

PARLIAMENT OF VICTORIA

**PARLIAMENTARY DEBATES
(HANSARD)**

LEGISLATIVE COUNCIL

FIFTY-EIGHTH PARLIAMENT

FIRST SESSION

Tuesday, 22 November 2016

(Extract from book 18)

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HANSARD¹⁵⁰



1866–2016

Following a select committee investigation, Victorian Hansard was conceived when the following amended motion was passed by the Legislative Assembly on 23 June 1865:

That in the opinion of this house, provision should be made to secure a more accurate report of the debates in Parliament, in the form of *Hansard*.

The sessional volume for the first sitting period of the Fifth Parliament, from 12 February to 10 April 1866, contains the following preface dated 11 April:

As a preface to the first volume of “Parliamentary Debates” (new series), it is not inappropriate to state that prior to the Fifth Parliament of Victoria the newspapers of the day virtually supplied the only records of the debates of the Legislature.

With the commencement of the Fifth Parliament, however, an independent report was furnished by a special staff of reporters, and issued in weekly parts.

This volume contains the complete reports of the proceedings of both Houses during the past session.

In 2016 the Hansard Unit of the Department of Parliamentary Services continues the work begun 150 years ago of providing an accurate and complete report of the proceedings of both houses of the Victorian Parliament.

The Governor

The Honourable LINDA DESSAU, AM

The Lieutenant-Governor

The Honourable Justice MARILYN WARREN, AC, QC

The ministry

(to 9 November 2016)

Premier	The Hon. D. M. Andrews, MP
Deputy Premier, Minister for Education and Minister for Emergency Services	The Hon. J. A. Merlino, MP
Treasurer	The Hon. T. H. Pallas, MP
Minister for Public Transport and Minister for Major Projects	The Hon. J. Allan, MP
Minister for Small Business, Innovation and Trade	The Hon. P. Dalidakis, MLC
Minister for Energy, Environment and Climate Change, and Minister for Suburban Development	The Hon. L. D'Ambrosio, MP
Minister for Roads and Road Safety, and Minister for Ports	The Hon. L. A. Donnellan, MP
Minister for Tourism and Major Events, Minister for Sport and Minister for Veterans	The Hon. J. H. Eren, MP
Minister for Housing, Disability and Ageing, Minister for Mental Health, Minister for Equality and Minister for Creative Industries	The Hon. M. P. Foley, MP
Minister for Health and Minister for Ambulance Services	The Hon. J. Hennessy, MP
Minister for Training and Skills, Minister for International Education and Minister for Corrections	The Hon. S. R. Herbert, MLC
Minister for Local Government, Minister for Aboriginal Affairs and Minister for Industrial Relations	The Hon. N. M. Hutchins, MP
Special Minister of State	The Hon. G. Jennings, MLC
Minister for Consumer Affairs, Gaming and Liquor Regulation	The Hon. M. Kairouz, MP
Minister for Families and Children, and Minister for Youth Affairs	The Hon. J. Mikakos, MLC
Minister for Police and Minister for Water	The Hon. L. M. Neville, MP
Minister for Industry and Employment, and Minister for Resources	The Hon. W. M. Noonan, MP
Attorney-General and Minister for Racing	The Hon. M. P. Pakula, MP
Minister for Agriculture and Minister for Regional Development	The Hon. J. L. Pulford, MLC
Minister for Women and Minister for the Prevention of Family Violence	The Hon. F. Richardson, MP
Minister for Finance and Minister for Multicultural Affairs	The Hon. R. D. Scott, MP
Minister for Planning	The Hon. R. W. Wynne, MP
Cabinet Secretary	Ms G. A. Tierney, MLC

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Minister for Planning	The Hon. R. W. Wynne, MP
Cabinet Secretary	Ms M. Thomas, MP

Legislative Council committees

Privileges Committee — Ms Hartland, Mr Herbert, Ms Mikakos, Mr O'Donohue, Ms Pulford, Mr Purcell, Mr Rich-Phillips and Ms Wooldridge.

Procedure Committee — The President, Dr Carling-Jenkins, Mr Davis, Mr Jennings, Ms Pennicuik, Ms Pulford, Ms Tierney and Ms Wooldridge.

Legislative Council standing committees

Standing Committee on the Economy and Infrastructure — Mr Bourman, #Ms Dunn, Mr Eideh, Mr Elasmarr, Mr Finn, Ms Hartland, Mr Leane, Mr Morris and Mr Ondarchie.

Standing Committee on the Environment and Planning — #Mr Barber, Ms Bath, #Mr Bourman, Mr Dalla-Riva, Mr Davis, Ms Dunn, Mr Eideh, #Ms Hartland, Mr Melhem, #Mr Purcell, #Mr Ramsay, Ms Shing and Mr Young.

Standing Committee on Legal and Social Issues — Ms Fitzherbert, #Ms Hartland, Mr Mulino, Mr O'Donohue, Ms Patten, Mrs Peulich, #Mr Rich-Phillips, Mr Somyurek, Ms Springle and Ms Symes.

participating members

Legislative Council select committees

Port of Melbourne Select Committee — Mr Barber, Mr Mulino, Mr Ondarchie, Mr Purcell, Mr Rich-Phillips, Ms Shing and Ms Tierney.

Joint committees

Accountability and Oversight Committee — (*Council*): Ms Bath, Mr Purcell and Ms Symes. (*Assembly*): Mr Angus, Mr Gidley, Mr Staikos and Ms Thomson.

Dispute Resolution Committee — (*Council*): Mr Bourman, Mr Dalidakis, Ms Dunn, Mr Jennings and Ms Wooldridge. (*Assembly*): Ms Allan, Mr Clark, Mr Merlino, Mr M. O'Brien, Mr Pakula, Ms Richardson and Mr Walsh

Economic, Education, Jobs and Skills Committee — (*Council*): Mr Bourman, Mr Elasmarr and Mr Melhem. (*Assembly*): Mr Crisp, Mrs Fyffe, Mr Nardella and Ms Ryall.

Electoral Matters Committee — (*Council*): Ms Patten and Mr Somyurek. (*Assembly*): Ms Asher, Ms Blandthorn, Mr Dixon, Mr Northe and Ms Spence.

Environment, Natural Resources and Regional Development Committee — (*Council*): Mr Ramsay and Mr Young. (*Assembly*): Ms Halfpenny, Mr McCurdy, Mr Richardson, Mr Tilley and Ms Ward.

Family and Community Development Committee — (*Council*): Mr Finn. (*Assembly*): Ms Couzens, Mr Edbrooke, Ms Edwards, Ms Kealy and Ms McLeish.

House Committee — (*Council*): The President (*ex officio*), Mr Eideh, Ms Hartland, Ms Lovell, Mr Mulino and Mr Young. (*Assembly*): The Speaker (*ex officio*), Mr J. Bull, Mr Crisp, Mrs Fyffe, Mr Staikos, Ms Suleyman and Mr Thompson.

Independent Broad-based Anti-corruption Commission Committee — (*Council*): Mr Ramsay and Ms Symes. (*Assembly*): Mr Hibbins, Mr D. O'Brien, Mr Richardson, Ms Thomson and Mr Wells.

Law Reform, Road and Community Safety Committee — (*Council*): Mr Eideh and Ms Patten. (*Assembly*): Mr Dixon, Mr Howard, Ms Suleyman, Mr Thompson and Mr Tilley.

Public Accounts and Estimates Committee — (*Council*): Ms Pennicuik and Ms Shing. (*Assembly*): Mr Dimopoulos, Mr Morris, Mr D. O'Brien, Mr Pearson, Mr T. Smith and Ms Ward.

Scrutiny of Acts and Regulations Committee — (*Council*): Ms Bath and Mr Dalla-Riva. (*Assembly*): Ms Blandthorn, Mr J. Bull, Mr Dimopoulos, Ms Kilkenny and Mr Pesutto.

Heads of parliamentary departments

Assembly — Clerk of the Parliaments and Clerk of the Legislative Assembly: Mr R. W. Purdey

Council — Clerk of the Legislative Council: Mr A. Young

Parliamentary Services — Secretary: Mr P. Lochert

MEMBERS OF THE LEGISLATIVE COUNCIL
FIFTY-EIGHTH PARLIAMENT — FIRST SESSION

President:

The Hon. B. N. ATKINSON

Deputy President:

Mr K. EIDEH

Acting Presidents:

Ms Dunn, Mr Elasmarr, Mr Finn, Mr Melhem, Mr Morris, Ms Patten, Mr Ramsay

Leader of the Government:

The Hon. G. JENNINGS

Deputy Leader of the Government:

The Hon. J. L. PULFORD

Leader of the Opposition:

The Hon. M. WOOLDRIDGE

Deputy Leader of the Opposition:

The Hon. G. K. RICH-PHILLIPS

Leader of The Nationals:

Mr L. B. O'SULLIVAN

Leader of the Greens:

Mr G. BARBER

Member	Region	Party	Member	Region	Party
Atkinson, Mr Bruce Norman	Eastern Metropolitan	LP	Mikakos, Ms Jenny	Northern Metropolitan	ALP
Barber, Mr Gregory John	Northern Metropolitan	Greens	Morris, Mr Joshua	Western Victoria	LP
Bath, Ms Melina ²	Eastern Victoria	Nats	Mulino, Mr Daniel	Eastern Victoria	ALP
Bourman, Mr Jeffrey	Eastern Victoria	SFFP	O'Brien, Mr Daniel David ¹	Eastern Victoria	Nats
Carling-Jenkins, Dr Rachel	Western Metropolitan	DLP	O'Donohue, Mr Edward John	Eastern Victoria	LP
Crozier, Ms Georgina Mary	Southern Metropolitan	LP	Ondarchie, Mr Craig Philip	Northern Metropolitan	LP
Dalidakis, Mr Philip	Southern Metropolitan	ALP	O'Sullivan, Luke Bartholomew ⁴	Northern Victoria	Nats
Dalla-Riva, Mr Richard Alex Gordon	Eastern Metropolitan	LP	Patten, Ms Fiona	Northern Metropolitan	ASP
Davis, Mr David McLean	Southern Metropolitan	LP	Pennicuik, Ms Susan Margaret	Southern Metropolitan	Greens
Drum, Mr Damian Kevin ³	Northern Victoria	Nats	Peulich, Mrs Inga	South Eastern Metropolitan	LP
Dunn, Ms Samantha	Eastern Metropolitan	Greens	Pulford, Ms Jaala Lee	Western Victoria	ALP
Eideh, Mr Khalil M.	Western Metropolitan	ALP	Purcell, Mr James	Western Victoria	VILJ
Elasmarr, Mr Nazih	Northern Metropolitan	ALP	Ramsay, Mr Simon	Western Victoria	LP
Finn, Mr Bernard Thomas C.	Western Metropolitan	LP	Rich-Phillips, Mr Gordon Kenneth	South Eastern Metropolitan	LP
Fitzherbert, Ms Margaret	Southern Metropolitan	LP	Shing, Ms Harriet	Eastern Victoria	ALP
Hartland, Ms Colleen Mildred	Western Metropolitan	Greens	Somyurek, Mr Adem	South Eastern Metropolitan	ALP
Herbert, Mr Steven Ralph	Northern Victoria	ALP	Springle, Ms Nina	South Eastern Metropolitan	Greens
Jennings, Mr Gavin Wayne	South Eastern Metropolitan	ALP	Symes, Ms Jaelyn	Northern Victoria	ALP
Leane, Mr Shaun Leo	Eastern Metropolitan	ALP	Tierney, Ms Gayle Anne	Western Victoria	ALP
Lovell, Ms Wendy Ann	Northern Victoria	LP	Wooldridge, Ms Mary Louise Newling	Eastern Metropolitan	LP
Melhem, Mr Cesar	Western Metropolitan	ALP	Young, Mr Daniel	Northern Victoria	SFFP

² Appointed 15 April 2015

³ Resigned 27 May 2016

¹ Resigned 25 February 2015

⁴ Appointed 12 October 2016

PARTY ABBREVIATIONS

ALP — Labor Party; ASP — Australian Sex Party;
DLP — Democratic Labour Party; Greens — Australian Greens;
LP — Liberal Party; Nats — The Nationals;
SFFP — Shooters, Fishers and Farmers Party; VILJ — Vote 1 Local Jobs

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Tuesday, 22 November 2016

The **PRESIDENT** (Hon. B. N. Atkinson) took the chair at 12.05 p.m. and read the prayer.

ACKNOWLEDGEMENT OF COUNTRY

The **PRESIDENT** — Order! On behalf of the Victorian state Parliament I acknowledge the Aboriginal peoples, the traditional custodians of this land which has served as a significant meeting place of the first people of Victoria. I acknowledge and pay respect to the elders of the Aboriginal nations in Victoria, past and present, and welcome any elders and members of the Aboriginal communities who may visit or participate in the events or proceedings of the Parliament this week.

ROYAL ASSENT

Message read advising royal assent on 15 November to:

Alpine Resorts Legislation Amendment Act 2016
Child Wellbeing and Safety Amendment
(Oversight and Enforcement of Child Safe
Standards) Act 2016
Powers of Attorney Amendment Act 2016
Sentencing (Community Correction Order) and
Other Acts Amendment Act 2016
State Taxation Acts Further Amendment
Act 2016
Traditional Owner Settlement Amendment
Act 2016
Victorian Fisheries Authority Act 2016.

CHILDREN, YOUTH AND FAMILIES AMENDMENT (YOUTH OFFENDERS) BILL 2016

Introduction and first reading

Ms **CROZIER** (Southern Metropolitan) introduced a bill for an act to amend the **Children, Youth and Families Act 2005** to provide for the safety and protection of the community in the administration of the youth parole system and for other purposes.

Read first time.

SCRUTINY OF ACTS AND REGULATIONS COMMITTEE

Alert Digest No. 16

Mr **DALLA-RIVA** (Eastern Metropolitan) presented *Alert Digest No. 16 of 2016, including appendices.*

Laid on table.

Ordered to be published.

PAPERS

Laid on table by Clerk:

Auditor-General's Report on the Annual Financial Report of the State of Victoria, 2015–16, November 2016 (*Ordered to be published*).

Coroners Court of Victoria — Report, 2015–16.

Crown Land (Reserves) Act 1978 — Ministerial Orders for the following approvals in relation to —

Lynch's Bridge Historical Precinct Reserve granting a licence, dated 25 October 2016.

Warrnambool Racing Club and/or to individual horse trainers for the purpose of 'horse training on beaches' between Warrnambool and Port Fairy, granting licences, dated 14 November 2016.

Members of Parliament (Register of Interests) Act 1978 — Summary of Primary Return — November 2016 and Summary of Variations Notified between 2 September 2016 and 18 November 2016 (*Ordered to be published*).

Mental Health Act 2014 — Report, 2015–16 on Victoria's Mental Health Services pursuant to section 118 of the Act.

Planning and Environment Act 1987 — Notices of Approval of the following amendments to planning schemes —

Brimbank Planning Scheme — Amendment C185.

Campaspe Planning Scheme — Amendment C105.

Cardinia Planning Scheme — Amendment C213.

Greater Geelong Planning Scheme — Amendment C337.

Macedon Ranges Planning Scheme — Amendment C103.

Maribymong Planning Scheme — Amendment C108.

Melbourne and Port Phillip Planning Schemes — GC50.

Mildura Planning Scheme — Amendment C96.

Mornington Peninsula Planning Scheme — Amendment C191.

Mount Alexander Planning Scheme — Amendment C79.

Whittlesea Planning Scheme — Amendments C68 and C201.

Subordinate Legislation Act 1994 — Documents under section 15 in respect of Statutory Rule No. 124.

Victorian Inspectorate —

Report, 2015–16 pursuant to section 39 of the Crimes (Controlled Operations) Act 2004 in relation to the Independent Broad-based Anti-corruption Commission.

Report, 2015–16 pursuant to section 39 of the Crimes (Controlled Operations) Act 2004 in relation to Victoria Police.

Report, 2015–16 pursuant to section 131T of the Fisheries Act 1995 in relation to the Department of Economic Development, Jobs, Transport and Resources.

Report, 2015–16 pursuant to section 74P of the Wildlife Act 1975 in relation the Department of Environment, Land, Water and Planning.

Report, 2015–16 pursuant to section 74P of the Wildlife Act 1975 in relation to the Game Management Authority.

Victorian Law Reform Commission — The Role of Victims of Crime in the Criminal Trial Process, August 2016 (*Ordered to be published*).

A proclamation of the Governor in Council fixing an operative date in respect of the following act:

Victorian Funds Management Corporation Amendment Act 2016 — 1 January 2017 (*Gazette No. S346, 15 November 2016*).

BUSINESS OF THE HOUSE

General business

Ms WOOLDRIDGE (Eastern Metropolitan) — By leave, I move:

That precedence be given to the following general business on Wednesday, 23 November 2016:

- (1) notice of motion given this day by Ms Wooldridge in relation to compendium documents from the Department of Health and Human Services;
- (2) notice of motion given this day by Ms Wooldridge on the two-year anniversary of the Andrews Labor government;
- (3) notice of motion 334 standing in the name of Mr Purcell in relation to a committee reference regarding Victorian roads;
- (4) notice of motion 331 standing in the name of Mr O'Donohue relating to the Victorian prison system under the Andrews government; and

- (5) notice of motion given this day by Mr Ondarchie in relation to the Minister for Small Business, Innovation and Trade.

Motion agreed to.

The PRESIDENT — Order! Can I just make a short statement on that motion that has been passed by the house. It is to the effect that I have looked at the motion that has been moved by Mr Ondarchie against Mr Dalidakis, and I note that points 5 and 6 of that motion are most grave issues — in fact there is substance to those issues. I must say, as Chair of the house, that I would be concerned if that motion was not given an opportunity to be debated at the earliest opportunity, because I think that the two matters described in points 5 and 6 are of such a nature that they ought not simply remain on the notice paper as an allegation against the minister without having an opportunity to have those matters discharged or determined by the house. The motion has been put and carried, and I am in the hands of the house. I simply make the observation that I would hope that that matter might be considered at the earliest opportunity.

MEMBERS STATEMENTS

Caulfield–Dandenong line elevated rail

Mr DAVIS (Southern Metropolitan) — Beena Avenue has borne the brunt of the government sky rail through this recent period. The construction process is ramping up — massive structures now within millimetres of people's homes — and last Wednesday we saw the amazing situation of a huge metal block cross across one person's house, over the clothesline, and land on the roof of the neighbouring house. If somebody had been there in that position, they would have died. If that metal block had landed at the time on somebody near the clothesline in the back of 20 Beena Avenue, it would have killed them. Children live in that house and those houses along that street within a very small number of metres.

Within the city here on a major construction site, where you have got 70-foot and 80-foot drilling equipment, massive metal plates and massive drilling occurring within 4 or 5 metres of a house, you would actually have proper protections, but those proper protections are not there. This is an arrogant Premier who is pushing forward with a project nobody voted for. People wanted rail under road, but they certainly did not want corners cut with the safety standards for workers or importantly with the safety standards for other people, for families and for children. It is an appalling situation where the Premier has put people at risk.

Paramedics

Mr MULINO (Eastern Victoria) — I would like to pay tribute to our paramedics, who have performed above and beyond the call of duty in recent days. Last Friday in Springvale they provided assistance in the midst of a very disturbing incident, helping dozens of people to safety, and last night they assisted over 1800 people with often very severe symptoms arising from the storm activity. Triple Zero was receiving a call every 4 seconds at one point. We should never take our paramedics for granted, and like everyone in this place I express my gratitude for their service.

Ramco Systems

Mr MULINO — It was a pleasure to represent the Minister for Small Business, Innovation and Trade at the opening of Ramco's Oceania headquarters. Ramco is a highly innovative global software firm supporting businesses across a range of industries, including logistics. Ramco's global leaders were present at the opening, one having flown out from New York, along with the Consul General for India. This is yet another regional headquarters opening and as such represents significant growth opportunity. It is on top of a significant agreement announced last week with the state of Virginia in relation to cybersecurity. I pay tribute to the minister's work in this area.

Economy

Mr MULINO — The Premier gave the state of the state address last week. In it he talked about the state of our economy. More than 184 000 jobs have been created since November 2014, which includes more than 93 000 full-time jobs. This is more than five times the amount of the previous term. The most recent state accounts showed gross state product (GSP) growth accelerated to 3.3 per cent. The most recent result is the strongest GSP growth Victoria has experienced since the global financial crisis — that is, since 2007–08, not coincidentally when Labor was last in government.

