yet when he was in need he was frustrated. It was soul destroying to see him slowly wither away over those many months, waiting, hoping and praying for a lifeline that should have come much sooner than it did. Here was a potentially—potentially—terminally ill man, vehemently opposed to voluntary assisted dying.

We have seen a huge outpouring of love for Vili. Tributes flowed from around the world. Hundreds attended his moving funeral mass at St Francis Xavier Cathedral. I was fortunate to be there. Loyal workers wept when his casket made the final journey to Mile End and more than 1,000 turned out to his state memorial at the Festival Theatre. His family, of course, is thankful the Premier bestowed that fitting farewell.

As Bill Muirhead said in his email, 'I was very happy to have spoken with Vili. Hopefully I cheered him up a bit. He is one of Australia's great business leaders and we use him as a case study in our South Australian government credentials.' I can tell you that at his lowest ebb, Vili was hanging out to get a call from anyone in the government, from the Premier down, even to lift his spirits, just as so many others in the community had made the effort to support him in his time of need. Well, not one did.

Vili's indomitable spirit and endeavours are immeasurable. I doubt we will ever see anyone like him again. Rosemary keeps a treasured item close to her heart. On the day he left for Sydney, Vili left a card with a huge red heart by her bed. It simply reads, 'Love you forever.' Our sincerest condolences go to Vili's family. I commend the motion to the chamber.

The Hon. S.G. WADE (Minister for Health and Wellbeing) (16:39): I would like to thank the Hon. Frank Pangallo for moving this motion and personally convey my sympathy to the Hon. Frank Pangallo as I know that he is a close personal friend of Mr and Mrs Milisits and provided support to the family as Vili pursued various options to receive a transplant. Mrs Rosemary Milisits personally thanked the Hon. Frank Pangallo in her eulogy at the memorial. Mr Vilmos 'Vili' Milisits passed away in Sydney on Friday 26 March 2021, surrounded by friends and family. I would like to offer my sincere condolences to Vili's wife, Rosemary, and his family for their loss.

Last week, South Australians celebrated the remarkable life of Vili Milisits at his funeral mass, held at St Francis Xavier's Cathedral, and at the state memorial service at the Festival Theatre. Over recent weeks, people from all walks of life have spoken about Vili and what he meant to them. Tributes have been published online and in the media, and a shrine has been established at the much-loved Cafe de Vili's in Mile End. It is clear that Vili had a significant impact on those who knew him and those who loved his products—Vili the husband, Vili the father, Vili the employer, Vili the businessman, Vili the innovator and Vili the friend, host and icon. Vili was inspirational.

Vili had an incredible fighting spirit. He overcame many obstacles as a migrant to this country and as a pioneer in the food industry. Faced with health challenges during a pandemic, he maintained a positive attitude and a determination to live life. Vili and Rosemary were partners in business and partners in life. They grew their business from humble origins to an international success story.

Vili never forgot the second chance he was offered in Australia as a Hungarian refugee, and he paid it forward throughout his life. Vili and Rosemary employed hundreds, if not thousands, of people locally and abroad, but it was their frequent employment of people from disadvantaged backgrounds, new arrivals to this country, young offenders and Indigenous people that they were most proud of.

On Wednesday 22 November 1995, around the time the former Premier of South Australia, the Hon. Dean Brown, had attended a launch of Vili's new halal export facilities, the Hon. Bernice Pfitzner updated this chamber about Vili's new success overseas, saying:

> Last week during the Grand Prix weekend the Government, in conjunction with the Australian Malaysian Business Council, promoted a trade delegation to Kuala Lumpur, Malaysia…There were approximately 30 South Australian businesses involved, and the three day event was most productive.
>
> As evidence of this, some of the connections made resulted in three to four Malaysian businesses competing for the franchise of Vili's halal pies…

Vili's natural business acumen saw his products sold to many foreign markets. Happy customers have enjoyed a Vili's pie in the far reaches of the globe. Speaking at Vili's state memorial service last week, the Agent-General for South Australia, Bill Muirhead AM, reflected on Vili's success in the United Kingdom. Mr Muirhead went on to describe the popularity of Vili's cocktail pies, noting that His Royal Highness The Prince Philip, Duke of Edinburgh, enjoyed eating the pies at the renaming ceremony of the City of Adelaide clipper in 2013.

The charitable contributions from Vili's bakery and organisations personally supported by Vili and Rosemary are too numerous to list. South Australians are certainly the richer because of their generous donations to community sport, the arts, the homeless sector and educational programs.

Vili was the winner of the private sector section of the inaugural Governor's Multicultural Awards in 2008. Speaking at the state memorial, His Excellency the Governor of South Australia, the Hon. Hieu Van Le AC, spoke to the contribution Vili made as a fellow refugee. His Excellency said:

> As a refugee who came to Australia to build a new life, I always felt a strong kinship with Vili.
>
> I admired him for his entrepreneurial vision, remarkable work ethic, enduring humility and love of family.

He went on to say:

> Like so many, Vili and his dear wife Rosemary have always shown a generosity of spirit in wanting to give back to the community. They have done so as proud supporters of many charities, community sports and the arts, for which both of them were recognised with Medal of the Order of Australia (OAM) in 2005.
>
> Vili was unstinting in sharing his skills and life-long learnings to various government boards schemes.
>
> To me Vili has always been an inspiration, a shining light in our community.
>
> Vale Vili. You have done your family, your heritage and your State proud.
>
> Rest in peace! We will dearly miss you!

I acknowledge the honourable member's concerns that Mr Milisits did not receive the care he needed. While I am unable to comment in detail, I will certainly take those concerns and seek a briefing. I hope and expect that Vili received the quality care that he should have. I will seek further advice. In conclusion, I too echo the remarks of the Governor. Vale, Vili—you have done your family, your heritage and your state proud. Rest in peace. We will all dearly miss you.

Debate adjourned on motion of Hon. I K. Hunter.

OFFICE OF THE VALUER-GENERAL

Adjourned debate on motion of Hon. J.A. Darley:

1. That a select committee of the Legislative Council be established to inquire into and report on—
    (a) the scope of operations of the Office of the Valuer-General in respect of state government and local government valuations for property taxation purposes;
    (b) the scope of operations of the Valuer-General in respect of valuations for stamp duty, acquisition, disposal and other purposes required by government;
    (c) the extent of compliance by the Valuer-General in respect of the Valuation of Land Act 1971 (SA);
    (d) the extent of knowledge required by the Valuer-General to satisfy the legislative requirements of the various rating authorities;
    (e) the standard of policy formulation and direction by the Valuer-General provided to Land Services SA to satisfy their contractual obligations with the SA government;
    (f) the relationship between the Valuer-General's revaluation initiative of all properties in South Australia as announced in the 2016-17 state budget and the general valuation of all properties in the state which occurs each year;
    (g) the effectiveness of the decision to privatise the valuation services of the state from 2016-17 including productivity gains/losses as a result of the privatisation;
    (h) the efficiency in the process of objections to valuations and appeals to the South Australian Civil and Administrative Tribunal; and
    (i) any other relevant matter.
2. That standing order 389 be so far suspended as to enable the chairperson of the committee to have a deliberative vote only.
3. That during the period of any declaration of a major emergency made under section 23 of the Emergency Management Act 2004 or any declaration of a public health emergency made under section 87 of the South Australian Public Health Act 2011, members of the committee may participate in the proceedings by way of telephone or video conference or other electronic means and shall be deemed to be present and counted for purposes of a quorum, subject to such means of participation remaining effective and not disadvantaging any member.
4. That this council permits the select committee to authorise the disclosure or publication, as it sees fit, of any evidence or documents presented to the committee prior to such evidence being presented to the council.

> 5. That standing order 396 be suspended to enable strangers to be admitted when the select committee is examining witnesses unless the committee otherwise resolves, but they shall be excluded when the committee is deliberating.

(Continued from 17 March 2021.)

The Hon. K.J. MAHER (Leader of the Opposition) (16:45): I will be very brief on this motion. I can confirm that the opposition will be supporting the formation of this committee. I think it is evident to everyone in here, from the many questions asked, that the Hon. John Darley does not just have a great wealth of knowledge, particularly from past positions he has held in the state public sector, about issues to do with valuations but still has a burning interest in representing the people of South Australia on issues that affect them about valuations.

This also finds effect for those who serve on the Budget and Finance Committee of this chamber. I think it is fair to say that it is a great passion of John Darley's to make sure things are being done properly. We will be wholeheartedly supporting the establishment of this committee to look into the operation of the Office of the Valuer-General and to make such recommendations in relation to that. I might at this juncture move an amendment to the motion, if I may. I move:

> Leave out paragraph 2 and insert new paragraph as follows:
>
> 2. That the committee consist of four members and that the quorum of members necessary to be present at all meetings of the committee be fixed at two members and that standing order 389 be so far suspended as to enable the chairperson of the committee to have a deliberative vote only.

The Hon. R.I. LUCAS (Treasurer) (16:47): I rise on behalf of government members to speak to the motion. The government's party room position is that it will not oppose the motion. We understand there are the numbers in the chamber to support the passage of the establishment of yet another select committee. In the brief discussions that I have had with the honourable member this afternoon, I understand there has been some discussion with the Hon. Mr Darley about interpretation of a number of the subparagraphs.

The government had raised the prospect of an amendment to subparagraph (b), but the member had indicated that he was not prepared to support that particular amendment. In relation to subparagraph (d), whilst I am not moving an amendment this afternoon, I think the honourable member's interpretation of this particular provision is the same as the government's position, that is, it currently reads 'the extent of knowledge required by the Valuer-General to satisfy the legislative requirements of the various rating authorities'.

The government proposed adding the words 'as it relates to their taxing statutes'. Whilst we are not formally moving the amendment at the moment, in the discussions I have had with the Hon. Mr Darley he does not disagree that that is a reasonable interpretation of the provisions of subparagraph (d) of the proposed terms of reference.

I acknowledge the Hon. Mr Darley's ongoing interest in the operations of the Office of the Valuer-General. He has been pursuing a particular issue in relation to retirement villages, which we made a commitment on. The Office of the Valuer-General continues to assure the Attorney-General that they will meet all the requirements of the office by the required time, which is 30 June, which is just under two months away. The honourable member has a strong view that that will not be met. I guess we will know by 30 June whether it is or it is not.

The honourable member, I understand from discussions I have had with him, also has strong disagreement with the policy position that was outlined and placed on the website, I think, on 31 March. As I understand it, we will have the opportunity to pursue his view of that particular policy position with the Office of the Valuer-General during the operations of the select committee.

Suffice to say that, whilst the government understands and on some of the occasions has agreed with some of the criticisms the member has made of the office, there are other times where we do not agree with some of the views the Hon. Mr Darley has expressed about the operations of the Valuer-General.

This particular committee, now that it is going to be established, will give the honourable member and indeed other members who serve on the committee the opportunity to establish the facts of the operations of the office and be in a position to, I guess, either come to a united view or maybe a differing view as to recommendations that might come from the proceedings of the committee.

As I said, I am assuming it is unlikely the committee will have concluded its view by 30 June. Certainly, in relation to the issue of retirement villages, the committee, as indeed will all of us, will know whether the undertakings the Valuer-General has given in terms of being able to deliver what is going to be required for the rating of retirement villages will or will not be delivered by 30 June.

In conclusion, as I said, the government's position is that, given the committee is going to be established, it is not going to oppose the establishment of the committee.

The Hon. F. PANGALLO (16:51): We will be supporting the motion.

The Hon. J.A. DARLEY (16:52): First of all, I would like to thank the Leader of the Government and the Leader of the Opposition for their contributions. In terms of some of the comments made by the Leader of the Government, I might add that my concerns about the Valuer-General's operations are not inconsistent with those of the private sector consortium Land Services SA. With that, I will be supporting the opposition's amendment, and I urge all honourable members to support the motion.

Amendment carried; motion as amended carried.

The Hon. J.A. DARLEY (16:55): I move:

That the committee consist of the Hon. Ian Hunter, the Hon. Frank Pangallo, the Hon. Terry Stephens and the mover of the motion.

Motion carried.

The Hon. J.A. DARLEY: I move:

That the committee have power to send for persons, papers and records, to adjourn from place to place and to report on 25 August 2021.

Motion carried.

SOUTH AUSTRALIAN PARLIAMENT WORKPLACE

Adjourned debate on motion of Hon. I. Pnevmatikos:

That this council—

1. Commits itself to leading cultural change within the parliamentary workplace;
2. Welcomes the recommendations made in the Equal Opportunity Commission’s Review of Harassment in the South Australian Parliament Workplace;
3. Declares that sexual and discriminatory harassment will not be tolerated in the parliamentary workplace; and
4. Takes the necessary action to implement Our Watch’s Workplace Equality and Respect Standards.

(Continued from 17 March 2021.)

The Hon. T.A. FRANKS (16:57): I rise on behalf the Greens in this parliament to support the motion of the Hon. Irene Pnevmatikos. I note that this motion is similar to one that I have moved, noting the equal opportunity commissioner's Review of Harassment in the South Australia Parliament Workplace. It is indeed a sad day when we have several motions and a report that is condemning of the practices in this place that have seen quite frightening, disturbing—but unsurprising to most women—cultural practices that include sexual harassment, and that create a toxic workplace and do not support the full enjoyment of democracy, particularly by women in this parliament.

I also note that this particular motion welcomes the report and I do welcome the report. It is an opportunity to have a conversation that has been silenced for far too long. Indeed, the report itself took quite a few motions over many months to ever see the light of day and to get to the equal opportunity commissioner's purview in the first place.

My fear is that while we have now had some response to the report, and I understand we have acceptance and acknowledgement of the recommendations, I have yet to hear where we are up to with issues, such as a people and culture unit, to ensure that human resources are managed in a way that befits the 21st century, not a fiefdom in the Dark Ages. I have yet to hear whether or not we are progressing with things like codes of conduct for all parliamentarians, not just those who are ministers in this place.

As a crossbencher, that was one of the concerns I raised with the government quite early on, as to how those who are not in the leadership of either of the two older parties (in this place and the other) would be informed and know that progress was being made.

I look forward to hearing the Leader of the Government tell us that we have made progress and that there is imminent work coming through, in particular one of the points of the Hon. Irene Pnevmatikos's motion, that our watch's workplace equality and respect standards will soon be implemented for this parliament. I look forward to hearing how that is to be implemented, when it is to be implemented and what progress we have made on these quite useful, timely and urgent recommendations within this report.

The Hon. R.I. LUCAS (Treasurer) (17:00): I wish to thank the Hon. Ms Bonaros; I have another engagement at 10 past 5 so she has kindly allowed me to speak before her. The government's position, as I am advised, is that this motion, in exactly the same terms I am advised, was passed with the support of government members in the House of Assembly and therefore, on that basis, government members are supporting the motion in this house, given that government members have already supported it in the House of Assembly.

The parliament has established a joint committee which will be charged with looking at some of these particular issues. As I understand it, the joint services committee is already considering a response to key parts of this particular report. I think, as I have indicated before, the author of the report, in my view, does not understand the complexity of the parliament, ministerial offices, members' electorate offices and a variety of other people who work in Parliament House who do not report directly to either the joint services committee or to the President or the Speaker—for example, protective security staff.

Staff who work for members of the Legislative Council, for example, are answerable to their immediate employer and are employed by Electorate Services within Treasury, so there are complexities. Clearly there are staff who answer to the Legislative Council, there are staff who report to the House of Assembly and there are joint services staff that the joint services committee has responsibility for. But there is a range of other people who work here—for example, ministerial advisers spend a good amount of their time in Parliament House but they are employed under completely different arrangements again through contracts with the Premier of the day and, in some cases, are actually public servants who operate in ministers' offices but spend time down here at Parliament House.

One cannot expect the author of this particular report to understand the complexities of the government's arrangements at Parliament House so I make no criticism of the author but, therefore, any committee or joint services committee or President or Speaker or, indeed, cabinet and government will have to bear in mind the complexities of who is actually employing whom and who is responsible for whom within Parliament House.

In a number of the other areas, for example, the recommendations about amendments to the Equal Opportunity Act, my understanding is that the Attorney-General is still taking advice in relation to those particular issues. Whilst the motion in the Assembly and in the Council welcomes the recommendations, the Attorney-General, sensibly, is seeking advice as to what the implications might be of some of the mooted amendments to the Equal Opportunity Act.

There are a number of others, as I said, which will be subject to the advice of the joint committee which this parliament has now established to make recommendations on back to both houses of parliament in relation to how various things might or might not be progressed.

The only other thing I can place on the record is that there are about 24 government departments and agencies, I am advised, that are implementing action plans in line with a workplace equality and respect framework, which is implicit in the member's fourth recommendation regarding Our Watch's Workplace Equality and Respect Standards.

I indicate that, as I said, as government members supported a similar motion in the House of Assembly some weeks ago now, government members in this chamber are supporting this particular motion, with those caveats in relation to what ultimately the parliament's response might be, because that will be a decision for parliament or for the Joint Parliamentary Service Committee or, again, as I said, whoever the employing authority is for various other people who work in Parliament House. They will each need to respond in their own way in relation to the implications of some of the recommendations that are canvassed in both the report and referred to in this particular motion.

The Hon. C. BONAROS (17:06): I, too, rise to speak on the Hon. Irene Pnevmatikos's motion calling for an end to sexual and discriminatory harassment in this place. I, too, welcome the recommendations of the Equal Opportunity Commission's review of harassment in the South Australian parliament workplace and look forward to the timely implementation of all of them.

I do not propose to take up too much time today. I am conscious that we have a very important issue to get through, but I think it is important to put some things on the record today. I have spoken before on this and will no doubt be speaking again until we get it right. In doing so, I echo the sentiments of the Hon. Irene Pnevmatikos and the Hon. Tammy Franks. I appreciate some of the complexities also that the Treasurer has just highlighted that we are working through.

As lawmakers, we should be absolutely leading by example, not being the bad example. This is, I think, as we all now appreciate, a defining moment in time, not just for the parliamentary workplace but for all professions and workplaces where clear power imbalances continue to exist. We know harassing behaviours are especially common in professions and workplaces where there is a significant gender power imbalance, as was exposed recently after an investigation into the legal profession.

We have had clear confirmation in not one but two reports now, sadly in the two professions in which the mover and I am a member. It is there in black and white for all to see. We know victims are afraid to speak up for fear of career repercussions. These are not irrational fears. It can be career ending to call out bad behaviour. Victims are blamed when clearly it is the perpetrator who should be.

Victims do not know where to turn or what the complaint processes are, even if they choose to report, but I think it is also important to say that in many cases we know what all the mechanisms are in terms of reporting this sort of behaviour. We know where we ought to go and what we ought to do, but we remain fearful of doing so. The complaints processes, though, are ad hoc and completely inadequate in this place, so it is encouraging that processes will be considered by the newly established parliamentary committee, along with other outstanding recommendations.

There has been some good news to date. A change of standing orders to allow breast or bottle feeding in the chamber has already been answered in one chamber at least. The other place has acted swiftly and promptly to address this issue. I remain hopeful it will soon be addressed in this chamber as well.

The committee has also been tasked with drafting the code of conduct for MPs—yet another long overdue reform. While an improvement in processes is absolutely welcome, the systemic issues—the power imbalance that I have alluded to—still need considerable work in this place and indeed many other places. We need to understand the risk factors and take real steps to address them. We know these include gender, we know they include age, disability, sexuality, cultural and linguistic backgrounds and insecure work status. We know harassment is more likely to occur in less diverse workplaces.

Next week, I will be introducing my gender equality bill, which seeks to address the gender imbalance in select public sector agencies. Why? Because we know that underlying issues of sexual harassment, and issues that have been highlighted in this report, are issues of gender inequality not just in the Public Service but all professions. I will speak more to that at that point, but again, if we do not start at the top, then what hope do other workplaces have?

For now, I commend the Hon. Irene Pnevmatikos for her continued robust advocacy in this space and look forward to zero tolerance of sexual and discriminatory harassment in this and every workplace. Before I close, I would like to reflect on reports yesterday and today of a magistrate facing two inquiries now over sexual harassment: one by the Judicial Conduct Commissioner and the other by the Chief Justice.

If you think, as apparently some members of this parliament do, that these inquiries are a waste of time or unnecessary, you only need look as far as the bravery exemplified by Ms Bitmead—the lawyer who made the claims against a sitting magistrate, a judicial officer—to appreciate the positive impacts these reviews are having. They are giving victims confidence to call out inappropriate and normalised behaviours. They are giving them the strength they need in the face of what is undoubtedly a daunting and extremely intimidating experience.

It is the abhorrent behaviour of perpetrators that brings the legal profession, and indeed this profession and all professions, into disrepute—not the bravery of those who are willing to stand up and call it out. The reputations of our professions do not suffer because people are willing to stand up and say, 'I have been victimised by a perpetrator.' They suffer and they find themselves in absolute tatters, as parliaments across the nation find themselves right now, because for decades we have failed to acknowledge our own failings. We have chosen to sweep bad behaviour under the carpet and we have normalised bad and inappropriate conduct. Regrettably, we have victimised those who have had the intestinal fortitude to question it, to fight for change, to fight for gender equality and to call it out.

As the President of the Women Lawyers' Association SA, Ms Kymberley Lawrence, said just today in InDaily, the issue of sexual harassment has been there for such a long time but this culture of silence is being broken by the Equal Opportunity Commission report. Precisely the same sentiment can be expressed about the report into this parliament and the practices in this parliament and indeed all other workplaces. As was highlighted today by the Judicial Conduct Commissioner, if it is not reported, if we do or say nothing, it will not stop.

The Hon. I. PNEVMATIKOS (17:13): Thank you to the Hon. Tammy Franks, the Hon. Connie Bonaros and the Hon. Rob Lucas for their contribution to the motion. I also wish to thank the member for Reynell for introducing this motion in the other place. Some of the behaviour of this parliament has not gone unnoticed. For years the rights and dignity of workers in this place have been ignored.

The amalgamation of the Equal Opportunity Commissioner, staffers and members both in the federal and state spheres coming forward with accusations of sexual harassment and rape, and the Enough Is Enough campaign, have forced both the state and federal government to act.

Since the introduction of this motion in March, women from all different workplaces have continued to fight for their rights, calling out inappropriate behaviour and taking action against misogyny in the workplace. Yet, both the state and federal governments remain complacent, with no meaningful or structural action taken to address the issues. It simply is not good enough that, after nearly three months of having the equal opportunity commissioner's Review of Harassment in the South Australian Parliament Workplace, we are still waiting to implement the recommendations.

If the chamber is to support this motion, it is a sign of support to survivors who have led the campaign asking for greater protection within their workplaces and a change to the deep misogyny entrenched in parliamentary culture. Further, it reinforces this chamber's commitment to work towards bettering our workplace and actively implementing recommendations made to the parliament on addressing issues of harassment.

I acknowledge that the Hon. Connie Bonaros has a similar motion on this issue and I will be supporting it. We can no longer remain complacent on these issues. A select committee was established by this chamber; we are yet to meet. There have been two false starts and no progress has been made on the issue. Now is the time for action, not words.

Motion carried.

