



VAD Consultation Team
Justice and Community Safety Directorate
Via: YourSay

6 April 2023

Dear VAD consultation team

Voluntary Assisted Dying Consultation

The ACT Human Rights Commission welcomes the opportunity to provide input into the consultation to inform the development of a voluntary assisted dying model for the ACT. The Commission provides the following comments:

General principles

1. A central tenant of the *Human Rights Act 2004* is that individuals should live lives of dignity and value.¹ Dignity encompasses concepts of self-determination, autonomy and freedom. These values are reflected in many human rights guaranteed by the HR Act, including the right to equality,² the right to privacy,³ the right to life,⁴ the rights to be free from inhuman and degrading treatment,⁵ and the right to security of person.⁶ The Human Rights Commission's view is that those rights are engaged and potentially limited by the prohibition on assisted suicide that currently exists in s 17 of the *Crimes Act 1900* and conversely would be supported by an accessible pathway, with appropriate safeguards, for a person who is suffering at end-of-life stage to seek medical support to end that suffering.⁷
2. A human rights approach to the development of a voluntary assisted dying model involves a balancing of rights and the appropriate balance may be subject to competing views. The Human Rights Commission supports human rights compatible legislation to enable access to appropriate and adequate health care to assist a person to die with dignity, in circumstances where other health interventions are futile or intolerable to the suffering person. Our position builds on previous submissions to the Select Committee on End of Life Choices in the ACT,⁸ and to the Standing Committee On Health And Community Wellbeing's

¹ Preamble, *Human Rights Act 2004*.

² s 8, *Human Rights Act 2004*.

³ s 12, *Human Rights Act 2004*.

⁴ s 9, *Human Rights Act 2004*.

⁵ s 10, *Human Rights Act 2004*.

⁶ s 18, *Human Rights Act 2004*.

⁷ See discussion in ACT Human Rights Commissioner, *Submission to the Inquiry into End of Life Choices in the ACT*, 26 March 2018, available at [477-ACT-Human-Rights-Commission.pdf](https://www.hrc.act.gov.au/477-ACT-Human-Rights-Commission.pdf), p 3-4.

⁸ ACT Human Rights Commissioner, *Submission to the Inquiry into End of Life Choices in the ACT*, 26 March 2018, available at [477-ACT-Human-Rights-Commission.pdf](https://www.hrc.act.gov.au/477-ACT-Human-Rights-Commission.pdf)

inquiry into abortion and reproductive choice in the ACT.⁹ Those submissions articulate issues of health consumer autonomy, access and balancing rights to non-discrimination and freedom of conscience and religious belief.

3. Internationally the right to privacy has been held to encompass the right of an individual to have control over how and when to end their own life, provided that the person has the capacity to make that decision. It has been acknowledged in a line of international cases that a prohibition on assisted suicide limits the right to privacy. As summarised by the UK High Court in *Conway v Secretary of State for Justice*: the right of an individual to decide how and when to end his life, provided the said individual is in a position to make up his own mind in that respect and to take the appropriate action, is one aspect of the right to respect for private life.¹⁰
4. In that case, the Court ultimately held in the balancing of individual rights and the wider public interest that Parliament was far better placed than the Courts to determine the difficult policy issues in relation to assisted suicide in view of the conflicting, and highly contested, views within society on the ethical and moral issues and the risks and potential consequences. The Court held that the balance of the rights that had been struck via a legislative prohibition was within a justifiable range of legislative responses.
5. We consider that the absence of a voluntary assisted dying regime may also potentially limit the right to be free from cruel, inhuman and degrading treatment where people experience ongoing suffering at end-of-life stage which is not able to be effectively relieved by palliative care or who feel compelled to take painful and protracted measures such as self-starvation to end their lives where they are not able to exercise other choices.
6. As the courts have noted the Parliament is best placed to design the scheme to balance individual rights with broader public interest considerations as required by s 28 of the HR Act. However, it is incumbent that Government give full regard to the rights that may be limited in the design of any scheme, and justify those limitations comprehensively.
7. Generally, health services are assessed in international human rights law on their availability, affordability, accessibility, acceptability and quality.¹¹
8. Any voluntary assisted dying (VAD) framework needs to embed safeguards to protect against the exploitation or abuse of people experiencing vulnerability because of terminal illness, loss of capacity and old age and emotional distress and suffering.
9. However, drawing from the experiences of other Australian jurisdictions who have implemented and had time to consider the effect of stringent safeguards, we are concerned that the protections do not diminish the workability and accessibility of the VAD scheme for

⁹ in ACT Human Rights Commission, Submission to the ACT Legislative Assembly Standing Committee on Health and Community Wellbeing's Inquiry into abortion and reproductive choice in the ACT, (22 August 2022) available at [Submission-49-ACT-Human-Rights-Association.pdf](#)

¹⁰ *Conway v Secretary of State for Justice* [2018] EWCA Civ 1431 [120].