Poker machines

Ms HARTLAND (Western Metropolitan) — On Saturday a group of 20 community members took action against the pokies at the Moreland Hotel in Brunswick. The group entered the venue and wrapped the poker machines in hazmat tape to highlight the fact that these machines are a hazard to the community, as pokies are known to lead to crime, job loss, domestic violence, family breakdown, depression and suicide.

I want to commend the Brunswick community for their peaceful and powerful protest and for sending a clear message to the Labor government that they do not want dodgy, deceptive and damaging poker machines in their community. I know this kind of protest is going to be the first of many, and there are groups of concerned community members all over Melbourne who are organising themselves as we speak.

People are fed up with this state government pretending there is not a problem and putting profits before people. These machines are deliberately addictive and misleading, and they are rigged so the house always wins at the end of the day. Victorians are being cheated out of \$2.6 billion per year, and that is money that is not being spent in local businesses.

The government needs to urgently put sensible measures in place to stop the pokies pain. We need to reform the machines so they are not deliberately deceptive and addictive. We need to implement \$1 bet limits so people cannot lose \$1000 an hour on these machines, and we need to give local councils more control over the number of poker machines in their areas. Minister Kairouz and Premier Andrews need to start listening to the community and urgently take action to stop pokies pain.

Numurkah District Health Service

Ms LOVELL (Northern Victoria) — I would like to congratulate the Numurkah District Health Service (NDHS) for receiving the Studer Group Australian Healthcare Organisation of Distinction award for hard work and dedication in clinical service and operation performance improvements and excellence. This is a prestigious award, and the NDHS has the distinction of being the first small healthcare organisation in Australia to win this award, which is a tremendous honour. Congratulations to the board; their outstanding CEO, Jacque Phillips; and the health professionals and staff of Numurkah District Health Service. This award is a result of their fantastic leadership and genuine care for the Numurkah community.

Ganbina Youth Achievement Awards

Ms LOVELL — On the Friday before last I was pleased to attend the Ganbina Youth Achievement Awards, which celebrate the success and achievements of Indigenous youth from the Shepparton area. Sixty of our local Indigenous students were recognised at this year's awards. It is wonderful that the hard work and dedication of these young people has been recognised. Once again, congratulations to everyone who received an award.

McHappy Day

Ms LOVELL — On Saturday, 12 November, I rolled up my sleeves and worked as hard as I have worked in a long time, helping out the crew at the Shepparton South McDonald's for McHappy Day. The Shepparton South crew were fantastic to work with, and it was great to help raise money for Ronald McDonald House Charities, which includes the program that provides families with accommodation while their children are in hospital.

Syd and Dot Burgess

Ms SHING (Eastern Victoria) — It was a great privilege to attend the Gordon Street Reserve in Heyfield to commemorate the opening of the Syd and Dot Burgess Pavilion. This is a collaboration between the Gordon Street Reserve Committee of Management, the Wellington Shire Council and the Victorian government. To be able to pay tribute to the pavilion sponsors, Syd and Dot, in relation to the ongoing contribution that they made to Heyfield and to the sports community in that area was really terrific to see.

Country Fire Authority Mallacoota brigade

Ms SHING — It was a great pleasure to welcome the Premier to Mallacoota last week for the handover of a \$450 000 Country Fire Authority truck, which will better equip the community to be able to respond to fires in this particular part of the world. Gipsy Point and Mallacoota are isolated communities, and they rely upon a cohesion and a support network at a local level which should be supported and is now being supported by better equipment.

It is also pleasing to note that plans for a relocation and a rebuild of the police station in Mallacoota are proceeding well and with full community input.

Gippsland Regional Assembly

Ms SHING — It was a great pleasure to see so many people participate in good faith with energy, momentum and optimism around the Gippsland Regional Assembly in Moe, which provided an opportunity for people to further participate at a local level in promoting the future of this important region insofar as the way in which we can maximise opportunities for trade, export, growth of jobs, industries and better investment in and within the area.

World Day of Remembrance for Road Trauma Victims

Ms SHING — It was also a great pleasure to attend as a representative the World Day of Remembrance for Road Trauma Victims event at Parliament House and to pay tribute to those who have cared for, loved and lost victims of road safety trauma this year. Special thanks to Road Trauma Support Services Victoria, which provides so much assistance to those in need.

Shooters, Fishers and Farmers Party

Mr BOURMAN (Eastern Victoria) — My little speech today is going to be about the Orange by-election in New South Wales. It has been a historic week for the Shooters, Fishers and Farmers Party (SFFP), and I congratulate Philip Donato of the Shooters, Fishers and Farmers Party for a historic win in the Orange by-election, which was announced yesterday. The win comes from dissatisfaction with the New South Wales government — particularly with the New South Wales Nationals — with the disaster that is the greyhound racing issue being a huge factor in the loss of a previously safe seat, held by The Nationals for 70 years, or 69 years to be precise.

The team at the SFFP in New South Wales have worked tirelessly on the campaign, which has resulted in the largest ever swing in any seat in any election in New South Wales, if not the whole country, which is a credit to all those involved. The result has shown that minor parties are a viable option in contemporary politics and that the SFFP are particularly suited to stepping into that role.

Snowdome Foundation

Ms CROZIER (Southern Metropolitan) — I would like to acknowledge an organisation, the Snowdome Foundation, whose very important work is to fight blood cancers by accelerating next-generation, improved treatments through research and clinical trials for Australian patients. Blood cancers are the third highest cause of death from cancer in Australia. The Snowdome Foundation focuses on supporting cutting-edge blood cancer research and works with leading Australian researchers to prioritise key research opportunities. With the introduction of new technology into human genes, next-generation treatments such as tailored or personalised ones to match an individual's type of cancer and personal genetic profile are now not a distant dream.

Recently the Snowdome Foundation's collaboration with Maddie Riewoldt's Vision was named the 2016

national Telstra business award winner in the new category of charity. The foundation's unique collaborative model was recognised for its innovative approach and entrepreneurial spirit within the charity sector. As Snowdome co-founder Professor Miles Prince — a friend of mine and a leader in his field — has said, the win was a special recognition of the hard work that both organisations are undertaking on the need to urgently find cures for blood cancers and bone marrow failure syndromes. I congratulate all those involved with the Snowdome Foundation and Maddie Riewoldt's Vision on this national recognition, which will lead to greater awareness to assist in raising more vital funds for new trials and new drugs to save more Australian lives.

United Arab Emirates National Day

Mr ELASMAR (Northern Metropolitan) — On 17 November I was invited, along with several of my parliamentary colleagues, to a reception hosted by His Excellency the Consul-General of the United Arab Emirates, Mr Saeed Alqemzi, to celebrate their 45th National Day. The unique occasion was very well attended by community members. Importantly this event nurtures and promotes harmony within the Australian-United Arab Emirates community here in Melbourne.

Islamic Council of Victoria

Mr ELASMAR — On another matter, on Sunday, 20 November, I was invited to attend, along with my parliamentary colleagues, the Islamic Council of Victoria's annual end-of-year celebration. At the event this year there was a special and moving tribute to mark the passing of well-loved and highly respected Sheikh Fehmi El-Imam, who is no longer with us and will be especially missed by the entire Islamic community.

Lebanon Independence Day

Mr ELASMAR — On another matter, today is the Independence Day of Lebanon. Yesterday I had the great honour to represent the Premier, the Honourable Daniel Andrews, and the Minister for Multicultural Affairs, the Honourable Robin Scott, at the 73rd anniversary of the Independence Day of Lebanon. The event was hosted by the Consul-General of Lebanon, His Excellency Ghassan El-Khatib. This is an event especially close to my heart, and together with several of my parliamentary colleagues — Mrs Peulich and Mr Eideh from this chamber and others — and fellow Australian-Lebanese friends, I enjoyed celebrating this distinguished occasion.

Asylum seekers

Ms DUNN (Eastern Metropolitan) — Citizens around the world are still processing what an unbridled conservative Trump presidency will mean for worldwide stability and for race, gender, religious and sexual equality in the US. This follows the resurgence of far-right nationalism across Europe and even in Australia with the recent re-election of Pauline Hanson. It is more important than ever to remember the power we have as a community to create the world we want to live in.

Recently the Eltham community made headlines for its welcoming and inspiring responses to people seeking asylum coming to live in this eastern metropolitan town. Butterflies and messages of welcome succeeded in stamping out messages from far-right hate groups, who flew in and were threatening local community members and the people seeking asylum who will now call Eltham home. With its tree-lined streets, Eltham has always been proud of its strong, progressive community, with its focus on art, culture and the environment. The arrival of these far-right hate groups contradicted the values of the local community. Local residents and the Welcome to Eltham activists demonstrated that they embrace inclusivity and diversity and recognise the many benefits people seeking asylum will bring to our local communities.

I am pleased and proud to celebrate these values alongside them. We need to have these discussions in a positive, active and peaceful way across Victoria. It is a pleasure to stand alongside the community in Eltham, as one of its representatives in the Victorian upper house, and my fellow Greens colleagues to welcome people seeking asylum to Victoria.

Western Hotel

Mr MORRIS (Western Victoria) — I would like to congratulate the team at the Western Hotel in Ballarat for winning the Australian Hotels Association Victoria Best Marketed Hotel award, after having painted the hotel red, white and blue following the Western Bulldogs' grand final victory. I was pleased to pop in on Saturday with a couple of colleagues and congratulate owner Dan Cronin.

Ballarat rail services

Mr MORRIS — Our V/Line service in Ballarat has been in crisis of late. I received a response to a constituency question from the minister recently. The question that I asked was: when will the promised train timetable changes actually occur? And the reply I

received from the minister was that a new V/Line timetable will be announced shortly. Such is the shameful disdain that Jacinta Allan shows to Ballarat commuters.

We had yesterday an announcement of just one new return service to and from Ballarat, which will be part of the new timetable. But this new timetable is not going to be released until 28 November — until Monday — and one can only imagine what shocking surprises are going to be in that new timetable for Ballarat commuters. Jacinta Allan has had her hand forced to ensure that peak Ballarat services will not stop at Caroline Springs, the new station that will open early next year. The minister must now consider reinstating express services on the Ballarat line.

Seabrook Primary School

Mr MELHEM (Western Metropolitan) — I wish to congratulate Seabrook Primary School and principal Susan Lee for being a successful recipient of the Andrews Labor government's \$16 million School Pride and Sports Fund. One of 10 schools to receive funding through this round of grants, Seabrook primary was recently allocated \$113 122 to build a much-needed new boundary fence.

When I was invited to visit the school on 19 July this year to launch the *Messenger Dogs — Tales of WWI* primary school roadshow, the issue of the school's low boundary fence, which is only 1 metre high, was raised in my discussion with the acting assistant principal for prep to grade 2, Sundrum Moodley. Seabrook primary has five boundary fences. One is along an often congested main road, and the others are along residential streets, a nature reserve and a petrol station, which actually compromises the safety of the children.

I am very pleased that the school has now received the funding, and I want to take the opportunity to thank the Minister for Education. After I raised the matter with him, he made an effort to make sure that boundary fence was fixed. I also commend the Minister for Health, the local member for Altona, for her effort in lobbying the government to make sure that funding was granted and the children at Seabrook can now play within the boundary of the school without any concern in relation to their safety.

Forestry Industry Taskforce

Mr YOUNG (Northern Victoria) — I rise today to speak about an apparent, but not unpredicted, conflict of interest that is happening right under the government's nose. I would like to say they are

oblivious to it, but I give them far more credit than that. The Wilderness Society have in past weeks been promoting a rally that is to take place on the steps of Parliament House this evening. It is a show of inner-city support for the great forest national park. You can see the details of it on their website, and there is also a press release about the petitions they have been delivering to the Premier and with it a contact for more information on the great forest national park.

The contact here is the issue. It is Amelia Young — I might add she is no relation of mine whatsoever — who also happens to be the Wilderness Society representative on the Forestry Industry Taskforce, a task force that was initiated by this government to look into the impacts of the forestry industry and its future. But they have tremendously overstepped and have actually indicated in their statement of intent that they will make recommendations about new parks and reserves.

I am all for having a look at the impacts of the industry, but if a decision to change operations or to withdraw from an area is made, that is the end of this group's input. They are not qualified nor complete in representation to say what the future use of the land should be. They do not represent all land users. With the scales tipped in the favour of the Wilderness Society and other 'environmental groups' pushing their ideology, it is obvious where this is heading. It is a preconceived outcome.

Western suburbs roads

Mr FINN (Western Metropolitan) — In the process of crawling down the Tullamarine Freeway yesterday and again today I pondered the great disservice the Andrews government has done to the motorists of Melbourne's west. It occurred to me while I was sitting among many thousands on the Tullamarine Freeway that not far away a similar ritual was underway on the Calder and West Gate freeways. On both days the Tullamarine was gridlocked from the Bolte Bridge to Melbourne Airport and down Sunbury Road. Listening to my car radio, I heard that the Calder was banked back almost to the Thunderdome. The West Gate was even worse, with solid traffic from the West Gate Bridge to Werribee.

It is a debacle on a daily basis. Not only does the government refuse to take any action to alleviate these problems, it has actually gone out of its way to sabotage congestion relief by scrapping the desperately needed east-west link — all at a cost to Victorian taxpayers of \$1.2 billion. It is a sure sign that this Socialist Left government is gripped by insanity. If further proof of

that is needed, Premier Andrews is preparing to extend tolls on the Tullamarine Freeway for a further 12 years as part payment for what will be the world's most expensive relocation of a traffic jam.

Labor has failed the people of Melbourne's west. We deserve better. In two years we will get it — roll on the Guy government.

Australian Flying Corps centenary

Mr EIDEH (Western Metropolitan) — On Sunday, 13 November, I had the pleasure of representing the Minister for Veterans, the Honourable John Eren, at the Australian Flying Corps (AFC) centenary commemoration event in Point Cook. I was honoured to lay a wreath at the commemoration and was privileged to hear the history and importance of the AFC.

I had the pleasure of meeting the many VIPs in attendance, including Dr Brendan Nelson, AO, director of the Australian War Museum; Air Commodore Geoffrey Harland; Air Commodore Steven Robertson; Air Vice-Marshal Chris Spence, AO, chair, Shrine of Remembrance trustees; Air Vice-Marshal Brent Espeland, AM, national president, Air Force Association; Air Vice-Marshal Rowley McLennan; Group Captain Carl Schiller, OAM, CSM, president, Air Force Association, Victorian division; Mr John Geary, deputy commissioner, Victoria, Department of Veterans' Affairs; Mr John McLeod, senior vice-president, National Servicemen's Association of Australia; and the mayor of the City of Wyndham, Henry Barlow.

The central flying school trained pilots for the Australian Flying Corps and was established at Point Cook, Victoria, in 1913 with two flying instructors and five flimsy training aircraft. From this modest beginning, Australia became the only British dominion to set up a flying corps for service during the First World War. The Victorian Anzac centenary program has been underpinned by the theme of 'sharing Victoria's stories and making connections', rather than simply holding a series of one-off events. The Victorian program has a dynamic focus, with a particular emphasis on helping Victorians of today make connections with their own First World War story. The Victorian Anzac centenary program aims to help Victorians make their own connections and then to share their stories regardless of where in the world their family was at the time. In May 2015 the Victorian government announced an additional \$5 million investment to support Anzac centenary commemorations to 2018.

Lennie Gwyther

Ms BATH (Eastern Victoria) — Last weekend I had the pleasure of attending a special fundraiser towards the creation of a memorial bronze sculpture of a schoolboy from Leongatha and his beloved horse. When completed this will be a unique tribute to an amazing journey starting in South Gippsland to attend the 1932 opening of the Sydney Harbour Bridge. This incredible nine-year-old boy was Lennie Gwyther, and his horse was Ginger Mick. Lennie was fascinated by the bridge structure and was determined to see it in reality. This fairytale story took place as people cheered and escorted him along the way. He was given letters of introduction to notables, including the then Prime Minister, Joseph Lyons.

Today many country towns are facing significant challenges for future prosperity, so the Leongatha Chamber of Commerce and Industry has been inspired to create a memorial to recognise the spirit, adventure, courage and goodwill of country people. It would like to provide a point of local interest for tourists to engage with this fascinating story.

Recently, under the guidance of talented music teacher Jess Stein, Leongatha Primary School students performed a musical dedicated to Lennie's story. This whole-of-school production incorporated close to 600 students in two casts and received rave reviews. I congratulate the staff, students and parents of Leongatha Primary School and commend the Leongatha Chamber of Commerce, including key drivers Peter Watchorn and Glenn Wright. There is a book about Lennie Gwyther, and I believe there is soon to be a movie, which I would love to see, about this fantastic story of a young man with a vision and the courage to carry it out.

RETIREMENT OF MINISTERIAL OFFICER

Peter McKenna

The PRESIDENT — Order! That completes members statements, but I seek the indulgence of the house to record that my driver, Peter McKenna, is retiring today. Peter McKenna is a legend in Victoria as a former Collingwood footballer of some renown. The stories have become more and more interesting over the six years that I have been driven by Peter. We have had many debates about sport in general. We have particularly reflected recently about the demise of the Australian cricket team.

I comment on Peter because he has been a driver for a number of ministers in this place as well as for my predecessor, Bob Smith, and for ministers in another place, including former Premier Kirner. Peter's service to the Parliament has been exemplary. We often do not think about the work the drivers do and the support they provide to ministers, not just in terms of their driving but also as a measure of security for our people. It would be remiss of us if we did not reflect favourably on the terrific work and support that drivers provide. I am sure members of this house will join me in wishing Peter a very long, healthy and productive retirement.

MEDICAL TREATMENT PLANNING AND DECISIONS BILL 2016

Second reading

Debate resumed from 9 November; motion of Ms MIKAKOS (Minister for Families and Children).

Ms WOOLDRIDGE (Eastern Metropolitan) — I am pleased to rise today to speak on the Medical Treatment Planning and Decisions Bill 2016. This is a very important bill and an important process, and I think we will spend some considerable time both on the broad principles and also on some of the specific details, because it is fair to say from the coalition's perspective that the policy intent of the bill has pretty comprehensively been supported in relation to what it is seeking to do.

When patients have capacity, their values and their decisions are taken into account and respected by treating physicians, by family and by friends. The issue, though, is when people do not have capacity. How do you ensure that an individual's views, values and beliefs in terms of what should happen to them in relation to medical treatment when they do not have capacity are incorporated into decision-making and in fact become the decision for that treatment? It is an important issue not only in principle but also in how we translate that in a legislative context. I think that is what a lot of the discussion will end up being about today because, as I have said, there is support for the policy and the principles but there is also concern that the drafting of the bill has left some gaps and inconsistencies and a lack of clarity. Hopefully through the course of the debate today we can clarify some of those inconsistencies and improve the bill.

The bill is seeking, as I have said, to give statutory recognition to advance care directives to allow a person to appoint a medical decision-maker and also a support person to assist them to make or communicate their

decisions. It also contains provisions in relation to medical research procedures and if and when they can be performed on people without the capacity to consent.

This is an issue that was first addressed in the Medical Treatment Act 1988, which established the right of refusal of a patient to medical treatment and allowed for the appointment of an enduring power of attorney. But it is fair to say that the law is complex; the law is addressed through multiple pieces of legislation. What this bill is seeking to do is to simplify those laws. It is seeking to bring them all into one piece of legislation to try to clarify, improve and enhance what is currently the case.

As a government, the coalition was committed to advance care planning and in fact released in July 2014 *Advance care planning — Have the conversation — A strategy for Victorian health services 2014–2018*, which really aimed to increase opportunities for people to develop advance care plans. There were some action, support, information and education materials produced when we were in government. We also were very committed to the issue of palliative care, which often sits very closely alongside — not in all cases, but in many cases — the issues around advance care planning and made some significant investments in palliative care over our time in government.

The government now has undertaken some reasonable consultation with the release of a discussion paper and a document called *Simplifying medical treatment decision-making and advance care planning — Ensuring Victorians can make decisions about their future medical treatment* and getting feedback on the way to achieve the legislation that we are seeing today. It has also released a framework for end-of-life and palliative care entitled *Victoria's end of life and palliative care framework — A guide for high-quality end of life care for all Victorians*.

I think one of the very significant issues that has happened in the life of this Parliament has been the work of the Standing Committee on Legal and Social Issues and its inquiry into end-of-life choices. That is a committee of this house that did a significant amount of work over an extended period of time, and I would particularly like to commend the members of that committee and the chair, Ed O'Donohue, for the work they did. They received over 1000 submissions, which I think is reflective of the issue of end-of-life care and how mobilising it is for people and the views they have. There were 925 submissions from individuals and 112 from organisations.