Bills

VOLUNTARY ASSISTED DYING BILL

Committee Stage

In committee.

(Continued from 31 March 2021.)

Clause 1.

The Hon. D.G.E. HOOD: During my second reading speech on 31 March on this bill, I referred to a document published by Palliative Care Victoria. This document suggested that the government funding for palliative care had decreased as a consequence of the introduction of their voluntary assisted dying bill of 2017. It has since come to my attention that this document that I used off their website contained a calculation error and has been removed from their website since.

I also acknowledge that the timing of the report is such that it does not provide any insight into the impact of the Voluntary Assisted Dying Act on palliative care funding in Victoria. I took that information off the website in good faith, assuming it to be correct; it turns out that it was not correct, and I assure members that there was nothing untoward and that I was acting in good faith.

The Hon. R.A. SIMMS: I welcome the opportunity to speak on this important reform—voluntary assisted dying legislation. I thank the Hon. Kyam Maher for putting this on the agenda and for his leadership on this issue. This has been a long-term priority for the Greens, and members will be aware that Mark Parnell moved his own bill back in 2008 and again in 2010. Of course, this is the first time that I have had the opportunity to put my support for this reform on the public record, so I want to make a few remarks about that. I will be exercising my vote in favour of this bill.

Like many in our community, my support for this reform is based on my lived experience and my family's experience. My nanna, Norma, died more than a decade ago, after a long-term battle with Alzheimer's disease. She had the disease for more than 20 years. In her final years she had no quality of life at all. Her mother, my great-grandmother, also died of Alzheimer's disease, and I know, from when my nanna was in good health, this was not a death she wanted for herself. She talked often about not wanting to face the same death that her mother faced. During her final years she was in a vegetative state. She was in obvious distress. She was unable to eat without assistance. Her death was prolonged and it was certainly one that was without dignity.

Obviously, I recognise that the bill before us will not deal with people in my grandmother's situation. She would not have been able to provide consent. But seeing her suffering, prolonged as it was over many years, has solidified my belief that as legislators we need to do what we can to give people choice in their final days.

I will be exercising my vote in favour of the bill for all those who I have loved who have not had the right to die with dignity and all those South Australians who have not only had to endure the loss of a loved one but have also seen them die in prolonged suffering. No-one should have to endure that in modern Australia. My thoughts are with them tonight. It may be too late for us to help them but we can do something to help other South Australians in the future.

I want to acknowledge all those who have shared their experiences in recent days. These matters of life and death are always difficult to talk about. In particular, I was saddened to read the news in *The Advertiser* about Ceara Rickard's health. Ceara is somebody I went to university with. I remember her from my Flinders University days. To quote Ceara:

> These laws are not about choosing death, but giving people a death that works for them when they are…dying and death is near.

As Ceara says:

> The choice of whether I die is not one that I get to make. But how and when I die can be a choice and it is one that I should be free to make.

Those are her words. I really hope that this parliament respects Ceara's choice and the choice of all other South Australians to end their lives with dignity.

The Hon. J.A. DARLEY: I did not make a second reading contribution because I thought my position was well known in this chamber, but I would appreciate the opportunity to make a very brief contribution now.

It is an appropriate time to point out that I have supported all the past bills and will again on this occasion. Many safeguards have been inserted and choice is provided for those who find themselves in an unacceptable end-of-life situation. Elsewhere in our health and welfare system there needs to be substantial improvements to services and their delivery and to make the options more acceptable to those needing extensive support or residential care.

Members have had some time to consider the VAD regime proposed and I will not be well disposed to support amendments that undermine its intent or structure.

The Hon. K.J. MAHER: When we last met to discuss this matter there were a number of questions that were asked and I appreciate that questions were put on notice. I think the nature of the way this debate has been conducted so far is what members of the public would expect of us as parliamentarians. It has been done in a very civil and respectful way. As we have noted before, reasonable people have come to very different views on these issues, and they are sensitive and difficult issues.

I think of the joint committee that the Hon. Mr Hood and I sat on. It was mentioned on more than one occasion that we do not discuss or deal with death in the way that we probably should as a society. I think the way that we have all conducted ourselves does us a great deal of credit. I think that started with the 18-month joint house committee on end-of-life choices. It did not start that well, with the Hon. Dennis Hood trying to roll the chair of the committee, but it has been very respectful and if there have been questions or issues to sort out I think it has been done in very good faith, not just with the Hon. Dennis Hood but with all members. I thank everybody for that.

I have quite a number of questions that were asked by the Hon. Dennis Hood and the Hon. Clare Scriven last time we met and I will go through the answers in relation to them. Some of them can be done reasonably briefly, some of them will take a few minutes more to answer, and if there is further follow-up needed I am happy to do that. The information that gives rise to the answers is probably a couple of hundred pages in total, but I shall not try to battle the Hon. Frank Pangallo for time speaking in this chamber and read them all out.

The first question from the Hon. Dennis Hood was in relation to medical associations opposed to voluntary assisted dying. I addressed that largely when I responded to that question previously in the first reading of clause 1, but I can get further information to supplement my previous answer. As stated by the Hon. Dennis Hood in his question, the Australian Medical Association has a stance of opposition to voluntary assisted dying; however, it should be noted that is not in line with its membership, a majority of whom said, in the AMA's own 2016 survey, that VAD should be provided by doctors if and when it is legalised.

Palliative Care Australia is now neutral towards VAD reform. The Royal Australian College of GPs, whose membership is larger than the AMA's, supports lawful VAD choice, as does the Australian Psychological Society and the Australian Nursing and Midwifery Federation, whose South Australian branch has directly made comment and recommended legislation to be passed in South Australia.

The Hon. Dennis Hood's second question raised the prospect that voluntary assisted dying will negatively impact on palliative care. The Hon. Dennis Hood had this question and a related question about palliative care funding, and he and I have spoken about this in recent days. I completely accept that he was relying on information that was put on a palliative care website in Victoria that was not correct, because we found the same information and were able to come to the same conclusion that it was reasonable to rely on that information, except that the source of the information was not correct.

I think it is important to acknowledge that, while the quality of palliative care services in Australia is world leading, even the two peak palliative care bodies, Palliative Care Australia and the Australian and New Zealand Society of Palliative Care Medicine, acknowledge that palliative care cannot address all intolerable suffering. A quote from them is:

> While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimum palliative care. It is simplistic to argue that palliative care can remove all suffering at the end of life.

Palliative Care Australia commissioned research into the impact of legal VAD on palliative care funding. The report focused particularly on European jurisdictions and Canada and found:

> …no evidence to suggest that the palliative care sectors were adversely impacted by the introduction of legislation. If anything, in jurisdictions where assisted dying is available the palliative care sector has further advanced.

Emeritus Professor Ian Maddocks AM, foundation chair of palliative care at Flinders Uni and a resident in South Australia, wrote in the *Medical Journal of Australia* in 2018:

> In countries where assisted dying has been introduced, palliative care has continued to flourish and grow.

The US states of Oregon and Washington, the first US states with voluntary assisted dying laws, are two of eight states across the US awarded the A grade in the 2011 national review of palliative care services and quality.

In Victoria, the Victorian government increased the funding of palliative care by $62 million and a further $17 million in 2017-18, the year in which the voluntary assisted dying legislation was passed in that state. I am informed there was an additional $23 million in 2018-19, and in the 2019-20 budget they allocated an additional $75 million over four years.

The third question the Hon. Dennis Hood asked was about a claim that people chose voluntary assisted dying to avoid being a burden to others in the state of Washington in the US. There are a number of questions that follow from the Hon. Dennis Hood's question, which uses examples from either the North American or European jurisdictions. The legislation that we are debating here today is substantially different from overseas schemes.

I think a useful summary of the very general, broad differences is provided in the final report of the Victorian ministerial advisory panel, which characterised the North American and particularly the US model as requiring a person to qualify as having a terminal illness, while it generalised the European model as requiring a person to be enduring suffering. The Australian model effectively takes both of those things: a requirement that a person is terminally ill and is suffering. So, as a general statement, in Australia we have taken both the qualifying elements of the European and the US systems. While examples from Europe or the US may be of limited utility, I will still try, as best I can, to answer the questions the Hon. Dennis Hood has asked.

The 2013 report that I think was cited in the Hon. Dennis Hood's question is the Washington State Department of Health 2013 Death with Dignity Act Report. The years 2013 and 2012 were the years when the highest number of participants included 'burden on family and friends' as an end-of-life concern. In 2013 it was 61 per cent and in 2012 it was 63 per cent. In the other eight years, the proportion of people nominating this ranged between 23 and 56 per cent.

Up until the publication of the 2019 report, there had been 10 annual reports of the Death with Dignity Act in Washington state. The most significant end-of-life concern for respondents in those reports was loss of autonomy, with 85 to 90 per cent of participants consistently nominating that as an end-of-life concern. The 10 annual reports listed that being a burden was consistently listed as the fourth most significant end-of-life concern. So while that was a concern, the year quoted was one of the two years when it was the highest proportion. They asked a whole lot of questions, and it is consistently ranked number four in order of the concerns in those reports in Washington state.

I think the next three questions from the Hon. Dennis Hood refer to particular individual patient cases. The first one is a claim that a vulnerable older woman was not competent and subject to undue influence in a case in Oregon in the US. Again, I will preface it by saying that there are very significant differences in the way the scheme operates in the US compared with what we are proposing here. I think what is developing as the Australian model of voluntary assisted dying is consistently recognised as much more stringent and conservative.

This particular case centres around a patient named Kate Cheney. The claim is that she was not competent to make decisions and was being pressured by her daughter. I am informed and advised in relation to this case that a mental health professional thought Ms Cheney was competent and also thought that her daughter was a strong advocate but that the patient was not pressured by her daughter in considering using the law.

The doctor referred her for a second opinion to another mental health professional, who also concluded that she was capable of making the decision to use the Oregon Death with Dignity Act. I am informed that Ms Cheney's physician did not claim she was incompetent. Instead, he refused to write her a prescription, as is his right, because he does not support the act of end-of-life choices.

The medical director of Ms Cheney's health management organisation (HMO), who provides oversight on all cases where a request has been made for a hastened death, determined that Ms Cheney was competent and under no duress. I am informed that Ms Cheney held on to the prescription for the voluntary assisted dying substance for some three months before she made a decision to use it.

The fifth question the Hon. Dennis Hood asked is again about a particular individual's patient case. The allegation is that mental illness was approved for voluntary assisted dying in Oregon. I think the allegation is that according to a physician, Dr Hamilton, Michael Freeland had a history of mental illness and was incompetent, therefore should not have qualified to receive medication under Oregon's Death with Dignity law.

I am informed that the facts are that five physicians involved in the case agreed that at the time Michael Freeland—I think he was quoted in the question as Freeman; I think the name is Freeland—received his prescription under that state's laws he was mentally competent and within six months of dying as well. I am informed that he was mentally competent when he received the medication, when he kept his medication and when he chose not to use the medication.

A particular doctor, I am informed, was apparently involved with the care of Mr Freeland for several months and never once raised an issue with authorities while he was still alive and could speak for himself about these concerns. Since the time Mr Freeland died, his family, I am informed, have been concerned that his private medical records have been used in a political campaign against voluntary assisted dying, and the family have requested for this to cease.

The sixth question the Hon. Dennis Hood asked was again about a particular case in Oregon, involving a woman called Helen. The concern or the allegation is that doctors found this patient, Helen, to be depressed, and that she then went to other doctors and that this is an example of doctor shopping—looking for someone who is prepared to write a prescription.

I am informed neither of the doctors in the Oregon system found the patient Helen to be incompetent. Instead, I am informed they simply did not support the law. One of the doctors, I am informed, said she was sad about her pending death and characterised her sadness as slight depression that did not interfere with her ability to make a rational decision. It was one of her original doctors who recommended that Helen seek further opinions, which she did.

I do note that in the Australian model being proposed by the bill before the parliament there is very significant oversight that requires every single assessment that is made by every single doctor involved to be sent to the Voluntary Assisted Dying Review Board that is proposed under the legislation for that extra oversight.

In the seventh question the Hon. Dennis Hood asked I think the question talks about the expansion of voluntary assisted dying in the Netherlands. I am informed that official data from the Netherlands showed after an initial gradual increase as the law became recognised the rate of voluntary assisted dying use in the Netherlands has levelled off and that these laws are based on establishing agreed criteria for its use, not a cap of how many people might use it.

I am informed that the Netherlands, since the introduction of the legislation in 2001, has not amended their legislation. I think the Hon. Dennis Hood asked, 'How can we ensure this bill will not be enlarged further in its scope in relation to what has happened in the Netherlands?' As I say, I am advised that the Netherlands have not increased their scope; they have not amended their law.

I know that is one of the common concerns that some who do not agree with this bill have—that slippery slope: how do we know it is not going to go further? I think quite simply the only way these laws, like any other laws, could possibly change is with the consent of both chambers of this parliament. It provides a pretty strong safeguard against concerns about the potential change of scope. It does not happen unless both houses of a parliament elected by the people of South Australia agree to it.

The experience around the globe is that once established, there is very little change that occurs with these laws. I think that mitigates the concern many have about that creeping scope. The laws change very little once they are established in a jurisdiction.

The Hon. Dennis Hood's eighth question was about the short-lived Northern Territory scheme and patients who were suffering from depression. I am informed that the NT act, while it remained operational—for that short amount of time—included many criteria which needed to be met for voluntary assisted dying. There was a claim that patients involved had symptoms of depression made by a Professor Kissane, who I am informed did not meet any of the patients who used the NT Rights of the Terminally Ill Act at the time.

I am informed three of the four patients in the NT had terminal cancer and the fourth, a Janet Mills, had mycosis fungoides—and the Hon. Denis Hood might know that better; I will give that to Hansard later, because I am sure my medical pronunciation is not correct. I think to the proposition that the Hon. Dennis Hood put—'Could that happen in the same circumstances here?'—the very simple answer is there are those 68 separate safeguards in the Victorian bill, which is what we have taken an almost carbon copy of in South Australia. In addition, it is very clear that section 13(2) makes it very clear a person is not eligible for VAD only because of a diagnosis of mental illness. It is spelt out in the bill.

The ninth question the Hon. Dennis Hood question asked is about mental competence not being addressed in the bill. In South Australia, the bill that is before us, again, as I said, does not permit VAD exclusively for the reason of mental illness in clause 13(2), and, I might add, nor for disability, as in clause 13(3). Clause 4 details the meaning of 'decision making capacity' in relation to voluntary assisted dying.

Clause 13(1)(c) expressly requires a person to have the decision-making capacity as a precondition for access to voluntary assisted dying, and it further requires both the coordinating and consulting doctors to assess and determine the person's decision-making capacity as part of the assessment process.

The 10th question Dennis Hood has asked about is, again, an expansion of voluntary assisted dying in a jurisdiction. I think he asked about an expansion in Belgium. Again, I will just restate the answer from before that the biggest safeguard we have against expansion is that two chambers of the South Australian parliament that are elected by the people of South Australia would need to agree on any possible changes, which the experience around the world shows are very few and far between.

The 11th question from the Hon. Dennis Hood is in relation to a question about whether VAD will negatively impact on the quality of palliative care. I will not restate what I said before about the experience in Victoria and the significant funding increase after palliative care was established in Victoria. I think that has been the experience in WA as well and the first two states in the US to introduce voluntary assisted dying regimes are some of the top-rated in terms of palliative care around the US.

The 12th question from the Hon. Dennis Hood is specifically about palliative care funding and the figure of a decrease of 6.3 per cent, and I do not think we need to go in to that. I think there was a reliance on information on a website that was incorrect. The 13th question by the Hon. Dennis Hood is about the use of voluntary assisted dying for minors. The question is: what would prevent that happening in the future? I will restate again: there have been very few changes once a scheme is established. I just cannot see that happening in Australia.

We have, for a very long time, held in Australia that the legal age for decision-making capacity in most areas is 18. This bill requires the person to have attained the age of majority before being eligible to access voluntary assisted dying. All those criteria have to be expressly attested to by two separate doctors. I do not mind placing on the record that I do not support voluntary assisted dying being made eligible for minors, and I think that if I do not support it, it is going to be very unlikely we are ever going to see a majority in both houses of parliament support that.

Question 14 from the Hon. Dennis Hood was in relation to a Dutch doctor being sued for not approving VAD. This is one where I might forward the further and better particulars to the Hon. Dennis Hood about this case. My information is—and it goes over quite a number of pages—that there was a doctor who was not sued for not authorising VAD, but in the case, I think it was a Mrs Demore wanted access to VAD and I think it was an unprofessional conduct complaint that was lodged against a practitioner for, as the details have been put before me, trying to stop the person using VAD. So it was not any lawsuit to try to force someone to use VAD as it has been put before me on the basis of alleged unprofessional conduct. That one ended in quite tragic circumstances with that particular patient taking their own life in a pretty gruesome sort of way.

The 15th question from the Hon. Dennis Hood was about the loss of life years when future medical discoveries may help. I think it outlined for a young person who elects to use VAD because they meet all the criteria, and the question essentially was about the possibility of a medical breakthrough that might appear when they are in their 20s or 30s that could potentially save them and cure them from such an illness, and what is in the VAD bill to protect against that.

The fact that the time period used in our VAD bill is 'diagnosed in the last six months of your life', except for 12 months with a neurodegenerative disease, guards against that. The possibility of a miracle cure—for someone with a terminal illness that will bring about their death in the last few months of their life—is unlikely. It would be a reasonable point if the time frame was five years or 10 years that someone was diagnosed to live, I think that is a realistic possibility, but it is quite deliberately conservative and restrictive and down to the last six months.

They are the questions from the Hon. Dennis Hood. As I said, on that second to last one I am happy to get further information rather than reading pages and pages of an allegation and then the response to the particulars of the allegation into *Hansard*.

The Hon. Clare Scriven asked a few questions. The first question was about the establishment in the later clauses of the bill of the Voluntary Assisted Dying Review Board, and was it possible to get an indication of what resources would be provided for them to carry out their duties. I would like to thank the Hon. Stephen Wade, the health minister in this place, who, on a number of things, has sought comment from his department. I think all members have benefitted from some of the comments from members of his department who, as Dennis said, without supporting or not supporting the bill, have made general comment that I think has provided useful guidance.

I can quote the departmental advice that the Hon. Stephen Wade sought in relation to that question. It says simply:

> If the VAD Bill was to pass into law the Department for Health and Wellbeing would undertake an assessment of the resource needs of the legal entity, the VAD review board, and fund accordingly.

I think that is what we would expect, and no less, from any legislation that we pass. It is not uncommon for us to pass legislation that establishes an office, a commissioner or an oversight function. I am grateful for that advice from the health minister that resources would be made available to implement what is required under this legislation.

I guess if this legislation did pass in South Australia the health department would not be starting from scratch and could then seek advice from Victoria, as they already have and have had in operation for close on two years a Voluntary Assisted Dying Review Board, and Western Australia, where I am assuming they have already established their Voluntary Assisted Dying Review Board given that their scheme becomes operational—I think it is at the start of the next financial year, the start of July, or if it is not then it is soon thereafter.

The second question from the Hon. Clare Scriven was in relation to the nature of doctor training, which is a mandatory requirement for any doctor whether they are the coordinating or consulting medical practitioner under the Voluntary Assisted Dying Scheme. They cannot complete the assessment and be part of the Voluntary Assisted Dying Scheme unless they have undertaken compulsory training, a number of elements of which are set out in the act.

I am grateful for some advice from Victoria, which has been able to give a little bit of information about the detailed training modules that the Victorian government established prior to the commencement of the Voluntary Assisted Dying Act and its scheme in 2019. I am informed that the modules are studied by a doctor prior to undertaking a VAD assessment. The VAD modules take approximately eight hours to complete and are able to be undertaken by the doctor at the doctor's own pace. Content knowledge is examined using approximately 30 multiple choice questions. I am informed that a candidate must score over 90 per cent to pass, and if they fail twice they must wait a prescribed period of time before being retested.

I am informed a detailed manual is available for doctors to remind them and ensure that a VAD case is conducted to the highest standard and meets every requirement. I think that has been reflected in the very strict compliance that the reporting on the operation of the VAD scheme in Victoria so far has found.

In Victoria, the state has funded a Care Navigator Service, which helps people, patients and, I think, doctors navigate the VAD system in Victoria. I am informed the Western Australian government has been developing similar modules prior to commencement of their act in July of this year. Again, I suspect it would be very similar. If a bill was successful in South Australia, for much of the training that doctors undertake, we would seek guidance and probably look to implement, I suspect, some of the Victorian and Western Australian modules, given that we both have very similar schemes, based on what I think the health minister has correctly described as the Australian model of voluntary assisted dying.

The final question from the Hon. Clare Scriven relates to advance care directives. I think the question was whether in South Australia advance care directives were considered. Section 23(1) of the act refers to information to be provided by the coordinating medical practitioner. I think the question Hon. Clare Scriven asked was why it is not in that section of the act. Was it because this is essentially a carbon copy of the Victorian legislation and in Victoria they do not have the advance care directive legislation that we have, or was it deliberately and specifically excluded from this act?

I am able to inform the chamber that in Victoria they do have advance care directives under their Medical Treatment Planning and Decisions Act 2016, so they have a very similar regime for the availability of advance care directives. The Victorian scheme has chosen not to include advance care directives as one of those items of information that must be provided.

As I said, we are following quite strictly the Victorian model and what is emerging as the Australian model of voluntary assisted dying. Palliative care is one of the options. I think clause 23(1)(c) states one of the matters to be provided is:

> (c) palliative care options available to the person and the likely outcomes of that care;

I appreciate the Hon. Clare Scriven asked me a couple more questions just before we started today. Advance care directives could be one of the items in there but also, equally, there are probably a whole lot of other possible end-of-life choices that could be in there. You could have a requirement that the doctor must inform the patient of the possibility that they can refuse medical treatment towards the end of their life.

You could also possibly include a doctor having to inform a patient about what the Hon. Stephen Wade talks about as the 'double effect' rule, that under the Consent to Medical Treatment and Palliative Care Act the patient can have a medical intervention that the doctor knows hastens their death, as long the primary intention of that is to bring about relief and comfort.

These are all things that could be included in there, but I think in terms of care options, the palliative care option is probably the one that is most relevant there. I suspect that was the motivation for the drafting in Victoria, given that they do have the same availability of palliative care options.

They are the answers to the questions that already have been put on notice. Again, I want to reiterate my gratitude to members for the respectful way this has been conducted and for those sorts of general questions to be put on notice to allow a full consideration and a response that helps understand the issues, rather than having a debate where things are brought up to test someone's knowledge on their feet about a specific thing in the bill or where a comma is. As I said, I think this does us a great deal of credit, as we are conducting this debate in a respectful way.

The Hon. D.G.E. HOOD: I will be quite brief initially. I thank the Hon. Mr Maher for his response to my multiple questions that I put on notice to him last time we met to debate this bill. He has obviously put in a good deal of work to compile those answers and I understand there is more detail to come, so I thank him for that.