¹¹ See detailed discussion in ACT Human Rights Commission, Submission to the ACT Legislative Assembly Standing Committee on Health and Community Wellbeing's Inquiry into abortion and reproductive choice in the ACT, (22 August 2022) available at [Submission-49-ACT-Human-Rights-Association.pdf](#), [18-20].

health care consumers. We encourage the Government to consider and seek advice of consumer health care networks about the lived experiences of families and carers navigating similar systems in other jurisdictions about what can be done to ensure that safeguards do not become unnecessary barriers.

10. In this regard, we fully recognise and respect the rights to freedom of thought, conscience, religion and belief as set out in s 14 of the HR Act and the right to freedom of expression in s 16, and the corresponding need for a means for faith-based health care practitioners to conscientiously object to facilitating VAD. However, we are of the view that faith-based organisations that perform functions of a public nature so as to fall within the definition of public authorities in s 40 HR Act should not be permitted to actively frustrate or obstruct a person from accessing VAD as a lawful health service once legalised.
11. Clear parallels exist with the work of the Government to regulate abortion as a lawful health service, to recognise a process for conscientious objection and to provide 'patient privacy' access exclusion zones around abortion clinics. We note that the terms of the conscientious objection provisions state that a practitioner "may refuse to prescribe, supply or administer an abortifacient, or carry out or assist in carrying out a surgical abortion, on religious or other conscientious grounds (a *conscientious objection*)".¹² These terms (carrying their ordinary meaning) respect the right to freedom of conscience or religion of individuals who may object to actively participating in the provision of the health service, but does not extend to enable active frustration or obstruction of that access.
12. Similarly, the 'exclusion zone' provisions balance the right to protest on religious grounds with the right of individuals to access lawful health services without harassment intended to obstruct or intimidate a person from accessing that service.¹³
13. In that case the right to protest in accordance with individual belief or conviction was acknowledged to be a fundamental right, but one that was not absolute, and which could be justifiably limited under the HR Act framework on the basis of the importance of supporting equal access to health services.¹⁴
14. That Bill also contained minor offences where a person intentionally contravened the terms of the administrative ban on protest by engaging in behaviour that would intimidate or obstruct access to health services.
15. The Commission considers that the HR Act provides a clear framework for the consideration of the reasonableness, necessity and proportionality of any limit on rights recognised under the HR Act. It is the task of policy makers to justify limitations chosen in the design of legislative responses to social issues. In this instance there is clear precedent for an appropriate response to support access to health care while minimising the impact on the freedom of religion and conscience of individuals.

¹² s 84A *Health Act 1993*.

¹³ Division 6.2 *Health Act 1993*.

¹⁴ Explanatory Statement, Health (Patient Privacy) Amendment Bill 2015.

16. As noted in our recent submission to the Standing Committee on Health and Community Wellbeing's inquiry into abortion and reproductive choice in the ACT:

"To minimise unnecessary limitations of the right to freedom of thought, conscience, religion and belief, governments are obliged to develop and effectively regulate a framework for conscientious objection by individual health professionals. Facility for conscientious objection provides for individual medical professionals to opt out of performing abortions or providing post-abortion care based on their cultural, religious or conscience-based objections. Freedom of thought, conscience, religion and belief, as recognised in s 14 of the HR Act, must not, however, be relied on to justify discrimination. In this regard, the exercise of conscientious objection by individual medical providers, and associated staff, must not present a barrier to their enjoying effective access to safe and legal [health services].¹⁵

17. While we understand that the Government has fixed certain parameters for access to the scheme, we consider that these exclusions must be demonstrably justified as reasonable limits compatible with a free and democratic society. If community feedback supports expanding eligibility and access to the VAD scheme, we trust that the Government will listen and consider those calls, rather than limiting the scope of what is deemed suitable for the ACT to only what has been rolled out in other states.