The committee made 49 recommendations and had some recommendations in one chapter of its report in relation to advance care planning. The bill we are debating today is consistent with those recommendations, in particular legislative reform to simplify and strengthen Victoria's advance care planning system with legally binding provisions, including for future medical conditions. This is one of the key areas where this bill differs from what we have had in the past in that you can not only make an advance care directive in relation to a current medical condition but also anticipate future medical situations and provide directions in relation to those circumstances as well.

I did want to make some comments following the report of the committee and some of the findings it identified as to why advance care planning is so important. The committee made a number of comments along the way, and I wanted to draw on a few of those key points for some context in relation to why this is an important issue. It is an integral part of ensuring that we get better patient outcomes at end of life.

In talking with any of the palliative care organisations I think one of the crucial questions I had earlier on was, 'What constitutes a good end-of-life process?', and certainly the capacity to be able to make statements and directions about your preferences and views is a very important part of it. Research does show that doctors and family members are poor predictors of a patient's preference. Often family members and doctors elect to perform treatment and interventions that the patients themselves have not wanted. That is what the research says. An overwhelming majority of people who create an advance care plan choose to receive palliative care, particularly at end of life, rather than life-prolonging measures. These are difficult conversations and difficult circumstances, but that is what the research shows. It also shows that people with advance care plans are also far more likely to die in their preferred location, which is a key indicator of what is described as a good death — something I think that we should all be striving to support.

Evaluation of a program called Respecting Patient Choices found that 100 per cent of residents with an advance care plan had their medical wishes respected at end of life and 85 per cent received end-of-life care in a residential aged-care facility. This number was significantly lower for those who did not have a plan, and it did not necessarily reflect their wishes. This is one of the key issues in relation to people having a choice to die at home or where they reside versus in a hospital, which is often actually the case these days. A subsequent study found that surviving relatives of

parents who participated in the program experienced significantly reduced anxiety, depression and post-traumatic stress disorder symptoms than non-participants. The program obviously has significant benefit for the person involved, but for those around them there is a very significant impact as well.

I thought it was interesting that an article by Jodie Whittaker in the *Geelong Advertiser* says:

Research has revealed that 82 per cent of Australians think it's important to talk to their family about how they want to be cared for at the end of their life; but only 28 per cent of us have that discussion.

This is an issue which is vital and an issue which needs to be addressed more, but it is still very difficult. I actually attended the launch of an organisation called Death Over Dinner. The organisation seeks to help create environments where family members and friends can have these conversations so that people understand someone's wishes in terms of how they wish to receive treatment. There is no doubt that advance care planning is an important part of our health system. There are significant opportunities to improve it. The point of this legislation is to try and improve it, put some statutory requirements around it and really drive the validity and use of such directions and therefore the wishes and decisions of the person in terms of how they wish to receive treatment or not receive treatment.

In terms of the main provisions of the bill, the bill allows a person to execute an advance care directive that gives instructions in relation to their current or future medical treatment, as I have said. These can be instructional directives, which are binding, or they can be values directives for guidance about existing or future conditions. The current refusal of treatment certificate only allows, as I have said, refusal of medical treatment for a current condition. An instructional directive essentially expresses an instruction on how the person wishes to be treated or not treated, such as 'I do not consent to being resuscitated when my dementia has progressed to the point where I am no longer able to recognise my family', so it is a very clear statement which would be binding, whereas a values directive is a broader statement indicative of a person's values that may be interpreted in a vast range of situations, such as, 'I value being lucid more highly than I value being pain free'. Values directives allow people to make the trade-offs in terms of the decisions around treatment. An instructional directive that is not directly relevant to a person's condition can still be considered as a values directive and provide guidance on a treatment approach, so there is some flexibility in terms of how these are used.

The bill also allows a person to appoint someone to make medical treatment decisions on their behalf when they no longer have decision-making capacity and allows a person to appoint a support person to support them to make or communicate their medical treatment decisions when they have decision-making capacity. The advance care directive — and it does make some prescription in relation to this — must be in English and must have the full name, date of birth and address of the person giving it. It must be signed by the person giving it and must be witnessed or signed by two adults, at least one of whom must be the medical practitioner.

I think one of the things that we have seen — and we have engaged in extensive negotiations with the government on this issue — is an amendment that was raised by us as well as others in consultation prior to the debate in the lower house. Originally the bill introduced in the lower house also allowed an authorised witness, which could have been a member of Parliament or a local police officer or a local lawyer. An amendment that was put by the government in the lower house required that it now be a medical practitioner, which was a position we supported, and I will make note of some comments from some of the stakeholders in their support of that as well.

An advance care directive very clearly cannot include any statement that is unlawful, such as a request for physician-assisted suicide, and there is a proposed amendment which will help make that even clearer. As well as medical treatment, this bill allows a person to execute an advance care directive and appoint a medical decision-maker or support person for decisions relating to medical research procedures, and it provides for the Office of the Public Advocate to be a decision-maker of last resort for significant treatment and for advance care directives to be tested in the Victorian Civil and Administrative Tribunal (VCAT). It also repeals the Medical Treatment Act and amends the Mental Health Act 2014.

This is an issue where a number of states have already enacted legislation for advance care directives, including Queensland, South Australia, Western Australia, the Australian Capital Territory and the Northern Territory, and New South Wales and Tasmania recognise advance care directives under common law, so it is an area that is addressed in other states, and it is timely for us to be dealing with this as well. What I wanted to take a little bit of time doing, first of all, is thanking the stakeholders, who have provided some quite extensive feedback to me and, I suspect, to the government and to others as well in relation to their views on the bill. The reason I will spend some substantial time on this issue is that these

are the issues that we will be seeking to address and to understand through the committee stage. I think, given that all of these are legitimate issues to be clarified on the record, that it is useful to foreshadow them and work that through.

Can I say, overall, all groups that I consulted with were supportive of advance care directives being put in place — that this is an important step forward — and most had engaged in consultation with the government and feedback through the process. That is not to say that they did not then have a range of concerns, and I said at the beginning one of the issues with this bill is the devil is in the details of the bill itself. It is important to say that each and every one of these organisations thought that this legislation should proceed, while acknowledging that there were some issues with the bill. Let me just take you through some of those issues.

Before I do, though, let me just talk about some of the amendments, because it will put in context some of the issues that I am raising. I understand there will be some amendments from the government, and I hope they are able to table them sooner rather than later. They relate, hopefully, to the definition of ‘significant treatment’, to clarifying a clause in relation to attempted suicide and also to making it clear beyond a doubt that this cannot be used as a backdoor mechanism for physician-assisted suicide.

The opposition will be putting forward some further amendments in relation to clarifying or requiring the certification of the medical practitioner who authorises the advance care directive, in relation to further clarification when there is an attempted suicide, in relation to allowing VCAT to review a situation where a person has given a directive that relied on incorrect information or maybe incorrect assumptions or did not foresee the circumstances that had arisen and in relation to allowing treatment to be provided in circumstances where there is a claim to VCAT until that can be resolved by VCAT itself. So there are some quite detailed amendments to go through, and a lot of that has come out of this input that we have had from the various stakeholders that have provided feedback.

For the Australian Medical Association (AMA), as I started to say before, one of their first issues was that significant treatment should be defined. They have given some thought to that, and the good news is that hopefully we will see some amendments from the government that progress it.

In addition there is concern that the public advocate has up to 14 days after receiving notification to apply to VCAT to review the decision. The potential for some

time delay in accessing VCAT, or the public advocate's decision-making capacity and then accessing VCAT, may lead to some delays in either treatment or not holding treatment and that 14 days can be a very long time before what might be an unreasonable decision by the medical treatment decision-maker is able to be applied to VCAT. Their view is that that should be no longer than 48 hours.

There is also concern from the AMA in relation to amendment and revocation of advance care directives. They said, and I quote:

In essence a person might not be able to effectively revoke a previous ACD refusing treatment at the 11th hour. Consideration should be given to the ability to do so verbally, and at very minimum taking account of the fact that the person might not be able to physically sign at the time.

As I have said, these are issues that we will explore through the committee stage. I am raising them now for the benefit of the government and the debate.

The AMA also highlighted concerns on clause 31 and the appointment of a support person. The limitation to only be able to appoint one support person, even though more than one medical treatment decision-maker can be appointed under clause 28, seems very burdensome for that person. They also raised some concerns that the legislation is silent in regard to other clinical research that is being undertaken by a nurse, dietician, physiotherapist or researcher in their own right as opposed to a medical practitioner or a person registered under the Health Practitioner Regulation National Law.

Also in relation to the issue of who the person's medical treatment decision-maker is, the AMA say that they caution codifying a suggested hierarchy into the legislation and that instead this hierarchy should be applied only as a guide. There is a concern in relation to that that relationships change, there is a diversity of views and therefore there are many variations. They go on to say:

A further dimension to this issue is that section 55(3) prescribes that a 'primary carer' as medical treatment decision-maker immediately after a spouse or domestic partner, but well before an adult child, a parent or an adult sibling. This is problematic as the primary carer role is defined in such a way through the terms of the bill and in conjunction with the Carers Recognition Act 2012 that many people could claim a primary carer status.

They also go on to say that in this situation the legislation seems to be cutting across family relationships and placing family members at odds with other well-meaning individuals who may have taken the primary care role upon themselves, which a vulnerable person would not ordinarily have allowed

when they had full decision-making capacity. So it was a comprehensive response.

I had some subsequent feedback from the AMA on a couple of issues just in the last week. They have also raised a concern about the reverse onus for unprofessional conduct, saying:

There is a very concerning 'reverse onus' of proof that this legislation applies to the matter of unprofessional conduct. The legislation automatically makes a finding of 'unprofessional conduct' (as distinct from 'professional misconduct') for contraventions under ...

clauses 50, 60 and 73. They continued:

The automatic determination of contraventions as being 'unprofessional conduct' rather than an allegation which is then required to be proved through an appropriate due process are counter to the usual notion of 'innocent until proven guilty'.

They raise a couple more concerns in relation to the provisions of clause 20, which:

... only permits amendment or revocation using the full formal requirements of clauses 16 and 17 for making a new directive; written in English, full name, date of birth and address, signed and witnessed by two witnesses, one of whom must be an 'authorised witness' —

or now be a medical practitioner. They are concerned that this does not allow for circumstances that may arise such as a car accident or a stroke, where a person might be lapsing in and out of consciousness and they may decide that they now want to pursue or refuse life-saving treatment different from the instructions that they had previously provided. They believe that there should be a clear mechanism to amend or revoke an advance care directive orally and without delay in emergency circumstances. They also go on to highlight the issue, as I have already said, about the 14 days. There have been some valuable concerns raised by the AMA in terms of issues within the bill.

The AMA in conjunction with the department released in March a report titled *Advance Care Planning — Have the conversation — Results of a survey of doctor's knowledge*. They have done good work in understanding doctors' knowledge of that. There are a lot of interesting things in it, such as 35 per cent of respondents — and these are doctors who are responding — believe they only had a basic knowledge in relation to the legislation relating to consent and medical treatment decision-making and end-of-life care. So there is still a big gap, although the lower house has amended this bill to include medical practitioners, and we all know that they play a very significant role in these sorts of discussions. There is still a very significant proportion of them who do not

yet have that understanding, and one of the challenges, I think, of this bill is the education that will be provided around the bill to make sure that this can increase, not only for medical practitioners but also for the community as a whole.

The Royal Australasian College of Physicians have also responded in support of the issue, saying that end-of-life care is a policy and advocacy priority for them. They go on to say, however, that in relation to medical research:

... our general advice would be that any research undertaken on a person who is unable to provide informed consent should only be conducted as part of a study which has specific and explicit approval of an appropriately constituted human research ethics committee. It would not be practically feasible to incorporate consent into an advance care directive because adequate detail of the research study could not be provided until the study is planned and approved. The circumstances in which this situation might arise are uncommon and the research procedures involved would (most likely) be unusual ones. Both aspects argue strongly for formal HREC —

human rights and ethics committee —

approval of a properly planned study in all circumstances.

So that is just some input.

They have also published a document called *Improving Care at the End of Life — Our Roles and Responsibilities*. One thing that I thought was very interesting from that work was the evidence about what advance care planning can do in terms of the impact that it has on people. They say that it improves:

- patient care, including end-of-life care;
- the likelihood of a person's end-of-life wishes being known and respected by doctors and families;
- patient and family ... satisfaction with care;
- families' perceptions of quality of death;
- the likelihood of a person dying in their preferred place;
- family ... preparedness for what to expect during the dying process.

Advance care planning also reduces:

- the likelihood of unwanted treatment at end of life;
- the number of hospital admissions of people who would have preferred to stay in their home/residential aged-care facility;
- stress, anxiety and depression in surviving relatives;
- distress amongst healthcare providers;
- ineffective or unwanted costly care at end of life without increasing mortality.

That is a good summary, I suppose. It is a little bit broader than the bill in front of us, but argues in relation to why advance care planning, and as part of that advance care directives, are an important issue to pursue.

Palliative Care Victoria did a very comprehensive response, as members will not be surprised to know. Once again I will touch on a number of the issues that they have raised. They raised a question about the ambitious target. I think the Scrutiny of Acts and Regulations Committee questioned why this bill was going to take longer than 12 months to implement. With a taking-effect date of 12 March 2018, Palliative Care Victoria thought this was a very ambitious time line given the broad scope of people impacted, the complexity of the provisions and the need for health education. It will be interesting and important to get some feedback from the minister on how that time line will be used in advance of the bill taking effect.

Just to touch on some of their other issues, I suppose one of their major concerns was the definition of palliative care. In the bill palliative care is defined as:

- (a) the provision of reasonable medical treatment for the relief of pain, suffering and discomfort;
- (b) the reasonable provision of food and water.

Their view is that this no longer reflects a contemporary view of what palliative care actually is, and I quote:

The use of this definition of palliative care in the legislation would undermine efforts to ensure that palliative care is properly understood as including specialist pain and symptom management, as well as holistic person and family-centred care, and that it can be beneficial soon after prognosis and not just at the end of life.

I think it is an issue that has not been responded to by the government, and it would be useful to get some feedback on a narrow definition of palliative care versus the reality of how it is effectively used.

They are also looking for a requirement that access to an accredited interpreter is provided for a person whose primary language is not English so that they can actually make some genuine and informed decisions in relation to advance care directives. They do raise the question of whether a standard form for the documentation of advance care directives and an associated checklist would be useful, and they say that:

This is important as a failure to accurately complete an advance care directive impacts on its use in making medical treatment decisions.

Obviously the government has said they will not be having a standard form, but the website will be important in forming how these are drafted and put in place.

Other issues relate to the appointment of a support person and the capacity to have more than one support person given there are a variety of people in people's lives and the valuable support that that could add to individuals. They also raised concerns around the issue of attempted suicide and noted that the legislation should address with clarity the situation with respect to attempted suicide and the relevance of the provision of medical treatment in such circumstances. We will be debating some amendments in relation to this. Their view is that the duration of emergency treatment decision-making can continue for a protracted time and therefore it may be appropriate to require that after some specified time the provisions of the bill for the decision-making processes in relation to significant treatment come into effect so that emergency treatment cannot continue on and on for an extended period of time.

They also recommend that the bill be amended to require a health practitioner to make reasonable efforts to locate a person's medical treatment decision-maker in relation to an instructional directive as well as a values directive. That would be a bit of a movement in relation to the policy that is put forward in this bill, but certainly that is Palliative Care Victoria's view. They also seek a definition of 'significant research procedure', and in relation to provisions in clause 95, they suggest that advance care directives by the person that were prepared in another country also be considered as an expression of the person's values and preferences. This would accommodate persons who are recent arrivals or visiting on holiday. These are lots of interesting ideas that are worthy of discussion and thought.

Cancer Council Victoria similarly provided a very comprehensive response and are very supportive of the bill, saying:

... we believe this bill will improve and simplify the existing complex legal framework for medical treatment, planning and decision-making. These are important changes that clarify the law for consumers, families, carers and health professionals, and strengthen protection of patients' choices. In Cancer Council's view, the changes will improve the experiences and outcomes for people affected by cancer and other illnesses.

It is interesting that in each of these cases they are very supportive of the bill, but that does raise a lot of questions. Some of the questions that the Cancer Council have raised as a result of the bill, and I know

they have had detailed discussions with the government, include, and I will quote a few of their areas:

Save for their possible role in witnessing an instructional directive, Cancer Council notes that there is no requirement for a medical practitioner to be involved in the completion of an instructional directive.

This is one of those matters that was fixed by the amendment of the government in the lower house — a positive step forward. They also said:

... the likelihood of an instructional directive being clear, relevant and applicable in the circumstances — and therefore the likelihood of it being complied with — is increased if a medical practitioner is involved in the signing.

That is certainly our view and is why we will also be putting up amendments to take that a bit further in terms of the certification from the medical practitioner. They went on to say:

However, the involvement of a medical practitioner in confirming that the person understands the nature and effect of each of the statements made in an instructional directive is one way to better ensure that people understand the medical implications of their advance decisions (and that they are thus reflective of their preferences), and to increase the confidence of health practitioners to comply with instructional directives.

They went on to say this can be approached in different ways:

Queensland requires a medical practitioner to be involved in the completion of an advance health directive, via a requirement that a doctor sign and certify that the maker had the capacity necessary to make the advance health directive (that is, understood the nature and likely effect of the statements made) ...

That goes to the heart of the amendment we will be moving. They are very supportive of the fact that an education campaign sits around this bill and they believe that is very important so that people can understand and utilise what this bill will allow them to do. They had made earlier recommendations:

... that health practitioners also be required to notify the public advocate or apply to VCAT for an order when a medical treatment decision-maker is refusing significant treatment against the known preferences and values of the patient — and is therefore not complying with their obligations pursuant to clause 61. While a health practitioner may apply to VCAT for an order in this situation, there is no mandatory obligation, as there is in clause 62.

There is also a question about what the effect of an advisory opinion would be. This is a question I would like to ask during the committee stage.

The cancer council is concerned that clause 95, in relation to mutual recognition:

... is confusing insofar as it refers to advance care directives validly made in other states or territories being taken to be valid advance care directives in Victoria to the extent the powers they give could validly have been given by advance care directives made under this act.

But it:

... does not cross-reference clause 12, which limits the effect of any such advance care directive to that of a values directive ...

Finally in relation to monitoring and evaluation — and it would be good to get some feedback from the government on this — there is certainly advocacy that there is some good evaluation and that there is extensive data collection, such as the instructional directives completed, rates of completion, rates of compliance and non-compliance, frequency of utilisation, types of routine treatment administered without consent, and community experiences in relation to the enablers and barriers of completion to advanced care directives and satisfaction with them, something that is very valid and very comfortably sits with the cancer council's perspective on making sure that there is an evidence base for the policy and legislative changes.

Many others have provided significant input, and I would like to touch on a few of those. Monash Health certainly was very supportive of an instructional directive being witnessed by a medical practitioner — obviously a good outcome in relation to those changes. The Royal Australasian College of Surgeons raised a number of different concerns but at commencement said it has:

... has always been strongly committed to improving standards and access to care and supports advance care planning in the surgical context.

It said the advance care directives:

... provide patients with a means of communicating their beliefs, values and goals, and can be an invaluable aid to surgeons, patients and carers when deciding how to proceed when the patient is unable to make decisions about their care.

The college does highlight, though, that this is a:

... complex area as not all eventualities can be predicted or discussed prior to the development of a condition or situation that may require surgery.

The college therefore recommends an additional section be inserted:

... so that it is explicit that medical practitioners are protected from issues of liability when they adhere to an ACD in good faith.

It noted:

... that surgery may require interventions not covered by the ACD or which may be inconsistent with the directives, wishes and values expressed —

but this may only be found out during the course of an operation.

The college too sought that the advance care directives be witnessed by a medical practitioner and that the language be clarified so that it is understood and that the question of valid time frames and requirements for review be put in place. They also raised the issue about reasonable efforts, which is not something that is in the legislation but which I understand will perhaps be in the regulations or certainly in some detailed guidelines. It would be useful to have some feedback from the minister on the interpretation of what reasonable efforts are so that everyone can be clear on the expectations and roles and responsibilities of doctors to ascertain the existence of an advance care plan.

The college also raised the issue about centralised storage of and access to advance care directives, and I have to say this has been raised a number of times with me as well. It is important so that it is not an ad hoc process but that there is a genuine and centralised mechanism for people to know if directives exist.