This is not a love-in, but I think it is appropriate to acknowledge the Hon. Mr Maher's comments about the respectful way in which this debate has been conducted thus far. I think it is very important. I think, frankly, that is what people would expect of us and I am pleased that that is how it has ensued.

It would be remiss of me not to acknowledge that the voluntary assisted dying committee that sprang from this bill looked at all sorts of issues around end-of-life care, including palliative care. That was a productive committee, chaired by the Hon. Mr Maher. Whilst there were very strongly differing opinions on both sides of that debate, it was conducted in a way that I think was befitting of this place and of what we are trying to achieve.

I have a number of amendments, as people know, which I will move, I guess, after dinner now and other members will too. In my discussions with the Hon. Mr Maher, he suggested to me that he may not support any of them. I wish it were otherwise, but that is my expectation. If they will not get up, I do intend to move them anyway because I think the debate is worth having. I will proceed in that direction later this evening when we return after dinner.

The Hon. C.M. SCRIVEN: I would also like to thank the Hon. Mr Maher for providing those answers. I would just note that, in the previous contributions when those questions were put on notice, he had undertaken to come back to me in the break in regard to my question about advance care directives so that I could decide whether or not to move an amendment.

I would like to place on the record that I think it is concerning that, in the bill as proposed, information will be provided about voluntary assisted dying and palliative care but not about the right to refuse care, for example, or indeed the double effect, as the Hon. Mr Maher suggested, could be an extra item that would be important to a person nearing the end of their life. I certainly would have prepared an amendment had I had that answer in the time frame. However, obviously, if the bill passes tonight there is an opportunity between the houses for others to prepare such an amendment.

I would like to just very briefly also place on the record the fact that, in my previous contribution, there have been some public comments saying that the information that I have provided, because it related to the 1990s situation in the Netherlands and the very extensive reviews there, was not relevant because the legislation did not change until the early 2000s. Perhaps those making those comments were unaware that there is a judge-made law, which happened in the Netherlands, whereby euthanasia was able to be accessed, and that is why the Attorney-General in the Netherlands was able to do such an extensive investigation over a number of years.

My points were that the law may not change but the practice does with safeguards ignored, which is the main drawback of any voluntary assisted dying law. Also, in the first years of new legislation there tends to be strict adherence, but culture changes over time and therefore practice changes over time, which is why the less than two years' experience of Victoria is insufficient to form an informed view about whether that legislation is indeed working in the way that it was intended or the way that is appropriate.

Sitting suspended from 17:59 to 19:45.

Clause passed.

Clause 2.

The Hon. D.G.E. HOOD: I state very briefly at the outset of my questions and amendments that none of this is intended to delay—I do not think it will delay—just so that the mover knows. I have a question at clause 2, and I have half a dozen questions roughly, and people are aware of the amendments I have filed. On clause 2, it may be a difficult one for the mover to answer, and perhaps is even a question for the government or the Attorney at some stage, but when would it be proclaimed? Obviously in Victoria there was an 18-month or thereabouts lead-in, and I understand they are doing similar elsewhere. What is the member's intention?

The Hon. K.J. MAHER: The health minister, the Hon. Stephen Wade, I am sure will supplement my answer. The honourable member is correct: it was about an 18-month lead-in time to get all the administrative things needed in place in Victoria. The appointment and the setting up of the Voluntary Assisted Dying Review Board, the training modules required under the act, the Care Navigator Service—there was quite a lot, as the member would appreciate, that went into setting it up. I think the Western Australian scheme comes into operation at the start of July this year, and I think off the top of my head that it may be around a 12-month, or maybe a tiny bit more, time frame.

It might be that it is somewhere around that 12-month time frame. I suspect the Victorian scheme probably will be the longest to do all those things necessary to become operational. My best guess would be 12 months up to 18 months, based on previous experience in other jurisdictions that have already passed this. Of course, we will not be reinventing the wheel, as the health minister pointed out in his second reading contribution. There is a developing Australian model for voluntary assisted dying, which Western Australia, Tasmania and certainly we are implementing very closely. There will be similarities, and my best guess is that it is a 12 to 18-month time frame.

The Hon. S.G. WADE: Thank you, Mr Maher, for suggesting that I might like to add to this. Certainly SA Health does not want to move too quickly. We get dizzy when we move too quickly. The advice from SA Health is that there be significant lead times involved—perhaps 18 to 24 months. Of course, first of all the government needs to decide where the act would be committed, if it passes the parliament, and whether it is committed to the health minister. My understanding is that in other jurisdictions it is, so my expectation is that South Australia would follow course.

Whilst I agree with the comments of the Hon. Kyam Maher that we do benefit from a number of jurisdictions having already implemented this or similar bills, there is always something unique. One of my amendments addresses the consent to medical treatment and palliative care legislation, which is unique to South Australia. That will impact on implementation if the bill is passed.

I think it is also really important to understand the operational issues that our clinicians will need to work through. SA Health convened a clinicians' forum to discuss the bill, and a lot of the issues that were discussed were the sorts of issues that will need to be discussed by clinical networks and not by parliamentarians. The people were talking about: if we are providing palliative care to somebody in a palliative care ward, how does that interact with any other clinicians who might be offering the same person voluntary assisted dying?

To be frank, it has been an issue in Victoria. Perhaps we have less consultation to do or less work to do because legislatively we follow in the footsteps of other jurisdictions, but their experience raises issues that are best discussed and worked through. I suspect we have less work to do legislatively and administratively but we have more work to do in terms of clinical consultation. SA Health is suggesting 18 to 24 months, but that would be very much the responsibility of the government to make an assessment about what are reasonable time frames and to make a proclamation at an appropriate time.

Clause passed.

Clause 3.

The CHAIR: We now come to the first of the amendments on clause 3. It is amendment No. 1 [Hood-1], clause 3, page 10, after line 22.

The Hon. D.G.E. HOOD: This is very much a test amendment and, with your agreement, sir, I will explain what I mean by that. Really, this amendment just inserts the term 'palliative care specialist' into the bill. There is no need to insert that term if my subsequent amendment, that is, amendment No. 6, actually fails.

So with your agreement, sir, it would be my proposal to have the substantive debate on amendment No. 6 now, although I will move the first amendment. If that fails, there will be no need to move amendment No. 6 when I get to it. Is that understandable and acceptable? There being no objection to that in the chamber, I draw members' attention to amendment No. 6 [Hood-1] which, as I said, is the substantive amendment upon which amendment No. 1 [Hood-1] is based.

To further complicate things, I have moved a subsequent amendment to replace amendment No. 6 [Hood-1], which is amendment No. 1 [Hood-2], just to make that clear, and they are very similar. The only difference is that the first amendment called for two palliative care specialists to be involved, but the second amendment, that is, amendment No. 1 [Hood-2], reduces the number of two palliative care specialists to just a single palliative care specialist. It is as simple as that. I move:

Amendment No 1 [Hood–1]—

Page 10, after line 22—Insert:

palliative care specialist means a medical practitioner with expertise in the area of palliative care;

As I said, I will debate the substantive issue and that will determine where we go from there. What is the intention of this amendment? The intention of this amendment is to insert paragraph (e) in clause 13. Clause 13 is a very central clause to the bill that deals with the criteria for access to voluntary assisted dying; so how one qualifies, essentially, for this scheme or program or whatever it is.

It goes through what you might consider a very reasonable list of criteria. That is, they have to be over 18 at least, they must be an Australian citizen ordinarily resident in South Australia, when they make their first request they have lived in South Australia for at least 12 months and they must have decision-making capacity in relation to this issue. Paragraph (d) is the paragraph that I am seeking to amend. I will read it verbatim. It says:

> (d) the person must be diagnosed with a disease, illness or medical condition that—
>
> (i) is incurable; and
>
> (ii) is advanced, progressive and will cause death; and
>
> (iii) is expected to cause death within weeks or months, not exceeding 6 months; and
>
> (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

I am seeking to put in paragraph (e), which provides:

> (e) [and] a palliative care specialist must have certified, in accordance with any requirements set out in the regulations, that such palliative care as may be reasonably available to the person would not be of therapeutic benefit.

In simple terms, this amendment requires a person seeking euthanasia or voluntary assisted dying to be consulted by a palliative care specialist to ensure that their pain cannot be treated using palliative care. I would argue that that is entirely reasonable. In fact, clause 13(1)(d)(iv) of the bill says that the medical condition 'is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'. How can we possibly know that it cannot be relieved if that individual has not seen the most qualified type of person in pain management available in order to see if they can relieve their pain?

It is my contention that we cannot know that that pain cannot be relieved if they have not seen a person who has the most tools in their armoury or the most capacity to treat that particular type of pain. As I said, the bill says if the suffering of that person 'cannot be relieved in a manner that the person considers tolerable' but we cannot know that until they have seen somebody qualified to make that decision. I refer to the AMA position statement on euthanasia and physician assisted suicide. Section 1.3 states:

> 1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life…

So the AMA is quite clear. They believe that not all but—their word is—'most' patients and most pain can be relieved. I am saying that if the intention of this bill is to allow for those who are at the extreme end—that is, as it says here, they have suffering that cannot be relieved, an incurable disease, etc.—then to really be sure of that we need to put them in front of a palliative care specialist so that they can make that decision. The World Health Organization has stated, and I quote directly:

> Palliative care affirms life and regards dying as a normal process. When palliative care of the highest quality is made available to every patient it improves the chances of pain being managed, thus reducing the desire to be euthanased.

The World Health Organization is quite explicit in that, and I will just repeat that last part:

> When palliative care of the highest quality is made available to every patient it improves the chances of pain being managed, thus reducing the desire to be euthanased.

I contend that we should give these individuals who are in this precarious situation the opportunity for their pain to be relieved before they take what might be the ultimate solution, and that is to accept assisted suicide. My amendment requires them to have a consultation with a palliative care specialist and then, if the palliative care specialist is of the view that he or she cannot adequately treat that pain, then so be it. The criteria has then been satisfied and the person has satisfied this part of the criteria for physician assisted suicide. That is essentially my position.

The Hon. K.J. MAHER: I thank the mover for his amendment. I have had the benefit—and I think it has been of benefit to both of us—to spend some time this week with the Hon. Dennis Hood discussing his amendments, and I appreciate the ability to have done that. For the benefit of the committee considering this tonight, I will outline that I am intending to oppose all the Hon. Dennis Hood's amendments. I think that comes as no surprise to the Hon. Mr Hood.

One of the overarching reasons, and I will reflect again on the second reading contribution from the health minister, is that I think the amendments the Hon. Dennis Hood is moving, however well intentioned, bring us to departing, and quite often in a quite substantial manner, from the Australian model that Victoria first enacted, that we have seen WA and Tasmania enact and that we are now looking at. I think there is great benefit in having a scheme or schemes around Australia that share substantial similarities. I am not keen to depart greatly from those, and I think this does possibly in a very major way.

There are a few reasons I disagree, and I will go through them briefly. The first one is, as the Hon. Dennis Hood has gone through, those qualifying criteria, if you like. They talk about suffering in a manner that the person does not consider tolerable. I think it is a feature that wherever suffering is required for voluntary assisted dying—as I talked about earlier, the differences in the models in Europe and in the US do not always require that, but I will look further into it later—in all the models that have suffering that is not considered tolerable it is up to the patient to decide that.

It is not something where an outside specialist comes in and tells a patient, 'Your suffering is tolerable.' I think it is reflected in all the Australian models, and I suspect the overseas ones, that it is subjective, that it is up to the patient to determine whether or not that suffering is tolerable. Suffering does not always necessarily mean, although it often does, immediate physical pain.

The substance of the amendment requires the involvement of a palliative care specialist; it was two and I appreciate that it has been refined back to just one. I oppose that insertion, but I oppose even more the idea that they must assert that no palliative care would be of therapeutic benefit. To the first part of that, we already have the coordinating medical practitioner and the consultant medical practitioner, one of whom must be a specialist in the disease, illness or medical condition that affects the patient. There are qualifications that both those medical people involved must have.

I think it is a very significant departure from the Australian model to require another health practitioner as a third person to be involved. For a couple of reasons, I do not think it is a good idea. Firstly, a palliative care specialist might not be the most appropriate person to give that diagnosis about the condition of the person.

The ministerial expert panel in Victoria talks in a number of places about palliative care specialists often being someone who can assist, whether it is in determining a patient's ability to understand, their mental capacity to enter into a voluntary assisted dying scheme or the pain of their condition, but there are a whole lot of others who could also assist, like gerontologists. By having only palliative care specialists, it narrows it down from any other form of medical practitioner or specialist who may be even more appropriate than only a palliative care specialist.

Even more concerning than just that—and we checked this morning—according to the Medical Board of Australia's registrant data for the reporting period of the last quarter of 2020, which was published on 10 February 2021, in South Australia there were 2,185 general practitioners, 4,589 general and specialist practitioners and 27 palliative care doctors. If we are limiting it down to palliative care specialists, which I think is a bad idea to start with, it also means you are quite likely going to have to find one of only 27 people. It would almost certainly deny nearly everyone in a regional area from accessing VAD, to get to that third person, the palliative care specialist, and I think it would substantially and to my view unacceptably limit the number of people who might be able to avail themselves of the scheme.

I appreciate the intention of the amendment but on that part I fundamentally disagree. I even more fundamentally disagree with the second part, that is, the palliative care specialist has to certify that for the person who has the treatment there would be a therapeutic benefit, that is, that there is nothing else that can be done. That even more fundamentally breaches a patient's right to refuse treatment.

The Consent to Medical Treatment and Palliative Care Act very specifically makes it clear that any person can refuse treatment and they can refuse treatment even if that treatment might be life saving. What this amendment would in effect do (if the bill passes) is create a legal option for a person to get a medical intervention, that is, voluntary assisted dying, but only if they have tried everything else.

A person has a right not to try something. I think it is an exceptionally fundamental right of a person to refuse medical treatment. What this would have the effect of doing is to say, 'You have to try this medical treatment if you want to be involved in what would be (if this bill passes) a legal medical intervention.' So, for a range of cascading reasons, I disagree a bit, I disagree quite a lot and I disagree very strongly with things in there. I understand where the Hon. Dennis Hood is coming from but on this one we have a different viewpoint.

The Hon. S.G. WADE: I would like to indicate that I also join the Hon. Kyam Maher in not supporting this amendment. I do agree with the Hon. Kyam Maher that the issue of being able to find medical practitioners in this legislation would be problematic with this amendment if it passed. The proposed amendment would seek to have palliative care specialists certify that the voluntary assisted dying applicant would not benefit from palliative care.

This additional criteria creates a significant barrier to access, requiring the approval of multiple different medical practitioners: one coordinating medical practitioner, one consulting medical practitioner, one specialist medical practitioner (if deemed necessary), in addition to the proposed palliative care specialist. From an implementation perspective, and given the dearth of medical practitioners willing to provide voluntary assisted dying, this proposed amendment I fear would render the bill inoperable in practice.

The amendment, though, raises a key issue for me. My amendment, which we will be discussing later—and I assure the Chair that I will not be dwelling on it—the key purpose of the amendment that I will be moving later is to try to avoid the conflation of palliative care and voluntary assisted dying, and this amendment does exactly that.

It not only, shall we say, does not avoid the conflation that I think is already in the current bill, it actually doubles it. It says, 'Not only are we not clear about the difference between voluntary assisted dying and palliative care, we actually want a palliative care specialist interposed in a voluntary assisted dying process.'

I was very fortunate to be an observer at a clinical forum for SA Health clinicians to discuss this bill. Let's be clear, the Department for Health and Wellbeing and SA Health does not have a view on this bill. There were people in that room who vehemently opposed voluntary assisted dying and there were people who actively supported it, but the overwhelming consensus was that we do not want conflation.

We do not want medical practitioners going into a treatment context and muddying the waters about whether they are providing palliative care or voluntary assisted dying. That forum emphasised that VAD and palliative care should not be conflated. Though most people who seek voluntary assisted dying would also be supported by palliative care and end-of-life services, it is important to clarify that voluntary assisted dying and palliative care are not the same.

Palliative care does not include the practice of voluntary assisted dying, nor is voluntary assisted dying intended to be an alternative to palliative care. Both are part of a range of end-of-life choices. The reason I oppose this amendment is because we need to have that distinction codified in law, and I believe that supporting this amendment would go in the opposite direction.

Respectfully, I disagree with the Hon. Dennis Hood in relying, as he did, on a policy statement of the AMA in support of this amendment. I refer honourable members to the letter sent to me on 3 May by the South Australian President of the Australian Medical Association together with the Chair of the Board of Management of Palliative Care SA, Professor Gregory Crawford. On page 2 of their letter—and I will, in due course, table this so that it might be to the benefit of the parliament going forward—there are two particular paragraphs that are relevant on this point. They refer to the same forum I was present at, and they say:

> The forum held on 10 February revealed major practical difference problems in the Victorian experience stemming from confusion between what constitutes voluntary assisted dying and palliative care. For example, a failure to have a clear, common understanding of the difference between these two concepts might cause confusion at the level of governance, transparency of funding and practical provision of care and the functioning of a palliative care service which might also provide VAD services, and this might then flow to a confusion for patients and their families.
>
> This would be especially problematic if health practitioners working within such a service had a conscientious objection to providing voluntary assisted dying. In addition, any confusion in the minds of doctors between palliative care and voluntary assisted dying could have the effect of undermining the provision of good palliative care, with the potential for some doctors then becoming fearful of providing adequate analgesia to terminally ill patients for fear of being accused of actively ending a patient's life without their consent. That is, euthanising their patient.

I would argue, with the support of that letter, that it is very important this bill maintains a clear distinction between palliative care and voluntary assisted dying. With all due respect, I believe the Hon. Dennis Hood's amendment increases the conflation rather than reduces it, so I cannot support this amendment.

The Hon. J.A. DARLEY: For the record, and for the reasons already given by the Minister for Health and the Leader of the Opposition, I indicate I will not be supporting any of the Hon. Mr Hood's amendments.

The Hon. D.G.E. HOOD: I will just make a couple of comments if I may. As I said, I do not want to prolong this. Just to be absolutely crystal clear, I was not at all claiming that the AMA position statement supported my amendment. What I was saying was that section 1.3 clearly states:

> For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and the improvement of quality of life.

I make no further claim than that; merely that that is their position as outlined in their statement.

Clearly, there are differences of opinion in the room, and I think you might expect that with something like this. I make no apology, I guess is the way of putting it, for creating a further barrier. I think physician assisted suicide is something that should be an absolute last resort. We are literally talking about people ending their life, and it literally is the last resort. What may drive someone to making such a request—and what drives many people, we are told—is that they have this unbearable pain. So to give them the opportunity to consult with a palliative care specialist would, in my mind at least, be very helpful.

With respect to the availability of palliative care services around South Australia, I understand there are 26 such centres around the state. I will not read them all—it would take too long—but they do cover many regional areas, including the Adelaide Hills, Ceduna, the Murray Mallee, Port Augusta, Port Lincoln, Whyalla. They are in the Barossa, Clare, Port Pirie, Wallaroo—all of which, I am told, if required have access to a palliative care specialist. Of course, that does not include all the ones in the metropolitan area. That may be a concern that could be dealt with. Certainly, in my conversations with people in palliative care, they maintain that that would be possible, but that is yet to be seen.

The Hon. S.G. WADE: Because I have had a good go I might leave some other comments I was going to make until after the Hon. Clare Scriven. On the point that the honourable member just made, I think we need to appreciate that the commonwealth legislation in relation to telecommunications does not allow communication—I cannot remember the detail, but basically telehealth cannot be used for euthanasia consultations. That being the case, the access that a lot of country services would have to palliative care specialists would not be possible under the honourable member's amendment.

The Hon. C.M. SCRIVEN: I think the objections to this amendment really go to a couple of very pertinent points. The first is that the majority of the discussion, certainly in the public domain outside of this parliament but also inside this parliament, about the reasons we need voluntary assisted dying is because of unrelievable pain.

We all know of and/or have heard of people who have had terminal illnesses that have resulted in a great deal of pain. Palliative care can relieve most of those symptoms, but we are told that it cannot relieve all. If we are saying that it is not essential to actually investigate the benefits of palliative care, it really does cause us to question whether those extreme examples that are being used as the major support for this type of legislation are really what the intention is.

However, I would move on to an even more important point. Being someone from a regional area, if this amendment were to pass it would force investment in palliative care in regional areas as well as elsewhere. We have heard that there are not enough palliative doctors or palliative care services, yet we have also heard that, where voluntary assisted dying legislation is in place, supposedly investment in palliative care increases.

If it is in fact a requirement before someone can access voluntary assisted dying that they do have consultation with a palliative care specialist, that means we will have to provide palliative care specialists. That surely is a good thing. Surely that is consistent with what most of the debate has said, which is that palliative care is an important part of end-of-life choices and, according to the proponents of the bill, is side by side with voluntary assisted dying. I think anything that would force investment in palliative care would be a very positive thing. I also challenge what the Hon. Mr Maher stated. He talked about paragraph (d)(iv):

> (d) the person must be diagnosed with a disease, illness or medical condition that…
>
> (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

He then said that this amendment would mean that someone else would decide what is tolerable. That would be true if this amendment was replacing subparagraph (iv), but it is not; it would be in addition to it. So the person would still be deciding whether their suffering would be relieved in a way that is tolerable, but they would also have the benefit of understanding what palliative care can and cannot do.

I think that comes to the crux of the matter, that while people do not have access to a good understanding of what palliative care can do they are not making an informed choice. This amendment would ensure those two things: that palliative care is available and that people are then making an informed choice.

The Hon. F. PANGALLO: I will be supporting the Hon. Dennis Hood's amendment. Interestingly, with regard to this argument, I would like to draw to the attention of members a very interesting article in the current *Medical Journal of Australia*, where the Victorians are actually grappling with a number of issues as a result of VAD.

I will go further into the aspect that will affect my amendment later on about conscientious objection, but in relation to this I want to read out this section which goes to show that palliative care, according to this Victorian working group, actually needs to work hand in hand with VAD. The section states:

> Perhaps the largest challenge was fulfilling the responsibility of a Pathway A public health service to provide VAD as an option while respecting the staff member's decision to conscientiously object to facilitating or being involved in VAD. The need to consider each case individually was highlighted…

It then goes on to give some examples in relation to deaths that occurred under VAD:

> Without comparable local evidence, the expected demand for VAD was inferred from international evidence, which predicted that a low number of people would request VAD…

But:

> Over a 14-month period (June 2019 to September 2020), the health service received 42 patient requests for VAD, with four patients progressing to a prescription of VAD medications and dying as a result. Three of these four patients died after receiving VAD as inpatients and one died at home after being discharged from the health service.

Here is where it gets interesting. The section continues:

> Patients who requested VAD were cared for across a number of services and received concurrent palliative care as part of appropriate end-of-life care management. The patients who died after receiving VAD were cared for in the ward that was most familiar and suited to their needs; palliative care was provided by the treating team, with specialist input as required.
>
> Most VAD requests were from patients in the final weeks of their lives, who therefore did not survive the full length of the VAD assessment process. This observation made it imperative that VAD processes complemented end-of-life care, thus not denying the patient and their loved ones appropriate palliative and bereavement care respectively. Indeed, a core tenet of staff education was that progression of VAD may occur during end-of-life care; therefore, palliative and comfort care must continue concurrently with VAD processes.
>
> Implementing VAD in a hospital setting demanded sensitive, honest and respectful communication between multiple health professional groups and the community, particularly between individuals with opposing views.