Eligibility

18. The right to equality in access to health care requires a beneficial interpretation of legislative parameters and safeguards to support the applicant, who should be the central concern of this scheme.
19. Restrictive access criteria, ostensibly to act as a safeguard for the protected person, should not be applied narrowly to prevent people accessing the scheme and defeating its core purpose. As noted in relation to the Victorian VAD Scheme, '[w]hile safety is of course an important value, safeguards have access consequences', and the coherence and effects of voluntary assisted dying 'safeguards' warrant scrutiny.¹⁶ A system that imposes rigid and arbitrary eligibility criteria and timeframes may itself become an aspect of suffering, where a person is powerless to take steps to change their situation and exercise their own autonomy, because of potentially arbitrary regulatory requirements which may be inconsistent with human rights.
20. The person should not have to meet any objective standard of suffering in order to access the VAD scheme. The VAD scheme should be available to any person who has a medically

¹⁵ Ibid, [17].

¹⁶ Courtney Hempton, 'The Constitution of 'Choice': Voluntary Assisted Dying in the Australian State of Victoria' Chapter 1 in *Voluntary Assisted Dying: Law? Health? Justice?*, edited by Daniel J Fleming and David J Carter, (2022, ANU Press, Canberra) available at [1. The Constitution of 'Choice': Voluntary Assisted Dying in the Australian State of Victoria \(anu.edu.au\)](https://www.anu.edu.au), p 26.

intractable condition, of constant and incurable physical or mental suffering that cannot be alleviated.

21. It may need to be clarified whether symptoms of illness such as psychological distress or anguish in association with a medical condition would comprise an eligible trigger for access to the scheme, so as to avoid technical disputes about symptoms / felt effects caused by the illness or condition.
22. The Commission strongly considers that eligibility should not be linked to a diagnosis that the condition is 'terminal', or which sets timeframe in which a person is expected to die. Timeframes obscure the lived experience and reality of a person living with an incurable or intractable condition. If a timeframe is proposed it should be longer to accommodate both the inexact nature of calculating length of time to live, but also the likely relative unavailability of practitioners meaning that someone must be so proximate to death they risk not accessing the service. An eligibility timeframe of death within 6 or 12 months assumes the approval process is streamlined, which we have seen in other jurisdictions is not always the case. If a timeframe is proposed we consider that there should not be different timeframes depending on the nature of the condition or illness, as this effectively discriminates against those suffering from certain conditions.
23. The Commission considers that there is no clear rationale for limiting accessibility of the scheme to Australian citizens or to those permanent or long-term residents of the ACT, and that the scheme should be open to any person in the ACT. If a residency requirement is retained this should be drafted openly so as to allow any person with familial / self-identified connection to the ACT to be considered as ordinarily resident per the decision of the Victorian Civil and Administrative Tribunal in *NTJ v NTJ*.¹⁷
24. The Commission also considers that there should be no effective barriers for non-Medicare eligible community members. Given the diversity of non-resident people living and working in the ACT, we need to ensure no artificial barriers prevent access by foreign citizens such as diplomats, embassy staff, international students, people on other types of work related visas, particularly where their illness or their own circumstances would prevent them from returning to some other place to access an equivalent health service. In this respect requirements about the makeup of the treating team being ACT resident health care practitioners may also act effectively as a barrier to people outside the ACT seeking to access ACT services.

¹⁷ *NTJ v NTJ* (Human Rights) [2020] VCAT 547 (5 May 2020) [83-89].

Capacity and voluntariness

25. The Commission reiterates its concern that there should be provision for individuals to make advance care directives indicating they wish to access VAD in the case of losing capacity, particularly for conditions which involve neurodegeneration. Capacity is a central issue to the operation of this scheme. Capacity is recognised to be a fluid, and evolving assessment. The VAD legislation should reflect this and not impose a static or unduly narrow definition of capacity which is inconsistent with other ACT statutes, as well as ignoring the lived experience of people suffering from terminal illnesses who may have fluctuating capacity.
26. Advance care planning is a core part of our systems for planning around end-of-life decisions.¹⁸ These systems must balance the need to protect people who may be experiencing vulnerability from abuse while also making sure that they are supported to exercise their free will to the greatest extent possible, and that they are involved in decisions affecting them. Legislation such as the *Guardianship and Management of Property Act 1989* provides a scheme for carrying out of irreversible medical interventions where the subject person cannot consent.¹⁹ Increasingly, the community and legal frameworks in Australia and internationally are moving away from substitute decision making to supported decision making that requires decisions which involve the person with impaired capacity, to give effect to their will and preferences over any best interests assessment.²⁰
27. The paper notes that all Australian states require that that a person must have decision making capacity at all stages of the process, but then says that this may mean that a person cannot request through an enduring power of attorney or health direction or advance care directive to access voluntary assisted dying should they lose capacity.
28. As noted by the UN Committee on the Rights of Persons with Disabilities, “[f]or many persons with disabilities, the ability to plan in advance is an important form of support, whereby they can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others. All persons with disabilities have the right to engage in advance planning and should be given the opportunity to do so on an equal basis with others”.²¹
29. The Committee considers that “[a]ll people risk being subject to “undue influence”, yet this may be exacerbated for those who rely on the support of others to make decisions...Safeguards for the exercise of legal capacity must include protection against undue influence; however, the protection must respect the rights, will and preferences of the person, including the right to take risks and make mistakes”.²²