The college of psychiatrists said:

After due consideration including consultation with our fellows, we would like to affirm our support of the bill including the proposed amendments to the Mental Health Act. The changes are broadly in line with RANZCP policies and much of the work that our fellows have been undertaking in the areas of advance care directives and nominated persons. We are satisfied with the bill's reasonable approach to these very important considerations.

Dying with Dignity Victoria said:

... we welcome the statutory recognition of advance care directives, something we have long advocated.

They went on to say:

It will be extremely important for the implications of the bill to be clear to the health practitioners expected to comply with it.

They said Dying with Dignity Victoria:

... believes that a plain English explanation of the rules, couched in language familiar to those expected to comply with them and not open to misinterpretation or misunderstanding, must be made available and widely publicised.

Carers Victoria have also reviewed the bill. Their input says:

... I am pleased to see that it has incorporated feedback that we provided in our submission on recognition of carers and distinguishing carers from paid care workers.

They go on to say:

We are pleased to see that under this amendment treating psychiatrists must have regard to the views of a carer of the person, if the psychiatrist is satisfied that the decision to perform a course of electroconvulsive treatment will directly affect the carer and the care relationship. However, we query how psychiatrists assess whether ECT will directly affect the carer and the care relationship if a carer has not been identified by the person receiving treatment or has not given consent for the psychiatrist to speak to their carer.

We foresee that although the bill seeks to clarify and simplify the existing law, it may still may result in confusion among healthcare providers around the new designated roles of 'support person', 'medical treatment decision-maker' and 'carer' and this will affect how these are communicated to carers and health service users by service staff.

We recommend that once the bill becomes law there will need to be more attention paid to enhancing health service staff capacity building such as training in 'having the conversation'.

Good input there.

The Victorian Council of Social Service (VCOSS) had some very useful and practical issues to raise, once again supporting the bill and the use of advance care directives, saying they support:

... the move to a more person-centred framework, giving appropriate weight to people's own preferences in their future treatment and care. We also support the legislation allowing people to make instructional and values directives guiding decision-makers about a person's ... wishes.

They too believe education and general health literacy are absolutely vital for this to be effectively implemented and also raise the concern about accessibility of advance care directives and support an electronic registration option. In context with that — not directly relevant to the bill but relative to the issues in the bill — they support increasing access to palliative care and also support for medical treatment decision-makers and support people to be able to take on that role effectively. They do say in relation to refusing medical treatment:

It appears the new bill does not allow a medical treatment decision-maker to pre-emptively make a directive about refusing treatment in this way. They are only able to make a decision about consenting to treatment as it becomes relevant.

It will be interesting to clarify that situation. In terms of protecting people vulnerable to abuse, they say:

If a person has not appointed a medical treatment decision-maker and does not have a legally appointed guardian, the decision-maker will be the first of a spouse, domestic partner, primary carer, adult child or parent. It is important that older people at risk of or experiencing elder abuse are not put at greater risk by these provisions. Health practitioners will need to be aware of the potential for abuse of older people, and provided with information about how to intervene appropriately.

I think that is a very important message and a potential risk in relation to the further rollout of these. VCOSS also talk about the expanded role of the Office of the Public Advocate and VCAT and the need to make sure that they are resourced appropriately to be able to deal with the extra demands that this bill will place on them.

The Council on the Ageing (COTA) supports giving weight to a person's wishes and, should they lose capacity to make their decisions, advance care directives having legal status. They too raise the issues about record keeping and access to records so that, with paramedics and emergency rooms, patients at their end of life who do not want to be resuscitated or given life-saving medical treatment are not resuscitated against a directive and that it is important that the records be available.

It is also important that an instructional directive has the capacity to be reviewed and updated and that that is incorporated. Certainly the advice from the government was that will happen as a matter of course, but we need to make sure that does happen. There need to be plain English regulations and practical implementation strategies, and they would encourage the processes and forms for people to work through their values and document them before actually writing the directive themselves, and an interpreter is, once again, important. COTA do say as a final comment:

Having conversations with family and friends and appointing someone who can speak on your behalf (who knows and respects your values and wishes) remains important to end-of-life planning and care.

That is, I suspect, something they will be sending very clearly out to their members.

Julian Gardner, the former public advocate, had a look in terms of the detail of this as well and was very supportive of giving statutory recognition. He was very supportive of ensuring that there are safeguards in place

in medical research and that there is ability for medical treatment decision-makers in supported decision-making. His perspective as a respected elder and also as someone who was very involved in the work I did on reform of the Mental Health Act 2014, having a look from those sets of eyes, was reassuring.

However, Victoria Legal Aid have recently raised some issues in relation to some aspects of the bill. They say:

The bill expands the definition of ‘medical treatment’ to include ‘mental health treatment’. This would permit guardians and certain family members to make mental health treatment decisions on behalf of a person who does not have decision-making capacity. This is concerning given the sensitive nature of mental health issues and the tensions which conflicting perspectives on treatment can create within families.

They go on to say:

The bill does not adequately explain how it will interact with the Mental Health Act 2014 (MHA). This lack of clarity is likely to cause confusion in practice, and risks people being subjected to mental health treatment to which they have not given informed consent outside of the safeguards established by the MHA.

It appears that the people most affected by the bill would be denied standing to seek independent oversight of its operation and application in practice. The person asserted to lack decision-making capacity and/or who is subject to medical treatment cannot apply to VCAT themselves for an order about whether they have capacity, about their appointed medical treatment decision-maker or about medical treatment decisions being made in relation to them because they are not included within the definition of an ‘eligible applicant’.

That might be something, I think, for the government to have a look at certainly as part of any future review. Victoria Legal Aid:

... urges further consultation be undertaken with consumers to ensure the bill provides adequate safeguards and clear and effective procedures.

So there are some genuine concerns there.

Wellways, the former mental illness fellowship, say the proposed amendments are applauded, as these highlight the importance of person-centred treatment and embed in law people’s advance preferences for treatment. They commend the bill’s proposed amendments to electroconvulsive therapy-related legislation, as these validate mental health patients’ capacity to make informed decisions when in a mentally well state. They do raise a question about clause 50 of the bill, which provides that a health practitioner must make reasonable efforts to ascertain if a person has an advance care directive and that failure to take these steps will amount to unprofessional conduct. The question is whether that applies to mental health

patients as well. Their members have expressed concerns about historical disempowerment of patients and stated that they foresee the need to develop fail-safe processes to ensure that advance care directives are indeed honoured and implemented.

Wellways members also noted the necessity for accessible resources to be developed to ensure that patients know about the proposed amendments and that these resources are disseminated to patients and their appointed decision-makers and support persons. Wellways members would also like to see mental health patients being afforded the right to develop advance statements about all forms of mental health treatment similar to those developed by patients in the physical health system.

The last one I want to touch on is from Eastern Palliative Care, who note that the bill is complicated and that there will be required a good deal of education for all health professionals to understand the implications and responsibilities of the bill, and that for people in the community there will also need to be a community education program to promote an understanding of the bill.

I have taken a fair bit of time to go through all of them, but I wanted to do that on a couple of bases. One is in recognition of the very substantial amount of time and contribution that these stakeholders have put into thinking about the bill, genuinely giving some comment and feedback, which I think is really important and really valued. Many of these issues will probably not get resolved today, although we will talk about them in more detail, but I think it is also important to have them on the record so that, if this bill is to pass, the government and the department will be able to take on those issues and try and manage them or see if issues need to be further explored or if further amendments are needed down the track in terms of the operation of the bill.

I have foreshadowed that the coalition will be putting forward some amendments, which I will do as we discuss this bill further, but I do want to touch on what those amendments will be in the time that I have remaining.

The first is that a witnessing medical practitioner is sought to ensure that they provide advice for the giver of an advance care directive to make an informed decision. That is essentially to say that they need to certify that those discussions have been had — that is, it is not enough for a medical practitioner to take on the role as an authoriser, but they are actually taking on the role as also someone who can have a genuine

discussion around the details of an advance care directive and the implications of the wording of that advance care directive.

We are also seeking to make sure that a VCAT review can be sought where a person who gave a directive relied on incorrect information, made incorrect assumptions or did not foresee the circumstances that have arisen. At present VCAT can consider whether a person relied on incorrect information or made incorrect assumptions for the purposes of deciding whether to revoke, vary or suspend an instructional directive; however, it is not a ground for someone to apply to VCAT in the first place, because it does not come under any of the matters listed in clauses 22(1)(a), 22(1)(b) or 22(1)(c). So we will be seeking the capacity for a VCAT review to happen in those circumstances, and we will also be seeking to allow VCAT to declare that an advance care directive is invalid where the maker did not understand its nature and effect.

It certainly seems that if a person does not understand the nature and effect of a statement in an ACD or does not have decision-making capacity, that will render the advance care directive invalid because it has not been fulfilled; however, clause 22 does not give VCAT a power to make an order declaring that a directive is invalid for one of these reasons. From our perspective, we see that this would make more consistent and put more comprehensively the capacity of VCAT to deal with an advance care directive in those circumstances.

There is also an issue on which we will be seeking amendment — that of interim treatment pending a review. As issues arise, and some of these are things that we are seeking to resolve through early amendments, or where there is a dispute about the appropriate course of action, either you can take the advance care directive and put that in place for the interim period or a doctor can make a decision in relation to treatment being given or not and rely on that until it has been determined whether an advance care directive is in fact valid. We are seeking some flexibility for a treating doctor to make that decision in the interim period until VCAT has had a chance to consider the validity of an advance care directive.

Finally, we are also seeking to make clear that the bill does not prevent treatment where a person has attempted suicide. As I have said earlier, there are some amendments from the government in relation to this, but we are seeking to take that further to make it absolutely clear that treatment is not to be prevented. It is not that treatment is required but that a treating paramedic can make a decision in an emergency situation of an attempted suicide that they can go on

and treat even if there is such a thing as a suicide note or other indications to the contrary.

They are the amendments we will be putting forward through the course of the debate. We look forward to receiving some feedback and taking that forward. As I have said from the commencement and throughout, this is a bill which will improve and make a difference in terms of treatment that people receive at their end of life, but there is a lot of devil in the detail. I do want to thank the minister, the minister's office and the department for the extensive discussions that we have had over the course of the last month. They have been most welcome. We have been able to agree on some amendments; we have not been able to agree on others. We believe that this bill can be stronger, more effective and better able to achieve its objectives not only through the amendments the government will be putting forward but also through the amendments the coalition are proposing through this process.

On that basis, I look forward to the rest of this debate and the ability to ultimately achieve the goal, which I think is supported, of having an advance care directive in place that allows people to express their values, their instructions and their wishes about what happens when they are not in a position to communicate that directly themselves.

Ms HARTLAND (Western Metropolitan) — Thank you, Ms Wooldridge, for that very detailed explanation of the bill. This is obviously a piece of legislation that the Greens wholeheartedly support. It has been a long time coming. We need to acknowledge the incredible work that was done by the committee in terms of end-of-life choices and also by the government in making sure that we have a piece of legislation that is actually going to achieve what we are looking for.

Of course end of life is something that many Australians find challenging to even think about or discuss, yet it is something we all will have to face. I hope we are all able to make comfortable decisions and to make the people we love as comfortable as possible, with as little suffering as possible, and that it will happen in a way that reflects our values, our individuality and our choices right until the end.

Today approximately 85 per cent of Australians are dying after a chronic illness and not a sudden event. Up to 50 per cent of people will be incapable of making their own decisions at the end of life. Further, many people with serious illnesses or injuries will have times when they are also incapable of making their own decisions, so it is critically important to have clear

instructions for healthcare providers and loved ones on their wishes in a range of circumstances.

I would like to add as well that I have dealings with many people with profound physical disabilities, and advance care directives is one of the things that is going to assist them. They have often talked to me about how they feel totally disregarded when they go into hospital, that the doctors just see their extreme physical disabilities and do not account for the fact that they have got brains as big as rooms and they could run rings around them. Advance care directives will also allow those people to say, 'This is how I want to be treated; don't presume because of my disability that I would want to die'. I think it is also really important for those people that they continue to receive the treatment that they want to receive, so that they can continue living, even if it is often a bit of a challenge. However, it is not a challenge to them; it is a challenge for the community that sees people with severe physical disabilities as somehow a burden. I certainly do not.

It is critically important to have clear directions for healthcare providers and loved ones on your wishes in a range of circumstances, yet relatively few people have advance care directives or right to refuse treatment certificates. In Victoria there is no legislative framework supporting advance care directives, meaning that even if you do write one at this stage, there is no obligation on doctors or other healthcare professionals to adhere to it. The reforms will ensure that Victorians have more control, have more say and get the health care that is true to their wishes, both within the legislative framework and culturally regarding end-of-life choices and choices on how they want to be treated if they are critically ill or, as I said, have a severe physical disability. That is why the Greens strongly support these reforms.

In June this year the inquiry into end-of-life choices reported. This was a year-long inquiry. It was incredibly thorough. It consulted widely with the health sector and received over 1000 submissions in relation to palliative care, advance care planning and assisted dying. When I went back and looked through the report I think I counted some 18 recommendations just on the issue of advance care directives, so clearly the committee thought this was an incredibly important issue.

Of course the scope of this bill is restricted to change with respect to advance care planning. However, I would like to note that much more work and much more funding will be required to meet the recommendations in relation to palliative care and the true demand for palliative care in the community. The

house would know that the Greens are passionate about reform with respect to assisted dying. We hope that all members of Parliament can work together to achieve reform on assisted dying in this term of Parliament. This reform would reflect the values and strong desire of the community for choice of death without suffering at the end of their lives.

In addition to advance care directives, as I said the committee made some 18 recommendations and 1 of those recommendations was for legislative reform that is consistent with the bill before the house today. Seventeen of those recommendations go on to reform the culture within hospitals and in other healthcare settings to integrate advance care planning and conversations about end of life into core business.

Ms Wooldridge talked about the organisation that I think calls itself Talking about Death. It is a thing we are all so afraid of, but we should not be, because to have a good death is as important as to have a good life, and to know what you want means your family is not burdened with those decisions when the time comes. These recommendations are not legislative in nature but are fundamental to the reform of end-of-life decision-making and to ensure the reform in this legislation is put to use in the community setting.

I turn to look at the actual substantive content of the Medical Treatment Planning and Decisions Bill 2016. I am not going to go through every aspect of the bill. I think this is one of those debates where people have gone through this bill line by line, and we all know exactly what we are debating because it is incredibly important. The bill repeals the Medical Treatment Act 1988 and repeals health substitute decision-making provisions in the Guardianship and Administration Act 1986 and the Powers of Attorney Act 2014. In its place this bill creates a new act that provides for legally binding advance care directives. These advance care directives can include instructional health directives, which will replace the refusal of treatment certificates; they will allow for specific refusal of or consent to a particular medical treatment in specific circumstances. The new advance care directives will also include values directives, which are more generalised statements about your wishes. These advance care directives will only come into effect when a person no longer has the capacity to make decisions for themselves.

The bill also creates a clear and simplified framework for establishing medical treatment decision-makers, who can act on a person's behalf to interpret values directives in specific circumstances a person faces when they are no longer capable of making medical

decisions for themselves. Medical treatment decision-makers can also act on a person's behalf when there is no advance care directive in place. The role replaces what was previously commonly known as medical power of attorney.

The bill also allows for nominating a support person, who can support the person with their care, especially when they still do have decision-making capacity, but they do not make medical decisions on their behalf.

The bill provides a framework for determining who should be a medical treatment decision-maker if no-one has been appointed. There will be no surprises here for partners, primary carers and close family members, who will of course be on top of the list.

Finally, in the case that no person has been located, the bill provides that the Office of the Public Advocate will be the decision-maker of last resort for significant medical treatment decisions, and I think everybody in the chamber knows of the work of the public advocate, and that is absolutely the logical place for it to sit. And their work is outstanding.

The Greens welcome all of these key aspects of the reform, and we believe it will enable people to both exercise choice and also express values that can be interpreted by a trusted person when new and unforeseen circumstances arise. The bill obliges health practitioners — meaning doctors, nurses, paramedics and other health professionals — to seek out a person's advance care directive and act in accordance with it if the person no longer has capacity. A failure to comply with these requirements will constitute unprofessional conduct, and the severity of the penalty in respect of this would be assessed case by case.

Having said that, the bill does not stop health practitioners from providing treatment in emergency situations where there is no time to locate the directive. Further, nothing in the bill requires a health practitioner to provide treatment or care they assess to be non-beneficial for the person. The professional judgement of health practitioners about which medical treatment would be beneficial will continue to be recognised.

There is a pressing need for this clear obligation on healthcare providers to adhere to advance care directives. It is concerning, but not unsurprising, that recent research reveals that health practitioners do not understand their legal obligations in relation to provision of care when someone does not have decision-making capacity. By creating a simplified new legal framework with clear obligations, this reform will

enable change in our healthcare settings. If the government embarks on an education program — which will be one of the questions that I will ask later, and it clearly needs to ensure the obligations and intentions of this new act are carried out — it will generate much-needed improvements in the provision of health care and will improve the community's confidence that the healthcare system can meet their wishes.

While the Greens are very supportive of the framework and most of the detail in the legislation, we also have one main concern. It relates to a potential barrier to appropriate care for people receiving home-based palliative care. In clause 17 the bill requires that the creation of a new advance care directive or the revision of an existing advance care directive must be witnessed by two adults and must be in the presence of the person making the advance care directive. I understand that there has been a change in the lower house and that one of these people must be a medical practitioner. So the amendment that we seek is that a registered nurse would also be allowed to be a witness.

I will circulate my amendments now.

Greens amendments circulated by Ms HARTLAND (Western Metropolitan) pursuant to standing orders.

Ms HARTLAND — What we are talking about is that isolated situation where someone is living far out of a town and the only people they are actually seeing are the palliative care nurses or the district nurses, and so to actually have the doctor come out to be able to witness changes in their advance care directives in those last few weeks of life would be difficult. We just want to make it a very simple thing that those people in that situation would be able to access.

I think we have made it fairly clear in our amendment that in the case of an advance care directive being made by a person receiving home-based palliative care at least one of the witnesses must be a registered nurse or a registered medical practitioner and must record that qualification of the witness. We do not think that this would happen very often; we just want to make sure that people who are in fairly isolated rural areas where they are not going to have access to the doctor but they have access to palliative care or a district nurse on a fairly regular basis are able to alter their directives. We do not believe that it would actually be used very often.

We want to do this because we can see through research that there is a very strong desire amongst people that they be able to die at home if they wish to

with the support of palliative care nurses or district nurses. This does not reflect current practice, where the majority of people die in hospital. However, given this bill should lead to more people getting their wishes at the end of life, home-based palliative care is bound to increase.

Obviously one of the issues the government needs to confront, while not in the scope of this bill, is that there needs to be much more funding for palliative care, especially in rural settings. In such circumstances a person might be in the last weeks of their life; they might be quite weak and unable to travel in these final days. It is quite possible that such a person may want to change the instructions of their advance care directive. Many people at this time decide that they want to withdraw all life-prolonging treatment and just be made comfortable. That is why we think this amendment is important.

It is also at this time that an advance care directive might come into effect, as the person's decision-making capacity may ebb due to pain relief drugs. Given that the new act obliges all healthcare providers to act in accordance with what is in the advance care directive, it is critical that it reflects the person's current wishes and instructions. However, given the person's weak state, changing an advance care directive at this point may prove to be a challenge, especially given the requirement that two witnesses need to be in the same room. Doctors do not ordinarily do home visits, especially in rural settings where you have got huge distances. That is why we think this amendment is important.

If families have the ability to arrange a visit by a locum at this time, this visit may come at some financial cost. Further, the doctor will not actually have any knowledge of the patient, whereas the palliative care nurse or district nurse will have a lot of knowledge of that patient and will have a relationship with them. These are the reasons why we think it is very important.

We generally support this bill. We think it is time that we have clear instructions so that families cannot be surprised when they arrive at hospital to find their very elderly parent and not know quite what that parent's wishes are. We think that this is incredibly important. I will be asking some questions during the committee of the whole, but generally we are extremely pleased with this legislation. I also wish to thank the minister's office for the number of briefings we have received — the last one was at 8.30 a.m. this morning on the amendment. I appreciate the effort that the minister's office has gone to to make sure that I fully understand all the implications of this bill.

Mr MELHEM (Western Metropolitan) — I rise to speak on the Medical Treatment Planning and Decisions Bill 2016. In doing so, I foreshadow that the minister during the committee of the whole will be putting forward amendments. I ask that the amendments now be circulated so they can be considered in the committee of the whole.

Government amendments circulated for Ms MIKAKOS (Minister for Families and Children) by Mr Melhem pursuant to standing orders.