So this working group is currently going through some issues that have arisen as a result of the Victorian legislation and, no doubt, if this legislation passes in South Australia, it may well be that South Australia will also need to have a working group looking into the legislation to see how it applies. It seems to support what the Hon. Dennis Hood is saying: that they need to work together and that we need stronger emphasis and input into ensuring there is more palliative care when we introduce this type of legislation. So I will be supporting the amendment.

The Hon. S.G. WADE: With all due respect to the Hon. Frank Pangallo, I strongly support the fact that voluntary assisted dying and palliative care need to work together, but the lessons you were relaying from Victoria actually support the view of trying to avoid conflation. Sure, there are two distinct treatment modalities: palliative care treatments and the voluntary assisted dying treatments. Both of those treatments may be provided in the same facility, the same institution; they need to learn to work together. Yes, they are complementary, but it is very dangerous for them to be conflated.

To further seek to rely on the letter from the AMA and Palliative Care SA about why that is so important, if the committee could indulge me I would like to read another three paragraphs from the letter. The heading is Informed Consent and the letter says:

> To be clear about the nature of a treatment, and in this case the intention of the treatment, is an important central tenet of health care and absolutely vital to respect the autonomy of a patient. As in all medical practice, a doctor must clearly explain the nature of a particular treatment and why it is being provided. To obtain informed consent from a patient, it is essential that both the doctor and the patient are absolutely clear whether they are being provided palliative care or voluntary assisted dying. A doctor's responsibility is to offer treatment options and to be clear in their own mind in explaining to a patient why the treatments are being offered. It is not the role of a doctor to unilaterally declare the fate of a patient based on their own values or because they themselves fail to properly understand the difference between treatment options. That is, it is not a doctor's role to play God.
>
> So, while arguments for voluntary assisted dying include patient autonomy and the prevention of others imposing their values onto a patient, the same holds true in reverse. For some patients who do not want voluntary assisted dying or euthanasia, it is important that both the patient and the treating doctor genuinely understand and accept the boundary between palliative care and voluntary assisted dying so that the patient's autonomy can be properly respected in the provision of their care.
>
> On the other hand, clearly defining palliative care and voluntary assisted dying will not undermine the ability of a patient who was waiting for or contemplating voluntary assisted dying to be provided with palliative care. The nature and timing of the two treatments would just need to be clearly explained to the patient.

The two treatments are complementary, but it is really important they are not conflated. If I can be self-indulgent, I am a Christian and I do not believe that voluntary assisted dying is an option that I feel morally able to take up. The conflation would actually make it more difficult for me to get involved with palliative care because the parliament is giving a lack of clarity to the medical practitioners who might be attending to me about what the difference is between the two.

I would strongly urge people who want to stand up for people who do not support voluntary assisted dying as a personal treatment option for them: you are doing them a service if you have clear legislative distinction between voluntary assisted dying and palliative care because, if they will not tolerate voluntary assisted dying, they will still have the moral comfort to be able to engage with palliative care.

The CHAIR: The Hon. Ms Scriven and then I will go to the Hon. Ms Bonaros. We have canvassed this amendment pretty well. We will be approaching a vote, but I will go to the Hon. Ms Scriven.

The Hon. C.M. SCRIVEN: Thank you. My question is to the Hon. Mr Wade. How does ensuring that a patient understands what palliative care can or cannot do, whether it can or cannot be of therapeutic benefit, how does that conflate palliative care with VAD?

The Hon. S.G. WADE: With all due respect, clearly the Hon. Mr Hood's amendment conflates it because it requires the approval team to be blended with palliative care specialists and people involved in the VAD treatment program. They are two separate pathways. People can have a consultation with palliative care specialists about whether palliative care can provide assistance to them in their journey. They can have conversations with the voluntary assisted dying team. It may well be that, within the particular institution, that is being offered by the same practitioners. But in the voluntary assisted dying journey, they are not compelled to have their patient choices determined by clinicians.

I completely agree with the Hon. Kyam Maher's position. I would like to know where else we are going to say that medical practitioners can determine an individual patient's treatment regime. But I think it is extremely important that we avoid conflation. Having mixed teams is clearly conflating.

The Hon. C. BONAROS: For the record, I am seeking to indicate that I will not be supporting the amendments. I agree with the arguments that have been put forward by the Leader of the Opposition and the Minister for Health. While I am on my feet, I want to make an additional observation at this stage of the debate, which I think is very important, and that relates to the use of language during this debate because I think language in this debate is very important.

I think the language in this bill has been very deliberately chosen and I think it is incumbent on all of us here tonight to be mindful of the language we use when speaking about voluntary assisted dying. There have been references to voluntary assisted suicide and to my knowledge that term has not been used in any Australian jurisdiction, but more importantly it does not appear anywhere in this bill. Indeed, clause 5 of the bill addresses this issue specifically when it refers to voluntary assisted dying not being suicide.

I think that is very important for a number of reasons, but first and foremost I think it is very important from a mental health perspective because language does matter and it matters very much in this context. So I am respectfully asking for members to bear that in mind when reflecting on voluntary assisted suicide as opposed to voluntary assisted dying, which is the terminology that we have accepted and has been drafted in the bill before us.

The Hon. I. PNEVMATIKOS: I indicate that I will not be supporting the amendments by the Hon. Mr Hood.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting the Hon. Mr Hood's amendment. I think it goes to the heart of this bill, which is the voluntary assistance of dying to therefore relieve suffering. The Hon. Kyam Maher spoke about the fact that the patient should be able to determine what is tolerable in terms of suffering, and I do not disagree; I completely agree with the Hon. Kyam Maher that the patient should have that decision.

But I struggle to see how they can make that decision if they have not accessed or at least been informed of any potential form of palliative care that may relieve them of their suffering. If there is potential for the relief of suffering by palliative care, then to ensure that this is realised a palliative care specialist really needs to be involved in this process. Therefore, I support this amendment.

The Hon. I.K. HUNTER: Sir, to assist you in your deliberation, I indicate that I will not be supporting the amendment.

The Hon. E.S. BOURKE: I would also like to put on the record that I will not be supporting this amendment or any other amendments from the Hon. Dennis Hood.

The Hon. D.G.E. HOOD: Just to round it off if I may, Mr Chairman, and then we can move to a vote.

The Hon. K.J. Maher: Are you going to be supporting it?

The Hon. D.G.E. HOOD: I will be supporting the amendment, yes, there is a shock. I want to make a few final comments. I want to be absolutely clear about this: there is nothing in my amendment that takes away a patient's right to refuse palliative care. Simply, that they would be consulted and the options explained that are easily available to those persons is what the amendment does. Specifically, it says:

> (e) a palliative care specialist must have certified, in accordance with any requirements set out in the regulations, that such palliative care as may be reasonably available to the person would not be of therapeutic benefit.

That is all. So the specialist has to have a view and then the patient decides what is appropriate for them.

With respect to the comment made by the Hon. Ms Bonaros, I mean no disrespect calling this anything other than voluntary assisted dying. I do not mind what term we use. The reason I have been using those terms is because those are the terms—that is, 'euthanasia' and 'physician assisted suicide'—on the Australian Medical Association's position statement on this issue, so it seems that they are satisfied that it is an acceptable term.

The CHAIR: We have canvassed this very largely, but I will allow the honourable—

The Hon. F. PANGALLO: It will be very brief, and it is just about the language. My honourable colleague raised the issue about suicide and I know that word tends to be quite sensitive to those who are supportive of this legislation, but I will just remind members what the actual definition of suicide is: suicide is the act of intentionally causing one's own death.

The committee divided on the amendment:

Ayes 7
Noes................ 14
Majority............ 7

AYES

Centofanti, N.J.
Hood, D.G.E. (teller)
Lucas, R.I.
Ngo, T.T.
Pangallo, F.
Scriven, C.M.
Stephens, T.J.

NOES

Bonaros, C.
Bourke, E.S.
Darley, J.A.
Franks, T.A.
Hanson, J.E.
Hunter, I.K.
Lee, J.S.
Lensink, J.M.A.
Maher, K.J. (teller)
Pnevmatikos, I.
Ridgway, D.W.
Simms, R.A.
Wade, S.G.
Wortley, R.P.

Amendment thus negatived; clause passed.

Clause 4.

The CHAIR: We come to clause 4, amendment No. 3 [Hood-1].

The Hon. D.G.E. HOOD: I have a question for the mover of the bill before I determine whether I will move this amendment or not. It deals with clause 4, as you rightly said, sir, and the issue I am particularly interested in is in subclause (1)(d), which reads:

> (d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

I wonder: what constitutes other means? What gestures are envisaged by this particular clause?

The Hon. K.J. MAHER: I thank the honourable member for his question. It is consistent with other pieces of legislation in South Australia that allow these sorts of wishes to be made known, for example, the Consent to Medical Treatment and Palliative Care Act 1995, regarding determining impaired decision-making capacity, takes into account in section 4(2)(a)(iv) 'communicating his or her decision in any manner'.

The Mental Health Act has a similar provision, communicated decision in any manner, not just 'a manner'. It is a good and reasonable question. It is certainly one that in the many, many hours that I have spent going through this bill and talking to clinicians in South Australia and around other parts of Australia I was interested in, as well.

For example, someone who communicates via an Auslan interpreter cannot use speech so that is a form of communicating. A different example and probably one of the most well-known examples was that of the late Professor Stephen Hawking who could communicate very well about very sophisticated concepts, but who was not able to speak and used a machine. There are people who use electronic aids, who use thumb movements to communicate—there is a whole range of very well-established means of communicating that are used outside of written or spoken communication, and they are used in South Australia, I suspect, every single day by medical practitioners in the treatment of people to understand their needs.

The Hon. D.G.E. HOOD: Yes, in fact, in the discussions I have had subsequent to filing my amendment, one of what I would call a usual supporter of my position actually took issue with this amendment because his view was that in his practice he had had experience of patients blinking for yes and no—blink once for yes and blink two for no. That being the case and I think given the response from the mover I am not inclined to move my amendment.

Clause passed.

New clause 4A.

The CHAIR: We now come to amendment No. 1 [Wade-2] which is the insertion of a new clause on page 12 after line 9. I call the Hon. Mr Wade.

The Hon. S.G. WADE: Thank you, Mr Chair, and I should thank you for referring to me as the Hon. Mr Wade and not the Minister for Health and Wellbeing because it reminds me to restate that this is a conscience vote for Liberal members. This is a private member's bill and I speak only for myself.

In some ways we have already started this conversation. I indicated in response to the Hon. Mr Hood's earlier amendment the importance that I see in avoiding the conflation of palliative care and voluntary assisted dying. Section 17(1) of the Consent to Medical Treatment and Palliative Care Act provides that a—

The CHAIR: The Hon. Mr Wade, this is replacing your original amendment.

The Hon. S.G. WADE: I am moving Wade 1 [Wade-2]—set 2.

The CHAIR: Right, but it replaces set 1.

The Hon. S.G. WADE: Yes, I am moving amendment No. 1 in [Wade-2], and I formally move:

Amendment No 1 [Wade–2]—

Page 12, after line 9—Insert:

4A—Voluntary assisted dying is not palliative care

(1) For the purposes of the law of the State, the administration of a voluntary assisted dying substance to a person in accordance with, or purportedly in accordance with, this Act will be taken not to constitute palliative care of the person.

(2) To avoid doubt, nothing in subsection (1) prevents a person who is providing, or who has provided, palliative care to a person, or an institution at which palliative care is provided to a person, from performing functions or otherwise being involved in the operation of this Act (whether as a coordinating medical practitioner, a consulting medical practitioner or otherwise).

(3) Nothing in this Act limits Part 3 Division 2 of the *Consent to Medical Treatment and Palliative Care Act 1995* (and, for the purposes of section 17(1) of that Division, a

> reference to administering medical treatment in that subsection will be taken not to include a reference to administering a voluntary assisted dying substance to a person in accordance with, or purportedly in accordance with, this Act).
>
> Note—
>
> Section 17 of the *Consent to Medical Treatment and Palliative Care Act 1995* provides that a medical practitioner does not incur liability where certain medical treatment incidentally, rather than intentionally, hastens the death of a patient.

The amendment would add an explicit statement in the Voluntary Assisted Dying bill that voluntary assisted dying is not palliative care. Section 17(1) of the Consent to Medical Treatment and Palliative Care Act provides that a medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness under the Medical Practitioners Division incurs no criminal liability by administering medical treatment with the intention of relieving pain or stress.

A specific and direct reference to section 17(1) in the Voluntary Assisted Dying Bill in my view highlights the difference between the medical practitioner's intention in two situations: firstly, under the Consent to Medical Treatment and Palliative Care Act the intention is to relieve pain or distress, and under the Voluntary Assisted Dying Act the intention is to facilitate death.

Again, I seek the indulgence of the council to read three paragraphs from a letter sent to me and provided to honourable members from the president of the Australian Medical Association and the chairman of the board of management of Palliative Care SA. It starts in Dr Moy's voice where he states:

> I write to you alongside clinical academic palliative care medicine physician Professor Greg Crawford who, as its current chair, is representing Palliative Care SA in support of this amendment.
>
> Together we write to you reinforcing the need for your proposed amendment which requires an insertion of a new clause 4A making it clear that voluntary assisted dying is not palliative care.
>
> In doing so, this clause clearly sets out that voluntary assisted dying and palliative care are defined and distinguished by the intention of treatment, with the intention of palliative care and the concept of double effect being solely and directly aimed at treatment and relief of a patient's distressing symptoms, while the intention of voluntary assisted dying is to end an individual's life.
>
> The addition of this amendment would enhance the legislation in creating an explicit reference to section 17(1) of the SA Consent to Medical Treatment and Palliative Care Act 1995, which remains the gold standard of legislation in Australia in setting out the protections for medical practitioners providing treatment under the framework of palliative care and the widely accepted principle of double effect (that is, while providing treatment aimed at the relief of symptoms, the medical practitioner does not incur liability where the treatment incidentally, rather than intentionally, hastens the death of a patient).

In conclusion, because I think I have made the point under two clauses now, I stress the point that I believe that the passage of this legislation, with the greater clarity of the scope of palliative care and the scope of voluntary assisted dying, will actually enhance the practice of palliative care in South Australia.

I have real concerns that there are some medical practitioners under the current Consent to Medical Treatment and Palliative Care Act who do not have clarity about the operation of the act. By having these complementary references in the legislation to stress the distinction, I think we will have better medical practice, because we will have practitioners having more clarity about what medical treatment they are offering and what informed consent they need to obtain. I think that will lead to better palliative care practice in South Australia.

The Hon. C.M. SCRIVEN: The Hon. Mr Wade refers to clarity, which raises a question that perhaps I should have asked at clause 1, but since he was not the mover of the bill I did not do so. Earlier on in the debate and in emails to members of parliament, the Hon. Mr Wade indicated that he might move an amendment in terms of death certificates. This comes to the point of transparency and clarity around how things are described in this case, voluntary assisted dying not being palliative care. Could the Hon. Mr Wade indicate why he has not gone forward with that amendment and any other relevant matters he might think would be useful for transparency?

The Hon. S.G. WADE: With all due respect, the honourable member is misstating what I wrote to members. I think the honourable member is referring to a letter that I sent two months ago, where I conveyed, merely as a messenger, six suggested amendments from the clinicians' forum on

10 February. I indicated that I might move some or none of those amendments and that other members were free to move them if they wished.

I think in that same correspondence I provided questions and answers—'frequently asked questions', as SA Health is inclined to call them—from the Department for Health and Wellbeing, and I did stress that the Department for Health and Wellbeing is agnostic as to whether or not this legislation should be passed. Unlike the termination of pregnancy legislation, which SA Health did support, the department in this context merely seeks to support an informed public discussion. I sent those six suggested amendments. At that stage I did not indicate that I would be moving any of them.

In my second reading contribution, I think I indicated that I would be moving two of those six amendments. Why it was so limited was because of what I also said in my second reading contribution, that I think it is really important that we maximise consistency. I know it can be somewhat galling when ministers quote themselves, but let me explain again by quoting my speech as to why I think consistency is important:

> I think it is helpful for patients, for clinicians and for regulatory bodies if the laws in an area of law such as this are similar across Australian jurisdictions. Consistency would support access, it would support quality and safe practice and it would reduce the pressure for what is sometimes called medical tourism.
>
> I support South Australia joining our sister states in enacting the Australian model of voluntary assisted dying. In that context, I want to be clear on my general stance in relation to amendments. I think that the basic framework of the bill is sound and should be supported. I think there is significant value in national consistency of voluntary assisted dying legislation.
>
> Accordingly, I indicate to the council that I will only support amendments to the bill that do not undermine close national consistency, and I will not support the third reading of the bill if the bill is amended in committee in a way that does not maintain close national consistency.

I went on. In the end, I had to ask myself which matters were so important to me that I thought I should move an amendment. I was tempted not to indulge myself with unnecessary amendments, so let me explain why I chose those two. The first one is the importance of maintaining what the AMA describes as the gold standard in palliative care.

We do not want to do anything in this legislation that would undermine an excellent piece of legislation that this parliament has already had the wisdom to pass. We need to make sure that palliative care and voluntary assisted dying are complementary treatments, but they are not conflated. It is in the interests of medical practitioners and their patients that we have clarity in terms of the two treatment modes.

The second and following amendments, because they are all related to the same issue, are to not allow a medical practitioner to be one of the relevant practitioners if a family member is involved or if they would benefit financially. I would argue that that is not a diversion from the Australian model because, whilst Victoria does not have it, Western Australia does have it. I think that it is also not a matter that would disrupt, if you like, the consistency across the regimes. With all due respect to the honourable member, I never proposed that I was going to do an amendment on death certificates.

The Hon. C.M. SCRIVEN: I appreciate the clarification. Certainly, I was simply going from memory. It was not my intention to misrepresent what the Hon. Mr Wade might have said, but one of his comments in regard to transparency just prompted me to remember somewhat vaguely that piece of correspondence. I agree with the Hon. Mr Wade that it is important that clinicians do have protections in terms of the double effect not being conflated with voluntary assisted dying, and therefore I will be supporting this amendment.

The Hon. K.J. MAHER: I rise to indicate that I will be supporting the amendment in the amended form that the Hon. Mr Wade is putting forward. For the sake of the smooth operation of this committee, I will also indicate that I will be supporting the rest of the Hon. Stephen Wade's amendments.

I agree with the Hon. Stephen Wade that neither amendment, and particularly the further amendments that we will come to later on, departs in any significant way from the Australian scheme of voluntary assisted dying. The minister is quite right: the second group of amendments appear in the WA scheme. A lot of those may be obligations that registered medical practitioners would have under a code of ethics and things that govern the way that they practice, but it is in here, and I do not oppose those.

I thank the minister for his discussions about the amendments that he has put forward. I think it has worked well with this slightly amended form. Most people who practise in this area are reasonably comfortable. I will indicate that, whilst I have appreciated those discussions with the minister, I will not get into the habit of engaging in a text message conversation with him at about 4:26 in the morning all that often in the future.

The Hon. S.G. WADE: The honourable member nudges me to properly acknowledge that the second version of the amendments was enhanced by the contribution of the Hon. Kyam Maher, so I thank him for that. I am disappointed that you are not willing to get up early, because that is my habit.

The Hon. R.I. LUCAS: The Hon. Mr Wade refers to the fact that the AMA has referred to Consent to Medical Treatment and Palliative Care Act, in particular clause 17, as the gold standard of palliative care. Given that, can the Hon. Mr Wade indicate whether any group representing palliative care doctors, palliative care society or any other medical association has made a submission either to him or indeed to the mover of the bill that the bill, as currently proposed, will undermine the gold standard?

The Hon. S.G. WADE: With all due respect, the honourable member is asking a broad question that relates to the bill as a package. Those are matters that should be asked of the Hon. Kyam Maher as the sponsor of the bill. I am only moving one amendment, and I would confidently say that, whether or not an individual clinician supports voluntary assisted dying, my expectation would be that this amendment would be welcomed because there are so many palliative care specialists who oppose voluntary assisted dying and are very disturbed about conflation.

As I said earlier, with the lack of clarity between the informed consent that is required and obtained for palliative care, there is concern that, because of that, there are administrations of palliative care that look more like assisted dying. Without a framework like voluntary assisted dying, you cannot be confident that it is voluntary.

The Hon. R.I. LUCAS: I did introduce my question by saying 'either to the mover of the amendment or the mover of the bill'. Given that Mr Wade defers the question to the Hon. Mr Maher, my question is to Mr Maher. Has he received submissions from people representing palliative care doctors who argue that the bill as he has drafted it would undermine the gold standard of the Consent to Medical Treatment Bill?

Parliamentary Procedure

VISITORS

The CHAIR: Before calling the Hon. Mr Maher, I acknowledge the presence in the gallery of the Hon. Sandra Kanck, former member of this chamber.

Bills

VOLUNTARY ASSISTED DYING BILL

Committee Stage

Debate resumed.

The Hon. K.J. MAHER: I thank the Hon. Rob Lucas for his question. I do not think I can remember exactly the nature of submissions that were put forward, but certainly one path we followed that differed from many of the other times this bill has been introduced is that, prior to the bill being introduced in parliament, we had a joint house select committee that spent some 18 months taking evidence. From memory there were about 130 written submissions and dozens of witnesses, both here and in Victoria, as the committee went to look at the operation of the scheme there, who put forward their views.

Certainly, bodies representing palliative care put forward their view. The consultation was over 18 months and ended some time ago. I cannot remember exactly the nature of the submissions, but I think it is fair to say—and as representatives of this chamber, the Hon. Dennis Hood served on that committee, as did the Hon. Mark Parnell, who up until recently was a member of this chamber—that we took a range of views, from very supportive to very unsupportive and everything in between.

It is some time since that committee did its thorough work and took submissions from all those stakeholders. I am sure there would have been some clinicians who probably expressed those views, but I cannot remember the exact details of all of them.

The Hon. J.A. DARLEY: For the record, I indicate that I will support the Hon. Stephen Wade's amendment and all other amendments of the member.

The Hon. C. BONAROS: I rise to indicate that I will be supporting the Hon. Mr Wade's amendment. I indicated at the outset during my second reading contribution that I will not support any substantive amendments that depart from the Australian scheme, as has been explained by the Hon. Kyam Maher and the Hon. Stephen Wade. In any event, I think for the reasons the Hon. Mr Wade has outlined in relation to the conflation of voluntary assisted dying and palliative care, this is an important amendment and as such we will be supporting it.

The Hon. I. PNEVMATIKOS: I also indicate that I will support the amendments of the Hon. Mr Wade because the bill needs to draw a distinction between the two processes but also acknowledge they can be complementary. I think the amendment does that.

The Hon. R.P. WORTLEY: I indicate that I will be supporting the amendment of Mr Wade and all his other amendments.