¹⁸ See discussion in Australian Human Rights Commission, *Euthanasia, human rights and the law: issues paper* (May 2016) available at [Euthanasia, human rights and the law | Australian Human Rights Commission](#), [2.1].

¹⁹ s 70, *Guardianship and Management of Property Act 1989*.

²⁰ Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) (Article 12: Equal recognition before the law)*, Eleventh session, 19 May 2014, CRPD/C/GC/1 [29]

²¹ *Ibid*, [17].

²² *Ibid*, [22].

30. The Commission is of the view that human rights compatibility is best achieved through a model which enables a person to access VAD through an advance care directive so long as there is appropriate oversight. There are parallels with 'do not resuscitate' instructions which are a regular feature of health care planning and provision for people nearing end of life.
31. The Government has not yet sufficiently justified why existing systems for upholding the valid expression of a person's will into the future in order to maintain personal autonomy are not appropriate within the scope of this model. On a prima facie view this rule, would constitute indirect discrimination on the basis of disability, and limits rights to equality and non-discrimination and rights to privacy.²³
32. The Commission also considers that human rights principles require consideration of the ability for young people with sufficiently developed maturity and understanding (Gillick competency) to be held to have capacity to make decisions about whether to seek VAD. Our human rights framework requires that there be due consideration of the rights of young people to self-determine and have a voice in decisions made about them, particularly where that will impact their equal right to access certain forms of health care. Likewise, those young people assessed as having capacity should be able to engage in advance care planning.
33. The Commission favours an approach that would enable a treating doctor, to make an assessment of capacity of the young person on the basis of their established therapeutic relationship, rather than establishing a separate additional process for determining capacity. We acknowledge that there may be a need for separate processes when the young person's wishes are different from the parent(s) or when the young person and parent(s) are in agreement.

Request and assessment process

34. While it is important that the request and assessment process is robust, transparent and removes the chance for improper or undue influence in a person's decision to access VAD, we note that there are several learnings from the practical operation of similar schemes, such as were analysed in the recent inquiry into abortion and reproductive choice in the ACT.
35. We understand that in some practices, even where they have practitioners authorised to prescribe medical abortion treatments, they do not do so because of stigma or pressure from within the practice. The design of the scheme should account for this reality, where many general practitioners (GPs) will be delivering services within a broader practice with its own distinct policies and contractual requirements and may be prevented from offering those services (or referring to other providers) by the owners/operators of the broader practice.

²³ See discussion in Courtney Hempton, 'The Constitution of 'Choice': Voluntary Assisted Dying in the Australian State of Victoria' Chapter 1 in *Voluntary Assisted Dying: Law? Health? Justice?*, edited by Daniel J Fleming and David J Carter, (2022, ANU Press, Canberra) available at [1. The Constitution of 'Choice': Voluntary Assisted Dying in the Australian State of Victoria \(anu.edu.au\)](https://www.anu.edu.au/research/publications/choice), p 20.