Mr MELHEM — There are three amendments. One relates to clause 3, and the others to clauses 52 and 53. The bill being presented by the government today is centred on the very simple and fundamentally important idea of modern medical treatment and that every patient should get to make their own decisions about their medical treatment. These decisions should include access to quality medical treatment delivered in a way that is consistent with the patient's preferences and values. The Medical Treatment Planning and Decisions Bill 2016 will help to ensure that people's preferences and values will direct decisions about their medical treatment even when they may one day lose capacity to make a decision. Currently the Victorian law does not provide people with certainty about their rights and responsibilities in relation to advance care directives.

I was very fortunate to be on the Standing Committee on Legal and Social Issues, which inquired into this very subject — end-of-life choices. The advance care directive was one of the many subjects that was canvassed during the committee period. We received over 1000 submissions in relation to the inquiry. Again I want to commend the committee for its work on that and also commend the government and the minister for picking up various elements from the committee's report, which was tabled in this Parliament not long ago. I understand the government is looking at putting up a comprehensive response to the full report. This bill comes a long way to address a specific issue that was raised in the committee in relation to giving people choices about their medical treatment.

The government has also conducted its own consultations with various groups. That went on for a while. There has been a fair bit of consultation with various groups in regard to their submissions as well. I just make the point that this bill does not talk about assisted dying. It does not deal with that; it is not an assisted dying bill. It simply talks about one issue, which is currently being exercised by patients in relation to whether or not a person would withdraw

treatment, for example. This currently happens today. Also when the person is not able to make that decision for various reasons, then a substitute person can make the decision on their behalf.

The bill is basically trying to formalise what is currently happening. It is trying to clarify the various pieces of legislation that deal with that particular issue. For example, before person A goes into an operation — it could be quite a complicated operation — a lot of questions are asked in the event of something going wrong. Patients now can say, ‘Look, I don’t want to be resuscitated if something happens’, and that wish is respected. With this bill the person can now put in writing a directive care plan, which is witnessed by a medical practitioner and another person. Basically that represents the values of that person in the event that something goes wrong with the operation and that person’s life would not be the same and he or she would not be able to live their life as they wished. They can now refuse treatment, and that is laid out up-front.

In any event, what is most important is that when loved ones are faced with a situation — as they are now — where the medical practitioner says to the family as a whole, or an individual member of the family or a carer, ‘We now need to make a decision about whether or not to continue treatment for this particular patient’, the advance care plan gives some guidance. In fact it will be binding, but it at least makes it clearer for the decision-maker making the decision on the patient’s behalf and the medical practitioner who is actually going to execute the wishes of the patient. The bill clarifies that point.

That is the purpose of this bill: to provide individual patients, individual Victorians, with some certainty that their wishes will be respected when they are in a situation where they have to face these decisions, which a lot of people will have to do from time to time. It is important that we do this. A lot of people put in submissions and argued in relation to this; we heard from a lot of people during the committee hearings, and I think this bill has more or less picked that up.

Business interrupted pursuant to sessional orders.

QUESTIONS WITHOUT NOTICE

Melbourne Youth Justice Centre

Ms CROZIER (Southern Metropolitan) — My question is to the Minister for Families and Children. On Saturday, 12 November, police were called to an incident involving young offenders trashing cells and rioting on the roof at the Parkville youth justice

precinct. Further riots occurred on Sunday, 13 November, and carried through until Monday afternoon. Minister, who informed you of each incident on Saturday and on Sunday, and at what time were you informed?

Ms MIKAKOS (Minister for Families and Children) — I thank the member for the question. Can I just say at the outset that the three incidents that occurred last weekend were absolutely disgraceful. We had a number of young people at the Parkville facility who were able to exploit the structural weaknesses that we have in the infrastructure there. It has been very difficult for me to canvass these limitations in the infrastructure publicly because the last thing I want to do in the course of discussing this is to effectively provide a how-to guide to any of the young offenders in that facility or any of the young offenders going into that facility into the future.

But the limitations of that facility are clearly apparent. The infrastructure has let us down, and it is unacceptable to have a custodial facility that is just not fit for purpose. Let us not forget that this facility was built in the early 1990s, and it was built to a residential standard; it was not built to a custodial standard. This is why the facility is not fit for purpose, as we have had more and more violent young offenders coming into this facility in recent years. Can I just say that these issues around the infrastructure and its limitations were clearly apparent in an Ombudsman’s report that was handed down to this Parliament in October 2010. It was just about four weeks before the then Labor government went into caretaker mode at that time. The Ombudsman — —

Ms Crozier — On a point of order, President, I am mindful of your guidance in relation to the minister giving context to the questions, but we have got 1 minute and 30 seconds to go and she still has not provided an answer, and I would ask you to draw her back to my question in relation to what I asked.

Ms Shing interjected.

The PRESIDENT — Order! Ms Shing tries to help me by saying it is not a point of order. The reality is that it is, in the sense that Ms Crozier is actually going to, I think, the question of relevance, and that does make it a point of order. The minister has actually provided some valuable information, and she has not been criticising previous governments in what she has said; she has talked about the shortcomings of a facility that have been apparent in these latest incidents. To that extent the minister has, I think, provided a good context to the house and allowed us an understanding of the issue.

However, the point of order is well placed in the sense that the question was quite specific in terms of notifications to the minister, and I would ask the minister now to turn to that question of notifications.

Ms MIKAKOS — I do think the context is important in understanding these issues, President, and I am going to come to the specifics in Ms Crozier's question, but it is important to understand that the Ombudsman's report in 2010 did, as its top recommendation, relate to the structural problems of this facility. The Ombudsman went on to say that he considered the structural problems identified were beyond simply maintenance and repair and that the only practical way to address the conditions at the precinct in the long term was to develop a new facility at another site, which is exactly what this government is going to do. The then Labor government in October 2010 accepted that recommendation and all the recommendations and in fact allocated more than \$16 million to actually begin work at Parkville in relation to some of these issues. But our government is going to do a full redevelopment of Parkville.

In relation to the notifications, I was kept informed about these incidents as they were unfolding. Obviously operational people on the ground needed to focus on the issues at hand, but I was being kept informed about these matters as they unfolded.

Supplementary question

Ms CROZIER (Southern Metropolitan) — I thank the minister for that extraordinary answer. Having been kept informed of the incident on Saturday, only after the third day of rioting did you front the Victorian community. Minister, why did it take you so long to provide any public accountability?

Ms MIKAKOS (Minister for Families and Children) — I find the member's comment extraordinary. I have provided comments in relation to a number of these incidents throughout the course of the year in terms of giving an explanation, as has my department, in responding to these issues. Can I just say that the departmental staff and also Victoria Police who were involved as incident controllers with some of these incidents are to be commended in terms of their particular response to what have been very serious issues in relation to our youth justice facility. We are taking the steps that those opposite did not take to address infrastructure, to address staffing levels and to address the legislative parameters around our youth justice facilities as well.

Questions interrupted.

DISTINGUISHED VISITORS

The PRESIDENT — Order! Can I take this opportunity to advise the house that in the gallery today we have some members of the Parliament of Kenya who are visiting us and are involved in a quite comprehensive program which is sharing some of their experience since they re-established a Senate in Kenya at their last election and also obviously drawing on some of our experience in democracy and our Victorian government experience. Leading the delegation is the Honourable Justin Muturi, EGH, MP, who is the Speaker of the National Assembly. His delegation is also accompanied on this occasion by His Excellency Mr Isaiya Kabira, the High Commissioner of Kenya. We welcome both of you, gentlemen, and the delegation to our Legislative Council today.

Honourable members applauding.

The PRESIDENT — Order! That is a rather tepid response. When I was in Kenya leading a delegation from here they had kickboards. When we were introduced they kicked the kickboards, and I can tell you that it was a resounding noise.

It was similar to that. Well done!

QUESTIONS WITHOUT NOTICE

Questions resumed.

Barwon Prison

Ms CROZIER (Southern Metropolitan) — My question is to the Minister for Families and Children. Minister, can you confirm that a \$12 000 sign-on bonus has been offered to youth justice staff to work at Barwon Prison?

Ms MIKAKOS (Minister for Families and Children) — I thank the member for her question. Obviously we have had to make some very rapid arrangements in relation to the issues that have arisen from the incidents of last weekend, and I take this opportunity to thank my ministerial colleague Ms Tierney, the Minister for Corrections, who has been incredibly helpful in working with Corrections Victoria to put in arrangements within less than a week effectively from the time that we made the decision to gazette the Grevillea unit at Barwon Prison for the purposes of using it as a youth justice and youth remand centre. I am very grateful to Ms Tierney, who has gone above and beyond in assisting me and my department with these matters.

Obviously we have had to put in staffing arrangements because the particular unit is being staffed following the gazettal by Department of Health and Human Services staff and obviously the staff have been accustomed to working at different sites up until now. Given that Barwon is some considerable distance for many of the staff members who work at either Parkville or Malmesbury, there have had to be some arrangements put in place to effectively compensate the staff for the additional travel involved in going down to Barwon Prison.

But can I say that our government makes no apology for the fact that around 40 young offenders will go to Barwon Prison because they have behaved disgracefully. It has meant that about 60 beds have come offline at the Parkville facility as a result of the damage. We are going to take the opportunity not just to repair those units at Parkville but to go above and beyond that, to fortify them to make sure that we strengthen them so we can minimise the risk of this type of damage occurring again in the future. But obviously the long-term solution is exactly what I referred to earlier, and that is to redevelop the entire facility — something that should have happened years ago and something that the Ombudsman identified years ago as an issue. For four whole years we saw zip from those opposite. They did nothing in relation to Parkville, but we are going to do the job properly. We are going to redevelop the facility, we have put on rolling recruitment, we are creating 41 additional positions and we are also putting in place legislative reforms so that where there are serious incidents they are reported to the Youth Parole Board.

Honourable members interjecting.

The PRESIDENT — Order! As I have said on previous occasions in dealing with this matter, this is really serious stuff. It needs to be treated with a degree of gravity by the house. We do not need a chorus. The minister, to continue without assistance.

Ms MIKAKOS — Thank you, President. We are also considering further legislation so that assaults on youth justice staff are taken into account as an aggravating factor in sentencing. We are working with the union, who have been calling for many of these changes for many years, because we do take the safety of our staff seriously. This is why we are putting these measures in place. These are issues that should have been addressed many years ago, but we are getting on with the job of fixing them.

Supplementary question

Ms CROZIER (Southern Metropolitan) — Minister, can you detail any inducements or bonuses that have been offered to youth justice staff to work at Barwon Prison?

Ms MIKAKOS (Minister for Families and Children) — As I explained to the member in answer to the substantive question, we have got staff who are now working at Barwon — and young offenders have been transferred there as of yesterday — who are accustomed to working some considerable distance away from the Barwon correctional facility. Obviously it is only appropriate that they be provided with some sufficient recompense for the travel involved to make sure that we can adequately staff this facility for the safety and security of the community.

Youth justice system

Ms CROZIER (Southern Metropolitan) — My question is again to the Minister for Families and Children. Minister, how many recommendations were made in the Muir and Comrie reviews of youth justice and how many have your government implemented in full?

Ms MIKAKOS (Minister for Families and Children) — I recall the many occasions where the member has come into this house and in fact criticised me for putting in place reviews following specific incidents. I have said on those occasions, and I do so again today, that I make no apology for the fact that I have put in place independent reviews of incidents so we can make improvements to these facilities. Not only are we doing that, we have been working with the union representing the workforce to be accountable in relation to the implementation of those recommendations. And there has been considerable progress made.

But the point that I make is this: most importantly, as a result of one of those reports that did identify the significant problems that we had with the infrastructure, this is exactly why we commenced a business case many months ago on the redevelopment of the Parkville facility. Directly arising from one of those reviews, we started the business case months ago to put in place the redevelopment of the Parkville facility — something that I have said publicly we are absolutely committed to doing. We have in fact expedited that business case so that we can get on with this particular redevelopment.

We have put in place a number of changes as a result of these independent reviews. They go to issues around occupational health and safety, they go to issues around infrastructure and they go to issues around training. It is important that we do have these independent reviews. For this reason I have asked my department to conduct an independent review of the incident relating to last weekend.

Ms Crozier interjected.

Ms MIKAKOS — Ms Crozier is critical of me putting in place an independent review of the incidents of last weekend. I make no apology for that, Ms Crozier. I have asked my department to put in place an independent review of the incidents of last weekend. Former police commissioner Neil Comrie will be undertaking that review into the events of last weekend so that we can continue to provide for the safety and security of the community by ensuring that we do have arrangements in place that meet the contemporary needs of our youth justice system — something that we are doing. Ms Wooldridge, opposite, commissioned a master plan — the secret master plan that was undertaken by the previous government to look at Parkville — and then she ditched it. Those of you sitting on the front bench there who were members of the Baillieu do-nothing government took that master plan and decided that you just did not want to spend the money on redeveloping Parkville. That is the reality of it.

The PRESIDENT — Order! Minister, the question was quite specific. Whilst the member has not risen to her feet to encourage me to bring you back to that question, I feel that I should on my own volition do so. The question was about recommendations that were made in the Muir and Comrie reviews of youth justice and how many the government has implemented in full. As I have indicated, this is a grave matter and it is of concern to all members. I do particularly appreciate that difficult position that you are in regarding this matter, but I think the house does deserve a response on what those recommendations were — the number of recommendations. I noticed that you are getting close to the time for the conclusion of your answer, so I would bring you back to that matter rather than discussing the more contextual matters.

Ms MIKAKOS — Thank you, President. The point that I was making is that the key finding that came out of those reviews was the issue around the infrastructure, which is why we are addressing that issue. There are a number of recommendations that have been fully implemented. There are a number that are still underway. I am happy to provide a written response to

the member in relation to these matters, but I can say that unlike the previous government that had a secret master plan but did not act on it and did not act on the Ombudsman's recommendations either, we are getting on with putting in place independent reviews and then acting on them, because the community deserves that. We need to ensure that we have youth justice facilities that are fit for purpose.

Supplementary question

Ms CROZIER (Southern Metropolitan) — Minister, you have previously refused to release those reviews or release the recommendations. Given the continuing crisis in youth justice, will you now release those reviews so the community can see how few recommendations you have acted on?

Ms MIKAKOS (Minister for Families and Children) — I thank the member for her question. I have made the point to her that the previous minister, sitting next to her, in fact commissioned a number of reviews that she never put out publicly, including the one into the escape in July 2014. The reason why these reviews are difficult to put out publicly is they do go to the security of how these facilities operate. If those opposite think it is appropriate that we compromise the safety and security of those facilities — —

Honourable members interjecting.

The PRESIDENT — Order! I have the opportunity to request written responses to answers that I do not feel have been satisfactorily responded to. My disposition on that matter will be influenced by the level of provocation from the minister. I think the minister has been moving into areas that are not responsive to the question that was asked, and I would bring her back to that question. I say to members of the opposition, let us all listen.

Ms MIKAKOS — President, I was giving the house the courtesy of an explanation as to why those reviews cannot be publicly released, and the reason for that is exactly the same reason as occurred under the previous government. I think that is a very reasonable position for me to put to the house in relation to why those reviews have not been publicly released. What I can say to the house is that I will be providing Ms Crozier with a written response in relation to the substantive question around the numbers implemented.

Melbourne Youth Justice Centre

Mr MORRIS (Western Victoria) — My question is to the Minister for Corrections, representing the Minister for Police. The Minister for Families and

Children has stated that 15 clients at the Parkville youth justice centre have been charged from the March 2016 riots. How many of those 15 have been convicted and given extended time in Victoria's youth justice system?

Ms TIERNEY (Minister for Corrections) — Was that a question directly to me or the Minister for Police? As it was directed to the Minister for Police, I am happy to take that question on notice and have the minister provide a response.

Supplementary question

Mr MORRIS (Western Victoria) — I thank the minister for undertaking to do so. Minister, how many of the 15 charged have had their cases dismissed with no change in their time served or in fact been released into the Victorian community?

Ms TIERNEY (Minister for Corrections) — I take it that that is also a question for the Minister for Police. I will convey that question to the minister, and she will provide a response.

Barwon Prison

Mr O'DONOHUE (Eastern Victoria) — My question is for the Minister for Corrections. Minister, a number of juvenile offenders are now at the Barwon Prison.

Ms Mikakos — Do you support that?

The PRESIDENT — Order! Ms Mikakos had ample opportunity to respond to questions that were put to her. I see no reason why she needs to be so effusive now.

Mr O'DONOHUE — Thank you, President. As I was saying, my question is to the Minister for Corrections. Minister, a number of juvenile offenders are now at the Barwon Prison.

Mr Dalidakis — Do you support that?

The PRESIDENT — Order! Mr Dalidakis! I ask the member to start again.

Mr O'DONOHUE — My question is for the Minister for Corrections. Minister, a number of juvenile offenders are now at the Barwon Prison.

Honourable members interjecting.

The PRESIDENT — Order! Mr O'Donohue, do you have this question written down?

Mr O'DONOHUE — Yes.

The PRESIDENT — Order! I will take the opportunity of reading Mr O'Donohue's question for him, and perhaps it will receive due courtesy. Mr O'Donohue's question is to the Minister for Corrections. A number of juvenile offenders are now at Barwon Prison. Will Corrections Victoria have responsibility for intervening in riotous activities or does that responsibility remain with the Department of Health and Human Services?

Ms TIERNEY (Minister for Corrections) — Thank you, President, and I also thank the member, Mr O'Donohue, for that question. The situation at Barwon is that the Grevillea unit is now a youth justice precinct, and as such it will be managed by the Department of Health and Human Services (DHHS), and the staff will be from DHHS, but they will be supported by Corrections Victoria officers, and they will be available if assistance is required.

Supplementary question

Mr O'DONOHUE (Eastern Victoria) — President, thank you for asking the substantive question and for the opportunity to ask a supplementary. Minister, by way of supplementary, the highly trained security and emergency services group is used by Corrections Victoria to respond to major incidents. In your answer just then you said that the DHHS staff will have primary responsibility for managing these juveniles. What specialist resources are available to DHHS at the youth justice facility at Barwon Prison to stop riots and out-of-control behaviour by juvenile offenders, or will it again be left to Victoria Police to sort out?

Ms TIERNEY (Minister for Corrections) — I thank Mr O'Donohue for his question. There have been discussions between both departments over the last few days, and they have come up with a regime that affects the operation and chain of command.

Barwon Prison

Mr O'DONOHUE (Eastern Victoria) — My question is again to the Minister for Corrections. Minister, the maximum security and remand estate has been under enormous pressure since the Metropolitan Remand Centre riot last June, the worst in Victoria's history according to the corrections commissioner. This has seen police cells overflowing and prisoners not being presented to court, in contravention of a court order. Indeed 230 prisoners were being held in police cells this morning. Placing juveniles in the Grevillea unit at Barwon will reduce the number of maximum security beds by a further 40. Minister, where have the

prisoners who until last week were held at GreVILLEA been transferred to?

Ms TIERNEY (Minister for Corrections) — I thank the member for his question. There were a number of questions within that question, and I am happy to answer them if I am given the opportunity. In terms of the 230 in prison cells, that is not the number that were in the cells.

Mr O'Donohue interjected.

Ms TIERNEY — I have checked, and that is not the case. In terms of capacity, can I refer you to a media statement that was given by the commissioner for corrections on 17 November when she was asked the question, 'You must be bursting at the seams'. Her response was, 'We're not bursting at the seams. We have capacity within our system to be able to accommodate this and to support youth justice in placing these young offenders within Barwon Prison'. In terms of the further question as to where they have gone, as a former Minister for Corrections you would well know that that sort of information is not provided as it is considered that it would compromise security.

Supplementary question

Mr O'DONOHUE (Eastern Victoria) — Minister, thank you for that answer. By way of supplementary, I ask: the Metropolitan Remand Centre has recently increased its post-riot capacity from around 800 to 853, despite the prison being a building site and the repair work still a long way from being completed. Can you guarantee that the safety of prison officers and other staff will not be compromised by this increase following the removal of 40 maximum security beds from Barwon?

Ms TIERNEY (Minister for Corrections) — Mr O'Donohue, on this occasion I do not know if I wish to say, 'Thank you for the question', but I do. Can I say that I do not agree with the question. However, in terms of the detail, I do not have it in front of me and I am happy to take that question on notice, provide an answer in writing and do that within the prescribed time period.