New clause inserted.

Clause 5.

The CHAIR: We now move to clause 5, amendment No. 3 [Hood-1]. You are just opposing this clause? You are not moving an amendment as such?

The Hon. D.G.E. HOOD: Correct, Mr Chairman, although I have a question before I proceed with that because I may not proceed. This intrigues me a little bit because you do hear this issue in these debates around the world. Some places around the world choose to consider that voluntary assisted dying—assisted suicide—is not considered to be suicide in a legal sense. I ask the question: why did the member choose to include this in the bill? I note that my understanding is that it is not in the Victorian act. I think that is right, so what was it that made the member include this in his bill?

The Hon. K.J. MAHER: I thank the member for the question. I think the Hon. Connie Bonaros has talked about language and the importance of the language we use. Much of the life's work of the Chair of the committee today in this chamber has been in suicide prevention. I think it is very important to recognise the difference between the two. The expert ministerial panel in Victoria discussed this at some length. Around page 145 to 150 in their report was the distinction between the two.

In a very practical sense, there are legal ramifications. In terms of potential superannuation or annuities, there are very real practical considerations. Should this bill pass and should this scheme operate in South Australia, someone who is availing themselves of a perfectly legal medical intervention might be penalised if it was suicide, in terms of some of those legal ramifications.

From a very practical sense, someone who is admitted and given approval under this scheme is going to die. They are suffering a terminal disease that two medical practitioners, one of them a specialist in that area, have determined a prognosis of less than six months to live, or 12 months for a neurodegenerative disease.

According to medical expertise, they are going to die from the condition they suffer from. They would not be able to be part of the scheme unless that was the case. It is necessarily the case that the considered view is that they are going to die. The fact of the matter that there is an intervention that, in my view, helps alleviate that suffering and with dignity does not take away from the fact that, if it were not but for that condition, they are going to die.

Andrew Denton, who many people would be familiar with, who is a very persuasive advocate in this area, describes the difference between these two in a very easy to understand way, with reference to New York in 2001 when the World Trade Centres had planes fly into them—the fall or the fire. The chief medical officer of New York did not record those people who elected to jump out of the building that was to collapse as suicides. He recorded them as homicides due to terrorism.

The very act of jumping out, if you accept that argument is suicide, ignores the fact that, faced with the choice of fire or fall, some people chose fall knowing full well that they would die from the natural consequence of the fire in the building. I think that is an apt analogy. You would be dying and succumb to your condition by the very nature of being involved in this scheme and the fact that there is an intervention that hastens your death should not detract from that.

Similarly, also under our Consent to Medical Treatment and Palliative Care Act, if you refuse medical intervention you are not committing an act of suicide by refusing intervention, even though it might have the effect of saving your life. I think they are two really important distinctions and that is why I think it is important that this clause is in the bill.

The Hon. S.G. WADE: I indicate that I support what the Hon. Kyam Maher has just said. I am also advised that it might have relevance in terms of medical codes. This clause ensures that a person who performs an act or omission in relation to a person will not be in breach of professional standards or codes of conduct.

The Hon. D.G.E. HOOD: I do not intend to move this amendment anyway.

Clause passed.

Clauses 6 to 8 passed.

New clause 8A.

The Hon. F. PANGALLO: I move:

Amendment No 1 [Pangallo–1]—

Page 13, after line 34—After clause 8 insert:

8A—Conscientious objection of entities providing health care

(1) A relevant service provider has the right to refuse to authorise or permit the carrying out, at a health service establishment operated by the relevant service provider, of any part of the voluntary assisted dying process in relation to any patient at the establishment (including any request or assessment process under this Act).

(2) A relevant service provider may include in the terms and conditions of acceptance of any patient into the health service establishment an acknowledgment by the patient that the patient—

(a) understands and accepts that the relevant service provider will not permit the establishment to be used for purposes of, or incidental to, voluntary assisted dying; and

(b) agrees, as a condition of entry, that they will not seek or demand access to voluntary assisted dying at the establishment.

(3) Subsection (4) applies in relation to a patient at a health service establishment if the patient advises a person employed or engaged by the relevant service provider at that health service establishment that they wish to access voluntary assisted dying.

(4) If this subsection applies in relation to a patient at a health service establishment, the relevant service provider who operates the establishment must ensure that—

(a) the patient is advised of the relevant service provider's refusal to authorise or permit the carrying out at the health service establishment of any part of the voluntary assisted dying process; and

(b) arrangements are in place whereby the patient may be transferred to another health service establishment or prescribed health facility at which, in the opinion of the relevant service provider, a registered health practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to participate in a voluntary assisted dying process in relation to the patient; and

(c) reasonable steps are taken to facilitate the transfer referred to in paragraph (b) if requested by the patient.

(5) In this section—

> *health service establishment* means each of the following:
>
> (a) a private hospital within the meaning of the *Health Care Act 2008* or other private health facility of a kind prescribed by the regulations;
>
> (b) premises owned or operated by a residential care provider as defined in section 41-3 of the *Aged Care Act 1997* of the Commonwealth;
>
> *relevant service provider* means a person or body that operates a health service establishment.

I would hope that members on both sides, particularly those who will be supporting the bill, will see that this is actually a fair and reasonable amendment that dovetails with clause 9 regarding conscientious objection of registered health practitioners.

Basically, this amendment covers the providers, the entities that actually provide health care—those that will have a conscientious objection because of who they are and who they represent. An example of that would be Calvary, which is of course through the Catholic Church. As members would know, they are opposed to VAD. They have told me, and health practitioners in that system have said, that while there is that conscientious objection for the health practitioners overall, it does not actually cover the entities that they work for.

I think it is only fair that if the service provider does have a conscientious objection to VAD they would not allow VAD to be carried out in their premises. Essentially, this amendment covers the health practitioners who work in there. I will go into what it does now. The relevant service provider could be a hospital—as I mentioned, it could be Calvary—an aged-care facility that may well be under the auspices of the Catholic Church or a Christian organisation that does not support VAD. It would also encompass aged-care facilities that would either have operators or staff who would be opposed to VAD.

It would work in such a way that the terms and conditions of accepting any patient into the hospital would be such that when the patient comes into the hospital, they understand and accept that that establishment would not permit it to be used for purposes of or incidental to voluntary assisted dying, and the patient agrees upon entry that they will not seek or demand access to voluntary assisted dying at that establishment. I think that is quite reasonable.

Furthermore, through this amendment the establishment would advise the patient of the service provider's refusal. They could also make arrangements whereby the patient may be transferred to another health service establishment or prescribed health facility where, in the opinion of the relevant service provider, a registered health practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to participate in a voluntary assisted dying process in relation to the patient.

In other words, if a patient wants to be admitted into a hospital like the Calvary, perhaps with a view to voluntary assisted dying as the end result, the Calvary would inform that patient that VAD is not to be carried out on those premises because they have a conscientious objection to that. If they wish to be admitted, they must understand those conditions. In the event that while they are there they do want to access VAD, the provider will enable that patient to go to a premises where it is carried out—it could be the Royal Adelaide Hospital, for instance.

I just want to go back to the article I was quoting from earlier in the current edition of the *Medical Journal of Australia*. As I pointed out, under their act, the Victorians have been required to review and have a look at the workings of their VAD laws. In mid-2018, they established a VAD working group with senior professional executive representation, which included the Chief Medical Officer, the General Counsel, the Executive Director of Nursing and Midwifery, relevant medical heads of units, senior nurses, allied health representatives and a senior clinical communications adviser. They looked at various issues that have arisen since that.

The clinical communications adviser conducted consultations with 25 working group members to explore the impact of VAD legislation on their professional group and clinical practice between September and December 2018. The outcomes of these consultations highlighted the systemic and ethical complexities inherent in implementing VAD and informed the next steps, including the need to engage with a range of appropriately skilled and experienced clinicians throughout the implementation phase.

A key consideration during the implementation phase was balancing staff members' right to conscientiously object to supporting patients when the assistance was related to VAD, with the expectation that health professionals would continue to provide care unrelated to VAD. Capacity for moral injury for staff whose beliefs and values were at odds with the employing organisation's approach to VAD needed to be recognised and addressed throughout the implementation process.

The article then goes on to say that a survey of medical professionals was undertaken in 2019. They were invited to complete an anonymous survey asking them to indicate their willingness to participate in VAD. The survey achieved 208 responses, which was a 17 per cent response rate, with 106 of those from senior medical staff and 72 per cent of respondents supporting a patient's access to VAD at the health service. In addition, eight senior medical staff members expressed a willingness to be involved in the facilitation of VAD. The survey results guided the health service's management to determine pathway A as the appropriate model of care for this health service.

In parallel with the survey, training for VAD was provided by the DHHS-led Voluntary Assisted Dying Implementation Taskforce. During these sessions, the need for local VAD procedures were identified as staff members required further guidance to navigate patients' requests for VAD and to ensure the health service adhered to legislative requirements. Importantly, the procedures need to support the right of staff to conscientiously object to VAD while fulfilling lawful access to care.

While the Hon. Kyam Maher's bill addresses the conscientious objection to health practitioners, I think it is just that it also covers the service providers who provide a similar service to public hospitals or aged-care facilities and that those providers do have a right to express their own conscientious objection to VAD. After all, if that is their approach and their policy against VAD, they should have the right to have that conscientious objection. VAD does present quite a moral and ethical dilemma for these organisations. I hope the Hon. Kyam Maher recognises that and agrees to this amendment.

Parliamentary Procedure

VISITORS

The CHAIR: Before calling the Hon. Mr Maher, I recognise the presence in the gallery of His Grace Bishop Silouan of Sinope. Welcome to you, sir.

Bills

VOLUNTARY ASSISTED DYING BILL

Committee Stage

Debate resumed.

The Hon. K.J. MAHER: I am not going to be supporting this amendment. I fundamentally disagree with it. I think this represents a significant and very fundamental departure from what we have talked about as the Australian model. This issue has been considered and rejected in other states that have implemented voluntary assisted dying, and I think there are very good reasons why the Victorian expert panel, in their deliberations and in their report, and parliaments around Australia have rejected this idea.

Take, for example, residential aged care, which is included in this amendment. There are around 16,000 South Australians who live in residential aged care. It is their home. People who live in residential aged care pay a refundable accommodation deposit, also known as a bond. Almost always they sell their house to essentially move into residential aged care, which becomes their home. It averages $440,000 and ranges up to $1 million to buy into their new home in residential aged care.

Particularly if a couple moves into residential aged care, a surviving partner in that couple after one passes away can live for years, even decades in residential aged care. It becomes their home as much as any other home that you or I might live in. To say that someone should be denied the possibility, if this bill passes, of legal medical intervention in their own home I think is a pretty fundamental departure from what we would consider reasonable.

People would find themselves in their own home unable to access their choice of care and would effectively be told, 'If you want to pursue this, move out of your own home.' In many areas that might not be financially possible. Particularly in areas of limited choice in regional South Australia, that might not even be a possibility to find other suitable care.

The wording of this amendment states that premises in both retirement villages and residential aged care are potentially captured because it refers to premises that are owned or operated by residential aged-care providers, which could be retirement villages, which I think would be even more problematic. But just on the residential aged care, I think it is a significant and fundamental departure from the Australian model. It appears in none of the other jurisdictions in Australia.

I will not go into all of them, but particularly in the Tasmanian debate, this occupied quite a deal of time for Tasmanian parliamentarians, who talked about that not just in aged care but in other hospital services it would be a perverse outcome if someone who had already been accepted and issued a permit in a VAD scheme was then denied other sorts of treatment by a hospital or residential aged-care facility by virtue of availing themselves, if this passed, to what would be a legal intervention. I cannot support something that is such a fundamental departure from what is the Australian model.

The Hon. J.A. DARLEY: For the record, and for the reasons given by the Leader of the Opposition, I will not be supporting this amendment.

The Hon. R.P. WORTLEY: I find this amendment quite appalling, to the fact that we are being asked to support an amendment which would in effect deny someone a service from a service provider for the simple reason that they may choose a process which is legal under the law. If I go to hospital, if I wanted to go to the Calvary hospital and wanted to indicate that I may want to use this legislation to assist my voluntary death, I would find it appalling that they would refuse me entry to that hospital. It is discriminatory; it is an appalling piece of discrimination.

It was not long ago when religious schools would not hire gays. They were very discriminatory, because it was against their religious principles. I fundamentally disagree with this amendment, and I hope it does not get up in this chamber.

The Hon. T.A. FRANKS: I indicate that I will also be quite strongly opposing this amendment. Not only was there a time—and there still is, unfortunately—when religious schools discriminated against both staff and students, there have also been times when hospices have refused to treat those with HIV/AIDS because of their sexuality. I certainly do not believe they should be in receipt of government funding should they do that.

I am also not of the belief that we can fool ourselves that this will not be used to diminish this legislation, and people in their own homes is the example the Hon. Kyam Maher has put quite profoundly and powerfully. It would be far more pervasive than that, but the fact that people in their own homes would not be given the choice to die with dignity is fundamental as to why this amendment should be defeated.

The Hon. D.G.E. HOOD: I will be supporting the amendment. The reason I will be supporting the amendment is encapsulated well by an opinion piece I think members would have seen. It was published in *The Advertiser* yesterday, I think. It was written by Jim Birch, the chairman of Calvary Health Care in South Australia. In part, he says:

> This is why Calvary cannot—and will not participate—in VAD. We do not believe assisting a suffering person to end their own life actually addresses and responds to their suffering. Rather, it ignores and fails to address the complex physical, psychosocial and spiritual causes of a person's suffering at end of life.
>
> If VAD is to be voluntary for the public, then it should be voluntary for clinical staff and medical officers and for the organisations that they work for.

I do not want to overstate this, so I am careful and genuinely do not want to be alarmist about this, but my concern is that if we compel these organisations to do things they do not want to do, ultimately they are going to stop existing—full stop.

These are not-for-profit organisations. They do not exist to make money: they exist to fulfil what they consider to be their mission. In fact, Calvary has a mission statement around its reasons for being, essentially. Something like voluntary assisted dying is so fundamentally against their mission statement that I worry about pushing these organisations into corners they do not want to be in, with the possibility of them just saying, 'Well then, we're not going to do it.'

I urge members to consider that. I think it is a real risk. Here we have the chairman of Calvary coming out and quite emphatically saying that they cannot and will not perform these tasks. So you do wonder what would happen if push comes to shove, and that concerns me.

The Hon. C.M. SCRIVEN: Another aspect to consider is that this amendment, if it were to pass, actually provides those who support voluntary euthanasia and who may want to avail themselves of it with real transparency. They know that if they may want to consider VAD in the future, then they do not go to an organisation such as Calvary.

It may be that organisations such as Calvary lose some of the market share, if I can use that term. Well, so be it. That is the opportunity for people to know; 'Okay, I will choose this organisation's hospital or aged-care facilities because their values align with mine in regard to voluntary assisted dying,' or, 'I will choose that one.'

It will ensure that people know what they are getting into, because they will know that if they go to an organisation such as Calvary and then want access to VAD there will be huge problems. They will not be able to do it, and it is likely to be full of conflict, which I am sure is not something we would want anybody to be experiencing as they are nearing the end of life. They will have transparency knowing this organisation will not provide those services; therefore, they can choose a different organisation. I would have thought that that kind of transparency, that kind of visibility, over what an organisation will or will not provide would only be of benefit to those who are nearing the end of their life.

The Hon. F. PANGALLO: I will point out to the Hon. Russell Wortley as well as the mover of the bill that their comments seem to be at odds with clause 9—Conscientious objection of registered health practitioners. Can the Hon. Kyam Maher tell me: when you refer to a registered health practitioner who has a conscientious objection to voluntary assisted dying, who would you be referring to in that case?

The Hon. K.J. MAHER: I would be referring to a registered health practitioner.

The Hon. F. PANGALLO: But who would they comprise, do you think? Who would have a conscientious objection?

The Hon. K.J. MAHER: I am just trying to find the definition of a registered health practitioner. A registered health practitioner means:

> a person registered under the Health Practitioner Regulation National Law [Act 2009] to practise a health profession (other than as a student);

That national law says a registered health practitioner means an individual who:

> (a) is registered under this Law to practise a health profession, other than as a student; or
>
> (b) holds non-practising registration under this Law in a health profession.

These individuals are health practitioners who provide health services to patients. I think the Hon. Frank Pangallo said—and I agree with him—that the health practitioner at their work should be well covered, and they should be. It is the express intention and effect of the next section, clause 9 of this bill, that no individual should be compelled to be involved in any part of the voluntary assisted dying act. They should not be compelled to be a coordinating medical practitioner. They should not be compelled to be a consulting medical practitioner.

No registered health practitioner should be required to take part in what is entailed in the Voluntary Assisted Dying Bill, and that is exactly what clause 9 does. What it does not do is take away that voluntary aspect. It does not take away the ability of the health practitioner who does wish to be involved in that. It is that choice that I think is fundamentally taken away not just from health practitioners but, more importantly, from patients, from someone who, as I said, is living in their own home.

I received a message, and I think I may have accidentally misspoken when I said the number of people in aged-care facilities is 16 in South Australia. I meant to say 16,000. It is a massive number of South Australians whose choice will be taken away.

The Hon. S.G. WADE: Just to elaborate on the comment the Hon. Kyam Maher is making, I think it is important to understand that registered health practitioners here are much more than the medical practitioners who are involved in the process. The Australian Health Practitioners Regulatory Authority (AHPRA) is the body that registers health professionals in Australia. I think about 13 professions are registered. Some of them one would not expect to be involved in the end-of-life journey, but many you would.

Let me mention a few that might well be involved: Aboriginal and Torres Strait Islander health practice, medical—and medical would also include psychiatric—nursing and midwifery, occupational therapy, pharmacy, physiotherapy, psychology. The Hon. Kyam Maher's bill puts forward a provision which does not have a limited provision of conscientious objection; it is actually quite inclusive. By way of contrast, we only recently considered the Termination of Pregnancy Bill. My memory might fail me, but my recollection is that we had quite a narrow scope for those who could claim conscientious objection. In terms of registered health practitioners, it is not only medical practitioners.

The Hon. F. PANGALLO: I must be missing something here. In terms of the health practitioners, there would be those who would have some sort of ethical opposition to VAD, but would the Hon. Kyam Maher also concede that some of those health practitioners perhaps hold Christian beliefs and would want to exercise those beliefs in their conscientious objection?

The Hon. K.J. MAHER: Absolutely, and that is exactly what clause 9 does—it precisely allows that.

The Hon. F. PANGALLO: Which is what my proposed new clause does as well. It covers organisations.

The CHAIR: I cannot have more than one person standing at a time, but I will call the Hon. Mr Wade now.

The Hon. S.G. WADE: Yes, I do not think he is a member of our house.

The CHAIR: No, I am talking about the Hon. Mr Pangallo. The Hon. Mr Wade has the call now.

The Hon. S.G. WADE: Thank you, Mr Chair. Again, I do not want to delve too far into this because I have not researched it properly. I merely observe that the Termination of Pregnancy Bill has a similar conscientious objection provision as the Hon. Kyam Maher's bill before us has. It does not provide a similar organisational exemption. I might have missed something, but Catholic health services are not compelled to provide abortion services in South Australia. I do not believe that the Hon. Kyam Maher's bill would have that effect in relation to voluntary assisted dying.

The Hon. F. PANGALLO: Does the Hon. Kyam Maher see there could be a situation now, if my amendment does not flow through and his bill passes, that you could actually have these organisations then having to, before they employ somebody, get them to enter contracts where they may have to disclose whether they are opposed or supportive of it, and that may impact on their potential employment?

The Hon. K.J. MAHER: Again, I am not going to delve too deeply into this, but I suspect you are probably going to fall foul of other legislation. I do not think health services have that sort of right of discrimination based on religious beliefs, but I am happy to check that and, as this goes between the houses, come back.

The Hon. S.G. WADE: The only observation I would make that I can think of in a case in Australia is that there is a hospital in the ACT—I think it is called Calvary—which is a public hospital run by Catholic health services. My understanding is that they do not provide abortion. So again, I would make the point that termination of pregnancy legislation in this state does not provide, if you like, conscientious objection to an organisation. I am yet to hear an argument about why we need to make it different in this bill.

The Hon. R.I. LUCAS: I, too, want to refer to the article Jim Birch published in *The Advertiser* yesterday. I guess for the benefit of members, I am sure we all realise that Jim Birch AM is a highly regarded health administrator. I think he might actually be assisting the government in its endeavours in relation to the Women's and Children's Hospital, but prior to that, of course, he was a highly regarded senior health administrator in this state.

His current role and the reason he wrote this op-ed in *The Advertiser* is that he is the chair of the Little Company of Mary Health Care Limited, otherwise known as Calvary Health Care, and is therefore in charge of the Calvary hospital.

The Hon. Mr Hood, I think it was, referred to one element of his op-ed, but I am going to refer to the concluding paragraphs. In it Jim Birch says that Calvary has served the South Australian community for over 120 years. It has been able to serve its most vulnerable citizens with compassionate dedication because Calvary in itself is a community of practice. He says the mission, vision, by-laws, policies and procedures attract and bind every person called to practise in this community.

The article states that many people choose Calvary and other faith-based services precisely because there is a clear, identifiable focus of purpose. There is an articulated code of practice, a strong and clear ethical and values-based proposition and a sense of continuity of care which is grounded in mission. The services are valued by the people in its care, as well as those who choose to practice as part of the Calvary community, because of this commitment. If the South Australian parliament attempts to impose VAD on its services it would violate the consciences of most of the individuals involved, together with the institutional commitment to promoting and upholding critical, ethical and other values.

The article goes on to state that the current bill does not provide for organisational conscientious objection and this needs to be addressed. If not provided, parliament risks choice being valued only when individual autonomy aligns with that of the state. Mr Birch says that we are all strengthened when we nurture communities, including faith-based communities, where people can maintain a sense of personal integrity while making their contributions to the common good of all. Choice must be honoured if assisted dying is to be voluntary.

I accept in part the concerns expressed by the Hon. Mr Maher in relation to residential facilities where persons might be in what is tantamount to their home environment and the potential interpretation of this particular proposed amendment in relation to that. That criticism certainly cannot be directed at a hospital or an institution such as Calvary. Whilst I can understand the criticisms he directs in relation to the other elements of this particular amendment, the issue that Jim Birch has raised is quite specific.

I am sympathetic to that aspect of the amendment, but I cannot support the amendment in its current form for the reasons that the Hon. Mr Maher has raised. I am, however, hopeful and I would expect that the more refined version of an amendment like this might be moved in another place to cater for the sort of circumstances that Jim Birch has outlined in, I think, a clear and concise argument regarding Calvary. I cannot immediately think of others but there may be other hospitals in similar circumstances where a similar argument might be made.

I accept the fact that this amendment has only been circulated in the last 24 hours. The op-ed was only published yesterday. I must admit the issue in and of itself had not been raised with me before. Should this be unsuccessful, as it will appear to be in this particular chamber this evening, there is the opportunity for the issue at least again to be canvassed and further explored in the House of Assembly debate, when it gets there. I would certainly be encouraging my colleagues at least to explore this issue in a more specific and refined way.