36. The Government should consider whether both individual practitioners and any health services in the ACT should be required to have information available on their website or through their booking systems and reception staff that makes clear whether the practice provides these VAD services and subject to what terms or conditions, or whether the services are not available at the practice. This may inform both choice of practitioner and practice, but also assist in minimising the chance of time wasted by a patient seeking services from a health practitioner only to discover that the practice will not permit such services to be offered.
37. We strongly consider it would be preferable in any case to have a government run care navigation / VAD health service by which to coordinate consumer care through the scheme to improve accessibility and to facilitate assessments. This would consist of government employed health professionals able to undertake patient outreach, initiate discussions, make assessments, coordinate witnessing and documentation requirements, and administer substances.
38. This would enable accurate information, financial assistance to access VAD and counselling and supports for family to be provided centrally, avoiding access barriers Liability could more easily attach to the Territory minimising professional risks and financial disincentives that may stop private practitioners from offering services under the scheme. This would be consistent with the obligations of the positive duty to eliminate discrimination under the *Discrimination Act 1991*.²⁴
39. A centralised government navigation service would be best placed to deliver a timely, accessible, and flexible service that responds to the individual needs of each patient. For example, the consultation paper outlines a requirement for two witnesses not in the treating team, family etc. This may be difficult for people in facilities such as aged care, who have mobility issues or have limited support outside family and service providers. The care navigation service should have available people who can assist with witnessing on an outreach basis.
40. Flexibility and responsiveness to individual choice and need will be integral to a scheme that is consistent with rights to equality, and which does no harm. We consider that there should be different options available for administration of the VAD substance that support effective access to the scheme, for example, if a person cannot swallow, or if a person's medical condition deteriorates to the point where they cannot self-administer. There should be no requirement to witness self-administration, as some people will choose to die alone as has been shown in Victoria and insisting on a witness at the most private time is unnecessarily intrusive, but we support a process to check in on a person who has been provided with such medication regularly.
41. Again, we reiterate the international human rights principle, that governments have "an absolute obligation to provide access to support in the exercise of legal capacity" and "are required to make any necessary modifications or adjustments to allow persons with disabilities to exercise their legal capacity, unless it is a disproportionate or undue

²⁴ s 75 *Discrimination Act 1991*.

burden”.²⁵ This extends to providing supports to young people to be supported to exercise capacity.

Role of health professionals

42. The valuable contributions of health practitioners to therapeutic relationships with patients must be respected and facilitated. The Commission does not consider that rigid qualifications requirements are necessary or the only relevant consideration in determining which practitioners should be empowered to support patients through the VAD process.
43. The availability of appropriately trained health practitioners willing to participate in the scheme will be a determinant of the effectiveness of the scheme.
44. Where many end of life and palliative care services are delivered by trained nurse practitioners, already employed by health services that may not permit them to provide VAD supports, the issue will be availability of appropriately trained staff outside of existing palliative care services. We consider that rather than specifying which qualifications are required, the legislation should require only that assessing and administering health practitioners be ‘appropriately qualified’.
45. Affording nurses and nurse practitioners an accessible opportunity for an expanded scope of practice given their expertise in community care and palliative care services and their greater accessibility relative to GPs would, in our view, better realise consistency with the human rights principles outlined above.
46. The Commission considers that medical practitioners should be able to initiate conversations about VAD with their patients as is consistent with their duties to provide comprehensive health advice. Some standard information produced by the ACT government would be helpful to support health practitioners explain the VAD process, administration options, timeframes etc so that any person can get complete, base line information, in order to support their right to informed consent to medical care.
47. Health practitioners who elect not to provide VAD care, on the basis of a conscientious objection should be required to provide a patient with any information relevant to the VAD process if requested and to refer to the Government run VAD navigation service.
48. The Commission would recommend an approach where health practitioners must refer to a centralised care navigation service to avoid patients being directed to wrong doors, for example, where the health practitioner is on leave, or is not seeing new clients, has no capacity or no longer offers those services. These become less pressing if a central ACT government VAD care coordination service is established to facilitate access to VAD through a network of supportive and subsidised health care providers.

²⁵ Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) (Article 12: Equal recognition before the law)*, Eleventh session, 19 May 2014, CRPD/C/GC/1 [34].