Safe Schools Coalition Victoria

Dr CARLING-JENKINS (Western Metropolitan) — My question is for the minister representing the Minister for Education, Ms Tierney, and it concerns the co-founder and manager of Victoria's Safe Schools Coalition, Roz Ward. On 12 November Roz Ward was photographed by a witness harassing a supporter of the President-elect of

the US, who was peacefully counter protesting — that is, the supporter was peacefully counter protesting — at an anti-Trump rally in Melbourne. The incident, which has now been widely reported, can only be characterised as the act of a bully. The Safe Schools program, fully funded by this government through the education budget, continues to employ Roz Ward as the manager and the face of the program. Minister, does the government still support Roz Ward's position as the manager and face of the Safe Schools Coalition, despite her ongoing inappropriate public behaviour and well-known adherence to radical ideology?

Ms TIERNEY (Minister for Training and Skills) — Can I seek clarification that that is for the Minister for Education, Minister Merlino; is that correct? I am more than happy to take that question on notice and ask him to provide you with a response.

Princes Highway west

Mr PURCELL (Western Victoria) — My question is for the Minister for Regional Development in her capacity representing the Minister for Roads and Road Safety. The A1 Princes Highway is in dire need of upgrade from Colac to the South Australian border. The A1 is the main vehicle and freight link from Portland and Warrnambool to both Melbourne and Adelaide and requires an additional 50 passing lanes to make it workable. In February 2014 the then Minister for Roads, Terry Mulder, wrote to the federal government asking for the Princes Highway west to be upgraded to a road of national significance — a high-priority road which would also receive federal government funding. So my question to the minister is: will the minister again write to the federal government identifying the Princes Highway west from Colac to the South Australian border as a high-priority road which should be upgraded to a road of national significance?

Ms PULFORD (Minister for Regional Development) — I thank Mr Purcell for his question and his ongoing interest in roads and road safety matters affecting the south-west of Victoria. They are certainly roads that I am well familiar with, as of course is Mr Purcell. The question posed a very specific matter and action as such from Minister Donnellan, so I will seek a written response from him for Mr Purcell.

Supplementary question

Mr PURCELL (Western Victoria) — My question is: when the minister writes to the federal government, and hopefully is successful, will the government commit to establishing the 50 needed passing lanes?

Ms PULFORD (Minister for Regional Development) — I thank Mr Purcell for his supplementary question and his interest in passing lanes as part of what he is seeking in respect of a change to the standard and the funding agreement that supports this particular stretch of road. I will seek a written response from Minister Donnellan.

Belfast Coastal Reserve

Mr BARBER (Northern Metropolitan) — My question is to the minister representing the Minister for Energy, Environment and Climate Change, the Honourable Lily D'Ambrosio, MP, regarding the protection of hooded plovers in response to significant community concern for the protected hooded plover habitat being trampled by racehorses training along beaches between Port Fairy and Warrnambool. The government has announced a plan to regulate the use of these beaches for commercial horse training. Why has the government responded to the damage caused by commercial horse training by increasing the number of horses and expanding their training area over more beaches, which both ignores the issues raised by the community and environment groups and exacerbates the cause of their concerns?

Ms PULFORD (Minister for Agriculture) — I thank Mr Barber for his question and his interest in this very complex matter that the Minister for Energy, Environment and Climate Change has been dealing with. I will pass Mr Barber's request on to the responsible minister and note that the minister representing Minister D'Ambrosio is not in the chamber because the Greens voted to have him suspended from the house. But he will be back next week, which is very exciting.

Supplementary question

Mr BARBER (Northern Metropolitan) — I cannot wait! My supplementary question is: exactly how does the government intend to monitor and enforce licensing conditions given no-one will be on the beaches actually counting these horses?

Ms PULFORD (Minister for Agriculture) — I will seek a response and pass Mr Barber's interest in this matter on to Minister D'Ambrosio. Mr Barber will receive a response upon Mr Jennings's return to the chamber.

QUESTIONS ON NOTICE

Answers

Ms PULFORD (Minister for Agriculture) — I have answers to the following questions on notice: 7479, 7488, 7490, 7513, 7515, 7517–8, 7520, 7610, 7642, 7644, 7686–7.

QUESTIONS WITHOUT NOTICE

Written responses

The PRESIDENT — Order! In the context of today's questions I would seek written responses to Ms Crozier's second question to Ms Mikakos, both the substantive and the supplementary question, and to her third question to Ms Mikakos, both the substantive and the supplementary question. In both cases it is one day.

I would seek written responses to Mr Morris's question to Ms Tierney, both the substantive and the supplementary question. That is two days as it involves a minister in another place.

I would seek written responses to Mr O'Donohue's first question, the supplementary question that he asked of Ms Tierney, that is one day; and to Mr O'Donohue's second question, both the substantive and the supplementary question, and that is one day.

On Dr Carling-Jenkins's substantive question to Ms Tierney, that is two days; Mr Purcell to Ms Pulford, both the substantive and the supplementary question, again that is a minister in another place, so that is two days; and Mr Barber to Ms Pulford, the substantive and the supplementary question, that is two days.

Ms Crozier — On a point of order, President, in relation to my question no. 1 to the minister about the incidents that occurred last weekend, the minister did not, I believe, answer who informed her of the incidents on Saturday and Sunday and at what time she was informed. I am wondering if that could also be reinstated, please.

The PRESIDENT — Order! The minister actually did respond in terms of saying that she had been kept informed of the incident right through. That was her response. She perhaps did not comment on who informed her. All right, I would reinstate the substantive question on question 1 as to who informed her on the incidents.

CONSTITUENCY QUESTIONS

Northern Victoria Region

Ms LOVELL (Northern Victoria) — My question is for the Premier, and it regards the need for storm recovery assistance for the Mildura community. On the Friday before last the Mildura community was hit by a severe storm, with winds of up to 150 kilometres per hour and hail stones larger than tombowler marbles that damaged cars, lifted roofs, smashed buildings and caused damage and significant losses to crops. Wheat crops from Werrimull down to the south have been wiped out. Some farmers were due to start harvesting on Saturday morning, the day after their crops were wiped out. Many of the grape growers, including wine and table grape growers, were not insured.

This storm will add cost to and significantly reduce the quantity of the harvest this year and additional pruning will be required, and the effect of the storm means there will not be a crop next year — so two years worth of income has effectively been wiped out. After last month's floods Mildura was added to the list of natural disaster sites, which allowed affected residents to access government disaster recovery funding. Will the government extend the natural disaster declaration for Mildura to include the storm so those affected can access the same range of assistance as those impacted by the floods?

Western Metropolitan Region

Mr MELHEM (Western Metropolitan) — My constituency question is for the Minister for Health and Minister for Ambulance Services, the Honourable Jill Hennessy, and the question I ask is: what actions has the government undertaken to improve ambulance response times in the western suburbs and what are the opportunities for further improvements there? I ask these questions in light of the new response time data that came out on 28 September, which showed improvements in the west. The Andrews Labor government has worked to fix the ambulance crisis since day one, and it is very encouraging to see that work paying off. It should never be forgotten how bad the crisis was under the former Liberal government, with response times being the worst on the Australian mainland.

Western Metropolitan Region

Ms HARTLAND (Western Metropolitan) — The Federation Trail is a key bike path in Melbourne's west. When the missing link in the path is completed it will connect Werribee to Melbourne and provide an

essential route for people of the western suburbs to ride to the city. The government has said that it will fix this missing link in the Federation Trail but only as part of the proposed western distributor toll road. The western distributor, if it is built, will not be finished until 2022, which is six years away. The people in the west should not have to wait this long.

The west is struggling with traffic congestion on roads, and the inner west in particular has serious pollution problems. By fixing this missing link in the Federation Trail we could provide safe cycling to the city, which could encourage more people to leave their cars at home and take their bikes instead. My question is: building the missing link for Federation Trail should not be expensive and it should be largely running through existing parkland, so when will the government actually commit to finishing it rather than saying that it can only be done with the western distributor?

Southern Metropolitan Region

Mr DAVIS (Southern Metropolitan) — My matter is for the attention of the Minister for Public Transport and it concerns the Ian Woodcock-inspired report released last week — the so-called *The Benefits of Elevated Rail — Case Study Two — The Frankston Line*. Mr Woodcock, as this chamber would know, is a sky rail spruiker. He is on a contract of \$125 000 to write reports that say sky rail is fantastic, and he is proceeding to do so. He has released a report which lays out 26 level crossings — that is 18 additional level crossings on top of the 8 that the government has promised to remove. What I am seeking from the minister is: will the minister rule out the removal of the additional 18 level crossings with sky rail? The community, I think, would be very concerned to see a huge sky rail running the length of the area from Exley Road to Overton Road. Eighteen plus 8 is 26 level crossings — a massive impact and blight.

Western Metropolitan Region

Mr EIDEH (Western Metropolitan) — On 26 October I asked the Minister for Energy, Environment and Climate Change, the Honourable Lily D'Ambrosio, a constituency question about the dumping of asbestos at a site in Cairnlea in my electorate of Western Metropolitan Region. I would like to thank the minister for her prompt response to the question and for the swift action of Environment Protection Authority Victoria (EPA) on this matter. I was informed that the EPA would be conducting a final inspection of the site on Friday, 18 November.

My constituency question is: can the minister please advise me and my constituents as to the results of the final EPA inspection at the Cairnlea asbestos dumping site?

Western Victoria Region

Mr MORRIS (Western Victoria) — My constituency question is directed to the Minister for Emergency Services. I note that in a response to an adjournment matter raised by the member for Ripon in the other place the minister wrote:

I understand the local community have an affinity with the air crane ...

No, minister. It is not an affinity; people in western Victoria just do not want to lose their lives and property to bushfire. After the dangerous conditions we saw yesterday, when near Swan Hill two firefighters were taken to hospital for smoke inhalation and a Country Fire Authority truck was engulfed by fire — and we know this is just the beginning of a very, very dangerous fire season, particularly in western Victoria — my question to the minister is: will you reverse your inexplicable decision to move Ballarat's skycrane to Moorabbin?

Western Victoria Region

Mr RAMSAY (Western Victoria) — My constituency question is to the Minister for Regional Development, the Honourable Jaala Pulford. It concerns Murray Goulburn's plan to build a new powder facility at Laverton. My question is: what is the department for regional development doing, with the ministerial office, to encourage Murray Goulburn to commit to placing its milk powder facility — its new facility — at Kororoit, adjacent to the current facility, which will provide very important jobs in regional Victoria?

Western Metropolitan Region

Mr FINN (Western Metropolitan) — My constituency question is to the Minister for Planning. I refer the minister to plans, released this past week, for a further 19 800 homes to accommodate an added 55 000-plus people in Sunbury over the next 20 to 30 years. The plan is for a significant change in Sunbury's future and will impact enormously on the town's population. Minister, taking that into consideration, why was the precinct structure plan not released for public consultation before the recent council election to allow candidates to state their views on this plan and allow residents to cast a fully informed vote?

South Eastern Metropolitan Region

Mrs PEULICH (South Eastern Metropolitan) — My constituency question is for the attention of the Minister for Energy, Environment and Climate Change, and it is in relation to trees. We hear a lot from the Greens about the trees, but I want to talk about the trees in my electorate. A key feature of a good suburb, a healthy suburb, is vegetation and trees, and I am concerned by the wholesale removal of trees associated with certain government projects, including the impact on St Kilda Road trees of the Melbourne Metro rail project. That is obviously outside my electorate, but in my electorate there are the number of trees that are being removed along the Caulfield–Dandenong line, the number of trees that would need to be removed along the Frankston line as a result of sky rail and the number of trees that are going to be removed at the Beaumaris Secondary College site.

I would like the minister to tell me: how many trees have been removed and are scheduled to be removed, and has she approved each of those projects and subjected them to an environmental assessment?

Eastern Victoria Region

Ms BATH (Eastern Victoria) — My constituency question is for the Minister for Training and Skills in the house, Ms Tierney. Previous to this question I asked other questions of the previous Minister for Training and Skills, Mr Herbert, and this relates to constituents Rochelle Parrilla, Girlie Lewis and Ferdinand Roncal, who have responded through a friend, Graeme Macreadie. They were among a number of students who were enrolled in TBM Training, a registered training organisation that has closed. They have almost — 90 per cent — finished their courses, but the shutting of that training organisation meant they did not complete their courses, and they are financially out of pocket. They are quite stressed.

Previously I have asked the minister to come down and speak with them and to understand their situation, which is quite complex. I do not have the time to go through it now, so I am asking the new minister: would she please commit to coming down to the Latrobe Valley and speaking to the aforementioned people to work through the issues around their loss of finances and also loss of time and stress in relation to future training experiences?

MEDICAL TREATMENT PLANNING AND DECISIONS BILL 2016

Second reading

Debate resumed.

Mr MELHEM (Western Metropolitan) — I return to the main purpose of the bill, which is to provide patients with advance care planning. The bill goes a long way to describe how that could occur, basically delivering or respecting the wishes of individual patients and also providing some guidance to medical practitioners and to carers. The bill will provide for instructional directives, which will provide specific directives about the treatment a person consents to or refuses. The bill also provides for value directives, which will describe a person's views and values, and medical treatment decision-makers and health professionals will be required to give effect to values directives. The bill also refers to appointing medical treatment decision-makers, who will make decisions on behalf of a person when they can no longer make a decision or have decision-making capacity. It provides for appointing a support person, who will assist a person to make a decision for themselves by collecting and interpreting information or assisting the person to communicate their decisions.

I go back to the preferences and values of the individual, which this bill will look at upholding. Any person at any age will have the capacity to create a legally binding instructional directive that specifically consents or refuses treatment for both current and future conditions. I want to expand a bit on that point. Now, it is not uncommon when a person goes into a major operation for a lot of questions to get asked as to what the person's wishes are, in the case where something goes wrong with that particular operation. This bill enables the person in that situation to basically put his or her wishes in writing and make them clear to the medical practitioners and their loved ones so that they are able to deal with that.

The bill also refers to future conditions. As with people who write their own wills and decide who their assets should go to, it would be very similar to that. Maybe one of the triggers could be getting to retirement age or entering aged care. Some of the evidence we have collected or heard from people during the legal and social issues committee hearings was maybe it should be a trigger point where a person is saying, 'Okay, it's time for me to put together an advance directive plan to take the pressure off my wife, my son, my children or the people that care for me so at least they know in black and white what I want done should someone have

to make a decision. If I've got to a situation where I'm in a vegetative state, for example, or on a life support system, I can make it easier for people if they know that my wish is to actually turn the machine off'. If it happened today, then that could occur.

Currently people cannot make any directive plan in relation to palliative care, so the bill will actually clarify that. You cannot put in your directive plan that you do not want to receive palliative care — the bill does not provide for that right — so it is not binding, but it at least clarifies that issue, which at the moment is not clear. So the bill tries to clarify the various current pieces of legislation to make it easier for patients and for practitioners and carers.

The bill does not propose to replace all the current laws. For example, a double effect, which exists under common law, is not affected by this bill, and that is sort of kept separate. Also in relation to children, for example, there have been guidelines and safeguards put in place to protect children. For example, in order to manage varying degrees in capacity amongst young people of the same or similar age, the presumption of capacity that applies to adults in the bill will not apply to children. This means that before a child is able to make an advance care directive they will need to show a decision-making capacity as outlined in the test in the bill. Child capacity will be assessed based on a four-part test in the bill, which requires the child to be able to understand the information relevant to the decision and the effect of the decision; retain that information to the extent necessary to make the decision; use or weigh that information as part of the process of making the decision; and communicate the decision and the person's views and needs as to the decision in some way, including via speech, gestures or other means.

So the bill addresses an issue which is not clear under the current arrangements, and as I said earlier, it is nothing new. A person in Victoria can currently refuse treatment for any reason. They do not have to give a reason, but basically if someone suffers from a terminal disease — cancer, for example — they can make the decision today and say, 'I don't want to receive any treatment — full stop', and that is respected. Simply, this bill formalises that, makes sure that people's choices are respected, gives some certainty and direction to medical practitioners to respect that and also provides them some guidance.

I will take the opportunity to commend Minister Hennessy for putting that bill together. As I said earlier, this was part of the government's election commitment in 2014 that we would do something in

that space, and I just want to take the opportunity to commend the minister for that.

And just a last point in relation to palliative care, one of the things I have learnt from being on the committee is that in Australia and Victoria we actually enjoy a high level of palliative care. In fact we are ranked no. 2 in the world behind the United Kingdom, and that is something we should be proud of. We can always aim to be no. 1 because at the end of the day I think it is important that, as a government of state, we continue to invest in palliative care and make sure that patients are given every opportunity to ensure they do not suffer when they are sick and that they get first-class medical treatment, particularly in the last days or weeks of their lives. With these words, I commend the bill to the house.

Mr DAVIS (Southern Metropolitan) — I am pleased to rise and make a contribution to the debate on the Medical Treatment Planning and Decisions Bill 2016. I am going to make a short contribution and point to some issues I see with this bill but point to broader points as well. I will pick up where Mr Melhem left off on palliative care. It is an area that is of significant importance and that I have a strong personal commitment to as a former health minister.

We increased funding and support to palliative care very substantially prior to the 2010 election. We committed that we would put in place a package of \$34.4 million over four years, which was in our very first budget, and we did deliver that in full. At the end of our period of government prior to the 2014 state election I made an announcement with the then Premier that we would commit an additional \$66 million to provide a package of support for palliative care across the state, including in rural and regional areas and including a large range of multicultural communities that had not had access to palliative care. We had already, in that first package, pioneered access for a whole range of multicultural communities — Maltese and Vietnamese communities and others — that had been very significantly advantaged by having access to palliative care services where there had previously not been services and there had previously not been services that were culturally sensitive for those communities.

I put on record, picking up Mr Melhem's finishing point, that I remain concerned that the government has not matched the package that the coalition had at the 2014 state election and that there is significant unmet demand in palliative care across this state. That funding needs to be provided; it needs to be provided urgently. I saw in government that providing that palliative care

support meant that people had the full range of options and treatment or at least a base of support in exercising many choices and options. I was very much of the view that without that support people would not be able to exercise the sets of options that in fact they needed, so I make that point.

In terms of advance care planning itself, the coalition was committed to expanding and strengthening advance care planning options for the community. We released a strategy in 2014 entitled *Advance care planning — Have the conversation — A strategy for Victorian health services 2014–2018*, that enabled us to increase opportunities for people to develop advance care plans.

I pay tribute to the work done by the Respecting Patient Choices program at Austin Health and the significant work done over a number of years to frame and explain how advance care planning in its various forms and iterations can work to put in place the system that we currently have here in Victoria before this bill has passage. I want to put on record my thanks and appreciation for that work and to note the work done by the Department of Health when I was minister in developing further strategies to support the education of health practitioners and in ensuring that we had a system of options for patients which was expanded and that clinicians and others knew how to implement those important steps.

I want to also say something about the inquiry — I will be very brief on this; I am conscious of time — conducted by the Legislative Council legal and social issues committee and its set of recommendations in relation to end-of-life choices. I want to pay respect to all of the members of that committee for the difficult task, but I do want to put on record my view that I do not believe many difficult issues have actually been dealt with sufficiently by that committee. I am putting that on record because I believe that it has enabled a head of steam and a trajectory, but I think there are issues that have not been grappled with.

These matters around end of life are always difficult. They are difficult in a social context, in a religious context and in the context of our Judaeo-Christian tradition largely, but also in our legal frameworks. I think it is important for me to say that in my own heart and philosophically I generally will devote support to increased agency and choice for people, particularly at difficult points. I am strongly persuaded by the need to expand options and choices for people, and that is what I sought to do as health minister. But I am equally aware that these things cannot be seen in isolation. We do live in a social context, and the outcomes that occur

are not simply the ones that occur in terms of the individual. Whilst perfectly legitimate points may be made about expanding the agency of a particular individual with a lot of support, there is a social context and there are risks of abuse and of changing cultural frameworks. I am always cautious that these things are balanced, and I do not believe that the inquiry has sufficiently balanced those significant points.

In terms of the main provisions of the bill, it sets up an arrangement of instructional directives which are binding and values directives which are for guidance. The instructional directives are an express instruction under this piece of legislation to enable a person to indicate how they wish to be treated or not be treated. I think that the right to refuse treatment is an absolutely critical aspect, and I do pay tribute to the old Community Development Committee of this Parliament for the work it did in the 1980s on pioneering the concept of the right to refuse treatment and to strengthen what was on one level a common-law tradition but to make manifest and clear the right to refuse treatment. To the extent that this bill deals with those matters more clearly, I understand its underpinnings.