I have huge regard for Calvary as an institution. I hold it in the highest of esteem in terms of the quality of the service it has provided to the South Australian community, as Jim Birch says, over 120 years. I also hold Jim Birch in high regard. He is a man of considerable reputation and I think he has argued a case that the parliament deserves to at least consider further, specifically, whilst removing from it some of the understandable concerns the Hon. Mr Maher has expressed in relation to its further extension into other institutions.

Again, the Hon. Mr Wade has more knowledge of the circumstances that relate to termination of pregnancies in various hospitals, where either the Catholic Church or churches might be involved but similar principles, I guess, as he has at least outlined, have certainly allowed, permitted to occur—I am not sure what the legal circumstances are in relation to the delivery of those sorts of health services. What it would appear that Jim Birch is arguing is similarly that the parliament should consider, as it relates to Calvary anyway, an amendment that caters for their situation.

I am sympathetic, the Hon. Mr Pangallo, to the amendment but because of the understandable concerns the Hon. Mr Maher has raised, I will not support the amendment in its current form this evening, but I will nevertheless argue to colleagues in the House of Assembly that a more refined amendment that at least addresses the Calvary circumstance should be addressed by members in the House of Assembly.

The Hon. C.M. SCRIVEN: I move to amend the Hon. Mr Pangallo's amendment as follows:

Delete subclause (5)(b).

Subclause (5)(b) is the part that says what a health service establishment means, saying it is a 'premises owned or operated by a residential care provider as defined', etc. This would overcome the problem that has been raised by the Hon. Mr Maher and that the Hon. Mr Lucas has said is also a problem for him in that it would only apply to a hospital or private health facility of a kind prescribed by the regulations.

That way, people will have the clarity of knowing not to choose a hospital such as Calvary if they want to avail themselves of VAD, but it would not impact on those who are already living in residential care facilities or residential facilities of any sort that might be owned by an organisation with such policies and concerns.

The CHAIR: If that was successful, there might need to be some other wording changes necessary as well, but we will work through that.

The Hon. S.G. WADE: I think the comment you just made in terms of the consequential flow-on impacts of even what seems to be a simple amendment by the Hon. Clare Scriven highlights the profound wisdom of the Leader of the Government in this place. I think these matters are best considered between the houses. Amendments on the run often look very ugly in the light of day.

The Hon. C. BONAROS: The Hon. Mr Wade almost took the words right out of my mouth. I think I indicated, again, during my second reading contribution that my biggest concern in this bill would be considering amendments on the fly and amendments being moved on the floor on the fly, and that is precisely what this is. I understand the dilemma that has been canvassed by all members, including the honourable Leader of the Government and including my colleague the Hon. Frank Pangallo, including the honourable Leader of the Opposition, but this is not the way to address this issue.

If we want to address this between the houses, then, by all means, let's do that, but simply trying to address this now, when we only had 24 hours to consider the amendment in its original form, is entirely inappropriate and not one that I will support at this stage.

I would like to make a couple of other points, generally, in relation to these amendments. I think my colleague has referred to what would happen in the hospital setting, and I appreciate that that is a concern for those who do not support this bill. I appreciate the concerns that are raised by Mr Birch. Hypothetically, I think if every doctor at a faith-based hospital or a Catholic hospital, whatever the case may be, was to conscientiously object, then voluntary assisted dying where you are relying on those doctors themselves to administer or to somehow be present for that process would be very difficult.

Of course, you are not always relying on those doctors to be present to administer, to supply the drugs or whatever the case may be. I may present to the hospital with a little box in my hands and not need any assistance from a doctor at that institution to be able to self-administer the substance that ultimately results in my dying. There are an array of issues here that I think we need to consider in the cool light of day and certainly not on the floor and on the fly in this place.

I also have a lot of sympathy for the points just made by the Leader of the Government and, indeed, by the Hon. Mr Maher in relation to aged-care facilities and the impact this would have on long-term residents, both prospectively and of course retrospectively for those residents who have already been living in those facilities for some time.

For all those reasons, I do not think this is the appropriate way to deal with this amendment. I will not be supporting in its original form, and I will not be supporting it in its amended form. But if there is discussion between the houses and we come back with something that is a sensible and acceptable to all that does not deviate from the scheme that is before us—because I think that is the key that the Hon. Mr Maher has said all along and what I have said all along in terms of my position on this bill—provided it does not deviate from what has become the Australian standard, then there may be some merit to it, but at this stage that is certainly not the case.

The Hon. K.J. MAHER: I think I have indicated that I will not be supporting the Hon. Frank Pangallo's amendment that was filed yesterday afternoon, and I also will not be supporting the amendment to the amendment that was foreshadowed moments ago. Just to be clear, whilst I have very serious concerns and problems with the inclusion of aged-care facilities, I do not want it to be misinterpreted that I do not also have problems even if that was taken out. I do, and I do not agree with it. I was going to make the point that the Hon. Connie Bonaros has made, that even with that taken out it is still a very significant departure from the Australian model. This has been considered and rejected in other parliaments. It has been considered and rejected by expert panels leading up to this.

I might just make an observation that I always get worried when the Hon. Rob Lucas says that he agrees with me. I often feel it is a trap, but I appreciate his points. I do not want it to be misinterpreted that I only think it is a problem with aged care; I think it is a problem with the other parts of the amendment as well. But when the Hon. Rob Lucas suggests that colleagues in another place might want to look at it, I am sure they will take his advice and look at it.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting the amendment to the amendment. I want to echo the sentiments put very eloquently by the Leader of the Government. In this bill, just as it is the decision of an individual to choose voluntary assisted dying, it should also be a decision of a doctor and indeed an entity, such as a private hospital, to conscientiously object to carrying out voluntary assisted dying in their facility because of their religious, moral or ethical beliefs.

The Hon. C.M. SCRIVEN: I have a question for the Hon. Mr Maher. Is it his intent with this bill that an organisation such as Calvary Care would be required to allow VAD in their hospitals if an inpatient requested it and the patient were able to have a visiting doctor?

The Hon. K.J. MAHER: Perhaps the best way to answer it is: no doctor would be required to administer it; no doctor would be required to be involved in it. But it is the Australian model that an institution or organisation cannot be a conscientious objector. It may well be that a hospital is not set up to provide that service, and I think the Hon. Stephen Wade has talked about the fact that that is the case in some settings with termination of pregnancy.

It may be that it cannot be provided in all circumstances, but I agree with every other parliament that has considered this, that an organisation or an institution should not have the ability to be a conscientious objector. I think it is right and proper that individuals can, and that is what the bill provides for and the Australian model provides for.

The Hon. C.M. SCRIVEN: I want further clarification from the Hon. Mr Maher. Is it his intent that voluntary assisted dying should be allowed in an organisation, such as Calvary Care, that is fundamentally opposed to such a practice?

The Hon. K.J. MAHER: I think I have answered that question. I do not think an organisation or an institution should be able to conscientiously object. I will give you an example that I think spells it out quite well. If someone has been approved for a scheme and then needs hospital admission, particularly if it is in a regional area where there are not many choices and it is a Catholic hospital or institution, I do not believe that the person who has had prior admission to the Voluntary Assisted Dying Scheme should be able to be refused medical treatment. I do not think that is right.

The Hon. I. PNEVMATIKOS: Can I indicate that I will not be supporting the amendment or the amendment to the amendment. The whole tenor of the amendment as proposed by the Hon. Frank Pangallo is inappropriate, inconsistent and discriminatory.

The CHAIR: The Hon. Mr Pangallo, and then I am going to put the question.

The Hon. F. PANGALLO: Yes, you can, Mr Chairman. I rise to say that I support the amendment to my amendment by the Hon. Clare Scriven. I have been in this place for three years now and I have seen many amendments done on the fly to far more complicated pieces of legislation. This is actually quite simplistic, and it goes a long way to addressing what the Hon. Rob Lucas has pointed out, and it quite simply addresses that issue with aged care. I can concede a lot of the comments that the Hon. Kyam Maher made in relation to aged-care providers. But again, as I said, it would certainly contradict what he is trying to do in clause 9 in relation to health practitioners.

The CHAIR: The first question I am going to put is that the amendment moved by the Hon. C.M. Scriven to the amendment moved by the Hon. F. Pangallo be agreed to.

Amendment to amendment negatived.

The CHAIR: The next question I put is that new clause 8A as proposed to be inserted by the Hon. F. Pangallo be so inserted.

The committee divided on the new clause:

Ayes................6
Noes 15
Majority 9

AYES

Centofanti, N.J.
Hanson, J.E.
Hood, D.G.E.
Pangallo, F. (teller)
Scriven, C.M.
Stephens, T.J.

NOES

Bonaros, C.
Bourke, E.S.
Darley, J.A.
Franks, T.A.
Hunter, I.K.
Lee, J.S.
Lensink, J.M.A.
Lucas, R.I.
Maher, K.J. (teller)
Ngo, T.T.
Pnevmatikos, I.
Ridgway, D.W.
Simms, R.A.
Wade, S.G.
Wortley, R.P.

New clause thus negatived.

The Hon. D.G.E. HOOD: My amendment, as members would be well aware, is very similar to the Hon. Mr Pangallo's amendment which has just failed, so I will not proceed with it.

The ACTING CHAIR (Hon. T.T. Ngo): Is that No. 5 as well?

The Hon. D.G.E. HOOD: Yes, Nos 4 and 5.

Clause 9 passed.

Clause 10.

The Hon. C.M. SCRIVEN: I have a question for the mover of the bill. Clause 10 says that voluntary assisted dying must not be initiated by a registered health practitioner and that such a practitioner must not initiate discussion with the person that is in substance about voluntary assisted dying or suggest voluntary assisted dying to that person. I am paraphrasing. Could the mover indicate how this will be monitored?

The Hon. K.J. MAHER: Like many things that have been monitored, I do not think there will be some sort of official standing in in every consultation that a patient has with their doctor to make sure this does not happen. I suspect it will be, like nearly all other offences, monitored upon complaint.

The Hon. C.M. SCRIVEN: So it would be up to the person to whom VAD has been suggested, who is facing a terminal illness, to lodge a complaint while they are in their final weeks or months; is that correct?

The Hon. K.J. MAHER: It might be one person. It might be a family member. It might be anyone else. Any time that there are transgressions of standards, of regulations, of codes of conduct or indeed of laws of the state, there are not people sitting around waiting to try to catch someone out, as a general rule. It would not just be a patient in the final stages of a terminal illness who could make a complaint; it could be anyone. It could be a family member or anyone else.

Clause passed.

Clauses 11 and 12 passed.

Clause 13.

The Hon. D.G.E. HOOD: This is the substantive amendment we debated earlier at clause 3 and it was defeated. This is consequential to that amendment, so there is no point in moving it, but I do have a question on this clause. May I proceed with that?

The ACTING CHAIR (Hon. T.T. Ngo): Yes.

The Hon. D.G.E. HOOD: Thank you. My question on this clause for the mover of the bill, the Hon. Mr Maher, is with respect to subclause (1)(c). It says:

> (c) the person must have decision making capacity in relation to voluntary assisted dying;

My question is: how is that to be judged?

The Hon. K.J. MAHER: I thank the honourable member for his question. Clause 4 of the bill before us delves into quite some detail in relation to the meaning of 'decision making capacity' for the purposes of this bill. It is of course a concept that is exceptionally well understood by the medical profession and medical practitioners. Every day of every week, most doctors will have to turn their mind to that.

Doctors have to turn their mind to the decision-making capacity of someone who, for example, elects to end or refuse treatment that may actually hasten or cause their death or any ordinary treatment that may have that effect. The double effect rule in the Consent to Medical Treatment and Palliative Care Act allows an intervention if it improves comfort but might have a secondary effect of hastening death. A doctor necessarily will have to turn their mind to the decision-making capacity of a patient who requests that.

It is a concept that nearly every day of practice a lot of doctors, particularly working with older people, particularly in the geriatrics area, will have to consider. It is given further clarity in clause 4 of the bill, which we have already passed, specifically in relation to voluntary assisted dying where it defines it further. A person has decision-making capacity if they can:

> (a) understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision; and
>
> (b) retain that information to the extent necessary to make the decision; and
>
> (c) use or weigh that information as part of the process of making the decision; and
>
> (d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

I think it is a very well understood and well used concept by medical practitioners that is given further guidance by clause 4.

The Hon. S.G. WADE: I agree with the Hon. Kyam Maher that this will not be an unfamiliar concept to medical practitioners. Day by day, when they are providing any form of medical treatment, they need to have informed consent. To obtain informed consent to any medical treatment, you need to be confident that the person has the decision-making capacity to give you that informed consent.

If they have not, then you need to go to other processes, perhaps the guardianship and administration act. So I believe that not only is this unsurprising but to not see it would be surprising.

I would like to make a comment, and this is, if you like, a comment for the future. As I have repeatedly said, I support this bill because it reflects the well-considered Australian model, which, as I have mentioned before, has its roots in Canadian legislation. I think it is really important going forward that we maintain national consistency, but I am not naive enough to think that the model is perfect and that it cannot be improved.

One issue, for example, I would flag that needs to be considered but needs a lot more consideration than this parliament could give and would need consultation with other jurisdictions is the issue of mutual recognition or the residency provisions. The reason it is relevant to this clause is that part 2, clause 13(1)(b) provides that for a person to be eligible for access to voluntary assisted dying they must be ordinarily resident in South Australia and have been ordinarily resident in South Australia for a least 12 months.

That is the sort of provision you put in a piece of legislation to avoid medical tourism. In other words, you do not want each state or territory's legislative regimes being undermined by the capacity or, if you like, an inappropriate flow of patients in response to varying legislative regimes in adjoining states.

It becomes less and less relevant the more jurisdictions take on the Australian model. It may well be that, as a matter of national consistency, in the not too distant future clauses such as this should be removed because they serve no useful purpose. I also think it is something that should be considered, particularly in the South Australian context. It is our privilege as a South Australian health service to provide a significant amount of services to people from the Northern Territory. Many of those services are cancer services. The experience in Victoria is that the majority of people seeking voluntary assisted dying are people on the cancer journey.

The impact of this clause as it stands is that people from the Northern Territory would be coming and receiving treatment in our cancer services in South Australia, and you could have two patients alongside one another and the treatment options available to them are based on the postcode, even though it is basically the one pool of patients. The issue of medical tourism is complicated in this context because the commonwealth has limited the legislative competence of the territory legislative assemblies to deal with voluntary assisted dying. Personally, as a federalist I do not believe that that limitation is appropriate, but that is a matter for the commonwealth parliament.

In the meantime, it means that we will have people coming from the Northern Territory who will be, as I said, receiving care from our clinicians in our services and the clinicians will not be able to offer them treatment options that they will be able to offer other patients. I believe that is an example of an issue where we may well need to consider developing the Australian model going forward.

Personally, as the chair of the health ministers' meeting at the national level, I think the health ministers' meeting should take it upon itself to monitor the implementation of the Australian model and discuss possible changes going forward. I would suggest that, in a situation such as that to which I referred, if the commonwealth maintains its limitation on legislative competence in the Northern Territory, the appropriate process may well be for the Northern Territory Legislative Assembly to pass a resolution for the Northern Territory government to advise the South Australian government that it seeks access for its citizens to voluntary assisted dying in our state at an appropriate time, either as an amendment to the act or a regulation, so that people who are not ordinarily resident in South Australia but are ordinarily resident in the Northern Territory might be provided access.

That is one example, and I appreciate that lots of people have different views about whether that is an issue and whether it needs to be addressed, but I come back to the fundamental point, which is that I agree with the Hon. Kyam Maher that a strength of this bill is that it is based on an Australian model. As we go forward, as the bill evolves, I think it would be very useful to share the wisdom of different jurisdictions. To be frank, it would be perhaps a handbrake on ill-considered reform, if it goes through an appropriate national consultative arrangement.

Personally, I believe it is appropriate for us to have a set of nationally consistent laws rather than a national uniform law. I am very happy for state and territory parliaments to continue to be custodians of these bills, but it would be useful for all the parliaments if there was to be an appropriate process for the jurisdictions to discuss amendments to the Australian model going forward.

Clause passed.

Clause 14.

The Hon. C.M. SCRIVEN: I have a question to the mover of the bill. This is really around trying to understand how this will operate in practice. It refers to the coordinating medical practitioner and consulting medical practitioner and what they must be. One of the things that they can be is a vocationally registered general practitioner, a GP, who has practised for at least five years; however, in subclause (3) of clause 14, it states:

> (3) Either the coordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed.

I am a little unclear. For example, if we are talking about cancer, what would be the relevant expertise and experience that a GP might have? I am not trying to make any judgement either way. I am just trying to better understand what would be relevant expertise or experience in cancer if we are talking about a GP.

The Hon. K.J. MAHER: I thank the honourable member for her question. To be clear, it is not a requirement that one of the two medical practitioners has to be a GP. I think it is a misreading if it is thought that the coordinating medical practitioner necessarily has to be a general practitioner. My understanding is that that is not the way that this is drafted or the way the scheme works.

What it requires is that one of the two (the coordinating medical practitioner or the consulting medical practitioner) have relevant expertise or experience in the disease—I think they are the ordinary meanings of the word—so that at least one has a more indepth understanding of what the disease is. Further on in the bill, it talks about the ability of the practitioners to refer for further specialist advice if they have questions around that. I think the requirements in here are exceptionally onerous to have both the coordinating and the consulting medical practitioners sign off on all the elements that we have canvassed a few of in clause 13. I think it puts in very strong safeguards.

The Hon. C.M. SCRIVEN: I was not suggesting what I think the honourable member thought I was suggesting. In my reading of it—and I am happy to be corrected if I am mistaken—it appears that both the coordinating medical practitioner and the consulting medical practitioner could both be GPs.

The Hon. K.J. MAHER: If each one of them has expertise or experience in the disease or medical condition, there is nothing necessarily that would prevent that, bearing in mind also that, as we go onto clause 22 and the relevant clause further on for the coordinating GP, a further specialist can be brought in. I do not think there is a limitation on them doing that.

I think that in many of these areas we place a lot of stock and trust in the expertise of our medical professionals. There are practitioners across all different fields of practice who are involved in these sorts of life and death decisions very regularly. I think there will be across the range of medical practice those who have expertise and experience in a whole range of things. I think the Australian model does not limit that range of practice where they come from as long as they have the relevant expertise or experience as the bill requires.

The CHAIR: Before I call the Hon. Ms Scriven, I respect that the Hon. Mr Maher was answering a question directly to his immediate adjacent colleague, but he should try to face me as much as he can. If he is going to turn a bit, he should angle his microphone a little bit closer to him.

The Hon. C.M. SCRIVEN: I am just trying to clarify. Thank you to the Hon. Mr Maher for confirming. Both the coordinating practitioner and the consulting practitioner can both be GPs as long as they have had five years' practice, etc. That then comes back to my question: if they are both GPs, what is the relevant expertise and experience? An example I would use is if it is ovarian cancer, for example.

The Hon. K.J. MAHER: It may well be there will be certain conditions. There may well not be a GP who has expertise, but it may be that there are.

The Hon. C.M. SCRIVEN: I place on the record my concern that that is not as robust as it should be.

Clause passed.

New clause 14A.

The Hon. S.G. WADE: I move:

Amendment No 2 [Wade–2]—

Page 16, after line 16—Insert:

14A—Certain registered medical practitioners not eligible to act as coordinating medical practitioner etc for person

A registered medical practitioner is not eligible to act as the coordinating medical practitioner or a consulting medical practitioner (as the case requires) for a person if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

  (i) may be a beneficiary under a will of the person; or

  (ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the person).

I have had positive indications of interest in this and related amendments, so I propose not to labour; I will just introduce the general point. This amendment and the following related amendments ensure that medical practitioners involved in voluntary assisted dying do not benefit, or are not family members of the person seeking assistance and they do not stand to benefit from the death. As I indicated previously, this is not an innovation on the Australian model; it is a preference for a Western Australian version or clause of the model rather than the original Victorian version. I think it is a sensible safeguard.

I do not demur from the point made by the Hon. Kyam Maher earlier that it may well substantially reinforce ethical obligations that medical practitioners already have, but I do think it is reassuring in the context of voluntary assisted dying to have this safeguard in place. It reflects Western Australia and also, as the minister responsible for elder abuse, I think it does reinforce the importance of protecting the rights of older people.

New clause inserted.

Clauses 15 and 16 passed.

Clause 17.

The Hon. S.G. WADE: I move:

Amendment No 3 [Wade–2]—

Page 17, after line 10—Insert:

or

(iv) is not eligible to act as the coordinating medical practitioner for the person.

I would suggest that this is consequential on the amendment we have just discussed.

Amendment carried; clause as amended passed.

Clauses 18 and 19 passed.

Clause 20.

The Hon. D.G.E. HOOD: My amendment to this clause is consequential on an amendment that did not proceed earlier, so I will not be moving it.

Clause passed.

Clause 21 passed.

New clause 21A.

The Hon. D.G.E. HOOD: I move:

Amendment No 8 [Hood–1]—

Page 17, after line 37—Insert:

21A—Referral to psychiatrist where person may be mentally ill

(1) If the coordinating medical practitioner believes on reasonable grounds that a person has, or may have, a mental illness, the coordinating medical practitioner must refer the person to a psychiatrist for the psychiatrist to determine whether the person's mental illness is, or is not, the primary cause of the person making a request for access to voluntary assisted dying.

(2) If the coordinating medical practitioner refers a person to a psychiatrist under this section, the coordinating medical practitioner—

(a) must adopt any determination of the psychiatrist in relation to the matter in respect of which the person was referred; and

(b) must have regard to that determination in determining whether the person meets all the eligibility criteria.

This is relatively straightforward. I will just read it out as it is almost self-explanatory. It is essentially requiring a referral to a psychiatrist when the person considering VAD may be mentally ill.

Subclause (1) states that if the coordinating medical practitioner believes on reasonable grounds that a person has, or may have, a mental illness, the coordinating medical practitioner must refer the person to a psychiatrist for the psychiatrist to determine whether the person's mental illness is, or is not, the primary cause of the person making a request for access to voluntary assisted dying. That is the crux of it, essentially.

If that is the case, subclause (2) states that if the coordinating medical practitioner refers a person to a psychiatrist under this section, the coordinating medical practitioner (a) must adopt any determination of the psychiatrist in relation to the matter in respect of which the person was referred; and (b) must have regard to that determination in determining whether the person meets all the eligibility criteria. That is the amendment in a nutshell.

The reason for the amendment is to ensure that people who are not suffering intolerable mental illness do not turn to see assisted dying as the only way forward for them. For the record, I remind members—not that they probably need reminding—that in clause 13, where it lists the criteria for voluntary assisted dying, it specifically says that the condition from which the person is suffering must be incurable and that it cannot be relieved in a manner the person considers tolerable.