Role of health services

49. Organisations, whether public or private, that provide health services with public funding are functional public authorities for the purposes of the Human Rights Act.²⁶ They are required to act and make decisions compatibly with human rights and give proper consideration to human rights. They will also be required to take reasonable steps to eliminate discrimination as the 'positive duty' reforms to the *Discrimination Act 1991* commence in coming years. In this respect health services providing public health services should not be permitted to frustrate access to health services including VAD.
50. In the ACT, the only palliative care in-patient service and publicly funded palliative care outreach services are provided by faith-based services, and a high proportion of aged care homes are managed by a religious-affiliated organisation. Similarly, a high proportion of retirement villages are operated by faith-based services and while they provide independent living options we are aware of other jurisdictions where access for VAD service providers within retirement villages was also identified as a concern.
51. The VAD legislation must address the realities of our health and aged care systems, by setting out expressly the obligations that are placed on publicly funded health service providers, or other aged-care services to refrain from any action or decision that actively frustrates or denies the rights of their patients or clients to equitable access to health care.
52. We do not consider that religious organisations should be allowed to actively prevent access to health services to which a person would otherwise be entitled to access.
53. Considering the large proportion of aged care homes are managed by religious-affiliated organisations, it is critical to emphasise that a person should be able to access the same services in their home irrespective of who the landlord/proprietor is. Accommodation status should not be a barrier to equitable access to health services in the ACT for existing residents consistent with the right to privacy.
54. Policies that would preclude access to health care providers, on the basis that they are understood to be seeking to provide VAD care, must be published and subject to oversight. The Commission considers that such provisions may constitute discrimination, or where the service provider is a functional public authority, a breach of the right to non-discrimination and privacy in sections 8 and 12 of the HR Act.
55. Where contractual provisions would contemplate the same, the Commission recommends that that information be conveyed up-front to prospective contractees so that they have sufficient notice about how their rights to enjoyment of any property rights acquired under the contract may be limited or constrained.
56. The VAD legislation should make explicit that health services which conscientiously object must make that position known publicly, must facilitate referrals of a person seeking VAD care to a government care navigation service and must not actively prevent a person accessing this care.

²⁶ s 40 Human Rights Act 2004.

Death certification and notification

57. The core priority for policy makers here is ensuring that a decision to access VAD does not affect any entitlements under a person's insurance or superannuation entitlements. This may require a deeming provision to state that, at law, were a person accesses VAD, the cause of death is taken to be the underlying terminal illness or disability that enabled them to access VAD.
58. The Commission does not consider that the fact a person has accessed the VAD scheme should be recorded on the death certificate unless that is the wish of the person accessing VAD.

Oversight, reporting and compliance

59. We prefer the WA model of oversight after the finalisation of the VAD process rather than on a stage-by-stage review as occurs in Victoria, as we understand that the iterative review has the effect of significantly delaying the VAD process and potentially frustrating its aims of facilitating a suffering person to avoid prolonged suffering.
60. We also consider that that the person should be entitled to seek further assessments from other health professionals, given the potential for differing clinical diagnoses about whether a condition is untreatable and particularly if there are timeframes in which a patient must be considered likely to die.
61. We do not consider that there be new mechanisms for review of health professionals. Health practitioners are already subject to Australian Health Practitioner Regulation Agency and the Commission's complaint mechanisms in respect of clinical decisions and patient treatment. The requirements in the applicable code of conduct pick up any requirements applying under law, so practitioners would be subject to compliance or compliance for non-compliance with the terms of any VAD legislation.

Other issues

62. There are several immediate questions that may need to be addressed in relation to the VAD scheme which have not been touched on in the discussion paper. These include:
 - a. permitted fees for service and the categorisation of service (e.g. is it a general consultation allowing access to Medicare rebate? We understand there should be a specific consultation item as these appointments are longer and need to be explicitly provided for as a specific consultation.
 - b. whether the scheme would be subsidised for people who may not be able to afford private consultation fees or how the government proposes to remove accessibility barriers to the scheme. We consider, as discussed above, that there should be provision for government support to cover costs (as is proposed to occur with abortion) to ensure the VAD scheme is accessible and affordable.
 - c. whether private medical practices, or a dedicated VAD provider/care navigator service (e.g. similar to the Marie Stopes model) would be able to offer 'one stop

shop' integrated organising and referral services with coordinating, consulting doctors and witnesses within one business structure

- d. whether businesses can advertise or offer promotions of such services and measures to mitigate the risks of compromised safeguards resulting from financial interests or to alleviate any barriers caused by conscientious objection
- e. powers for coronial investigation where scheme deaths appear to be inconsistent with the framework. It may be appropriate for s 13 of the *Coroners Act 2007* to be amended to require the Coroner to hold an inquest into any death under the VAD framework that appears inconsistent with the legislative requirements.

Should you wish to discuss this matter further or provide feedback regarding our advice, the contact in my office is Alex Jorgensen-Hull, who may be reached on 6205 2222.

Yours sincerely

Dr Helen Watchirs OAM
President and Human
Rights Commissioner

Jodie Griffiths-Cook
Public Advocate and Children
and Young People
Commissioner

Karen Toohey
Discrimination, Health
Services, and Disability and
Community Services
Commissioner