A values directive, a broader statement that is indicative of a person's values, may be interpreted to apply to a vast range of situations. Whilst elegantly simple, none of this in this area is simple; it is in fact complex and difficult.

It is at this point that I want to put on record my concern that the government has not got much of this right. This bill is an important bill. It is a bill that, as I said, in its essence I understand and have enormous sympathy for, but there are issues with the bill in the difference between routine and significant. The safeguards in the bill need to be, in my view, somewhat stronger, the language of the bill must properly express its stated intentions and a number of my colleagues and others have pointed to weaknesses in the drafting. I know that the opposition and others have sought to engage with the government on a number of these points and have done so with only a measure of success in strengthening the bill and sharpening some of the weaknesses in it.

The issue of authorised witnesses is an area where some progress was made. The age of people making these directives is also a point of contention. There are some genuine issues, I think, around those points. If it is successful in the chamber, this bill will not easily be implemented and will need a lot of information and support behind it to explain it to the community,

because the propensity or the capacity for confusion and misunderstanding in this area is quite significant.

There is also no clear evaluation in the bill, and I agree with others that it should be built into the bill. On advance care directives, let me just say that I have concern about where the bill is going, and I have concern about the failure of the government to fully engage with the opposition and the minor parties on these points and some of the medical groups that have pointed to weaknesses. A bill that ought to have been smoothed and taken to near perfection, because of its very nature, has not been. I think that that is a concern, and I look forward to seeing the proposed amendments that are going to be put forward. There may be more than one put forward in the committee stage.

I also note that by its nature this is an area on which people have very strong and genuine views — obviously in some cases religious views and in other cases views that are driven by deep philosophical positions on a range of issues. In that circumstance it is often important to make sure that there is a maximum zone for people to make choices and to exercise their genuine conscience. Those are important principles in bills of this nature — bills on genuine life-and-death matters.

With that small number of comments, I do not think the government has performed well in this area because it has not put in the additional palliative care resources that should be an underpinning for these sorts of steps. Whilst I have great sympathy for the agency issues and the need to ensure that people have the maximum ability to exercise their own rights, I also believe that these things need to be balanced more broadly. That is the pity — that the government has not actually done the work and has not actually genuinely engaged with the broad group of stakeholders and interested parties in the community, where I believe there is actually a lot of goodwill and where I believe they could have got a much tighter and more satisfactory outcome.

Mr EIDEH (Western Metropolitan) — I rise to speak in support of the Medical Treatment Planning and Decisions Bill 2016. Firstly this bill fulfils the Andrews Labor government's election commitment to consolidate and clarify existing laws in relation to medical treatment decision-making. Is there a more fundamental human right than the right to make informed and considered decisions about your health? This right is even more necessary when dealing with life-threatening or terminal illnesses.

This bill is necessary and consistent with the wishes of the vast majority of Victorians. It provides dignity and

empowerment to people who are often in critical health conditions and gives them the opportunity to ensure that their health decisions determine the outcomes they want for themselves. It will also serve to provide comfort to the families of sick and critically ill people, knowing that their relative is receiving the treatment that they have determined in advance is the best outcome for them. Of course medical practitioners still have a duty of care to their patients, but under this bill patients are comforted by the process that allows them to direct their own health priorities.

The bill will introduce key improvements to the law that reflect contemporary views about how people participate in decisions about their own medical treatment consistent with their preferences and values. This will be the case even if they lose decision-making capacity. The bill will repeal the Medical Treatment Act 1988 and repeal and amend relevant provisions of the Guardianship and Administration Act 1986 and the Powers of Attorney Act 2014.

Victoria already has world-leading advance care planning programs in its hospitals, and repealing the above acts and implementing this bill will ensure that Victorian laws support contemporary practice and the high-quality care already offered in Victoria's health and hospital system. The new legal framework will make a number of essential changes, including recognising that medical treatment is often provided by multidisciplinary teams and a range of professional groups. The bill will apply to all health practitioners registered under the Health Practitioner Regulation National Law and to paramedics, not just doctors.

The bill creates a consistent definition of medical treatment that includes prescribed pharmaceuticals. Currently there are three definitions of medical treatment across different acts. It introduces a single test for capacity in line with existing good clinical practice and consistent with the capacity test in the Powers of Attorney Act 2014, providing safeguards and protections for people making advance care directives and for health practitioners who comply with an advance care directive in good faith.

The bill clarifies the legal hierarchy for selecting a medical treatment decision-maker. This bill adds the requirement that a medical treatment decision-maker that has not been appointed by the person must have a 'close and continuing relationship' with the person they are making medical treatment decisions for, removing the confusion about the powers of medical treatment decision-makers so that all medical treatment decision-makers can consent to treatment and refuse treatment. It expands the role of the public advocate as

the decision-maker of last resort and allows the public advocate to review refusal of treatment decisions where a person's preferences and values are not known. It ensures clear dispute resolution mechanisms, including provision to apply to the Victorian Civil and Administrative Tribunal.

All of these measures will ensure that all Victorians have better access to the best medical treatment processes in the country and will have the satisfaction and comfort of knowing that they are in control of their treatment at a period in their lives that can range from difficult to devastating. I know that every day many citizens in my electorate of Western Metropolitan Region have to make difficult and often harrowing health decisions. I want them to know that the Andrews Labor government is delivering on its promise to improve and clarify this process by offering them the chance to make advance decisions about future treatment. I am very proud to support this bill, and I commend the bill to the house.

Dr CARLING-JENKINS (Western Metropolitan) — I rise today with a somewhat heavy heart to speak to the Medical Treatment Planning and Decisions Bill 2016, which was introduced into the other place just over two months ago. During this time I will admit that I have been distracted — distracted by other pieces of controversial legislation brought up by this government, a government which seem to me to be leaning so far to the left that they are about to fall over. And they would, if not propped up by biased media, cashed-up unions and Marxist-loving propaganda machines. I will also admit that I had an academic response to this bill mapped out, but last night I threw it out and I started again.

Mr Dalidakis — Can I just object to you calling me a Marxist lover.

Dr CARLING-JENKINS — You can object all you like, Mr Dalidakis.

I started again because this bill simply cannot be addressed systematically and academically alone, because this bill is flawed. I believe it is deeply and fundamentally flawed, and I struggle to see that any number of amendments or clarifications will improve this bill to such an extent that I will be able to support it. However, what I intend to do this afternoon is state my concerns here and then to listen to the debate. I will listen to and maybe even participate in the committee stage, and sometime tonight I will make a decision on whether or not to support this bill once amended, as I certainly cannot support it as is.

I do not question that some involved in the drafting of this bill had good hearts and kind intentions. However, this should not obscure the profound questions raised by this final product. I do question that some involved in the drafting of this bill had other intentions, intentions to initiate the first step leading the way for practices currently categorised as euthanasia to be given a legislative basis.

When a person approaches the end of their life, they should be afforded human dignity and respect. The pillar of human dignity is one which I have spoken of often in this place. Currently we do have the right to refuse or request healthcare interventions, so what does this bill actually give us that we do not already have? Considering my earlier comments, I guess I simply do not trust this government to write the policies to back up this legislation in such a way that human dignity is preserved.

Minister Hennessy has admitted that this bill is about:

... clarity around the law, but most importantly it's about changing the culture and the conversations and the practice.

Really, is this bill most importantly about changing culture? I truly worry about statements like this. They indicate a time line towards changing the way we treat or do not treat people at the end of their life, moving from a position of care and support to a position of acceptance around ending the life of another prematurely. This is a dangerous cultural shift for society as a whole and for the medical profession in particular.

I believe that when we as parliamentarians are going to get involved in end-of-life legislation we must keep in the forefront of our minds the need to treat people in need in a way that respects their human dignity and the eternal destiny for all. Care provided must assist those in need to experience their own dignity and values, even when — no, especially when — these are obscured by the burdens of illness or the anxiety of imminent death.

Paul Russell, from HOPE: Preventing Euthanasia & Assisted Suicide, wrote this commentary in September:

A cursory glance at the Medical Treatment Planning and Decisions Bill suggests that some of it at least may have some merit. In detail, it would appear more like the 'curate's egg' — parts of it may indeed be good, but problems do exist.

In her second-reading speech on this new bill, Ms Hennessy made some observations that should give pause for thought on the whole question of euthanasia.

Mr Russell points to the minister's comments on vulnerability and the difficulties of making choices at the end of one's life, for example, and uses this to raise questions about the idea of choice as an illusion in the whole discussion around euthanasia. So this bill may well be interpreted not only as setting up the process for adding euthanasia later on but also as setting up the rhetoric as well — or the cultural change. And a cultural change is necessary if we are to accept such a massive shift in the way we view end-of-life care and the way we understand the role of the medical profession during this time.

It is a risk — a clear and dangerous risk — and in addition to this risk are the flaws within the bill itself. As Ms Sheed spelt out in her speech in the other place — and I thank her for her speech — the devil is in the detail. This was also mentioned earlier in Ms Wooldridge's contribution to this bill. They both outlined serious misunderstandings within the bill and the need for increased clarity, and I agree with these assessments.

So I would like to take this opportunity now to outline a few concerns of my own. Firstly I am concerned around the quality in decision-making. According to Hickman et al:

Decision quality is an important marker of patient-centred care. High-quality decisions result in medical care that reflects the preferences of well-informed patients.

Quality in decision-making in health care is often marked by the process of full, informed consent, so I would like to briefly review how that relates to the directives described in this bill. Consent, or the refusal of consent, to a proposed medical course of action is understood to be informed consent when clear and comprehensive information is given — for example, about the diagnosis, including the degree of certainty in the diagnosis; the nature of a patient's condition; the specific details of the treatment being proposed, including the risks and implications, such as recovery time and side effects; the other options available, including the likely risks and outcomes of other types of treatment; the likely consequences of having no treatment; and the ability to commence treatment but subsequently withdraw or refuse consent.

This bill states that a person has the right to make informed decisions about the person's medical treatment. However, how can informed decisions be made — with informed consent being at the heart of making informed decisions — when the person simply does not know what medical conditions or medical emergencies lie in their future? How does this bill facilitate or ensure that people are able to make the best

quality decision at the time of signing off a directive? I do believe that some of Ms Wooldridge's amendments will go some way to alleviating these concerns.

A second problem I have is a problem with the passage of time. According to this bill, an advance care directive made by a 15-year-old and never reviewed could still be binding at 35, 65 and even 95. The failure to have a review mechanism embedded within this bill is a grave concern. As we age and pass through different life stages we tend to view life, illness and injury in different ways. As we change our belief structures, as we mature and as our life circumstances change, this has a direct impact on the way we view life, illness and injury. However, this bill does not acknowledge or take into account in any way this passage of time.

A third concern that I have is around the capacity of children. Children can, and in many cases do, have input into the medical treatment they receive. And I will acknowledge that many children with illnesses have a very mature and understanding outlook regarding their medical needs. However, for a child who does not have a current medical condition, I worry that they may be encouraged to make directives without an understanding of what they are committing themselves to. Children are not generally expected to make binding decisions about their lives — for example, about their future careers, their relationships and their housing — and yet we are expecting them to have maturity and the ability to make binding decisions about medical treatments they may want in relation to medical conditions that they do not yet have. Does anyone else see a problem with this?

And then of course there are the implications for people with disabilities. I do hope that Mr Finn is going to follow up on this point, as I am sure it would also be one of his areas of concern. I just wonder how the rights and specific needs of people with disabilities have been taken into account in drafting this legislation. I am concerned that this legislation will actually increase vulnerability and not empower people with disabilities. I wonder who has been consulted from this field, even down to the simple things like whether or not regulations or policies related to this bill will be available in accessible formats.

Another concern I have is ensuring an understanding of one's own directive. Hickman et al published in the *Journal of Palliative Medicine* in November 2016 an article headed 'The Quality of Physician Orders for Life-Sustaining Treatment Decisions — A Pilot Study'. It was quite an extensive pilot study. The authors established that with physician orders for life-sustaining treatment, which is the statutory advance care directive

in place in 19 states in the United States, including California, Oregon and Utah, there were a number of concerns around people not understanding what their directive actually meant. For example, 21 per cent of people had an inaccurate understanding of what their directive meant in relation to artificial nutrition, 26 per cent had an inaccurate understanding of what their directive meant in relation to the provision of antibiotics, 32 per cent had an inaccurate understanding of what their directive meant in relation to the provision of CPR and 50 per cent had an inaccurate understanding of what their directive meant in relation to levels of medical intervention.

This is a huge concern to me. I will just take one example here, and that is of CPR. Say a person inserts a clause saying they do not wish to be resuscitated if their heart stops beating. Will they be prompted to explore this further according to different circumstances? For example, if a person signs off on not being resuscitated, they may have in mind an intention to refuse CPR in the event of a spontaneous cardiac arrest. However, their directive also means that an anaesthesiologist cannot administer CPR in the event of a reaction to an anaesthetic drug during surgery. I think there is a fundamental flaw here in this legislation, and it needs to be covered during the committee stage.

Then I come to another point — my sixth concern — and it is about the legal precedent of the withdrawal of food and hydration, which is effectively starving someone to death. There is legal precedent in Victoria from Gardner; re BWV in 2003 on the withdrawal of food and hydration. That case deemed PEG-feeding, which is the provision of nutrition and hydration intravenously or via a PEG tube, as being a medical procedure. I have worked in the disability field where percutaneous endoscopic gastrostomy feeding is a routine supplement given to people with disabilities who are unable to take enough food or water by mouth. Often this is part of a progressive disability. By considering basic food and hydration as a medical procedure, as this case in the Victorian Supreme Court established, it means that the withdrawal of such can be included in an advance care directive according to this legislation as it stands. I will need clarification around this — for example, assurances during the committee stage, because if this is taken on face value, this is euthanasia by stealth, which I cannot support.

I cannot help but reflect on the famous case in the US, the case of Terri Schavio. Terri's feeding tube was removed in 2005 under court order after a determination was made that she would have wished for this course of action. It took Terri an agonising 13 days to die. The lack of value afforded to this

woman who was disabled but not dying is a cautionary tale of where this bill might take us if we do not have adequate safeguards in place around it.

This leads me to my next point: the need for safeguards to prevent abuse. Very strong safeguards are needed to prevent abuse in this area, particularly when we think about the areas of elder abuse and family violence or even family pressure. How can we ensure that no undue influence is placed over a person with a disability, over an older person, over a person living within the confines of a cult or over a spouse to sign off on a directive — or the many other abusive scenarios we could all come up with?

I wonder what information the doctor will be required to provide and what detail will the doctor be required to go into? I would certainly hope that it is painstaking detail, but if so, how can they do that within the confines of a 15-minute GP appointment slot? What kind of regulations will accompany this bill, and will they promote a standard format with standard clauses with accompanying clause-by-clause explanations?

I do recognise that clause 14 of the bill provides for it to be an offence to induce the giving of advance care directives, thus recognising the danger that a person may be induced by dishonesty or undue influence to give an advance care directive. I would like to know more about this — for example, does this offence extend to influencing the content of an advance care directive, and how might this be safeguarded against? I will also note here that in relation to witnesses there does not appear to be anything to prevent a person who stands to benefit financially from the death of a person from either signing off on an advance care directive on behalf of the person under clause 16(2) or witnessing an advance care directive under clause 17. What are the safeguards here? Particularly, what are the safeguards that will protect people who are vulnerable to or experiencing abuse?

Finally, my last point is around electroconvulsive therapy (ECT) for adults without capacity. I have already spoken about this issue in this place, so I will not go over too much ground except to say that this government has already been reported to the United Nations for failing to recognise the capacity of an individual being subjected to forced ECT here in Victoria despite in their lucid moments repeatedly stating that they did not wish to receive ECT. However, ECT was repeatedly approved and delivered when the person was deemed as not having capacity to consent. I find the addition of this clause in an already complex bill suspicious at best.

Of course I could go on to explore the issue of suicide prevention and how that sits within the bill or to explore the issue of attempted suicide in relation to this bill. However, I do not think everyone needs to hear me all afternoon, and these are covered in amendments that will be presented to the house.

Overall, I have a problem with binding advance care directives when they operate on their own as opposed to, for example, the appointment of a healthcare proxy or a power of attorney for health care, which may well be accompanied by a set of guidelines or directives. I am concerned about the inflexibility contained within a directive. Any attempt to write detailed instructions for future unknown medical treatments and other unknown factors requires a level of sophistication and support that many people simply do not have access to. No-one can be reasonably expected to predict in advance all the decisions that must be made in a time of medical crisis. Appointing a trusted person to assist in such times is, in my opinion, preferable.

A static document does not — because it cannot — provide the level of flexibility or management needed for medical care. I would promote a holistic care approach as being best, and making directives binding simply does not — because it cannot — achieve this. A holistic approach involves elements of responsiveness, flexibility and adaptability when faced with unpredictable illnesses or circumstances. Advance care directives on their own simply cannot encapsulate all of this.

In conclusion, I feel a little bit like the watcher on the wall standing here today. This makes me think of descriptions of ancient times where watchers surveyed the city walls in times of stress, monitoring, warning and staying ever vigilant. I have not necessarily been a good watchman on this bill to date. I feel as though I have not advocated strongly enough against it and I have not proposed enough amendments, but I do thank Ms Wooldridge for presenting her amendments.

I believe this bill should be completely redrafted in order to address the concerns raised regarding it. I will admit that I am disappointed with the coalition for not suggesting the reasoned amendment they proposed in the lower house, because this is something I could have supported wholeheartedly and without hesitation. But I do commend the coalition for thinking about having a conscience vote on this bill at the last stage if that is necessary.

However, well above and beyond this I am deeply disturbed that the government has suggested such a flawed bill to begin with. Surely end-of-life

decision-making demands of our Parliament a better, more thought out approach?

I want to make one point very clear: I am all for advance care planning that can reduce stress, anxiety and depression, both for people at the end of their life and for their surviving loved ones. Advance care planning can be empowering and informative when done correctly, but when it crosses a line into directives which are not flexible, which are poorly drafted and which are open to interpretation or abuse, then I have a problem. I simply do not have confidence that this government has done the foundational work required to match this bill to the good intentions touted by many in this chamber and in the other place.

I reserve my right to declare how I will vote on this bill today until I have listened to the arguments around amendments and until the committee stage is underway, but in watchman style I warn that this legislation is the beginning. It is the opening of a Pandora's box. Once opened, it may have dangerous — albeit unintended by many here in this chamber — consequences, especially for people who suffer from chronic terminal illness or disabling conditions. Ultimately there is a cost for society as a whole.

As Gandhi said, 'The true measure of any society can be found in how it treats its most vulnerable members'. I end my contribution as I started it: it is with a heavy heart that I draw my concerns on this bill to the notice of this house today.

Mr FINN (Western Metropolitan) — I rise today to speak on the Medical Treatment Planning and Decisions Bill 2016. I have to say in rising to speak on this bill that I fully accept and indeed support the right for anybody to refuse medical treatment. That is a basic right and one that must be respected. If somebody has a condition that they do not wish to have treated, then they have a right to say that; they have a right not to have treatment forced upon them in a way that would — I believe — go against their basic rights as a patient and indeed as a human being.

I am thinking of one person close to me some years ago. He was an 83-year-old who had spent many years in the medical profession. He was diagnosed with leukaemia. He went home from the doctor after the diagnosis and he got his affairs in order; he spent some months getting his affairs in order. I think it was about four or five months after the diagnosis that he died at home, surrounded by his family in the way that he wanted to.

Being from the medical profession this man knew just how intrusive — how painful in fact — the treatment for leukaemia would be, and he decided that that was not for him and that he would just accept what was coming his way. He was quite a religious man in fact, so it was not any religious or anti-religious thoughts entering his head on this occasion; he just accepted what was coming and decided that he did not want to go through the extraordinary difficulties of the treatment that would be in store for him if indeed he decided to fight this leukaemia.

One of the really good things about this bill is that it emphasises that there is no need — and I use that word 'need' in inverted commas — for euthanasia legislation. There is an argument among some who say that our hospitals are full of people who are living purely because they are on life support systems — that they are being kept artificially alive. This could not be further from the truth; indeed it is quite the opposite. Let me assure you that the medical profession and the stretched hospital system that we have in this state — indeed in this country — value their resources far more than to keep somebody alive artificially who has no future, who may be brain dead and who has no hope of recovery.

It is a daily event in hospitals for families to gather around a loved one and make a decision to turn off the machine. That is good medical practice; that is the way it operates. Anybody who says that people are being forced to be kept alive by medical professionals or families against what may or may not be their wishes is wrong. It is just not happening; it is just not the case at all, and I really think in considering this whole matter that that is something we should take into consideration.