I refer again to the AMA position statement on euthanasia and physician assisted suicide—their words. In section 2.1, it states:

> A patient's request to deliberately hasten their death by providing either euthanasia or physician assisted suicide should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and/or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

That is what this amendment will require. Again, I just stress that the criteria to qualify for voluntary assisted dying under this bill is that it be incurable, yet the World Health Organization states in their fact sheet on mental disorders, and I quote directly from their website, that 'there are effective treatments for mental disorders and ways to alleviate the suffering caused by them.'

Dr Caryl Barnes, a leading psychiatrist specialising in the diagnosis and treatment of depression and bipolar disorder, has said on an ABC news report, and I quote directly:

> Euthanasia… is when people voluntarily seek to end their lives when they're faced with a terminal illness. Depression is not a terminal illness. It's a treatable mental disorder.

The Royal Australian and New Zealand College of Psychiatrists does not believe that psychiatric illness should ever be the basis for physician assisted suicide, according to the news archives on their own website. Furthermore, the former president of the Royal Australian and New Zealand College of Psychiatrists Professor Malcolm Hopwood has said, and I quote directly:

> Unrelievable psychiatric suffering is rare, and ensuring that a person suffering from mental illness has the appropriate capacity to make decisions in this context poses significant challenges. Mental illnesses are treatable, and there are many ways to get help.

If we refer back to the bill itself, it requires that the condition the person is suffering from is incurable—I agree with that, by the way. I am not criticising that in any way; it is as it should be in this bill. As the Australian Medical Association has said, as senior psychiatrists have said and as the Royal Australian and New Zealand College of Psychiatrists has said, mental illness in most cases is not an incurable condition and in most cases it certainly will not result—in some cases it does—in death.

Of course, that is another criteria in this bill. Clause 13(1)(d)(i) requires that a disease, illness or medical condition be incurable, subparagraph (ii) requires that it is advanced, progressive and will cause death, and then subparagraph (iii) says it will cause death within weeks or months, not exceeding six months.

I am taking a long time to say that mental illness is a significant concern for people who are considering voluntary assisted dying. It is something that can be treated; therefore, in my mind it clearly does not qualify under this bill as a reason to be successful. In fact, the bill specifically states that if it is a standalone condition it does not qualify. I am anticipating what the Hon. Mr Maher might say. I am fully aware that the bill says that. In fact, it is in this clause that it says that, is it not? Yes, it is in clause 13(2). It says that a standalone is not a reason, but my amendment requires the treating doctor to refer the person to a psychiatrist if they suspect they have a mental illness problem. I think it is prudent and, if I have not already, I move the amendment standing in my name.

The Hon. K.J. MAHER: I thank the honourable member for his contribution and the amendment that forces us to consider these things. I think it is worth delving into, and certainly the discussion that happened around amendments in other parliaments I found very useful in better understanding many of the issues involved.

I was going to say that I agree with much if not the vast majority of what the Hon. Dennis Hood has said, that a mental illness alone should not qualify a person for voluntary assisted dying. As the honourable member pointed out at the end of his contribution, the bill specifically provides for that under clause 13(2) of the bill:

> (2) A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness within the meaning of the Mental Health Act 2009.

I think the quotes read out by the Hon. Dennis Hood go to that and I agree with him, and that is indeed why this is in there, and this is a feature of the Victorian bill that this is modelled on exceptionally closely and a feature of the Western Australian bill and I think, but I will need to double-check, a feature of the Tasmanian legislation. I agree with him in that respect.

I might make two points. If that is all we were debating, then this would be entirely redundant because it is very explicitly provided for in clause 13(2). But in relation to a couple of other things I think this does, I will explain why I also disagree with other elements of this. I do not agree—and, from my discussions with practitioners who have been involved not just with this but in other areas of treatment of patients, particularly end of life, having a mental illness does not necessarily mean you lack decision-making capacity in relation to choices in your life, particularly choices for your medical treatment.

Many people in our society live with a mental illness and have decision-making capacity for most if not every part of their life. I do not think the Hon. Dennis Hood is necessarily suggesting it means you necessarily lack decision-making capacity, but I think the amendment he has moved tends to suggest that you may do, so I do not agree with that.

There is another thing I do not agree with, and this was specifically considered in the expert report for the Victoria legislation before it was enacted. It considered very closely, from page 63 onwards, that issue of decision-making capacity and mental illness. I think it included similarly that a mental illness does not necessarily mean and quite often will not mean that you lack decision-making capacity in relation to your treatment, including for voluntary assisted dying, but they canvassed who would be appropriate to assess that.

I think they made the good point that, even if you were to suggest that or that there was something like the Hon. Dennis Hood is suggesting here, limiting it just to a psychiatrist would not be an appropriate thing to do. They point out in the expert panel's report that there may be other medical practitioners and specialists who are more appropriate in the circumstances for a particular patient than a psychiatrist—for example, geriatricians, psychogeriatricians, neurologists, neuropsychologists, psycho-oncologists, psychologists and even palliative care experts may actually be in a better position to assess someone's capacity in a given circumstance.

From the reasoning the Hon. Dennis Hood gave for the amendment, I think that field is explicitly covered by clause 13(2) of the bill. However, even if all the reasons were not just in relation to that, many people living with a mental illness in our community do, in fact, have decision-making capacity in some if not all their choices in life, including choices of medical treatment and including choices of voluntary assisted dying. The fact is that by limiting it to only a psychiatrist necessarily excludes other professionals and specialists who may be more appropriate in the circumstances.

The Hon. D.G.E. HOOD: I thank the Hon. Mr Maher for his response. There is a lot of agreement here. Clearly, 13(2) is in the bill and it specifically rules out—it provides 'is not eligible for…voluntary assisted dying only because the person is diagnosed with a mental illness'. That is clear, we are not disputing that.

Where we do have a dispute is when the Hon. Mr Maher talked about other medical professionals being in a better position to judge mental illness. That is specifically what this amendment is about. Psychiatrists are the specialists who deal with mental illness, and I am not specifically saying that it is necessarily in respect of decision-making capacity, although that may be an element.

I want to talk about things like depression, for example, as I mentioned in one of the quotes I just gave. It can be very sad; depression can become an overwhelming thing for some and it drives their behaviour. It spirals downward, and some people may want to choose to just end it all through a VAD scheme as a result of depression.

It is not just depression, of course, but also personality disorders, as they are called. I actually have a case study here that might be worth quoting at this time to emphasise my point, if I have not enunciated it particularly clearly. I turn to a case from the Netherlands:

> where a 36-year-old man with a history of attention-deficit hyperactivity disorder, drug abuse, psychological trauma, obsessive-compulsive personality disorder, and therapy resistant schizophrenia had been experiencing psychotic episodes with delusions and…(hearing voices) for [some] 10 years.

So quite an extensive period. It continues:

> their intensity—

that is, the voices—

> increased when his mood worsened and when he was in a stressful environment.

The patient was unsuccessfully treated with antipsychotics and the condition became increasingly unbearable for the patient, eventually resulting in a request for 'physician-assisted death' (those are their words). It continues:

> During the initial assessment period he was referred to an academic hospital—

Sorry, that is a misprint there; it should be 'after'. What happened was that he was initially treated by his GP and unsuccessfully with antipsychotics, as I have just said. After the initial assessment period he was referred to an academic hospital under specialist care for an obligatory second opinion. During admission the patient's symptoms were carefully analysed and his condition was recognised as what is known as 'intrusive thoughts' and not psychotic phenomena.

He was given the appropriate treatment for intrusive thoughts, and within three weeks of treatment that patient had significant clinical improvement. Some time afterwards—I am not sure how long exactly, we could not find that out—cognitive behavioural therapy was added to the pharmacological treatment, and a few weeks later the patient reached full remission, leading him to withdraw his request for 'physician-assisted death'.

My contention is this: psychiatrists are the experts in mental health, and they are the people best placed to judge to what extent someone's mental health problems are driving the request for physician assisted suicide, or voluntary assisted dying. As I said before, and as I have indicated in the quotes I read out, many—not all, but many—mental health conditions are very treatable and some really substantial improvements can occur, as in the case I just read out to the chamber.

It is a simple amendment. It is another—what is the word?

An honourable member interjecting:

The Hon. D.G.E. HOOD: Safeguard, thank you. It is another safeguard in the process of making sure that people who end up qualifying and going through the process of voluntary assisted dying are genuinely those who cannot be treated in other ways that would, as in the case study I have just read out, lead to them actually completely recovering. If he had not gone to the hospital and had specialist assistance, that gentleman, 36 years old at the time, would be dead today. It is one case; I am sure there are many, many others that we are not aware of.

The Hon. S.G. WADE: With all due respect, the case studies the honourable member has just sketched for us would fail to meet three of the four criteria in section 13(1)(d). The condition that the honourable member is referring to is not incurable, the condition would not have caused death, it would not have caused death within weeks or months not exceeding six months. The only criteria that it might have met is not an 'or' criteria; it is an 'and' criteria, and that is 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'. So under this legislation, the case the honourable member is referring to would not be eligible.

I know the Hon. Kyam Maher has alluded to this, but I think it is worth specifically highlighting clause 22(1). Clause 22 provides that where a coordinating medical practitioner is unable to determine the decision-making capacity of an individual seeking voluntary assisted dying—for example, due to a past or current mental illness of the person—the coordinating practitioner is required to refer the person seeking voluntary assisted dying to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of a mental illness.

That clause acknowledges the comments that the Hon. Kyam Maher made, which is that a person with a mental illness may well have the capacity to make decisions and, to the extent they are able, they should be allowed. It also recognises the point that the Hon. Dennis Hood is making, that in assessing that capacity one may well need to have specialist skills, and it specifically references psychiatric skills. I think the legitimate concern that the honourable member is raising is appropriately addressed in the bill.

The Hon. T.A. FRANKS: I have some questions for the mover. He noted that 'psychiatrists are the experts in mental health' in his contribution. Does he believe that only a psychiatrist is relevant in terms of mental health expertise? What mental health expertise did he seek to support this amendment? Who has he consulted with and who supports this amendment within the mental health sector?

The Hon. D.G.E. HOOD: Thank you for the question, the Hon. Ms Franks. I missed some of the end of it. I might ask you to repeat that. I think the start of what was: do I accept psychiatrists as a specialist in mental health? Was that the thrust of the question?

The Hon. T.A. FRANKS: I noted and reflected back to the Hon. Dennis Hood's words that were, I quote, 'psychiatrists are the experts in mental health'. I will elaborate more fully now. Why has the Hon. Dennis Hood chosen only a psychiatrist here? What consultation did he take with the mental health sector? What mental health advocacy bodies or professionals support this particular amendment that he has brought to us today?

The Hon. D.G.E. HOOD: I thank the honourable member for the question. Yes, it is my understanding. Perhaps I should have said 'in the treating of mental health problems or mental health conditions'. They treat schizophrenia, they treat psychosomatic disorders, they treat personality disorders. They are the experts we turn to when it comes to mental health problems. Yes, GPs treat these problems and some other doctors do as well, but those who require significant assistance would almost always end up in the hands of a psychiatrist.

They will be on drugs like risperidone and olanzapine and a whole lot of these medications which have been around for quite some time and which are now used by general practitioners but certainly in their origins were used exclusively by psychiatrists because they are recognised as the experts in treating mental health conditions. There are a number of medications treating mental health conditions which are still exclusively prescribed by psychiatrists in the medical field. That is why I consider them experts in treating mental health conditions. That is my answer to that part of it.

In terms of who I have consulted—I think was the next part of the questions—I have spoken to I think five psychiatrists about this particular amendment, on the condition of anonymity, so I will not name them. The general theme of my discussion with these people was that there is concern about the underdiagnosis of mental health in any potential assisted dying scheme, and they did think it appropriate on the whole, some more enthusiastically than others, that a mental health diagnosis is ruled out, basically.

Can I just go to a point the Hon. Mr Wade made just before I resume my seat; that is, I fully accept that the case study I read out would not qualify under this bill. That was not the intention. The intention of reading out that case study was simply to explain that this person had had the benefit of a specialist psychiatrist to diagnose a mental health problem which was misdiagnosed previously, and that did help in this person's recovery, so the value of the psychiatrist, I think, in treating mental health should not be undervalued. That is what my amendment attempts to do.

The Hon. T.A. FRANKS: So there have been five individual psychiatrists consulted with regard to this particular amendment. I am certainly concerned about language that has been used in discussing mental health in the promulgation of this amendment. I certainly would dispute that psychiatrists are the only experts in mental health. I heard no mention of psychologists, for example, or, indeed, other clinicians in this area.

I saw very little understanding of comorbidities. So was that consultation on comorbidities? Indeed, when one has a diagnosis of a physical condition that means one is going to be dead within six months and one is in intolerable, insufferable pain, I imagine one probably would be able to get a diagnosis of depression and anxiety, but it would be very cold comfort indeed.

The Hon. D.G.E. HOOD: I think we are in agreement. These people are obviously in very difficult times, and they are suffering. The thing about psychologists is, psychologists are not doctors; psychologists do not prescribe medication. The intention here was to provide the capacity for an individual to see a psychiatrist and, if appropriate, to diagnose medical illness, which can be treated with medication. That was the intention.

The Hon. S.G. WADE: I would, again, commend to the house clause 22(1). It talks in general terms about decision-making capacity and, in the context of concern about decision-making capacity, that a registered health practitioner who has appropriate skills and training be engaged. I agree with the Hon. Tammy Franks in relation to the fact that the person with appropriate skills and training may not be a psychiatrist. I have it on very good authority that one of the leading disorders causing mortality, that being eating disorders, is very successfully treated in many cases by psychologists. It may well be that in section 22(1) the appropriate referral to a specialist is not to a psychiatrist; it is to a psychologist.

Likewise in the area of older persons' mental health, if somebody is experiencing BPSD—sorry, the behavioural and psychological symptoms of dementia—it may well be a geriatrician who has the appropriate skills and training. I also think it is important, and I respect the fact, that the Hon. Tammy Franks reminded us of comorbidity. Let us not forget that decision-making capacity can be affected by things other than a mental illness: a brain injury, for example, or intellectual disability. Again, a psychologist may be a more appropriate specialist to ensure that the decision-making capacity of the individual is respected.

So as I said in my earlier remarks, I am fully behind the concerns that the Hon. Dennis Hood is raising, but I believe that the bill handles the issue well and handles the issue well by keeping it general. We are not in a position to say this disorder should be dealt with by a registered health practitioner. What the bill requires is that you identify the decision-making capacity issue, and you are then in a position to identify which registered health practitioner has appropriate skills and training.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting this amendment. As the Hon. Tammy Franks pointed out, I think it does become quite difficult for a number of people who are in pain, especially chronic pain. They are not necessarily suffering intolerably but they are dealing with pain, and they often do experience some form of depression due to that pain. Consequently, whilst they may or may not have a known history of a mental illness and are still mentally capable of making a decision, I think that those people are at risk of choosing voluntary assisted dying for perhaps the wrong reasons. We do talk about the importance of safeguards within this bill and I think that this is another critical safeguard.

The committee divided on the new clause:

Ayes................7
Noes 14
Majority 7

AYES

Centofanti, N.J.
Hood, D.G.E. (teller)
Lucas, R.I.
Ngo, T.T.
Pangallo, F.
Scriven, C.M.
Stephens, T.J.

NOES

Bonaros, C.
Bourke, E.S.
Darley, J.A.
Franks, T.A.
Hanson, J.E.
Hunter, I.K.
Lee, J.S.
Lensink, J.M.A.
Maher, K.J. (teller)
Pnevmatikos, I.
Ridgway, D.W.
Simms, R.A.
Wade, S.G.
Wortley, R.P.

New clause thus negatived.

The Hon. D.G.E. HOOD: Just very briefly, members will be pleased to know that all my remaining amendments are consequential, so I will not be moving them.

Clause 22.

The Hon. S.G. WADE: I move:

Amendment No 4 [Wade–2]—

Page 18, after line 34—Insert:

(5a) A registered health practitioner or specialist registered medical practitioner is not eligible to act in relation to the referral of a person under this section if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

(i) may be a beneficiary under a will of the person; or

(ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services referred to in this section).

I put that this amendment is consequential on amendments previously supported by the council.

Amendment carried; clause as amended passed.

Clauses 23 to 26 passed.

Clause 27.

The Hon. S.G. WADE: I move:

Amendment No 5 [Wade–2]—

Page 20, after line 29—Insert:

or

(iv) is not eligible to act as a consulting medical practitioner for the person.

I put it to the council that that is a consequential amendment or a related amendment to amendments previously supported by the council.

Amendment carried.

The Hon. K.J. MAHER: I move:

Amendment No 1 [Maher–1]—

Page 21, line 9 [clause 27(6)]—After 'person's' insert 'death'

I emailed members earlier in the week that after discussions with parliamentary counsel there were identified two typographical errors. This is the first one of them. I think it is apparent to members that the word 'death' is missed out. It says 'a person's' and it makes no sense without the word in there, and I thank parliamentary counsel for their very thorough due diligence to make sure every i is dotted and t is crossed.

Amendment carried; clause as amended passed.

Clauses 28 to 30 passed.

Clause 31.

The Hon. S.G. WADE: I move:

Amendment No 6 [Wade–2]—

Page 21, after line 36—Insert:

(2a) A registered health practitioner or specialist registered medical practitioner is not eligible to act in relation to the referral of a person under this section if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

(i) may be a beneficiary under a will of the person; or

(ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services referred to in this section).

I put it to the council that that is a consequential and related amendment to amendments previously supported by the council.

Amendment carried; clause as amended passed.

Clauses 32 to 34 passed.

Clause 35.

The Hon. N.J. CENTOFANTI: I want to ask the Hon. Kyam Maher a question in regard to clause 35—Coordinating medical practitioner may refer person assessed as ineligible for further consulting assessment. Basically, the clause provides:

> If a consulting medical practitioner assesses a person requesting access to voluntary assisted dying as ineligible for access to voluntary assisted dying, the coordinating medical practitioner for the person may refer the person to another registered medical practitioner for a further consulting assessment.

My question to the honourable member is whether there is a potential for continuous further assessments until the desired outcome is achieved. In other words, what is to stop doctor shopping in this instance?

The Hon. K.J. MAHER: I thank the honourable member for that question. It is something that is raised in all jurisdictions where voluntary assisted dying is proposed. I do not think this clause necessarily would either allow or encourage that, but it is a reasonable question to ask, so I will answer it.

In terms of this clause, though, the coordinating medical practitioner also may not refer someone on, so that may be the end of it. I am not aware of any scheme around the world, particularly not a scheme that is part of the Australian model, that precludes a person from seeking other medical opinions. It would be very perverse if we cut off the ability for someone looking for this intervention to have further medical advice and opinions sought when we do not for any other sort of medical intervention.

One of the things that it does do—and it is something that I have asked, based on the experience in Victoria—is ask: what is there to monitor or guard against this? Every step of the way, each of the forms—the initial request, the consulting medical practitioner's form, the coordinating medical practitioner's form and the final written request form—have to be submitted to the Voluntary Assisted Dying Review Board as you go through the process. So, if there were a suggestion of that, the Voluntary Assisted Dying Review Board would see those forms and refusals come in.

the clause does not preclude the possibility of a patient seeking further medical opinions and nor should it, because we do not do that in any other way that a person seeks treatment. But there is that oversight because, every step of the way, including the decision of a coordinating or even a consulting medical practitioner to say someone is ineligible, such things need to be forwarded to the review board.

Clause passed.

The CHAIR: I seek some clarification from the Hon. Mr Hood. Is my judgement correct that none of your remaining amendments are going to be moved?

The Hon. D.G.E. HOOD: That is right. They are consequential on ones that have failed or have not progressed. But I would like to ask two brief questions on clauses 40 and 68.

Clauses 36 to 39 passed.

Clause 40.

The Hon. D.G.E. HOOD: There are two final questions from me, and members will be happy that that is it from me.

The Hon. D.W. Ridgway: Hear, hear!

The Hon. D.G.E. HOOD: Yes, thank you, the Hon. Mr Ridgway.

The CHAIR: The Hon. Mr Ridgway is out of order.

Members interjecting:

The Hon. D.G.E. HOOD: You wonder if it is worth pursuing, but I will ask the question for the sake of clarity. Clause 40 talks about witnesses witnessing declarations. I am particularly interested in subclauses (1)(a)(iii) and (2)(a)(iii). I will read them:

> that, at the time the person signed the declaration, the person appeared to understand the nature and effect of making the declaration;

My question is a pretty simple one: how can a layperson objectively judge that? What is the experience either interstate or elsewhere?

The Hon. K.J. MAHER: I thank the Hon. Dennis Hood for his question. Again, it is probably not surprising that the things the Hon. Dennis Hood has turned his mind to are things that, as this bill was being developed and I became more familiar with it, these are the questions I asked practitioners, not just here but in Victoria.

In particular, that goes to a topic that we talked about before—that is, someone who does not necessarily have the capacity to communicate in a more traditional way by speech or writing—to make sure that the field is covered for someone who communicates in a different way, so that someone who appears to understand the nature and effect can make that communication. In those sort of situations it will often be someone who has known that person for a long time who will be best placed to do that.

The honourable member raises that it is a witness, it does not require a further medical practitioner, but before we get to section 40 we have gone through the coordinating medical practitioner and we have gone through the consulting medical practitioner and both of them have had to turn their mind to capacity issues. In fact, every step of the way the issue of capacity has to be resolved for it to continue.

This is that final step and there have been medical practitioners, or at least one, who have expertise or experience in the disease or condition who has gone before that. It intends to capture the field so that it might be those cases where someone is not speaking or writing but the witnesses say that the person appeared to understand the nature and effect of the making of the declaration—in those situations where, for example, someone cannot write.

The Hon. C.M. SCRIVEN: I am sorry, this is something that is not clear to me: is it correct that there needs to be a witness at that time, regardless of whether the person communicates by those other means or communicates verbally, and if so, is there any limit on who the witness can be other than the definition of ineligible witness?

The Hon. K.J. MAHER: In terms of the limitations, yes. The preceding clause 39(2)(a) precludes someone witnessing if they know or believe that they are a beneficiary under a will of the person making the declaration or may benefit otherwise financially in a way from the death of the person. They are precluded from being a witness.

Now that I have answered that, I think the other question was that if the person who is seeking voluntary assisted dying cannot communicate in writing, for instance, does there still have to be a witness? I think, and I will double-check to see if it is wrong later but, yes, there still needs to be that witness.

The Hon. C.M. SCRIVEN: I am sorry, that was not—

The Hon. K.J. MAHER: Was that the question?

The Hon. C.M. SCRIVEN: No, that was not my question. My question was, firstly, are witnesses required every time? At this step are witnesses always required? Is that correct?

The Hon. K.J. MAHER: According to section 40, yes, witnesses are required at this step.

The Hon. C.M. SCRIVEN: My second question was: other than the definition of ineligible witness, which is fine and understood, is there then no limit on who the witness could be? I guess my question is—

The Hon. K.J. Maher: A family member.

The Hon. C.M. SCRIVEN: Yes, a family member, that is all under the ineligible part. My question is: if it is, I do not know, a person making a delivery of flowers at the time, can that person be a witness?

The Hon. K.J. MAHER: I think what the Hon. Clare Scriven is asking is: does it have to be someone who knows the person exceptionally well? No, it does not. Is it going to be someone who is delivering flowers at the time? I doubt it very much but I am not sure they are excluded from that, as long as they meet all the other criteria.

From my discussions with practitioners in the scheme that is operating in Victoria, witnesses will almost always be people who have known the person quite well. Often they will be friends of the person. As part of the difficult decision and the difficult progress of a voluntary assisted dying application, the witnesses are often those who are close to the person, but there is no qualification about how well the witness has to know the person.

The Hon. C.M. SCRIVEN: That really leads to the crux of my concern, which is that it can be pretty much anyone, as long as they are not precluded through one of those other criteria, and therefore their ability to assess whether the person understands the nature and effect of the declaration is not necessarily particularly meaningful at all.

I appreciate that in the current short-lived time of the Victorian legislation it might generally be someone who is well known to the person who is requesting voluntary assisted dying, but there is nothing in the legislation to ensure that it is someone who actually does know them well or has really any capacity to be able to make a judgement of whether the person understands the nature and effect of the declaration.

The Hon. K.J. MAHER: I think we just do not agree on the necessity for involving more people who have intimate knowledge of the patient in this circumstance. As I have answered the Hon. Dennis Hood, the steps that are gone through before you get to that stage are pretty rigorous and onerous safeguards.

The Hon. D.G.E. HOOD: It is good news, Mr Chairman. I just want to let the chamber know that the discussion that has just ensued here has aired my issue at clause 68, so I will not need to ask the question.

Clause passed.

Clauses 41 to 67 passed.

Clause 68.

The Hon. C.M. SCRIVEN: I have a question at clause 68. On reflection, I suspect it is actually more of a statement, which I just want to put on record, rather than a question, because I think it has been answered by the Hon. Kyam Maher already. I draw members' attention to the fact that this is where there will be a witness to the administration of the substance that will end the life of the person.

Again, it says that the witness must certify in writing that the person at the time of making the administration request appeared to have decision-making capacity in relation to voluntary assisted dying. Again, at this stage, the actual stage where the administration of the substance will occur that will end the life, it is someone who does not necessarily have any ability to assess whether the patient has capacity at all. I think that is a defect.

Clause passed.

Clause 69 passed.

Clause 70.

The Hon. C.M. SCRIVEN: Regarding division 3, Notification of cause of death, could the mover of the bill indicate whether the death certificate will record that voluntary assisted dying was the cause of death or that the underlying condition was the cause of death?

The Hon. K.J. MAHER: I thank the honourable member for her question. I think she will have noticed this does not prescribe that. What it does do is interact with clause 5, but it is not regarded as suicide. The intention here is that there is a recording of the fact that voluntary assisted dying has been used, but in practice this will be one of those ones where it is how it is done in practice rather than how it is legislated. I suspect, in practice, on the death certificate it will list the underlying cause rather than the administration of a substance according to voluntary assisted dying. For the reasons that were advocated earlier on, I think that is appropriate.

Clause passed.

Clauses 71 to 98 passed.

Clause 99.

The Hon. R.I. LUCAS: I address some comments to the functions and powers of the Voluntary Assisted Dying Review Board, but they also will relate to the constitution of that board, which is clause 93. The issue of doctor shopping was something that I addressed in the second reading. Whilst I acknowledge the response the Hon. Mr Maher gave, and I do not necessarily disagree with that, it is very difficult to address what is a significant issue in a number of areas of public policy—the issue of doctor or forum shopping.

I instanced in the second reading the clear examples in relation to workers compensation, which I am sure is evident to anyone who has been involved in the workers compensation field. In addressing comments back to clause 93, which is the constitution of the members of the board, given the time line the Minister for Health has indicated, which was a little more conservative than the time line the mover of the bill did, which was that this would all be up and going in 12 months, the health advice to the minister is that it is more likely to be 18 to 24 months.

If it is closer to the estimate of the mover of the bill, which is 12 months, given I am rapidly approaching my political demise I might have the good fortune of being in the party of the government that consults in relation to the constitution of the members of the board. If it is closer to the Department of Health's estimate, which I suspect is more likely to be the case, it will certainly be beyond my powers of limited influence.

Nevertheless, I place on the record, given this debate and the fact that the legislation is likely to pass at least the Legislative Council, it is certainly my very strong view that the membership of the Voluntary Assisted Dying Review Board should be a broad church—and I use that word with a small 'c' church; it might offend some people if I use the capital C. That is, in particular, there should be representation on the board of either a devil's advocate or an active opponent, a cynic or a sceptic—someone who is prepared to ask the hard questions in relation to the implementation of the policy.

The membership of the board should not all be card-carrying members and supporters of voluntary assisted dying, there should be at least some representation, in my view, on the board that promotes genuine review of how the policy is being implemented within the board. The reason I do that comes back to the functions and powers of the board, which are fairly broad, and I have no great opposition to them.

In relation to the issue of forum shopping, one way it has been addressed in the workers compensation field is that the board—management also but the board in particular—of ReturnToWorkSA has identified the particular concerns and has considered policies. In their case, they have the capacity to implement those policies. In this case, this board would not. It would have to recommend options to either government or ministers—they have collected statistics and identified those who, for example, appeared regularly in terms of workers compensation claims, and in this particular public policy area it would be perhaps the names of doctors who appear regularly in terms of signing off on voluntary assisted dying, etc.

A board that is capable of looking at that and, if there are particular issues, I note that under the functions and powers the board has the following functions: it can refer any issue or identify the board in relation to it to relevant persons, authorities or bodies, one being the Australian Health Practitioner Regulation Agency. That would be a pretty serious step; it would have to be a pretty serious offence to justify a reference to that particular body.

Nevertheless, I think that in terms of the functions there ought to be a regular reporting mechanism at the very least within the board in terms of evidence that might be able to be gathered on doctor shopping in relation to the issue, and then a consideration of advice to the minister in particular in relation to whether there are any options in terms of a policy response.

Again, I return to the workers compensation field, which is different because, as I said, the corporation does have the power to institute policy change themselves without reference to government or ministers, and they have done so in relation to some policy directions in terms of trying to provide greater rigour and oversight in relation to this important policy area. It is an issue that the Hon. Mr Maher has acknowledged is an ongoing debate in other jurisdictions. I raised it in the second reading and a number of members raised the issue during the committee stage of the debate as well.

I just wanted to place it on the record during the particular debate about the board, because when one looks at who might have power and authority to do anything, to monitor anything, to report on anything, in relation to this it will be the board. Therefore, the make-up of the board is important and the way they set about collecting information and reporting to the particular minister of the day will also be important in terms of at least considering whether or not there is an issue.

It may well be that there is not an issue, but if there is an issue, what if any policy response is open to the government of the day or the minister of the day in terms of seeking to address a response if sufficient evidence is gathered that doctor shopping has become much too apparent and beyond what might be deemed to be acceptable in terms of the practices of a particular doctor in relation to the legislation that has been outlined?

The Hon. S.G. WADE: Very quickly, I agree with the Hon. Rob Lucas that monitoring and the implementation of the legislation will be very important. The issues he raises, particularly in relation to doctor shopping, I think he called it, are covered by a number of the functions and I am sure the board could do that.

I would like to bang the drum again for the Australian model and national consistency, because the fact that we have a board in South Australia that will be similar to other boards operating around the country I believe will give us the opportunity of having not only nationally consistent legislation but nationally comparable data so that we can identify issues. After all, how do we know that our patterns in terms of referrals and the like are a concern if we cannot see how it compares with other jurisdictions? If you like, we can benchmark. I support the approach taken by this council tonight, which is to try to be part of an Australian model movement.

The Hon. R.I. LUCAS: I will quickly respond to those comments and indicate that I am not aware of the functions and powers of the equivalent bodies in the other jurisdictions, but certainly between the houses it would be worthwhile, and I ask one of my colleagues in the House of Assembly to pursue the issue as to whether or not there is the capacity in the legislation in other states to actually share information or whether they will be producing public information, which would throw light on it.

Whilst I completely understand the point the Hon. Mr Wade has outlined, if the legislation in and of itself is either not producing information capable of being shared or something prevents the information from being shared, we will not be able to learn from what would be an important point that the Hon. Mr Wade has made. I think it is an issue. I do not intend to delay further the debate this evening. I will just flag the issue and I will certainly pursue it with one of my colleagues in the House of Assembly to pursue the issue in the House of Assembly. It is an issue I would invite the Hon. Mr Maher, given his knowledge of the equivalent boards in the other jurisdictions, between the houses perhaps, to better inform the debate in the House of Assembly.

The Hon. K.J. MAHER: I will not comment very expansively. In relation to doctor shopping, I know that there have been reviews, particularly in the north American experience. I think one review in Oregon is that two-thirds of doctors wrote only one prescription. There has not been a lot of evidence internationally that this has been a major problem once implemented.

I do agree with the Hon. Rob Lucas. I think it is something that those who do not support and those who support a scheme would agree on. I think it meets both interests that a scheme is vigorously reviewed. I think those who support a scheme would be inclined to vigorous review to dispel myths or concerns that people have. I do agree with the Hon. Rob Lucas that a scheme is better if it is vigorously reviewed and interrogated.

I think it is not a bad idea to be able to have the powers to be able to have that ability to perhaps look between boards in different states, given that the functions of our board are almost identical to the Victorian ones. I do note clause 103 allows the board to disclose any identifying information obtained as a result of the board performing a function for the purpose of referring the matter to a range of people that includes the commissioner; the Registrar of Births, Deaths and Marriages; the chief executive and the Australian Health Practitioner Regulation Agency, which I suspect may cover the thought that the Hon. Rob Lucas had but it is something worth looking at between the houses.

The Hon. S.G. WADE: I want to comment on what the Hon. Rob Lucas said earlier. The Victorian Voluntary Assisted Dying Review Board does publish reports. On 25 February, it released its fourth report, which is public and detailed. It is available on the web.

On the honourable member's further point about the appropriateness of sharing between the boards, I note the remarks of the Hon. Kyam Maher. Again, no matter what cooperative regulatory arrangements are put in place between the jurisdictions, the health ministers do have oversight of AHPRA and it may well be that AHPRA is the repository of that information sharing arrangements with all of the privacy provisions that it has, so the oversight of the Australian model may well be supported by AHPRA.

Clause passed.

Clauses 100 to 107 passed.

Clause 108.

The Hon. K.J. MAHER: I move:

Amendment No 2 [Maher–1]—

Page 50, lines 30 and 31 [clause 108(1)]—Delete 'the rights, development and wellbeing of children and young people at a systemic level' and substitute 'voluntary assisted dying'

This is one of those typographical amendments that had a wrong cut and paste essentially in relation to this particular area. I again thank parliamentary counsel for the diligent work that they do and I commend the amendment to the chamber.

Amendment carried; clause as amended passed.

Remaining clauses (109 to 115), schedule and title passed.

Bill reported with amendment.

Third Reading

The Hon. K.J. MAHER (Leader of the Opposition) (23:25): I move:

That this bill be now read a third time.

The Hon. C.M. SCRIVEN (23:25): I want to make some final comments as a third reading contribution. We know that no-one wants to suffer themselves, and no-one wants to see someone they love suffer, but there is clear evidence, for those who care to look, that safeguards in voluntary assisted dying are ignored or diluted in practice once voluntary euthanasia becomes legal.

In jurisdictions that have had voluntary assisted dying for decades, the number of people who are euthanised without asking for it is about the same number as those who do ask, including people with disability, people with dementia and people with mental health challenges, regardless of the model in law, regardless of the safeguards in the law.

Victoria has not had its legislation in place even for two years. Culture and practices change over time. There are already calls to make changes in Victoria on the basis of equity. Doctors have already noted a change towards euthanasia instead of presenting all the options for relief of suffering. We need to ask: do we want our loved ones to feel pressured to end their life? Do we want our loved ones to feel they are a burden on society or on their family? Do we want our loved ones to feel that they have a duty to ask to die prematurely?

It does not matter what the model is in law or how many safeguards are in the law if they are ignored, and over time experience in other places in the world has showed that they are ignored. As a legislator, I have a responsibility to legislate for the safety of all citizens, so I will not be supporting this bill.

The Hon. T.A. FRANKS (23:27): I will make a brief third reading contribution because I want to put on the record that I thank all those members of the community who wrote to me and the other members of this chamber. Many of those pieces of correspondence were quite personal and deeply traumatic, and I appreciate their sharing their stories with me as an elected member. Indeed, they are very reflective of what we know now from the Australia Institute poll, that some four in five South Australians do believe we need voluntary assisted dying laws. For the Greens, 97 per cent of our membership believes that we need voluntary assisted dying laws. But it is significantly high for all members of all political parties.

This is simply the right thing to do for the wellbeing of our society, to ease the burden on those who are suffering, as well as their friends and family, their loved ones. No matter how caring or supportive palliative care staff are, there is only so much they can do to ease the suffering, and the toll that it takes on them as workers must be quite significant.

This bill is and always has been about the overall quality of life and enhancing that for these people, who are deserving of choice in the most difficult times and of that choice of how to end their time—a choice of autonomy, dignity and control, of not being forced to suffer an agonising death, of not being forced to spread the suffering to their loved ones, who are often needlessly traumatised, and that bereavement comes with its own particular pain and suffering that we can help them avert.

As an elected member of parliament, I am very proud tonight to see that we are probably going to pass this bill. I urge the other place to afford this piece of legislation, which is overwhelmingly supported by the public, the unfettered debating time that it needs to be done properly in the other place. We have seen time and time again bills prorogued, bills not getting to a final vote or bills rushed and then voted on in the very early hours of the morning, with people regretting that they were put under undue stress and time constraints and that perhaps their votes may have been different.

I believe people should be given the voice and control over their own deaths in their own way and I believe this bill is deserving of time in the other place that is reflective of the importance of this issue.

The Hon. K.J. MAHER (Leader of the Opposition) (23:30): I wish to take this opportunity to make a few brief comments. I will again reiterate, as I did when we started this before the dinner break, that I think it reflects very well on us as individual members and as a parliament that we can have a discussion with deeply held opposing views on such a sensitive issue yet maintain respect and decorum. Contributions tonight, but particularly on the second reading debate, have been heartfelt, sincere and emotional.

I want to acknowledge all those that have come before in this parliament on the issue. I think there were 16 different bills, and if you count the reintroduction of the same bills I think the bill that was introduced in the Legislative Council and by my colleague Dr Susan Close in the lower house is now the 24th separate piece of legislation to have been introduced over 26 years.

I want to acknowledge John Quirke, way back in 1995; Anne Levy; Sandra Kanck; Bob Such, who if you count those 24 separate times was responsible for 11 of them; Lyn Such, who has been a regular communicator with me and has provided a great deal of support and advice; Mark Parnell; Steph Key; and Duncan McFetridge. I know quite a number of those ought to be referred to as honourable but I am pretty sure most of them probably prefer not to be.

There have been nine second reading votes on voluntary assisted dying and the second reading vote on this bill last month became the fifth successful one out of those nine occasions. It has been to a third reading vote three times previously, most notably on the last occasion in the lower house where it failed on a casting vote after a 23-all tie.

Unlike other attempts before in South Australia, this time our scheme, if successful, would not be the first in the country, nor the second or the third, but we will be the fourth state to implement what we have discussed and what has become known as the Australian model. I think that has given a significant degree of comfort to some members in both chambers who may not have voted for this before and may not have considered voting for it before but may this time.

I wish to sincerely thank the many people in SA who have been advocating and campaigning for these changes over many years and, in some cases, even decades. I will single out particularly Frances Coombe and Anne Bunning. If it were parliamentary to do so, I would probably acknowledge that they are in the chamber, but it may not be so I will not. I wish to thank my staff, both the current kids in the office and the ones who have been there before. It has been a rollercoaster of a journey.

I want to thank the politicians and practitioners, particularly in Victoria, who have shared their expertise and experience. I want to single out Dr Roger Hunt, whose expertise in voluntary assisted dying is probably unrivalled. I think Roger is the only person who has been on both the Victorian and the Western Australian governments' expert panels in setting up the scheme. He has provided heaps of time and advice, including a big chunk of last Sunday, to help with preparation and understanding for this bill.

It would be remiss of me not to thank Andrew Denton, who has almost become a full-time advocate for voluntary assisted dying and whose persuasiveness is well known to most politicians around Australia who have considered these end-of-life issues.

Most of all, I want to thank the many South Australians who have been in touch with me on this issue over the last six months. It has been a rare privilege indeed to share some of the most intimate and difficult moments of your lives. The traumatic last moments and days of witnessing the extreme suffering of a loved one that people have shared—I know exactly what you mean.

To the people who I have met, talked to and messaged who are themselves in the final stages of a terminal illness, the fact that you take your time in those last precious moments to try to ensure that others do not have to suffer and go through what you do is an extraordinary thing. I have shared the whole gamut of human experience and emotion with so many people: courage, distress, sadness, strength, love, loss and coping. Thank you, everybody. I commend this bill to the chamber.

The council divided on the third reading:

Ayes 14
Noes................ 7
Majority............ 7

AYES

Bonaros, C.	Bourke, E.S.	Darley, J.A.
Franks, T.A.	Hanson, J.E.	Hunter, I.K.
Lee, J.S.	Lensink, J.M.A.	Maher, K.J. (teller)
Pnevmatikos, I.	Ridgway, D.W.	Simms, R.A.
Wade, S.G.	Wortley, R.P.	

NOES

Centofanti, N.J.	Hood, D.G.E. (teller)	Lucas, R.I.
Ngo, T.T.	Pangallo, F.	Scriven, C.M.
Stephens, T.J.		

Third reading thus carried; bill passed.

Motions

INTERNATIONAL DAY OF RURAL WOMEN

Adjourned debate on motion of Hon. C.M. Scriven:

That this council—

1. Acknowledges that 15 October is the International Day of Rural Women;
2. Recognises the critical role and contribution of rural women, including Indigenous women, in enhancing agricultural and rural development, improving food security and eradicating rural poverty; and
3. Commends the many valuable contributions of rural and regional women to South Australia.

(Continued from 14 October 2020.)

The Hon. N.J. CENTOFANTI (23:39): I rise to speak to and support the motion of the Hon. Clare Scriven. I commend the Hon. Clare Scriven for putting forward this motion, which recognises the role rural women play in their communities. As a member of a regional community myself, I know the effort and sacrifice that goes into their contributions. I am proud to be here today to speak to this motion, which celebrates these women on their merits in an indispensable sector of the South Australian economy and community.

Agribusiness generates an estimated $15 billion in economic activity. What is often overlooked is the role women have as business people, their trials and successes, which generate growth and keep our regions alive. They provide security and jobs in no different way than rural men. Recognising the International Day of Rural Women acts not just to encourage more of their success through public awareness, it also encourages young girls and women about to enter the workforce to consider a career outside the city office in one of the strongest and most rewarding industries in this state.

I speak to all women out there when I say that gender is no barrier to a rich and engaging life in agriculture, where you can work and live on the land that sustains our communities. The Marshall Liberal government realises the importance of this, and is committed to promoting the contributions and achievements of rural and regional women in South Australia. The government is currently developing a new Women's Leadership and Economic Security Framework to encourage and support the advancement of women in South Australia.

This includes all women, as we recognise the value of our state's growth sectors, including food, wine, agribusiness, energy, mining and tourism. This framework will outline the road map for the South Australian government to partner with the private sector to achieve the best outcomes for our state and to ensure that South Australian women are supported to thrive.

Women comprise 41 per cent of the agricultural workforce but only 18 per cent of management roles and 2.3 per cent of CEO positions. There are vast amounts of opportunities for women farmers. Visible Farmers, a unique campaign supported by the federal Coalition government and the National Farmers Federation, is helping to change perceptions and inspire new generations of women to help shape the future of Australia's sustainable food production. Their goals include:

- building a positive profile of women in agriculture by highlighting their contributions and achievements;
- empowering women to find their voice and helping them to connect and engage with each other; and
- inspiring and encouraging women to enter the rural workforce and help narrow the gender gap in Australian agriculture.

The National Farmers Federation itself is also doing its part to change the statistics around women in leadership roles. Its program Diversity in Agricultural Leadership is in its third year and mentors aspiring female leaders in agriculture. These initiatives are ensuring that our thriving and enduring women out there are able to tell their stories, and their stories are proof that hardiness and grit are in no short supply in our regions.

It is not just farming where women excel. Tourism, fisheries and natural resources are all areas populated with talented women. Outside of primary producers, women also occupy the jobs that are crucial to the continued functioning and wellbeing of towns and communities across rural Australia. They are more than competitive across the board in STEM, business and health. Whether it is vital service jobs or providing critical health care in remote areas, the expertise they hold is in critical demand where supply and access can mean life or death.

The participants in the annual Rural Women's Award are an example of the breadth of expertise and diversity of skills applied by women in the rural context. Jointly supported by state and federal government departments, it is open to all women over the age of 18 who are involved in rural and regional communities, businesses and industries. For 20 years, projects in varied fields such as psychology, commerce, tourism, health and sustainability have competed for a grant of $10,000 at state and national levels.

A similar grant prize is awarded by the South Australian Research and Development Institute. The Science Bursary for Women is targeted towards female university graduates undertaking further studies in agriculture, fisheries, natural resources management or forestry science. This award was established under a Liberal government in 1994 to celebrate the centenary of suffrage in our state.

It supports a long tradition of freethinking and innovative women in our community, innovative women such as Caroline Schaefer, a fellow South Australian Liberal member of the Legislative Council from 1993 until 2010 and a strong advocate for rural South Australia. From a farming background and having grown up on Eyre Peninsula, Caroline was a farmer for 30 years before becoming the state's first female Minister for Primary Industries. To this day, she continues her lifelong passion of being an advocate for our regions, having tackled the full range of issues these communities face. To quote Caroline:

> I have encouraged rural women to take their places in public life. My message has been 'If I can do this so can you'. One of my basic beliefs is that we must strive to leave our space in the world a better place for us having been there.

It is women like Caroline that we celebrate, not only on occasions such as International Day of Rural Women but on every single day for their outstanding contributions to our communities. Looking forward, I see great opportunity for our rural and regional areas. We have the talent and the networks, but it is up to us to continue to cultivate and promote the success of these women. It is our loss should we not help bring the best out of our communities.

International Day of Rural Women is a reminder that, when it is said that man has mastered his environment, this means women too, in the feeding and clothing of Australia and the rest of the world through exports to working a sunburnt country into fertile land and the provision of crafted products of a premium that is uniquely South Australia. For all that our regions do for us there is always more we can do for them. Acknowledging this day in the council is a way to rally behind the practicality and resourcefulness of rural South Australian women and cheer on their victories.

Debate adjourned on motion of Hon. I.K. Hunter.

Bills

CRIMINAL LAW CONSOLIDATION (BUSHFIRES) AMENDMENT BILL

Introduction and First Reading

Received from the House of Assembly and read a first time.

COVID-19 EMERGENCY RESPONSE (EXPIRY) (NO 2) AMENDMENT BILL

Introduction and First Reading

Received from the House of Assembly and read a first time.

At 23:49 the council adjourned until Thursday 6 May 2021 at 14:15.