Mr Davis mentioned earlier the importance of palliative care. I think palliative care is something that does not have the full breadth of understanding in the community that perhaps it should. I think there are some people who think that when you get to a certain point then it is time to go. They want out. But palliative care allows people to have a standard of living despite their often chronic disease. Palliative care allows them to live out their lives in a way that we would regard as being dignified and indeed allows them to have a dignified death. I support Mr Davis's view that palliative care is something that should be supported by governments and the community and should have far greater resources put into it. I hope at some stage that we will come to the view as a Parliament and the government will come to the view that palliative care is worth giving wholehearted support to.

I have to go along with Dr Carling-Jenkins when she says that this is flawed legislation, because whilst it does to some extent express a view that I support, and that is the right to deny medical treatment, there are flaws in this bill that concern me enormously. Having heard Dr Carling-Jenkins this afternoon, there are a lot more flaws in this bill that I am concerned about.

I was and I continue to be concerned about the effect this legislation will have on children. Children need the full protection of the law. Children are vulnerable. Children are not necessarily in a position to be making far-reaching decisions. When I was 10 years of age I could not have been expected to make a decision on what my treatment would be if I contracted some disease now. That would be quite ludicrous, yet that is what this legislation allows. It is a nonsense. We need to protect our children. They are — many of them anyway, not necessarily my kids — very much open to suggestion; they are very much open to pressure. These are things that we really have to take into consideration.

The other group of people that I am particularly concerned about are people with intellectual disability. They too are very vulnerable; they too are not in a position to properly think through what they want. They are not in a position to properly defend themselves if need be. Then of course we have people with disorders such as autism. I know with autism that it is such a mystery to so many of us that we do not quite know which autistic child, which autistic person in this particular instance, has the ability to think through the full implications of what they may be wanting to do. That concerns me. I think we have to take these things into consideration. If we do not, then we are letting the show down and we are putting into law legislation which is, as Dr Carling-Jenkins said, deeply flawed.

One thing that all of us must accept with this legislation is that abuse will lead to the deaths of people who should not have died. The only conclusion one can come to is that if this law is abused, then we are going to have a situation where people will die for any number of reasons. They will die without having expressed a desire to do so under certain circumstances. That is something that I think should weigh very heavily on our shoulders; it should weigh very heavily on our consciences.

There are any number of pieces of legislation that go through this place and we say, 'Well, if it stuffs up we can call it back. We can fix it up'. We can do this; we can do that, but we cannot bring people back from the dead. That is what this bill will lead to if abuse is allowed. The aspects of the bill that were referred to by

Dr Carling-Jenkins, the aspects of the bill that I have referred to with regard to children, with regard to people with intellectual disability and with regard to people with autism and similar disorders, are real and genuine concerns that let this bill down enormously.

This is a bill that may be well intentioned. As was pointed out earlier, it may not be too. There may be some people who put this together who may well have ulterior motives. I am not going to judge that, but it is a distinct possibility. On the other hand there may be people who have very good intentions. But whatever the intentions, the end result, if abuse occurs, will be the unwanted and unwarranted death of a human being. That is something that I cannot support and that is something that concerns me enormously.

Obviously I will be supporting the very welcome amendments that will be proposed by Ms Wooldridge. I understand that there are some amendments proposed by the government which I will also be supporting, but I reserve my right to oppose this bill if during the committee stage matters that I have raised are not sufficiently explained and amendments are not passed that I believe should be passed. This bill is far too important to just let go through on its own. I will in fact oppose this bill if I find it necessary to do so. I would regret having to do that, because I think there are some parts of the bill that are very good, but as I said —

Mr Dalidakis — A man's got to do what a man's got to do.

Mr FINN — That is right; that is very true. I have been saying that for some years, and I will in fact do that, Mr Dalidakis.

I hope that the house will think through the implications of the matters that I have raised and the matters that Dr Carling-Jenkins has raised. I am hoping that we can in fact fix this bill to some degree, although I have to say at the end of the day it needs a great deal of work — a lot more work than probably any of us can put into it at the committee stage. But I will leave it at that point. I will listen, I will watch and I will make a decision, as they say in the classics, in the fullness of time.

Ms PATTEN (Northern Metropolitan) — I am very pleased to be rising today to speak on the Medical Treatment Planning and Decisions Bill 2016. As members are aware, I was fortunate enough to be on the Standing Committee on Legal and Social Issues when they conducted the end-of-life choices inquiry. I am also very pleased to say that I initiated that inquiry. This is why we initiated it. We needed to look at end-of-life

choices and we needed to provide new tools for people at the end of their life. We needed to provide ways for patients' wishes to be heard, to be respected and to be adhered to.

Through the inquiry, which I still feel incredibly honoured to have been part of, we had well over 1000 submissions, we held hearings throughout the state and we travelled internationally. I also personally travelled to California and spoke to the Californian senators who had initiated the advance care planning directives and information and education campaigns over there. I feel that finally we are coming to realise something that has been a passion of mine since prior to my being elected and certainly in the period that I have been fortunate to be sitting in this place.

When you look at the report of the inquiry, which I know many of you have — they are impossible to get; they are completely sold out; I gave away my last copy and have had to borrow somebody else's for today — you see it is an issue that the public is completely engaged in. They want to talk about it, but they are scared to talk about it. We had over 1000 submissions and we held hearings around the community. What you will see from the 49 recommendations that were made in that report is that 19 of them were about advance care planning and advance care directives. This is a really, really important issue that the community responded to. I have to say we heard so many different opinions, evidence, recommendations and ideas around how we can improve end-of-life planning and end-of-life directives that will improve end-of-life experiences in our society to no end.

Currently we do not really like to talk about death; in fact we just do not. In some ways death is quite invisible to us in society. We do not see it anymore. Most people do not die at home. In fact while 80 per cent of people want to die at home, less than 15 per cent do. It is kind of invisible to us. Having said that, we probably see thousands and thousands of deaths on television. Whether it is gangsters being shot down, people dying in the most tragic circumstances or Arnie Schwarzenegger having a go at them, we see death all the time, but we do not see realistic deaths — we do not see what actually happens. We do not talk about what you want, how you want to die, what is important to you. These are the conversations that we must be having in our community. We are an ageing community. We are not all going to wake up dead, as many of us would love to do. We are not going to suddenly die — most of us anyway. Most of us are going to die of a chronic illness; most of us are going to be on that continuum for quite a long time.

As one of the witnesses said to the committee, we insure our houses for fire but when that person last looked the research said we are all going to die, but very few of us actually plan for it — very few of us think about this. The numbers are extraordinarily low in Victoria. Less than 14 per cent of Victorians have done any form of advance care directives or advance care planning, and I understand why. Up till now the tools we have had for this have been incredibly complicated and difficult. We have had to cover four different pieces of legislation to pick out who might be the substitute decision-maker. The Medical Treatment Act 1988 was actually fairly progressive for its time. We were the first state to say that a patient had the right to refuse treatment; we were the first state to do that. Since then every other state has introduced advance care directive legislation, and Victoria is the only state that does not have it, so I am very pleased to see that we are catching up. This meets the agreement that was made by all of the state health ministers in 2011 when they agreed to an advance care directive framework.

I like this bill. I think this bill finds the right space. I do not like its name, I have to say; I think one of the committee's recommendations was that we call it the Future Health Bill, and I would have preferred that name, but I am not going to quibble or put amendments up about the name of the bill — the Medical Treatment Planning and Decisions Bill it is. The particular sections that I like are clauses 6 and 7, where the bill outlines what we want to hear from people about what they want in their treatment and how they develop that position. That is around values; very often it is around values. It is around expectations of the way they want to live and the way they want to die. It is around expectations for their families and how they want their families to remember them and how they want to remove the suffering for their families.

One of the great pieces of work that has been done on advance care planning, and I think it is one of the best in Australia — it has actually been done here — is MyValues. This service was produced by Barwon Health, by Dr Corke. Last night I did MyValues. As an example I tried it during the committee, but I filled in the MyValues survey again last night, and I encourage everyone to do it. I was quite surprised by the results. At some points I do want to be resuscitated at any cost, and this is what has been interesting. Research has found that people do want to be resuscitated. When they go through an advance care planning directive or an advance care planning conversation they talk about what they do want to do. They do want to see their grandchildren get married. They do want to do this, and they set this within their advance care planning. It is this conversation that takes the stress away from

families and that enables a patient to get treatment that aligns with what that patient wants.

I have been hearing here today people saying that we cannot really trust patients to make those decisions for themselves, because they might make the wrong decision. Who do we want the decision to be made by if it is not the patient? If it is not yourself, who do you want the decision to be made by? Do you want it to be made by the doctor? Doctors do not want that. Doctors are supporting this bill; they want advance care directives. They want patients to be part of the conversation. We no longer have a paternalistic health system; we have a system where we are trying to make it patient centred — patient focused — and this is what advance care planning and advance care directives absolutely do.

I will be happy to talk more in the committee process about the proposed amendments that have been circulated today. I look forward to discussing this bill further in the committee process, but I just go back to the fact that there are very few health organisations that do not support this bill. In fact on looking back at the submissions from the end-of-life choices inquiry, I could only find three organisations that did not support advance care directive legislation, and they were the Australian Christian Lobby, the Australian Catholic Church and the Anglican archdiocese — those three for reasons that were completely religious.

I completely support everybody's right not to have an advance care directive. In fact I do not think this legislation is going to mean that people will be running out and getting advance care directives; I do think it means that people are going to have a conversation around death and around their choices of treatment. I look forward to hearing more about the education campaigns that will follow this legislation. My understanding from the briefings is that \$1.5 million has been put aside to provide training to doctors to enable them to have better conversations about death.

We heard throughout the inquiry that conversations about death were difficult. People did not know how to start them, whether they were doctors or not. Some doctors were saying to us, 'You know, sometimes it is just easier to treat than to have the conversation', so I look forward to the campaigns that will follow this legislation around educating us as a community. Many do not realise that 8 August is Dying to Know Day. It is a day that I think we should all be encouraging involvement in. The Shepparton valley hospice group tried to do it in a shopping centre last year. Sadly, people gave them a wide berth; people do not want to have the conversation. We are still concerned about

having a conversation about death, dying and planning for it.

I want to quickly touch on the palliative care sector. Victoria has some of the best palliative care in Australia and around the world. We have great palliative care, but it is sometimes difficult to access palliative care. We often find that patients are accessing it too late. They should have been in there earlier, when they could have gotten much more sophisticated and holistic palliative care. Palliative care is not just about pain relief and adequate food and water; it is about a lot more. The advances in palliative care are really wonderful and something that we need to fully utilise and expand on, and certainly we will need to be funding it.

I listened to the point Dr Arup Bhattacharya, the divisional clinical director of Goulburn Valley Health, made at a public hearing when he said:

Unless we fully embrace advance care planning we will always fall short of good and effective palliative care because we will not know what our patients have wanted.

That is what this bill is about. This bill is about providing that information to your general practitioner, talking to your general practitioner and educating everyone around this. I fully support this. As I said at the start of my contribution, this is one tool in the toolbox of end-of-life choices. This is enabling patients to now talk about what they do not want and what they do want around end-of-life care and treatment.

As we know, the end-of-life choices inquiry made a very strong recommendation that we should have a body called End of Life Care Victoria, which I think would be a great centralised body that could deal with how we are going to ensure that advance care directives are able to be accessed by doctors, not only in Victoria but also interstate given the mutual recognition that these directives are receiving.

But we also want to consider what 80 per cent of the population want. They want to have this autonomy, they want to have these decisions about refusal of treatment but also they want to have a decision about the right for physician-assisted dying. The community is there. Politicians in this house may not be right there with them, but 80 per cent of Victorians want us to allow them greater autonomy at their end of life so that they can die with dignity, die in comfort, die without stressing out their families and die with the support of their medical practitioners. I would hope that as this Parliament moves on this year we start to provide a legislative framework for dying with dignity.

This bill is commendable and a well overdue first step in the process towards ensuring that everyone has as much choice as possible when it comes to the end of life. I feel privileged to have been part of this. I feel privileged that most of the recommendations of that committee have been incorporated into this bill, and I commend this bill.

Mrs PEULICH (South Eastern Metropolitan) — I am always very grateful to follow Ms Patten because I could not think of a person that I am more diametrically opposed to in my views on many of these issues than Ms Patten. She has let the cat out of the bag in relation to this bill. There is a very strong emphasis in white Anglo-Saxon society, especially amongst the middle class, on this myth that somehow committing to physician-assisted dying or euthanasia is an expression of one's autonomy.

Ms Patten interjected.

Mrs PEULICH — Eighty per cent and they have not had the conversation yet, Ms Patten. If you ask them what advance care planning is, most people would not have a clue — most doctors would not have a clue.

Having been a member of that committee and having looked at the legislation, can I say it is a bureaucratic nightmare. Ms Wooldridge was right in saying that the devil is in the detail, and there is certainly a lot of detail and no doubt there will be a lot of devils emerging. I see this legislation as basically being the scaffold that is being built to erect that building, and Ms Patten sees that building she referred to as the first step towards legislation facilitating physician-assisted dying. Indeed I would say Ms Hartland believes in that; that is certainly the Greens policy. Having served on that committee, I found it extraordinary that whenever anyone spoke or presented a case in favour of physician-assisted dying, Ms Patten would writhe and wriggle with excitement and clap her hands as if it was somehow ice-cream to a child.

I am sorry, but I do bring culturally and experientially a very different perspective. I come from a war-torn country. I come from a family that has had many family members disappear in war and conflict — in concentration camps. As a child of 10, my mother was in a concentration camp. To them, life is precious and the medical fraternity is there to help make life better.

The entire argument in favour of euthanasia or physician-assisted dying is based on three fallacies. Number 1 is that euthanasia is somehow an expression of personal autonomy. I do not believe that is the case, because you are actually asking for legislative change,

for institutional change, for cultural change and for other people to do it for you. If it was going to be a genuine expression of autonomy, it would, regrettably — and I do not condone it or endorse it, and people who are suicidal need help — be committing suicide. That may be an expression of autonomy.

The second myth is that somehow pain cannot be managed effectively. Well, we are indeed lucky to be living in Australia, and I feel for people who do not have access to palliative care in Third World countries, such as, say, India. People who do not have access to palliative services or care unfortunately can be consigned to a very painful death. But in Australia, a First World country with the quality of medical services that we have and with technology and medical treatment improving all the time, there are no grounds for anyone to die in pain. Of course none of us — no doctor, however good, however experienced, however qualified — can guarantee a completely painless death.

So one fallacy is that it is an expression of autonomy, the second fallacy is that pain cannot be managed effectively and the third is that there can be safeguards and it can be done without any risk. That is the biggest lie. As I mentioned before, this is very much a regime that is typically Labor and typically left-wing. When you talk about social reform, Labor is very good at it. They want to turn everything on its head. They want to give you the whole stick of salami even though you may not like it. What they will do is slice and dice it and feed you a slice at a time until the public has given up, and this is the start. This is the first slice of the salami. This is the scaffolding for building a regime that facilitates physician-assisted dying.

If this were about advance care planning, I would have no difficulty with it. A lot of people would not know — the inarticulate, the uneducated, people who are illiterate, people from multicultural backgrounds and people who have mental health issues. My brother died prematurely from a heart attack as a result of several GPs simply not making sure that he had a mental health plan. He suffered from depression. He got himself into a rut and ended up dying from a heart attack. They could not even do the basics, and that is look after a person's mental health, let alone give them the God-given right of deciding for and making subjective interpretations for people who may be in a position to neither understand informed consent nor give it.

If you google 'euthanasia' or 'physician-assisted dying', you will get the agenda. It is a worldwide agenda. It is on the march, and it is push, push, push, let us make inroads, let us open it up to a greater cohort and let us open it up to children, to people who have

mental health issues or to people who suffer from experiential pain. The agenda is there, and it will not stop. I do not understand it. As a person who has lived in a country where life could be ended at the click of a finger, I do not understand this fascination with death. It is a culture of death. I will not speak for a long time. I just want to say this regime will allow the death culture to creep in further and further and to permeate irrevocably the relationships and the institutions which should be committed to helping protect life.

Every person has the right to refuse medical treatment. That occurs now. The greatest difficulty with a directive is that at the moment it does not contain euthanasia, but just imagine a piece of legislation that then suddenly inserts it and you have got advance care directives where people who may not wish to facilitate euthanasia or physician-assisted dying are required to do so.

My father died at the age of 63 from lung cancer, and he received palliative care in the home. He had very good care. We did not know what the hell palliative care was. A nurse came around, first of all three times a week, then every day and then on the final day that he died a different nurse came. It was a good routine; it was a good regime. The specialist under whose care he had been had guaranteed when he was first diagnosed — and it was only an eight-week diagnosis — that he would remain lucid, that we would be able to have those final conversations and that there was no urgency. We were not able to have those conversations. One thing that was interesting was that my father had always said, ‘When I’m ready to die, I don’t care what they do with me’. But it was interesting that as death approached he wanted to cling onto life. He thought not of himself; he wanted to see more and more of his own grandchildren’s lives reach the next milestone.

So how can an advance care directive that someone may have been a party to preparing at the age of 20, 25 or 30 and then forgotten about still be in existence? The medical fraternity would be required to make every endeavour to locate that advance care directive. How could you actually then observe it when you are 65 or 60? How can we be sure that a person being faced with death does not have his or her mind changed at the last minute? You cannot. Human beings and doctors are not gods.

How can we be confident that a diagnosis by the medical fraternity that a person has a terminal illness is indeed right? I have referred to this instance before: the young man who was diagnosed and was on life support. He was said to be 90 per cent brain dead. His father was

advised that he needed to come quickly to the hospital. This was in the United States. The nurse had her injection ready, because they wanted to harvest his organs. The father flipped. He had decided that because of the close relationship between the two that the two of them would exit this world together. This is all on YouTube; please feel free to google it. During the time he held the hospital under siege, he held his son’s hand, and the hand moved. The fingers moved. Suddenly *60 Minutes* cuts to a different scene, where the young man had fully recovered and was anticipating resuming life, including training in Little League. This is a guy who was diagnosed as being 90 per cent brain dead. People are not gods.

In summary, people change their minds. This in my view cannot be foreseen in every instance. People who are inarticulate or uneducated, or people who come from a different culture — my own mother — would struggle to understand any of this. She was barely literate, and even now when she receives a letter she has to bring it to me to read it to her. How do you expect people from multicultural backgrounds, who may not have ever spent a day in school, to negotiate this convoluted middle-class white Anglo system where their life is at risk as a result of errors being made through subjective interpretations? Apart from that, errors do occur, and they will occur, and this will mean that more will occur. That is why it is so crucial for those amendments to be adopted.

I think the bill should be withdrawn or referred to a committee. I was a part of that committee. I did not vote for advance care directives. I do not like anything that is compulsory, especially when there is a government involved. I do not trust governments, and I especially do not trust left-wing governments. Left-wing or right-wing authoritarian governments, I do not trust. In closing, I appeal to the house to make sure that many of those amendments are adopted, or the bill will indeed do all the things that I have now tried to raise alarm about.

There is a polarisation of views in the community, there is no doubt, but basically that debate out in the community has not been had. Ms Fiona Patten spoke about the need to educate and to campaign. This came through the report as well. Suddenly we are going to allocate a whole lot of money in order to promote and encourage people to actually buy into advance care directives, to have them. So the campaign begins. I am very concerned.

Also, for many cultures, we do not speak of death. It is considered to be superstitious. You might think that superstitions are believed by only the uneducated, but

people who have confronted death, who have lived under the threat of death, who have lived in war-torn countries or who have seen loved ones die or perhaps disappear, never to be found again, do not speak of death. They want to speak of life.

This bill has all of the hallmarks of creating a scaffold for the building of an institution, a medical institution, whose culture will be focused on a culture of death. Again I would urge important questions to be asked and amendments to be moved. My concerns about this bill will be very hard to alleviate.

Ms LOVELL (Northern Victoria) — I will just make a very short contribution to this bill. I think what is really important to note with this bill is that we are not talking about euthanasia here. This bill is not introducing a euthanasia scheme. This bill is purely about advance care directives that are made by a person while they are lucid about how they want to be treated at the end of their life. Many people in this chamber have pointed out that that may include a directive that someone wants every intervention possible and that they want to be kept alive no matter what the situation. This bill actually takes the decision away from families, who would otherwise have to make a decision about turning on or off machines, because the person themselves has made a directive at a time when they are lucid about how they want to be treated at the end of their life.

I have experienced several different scenarios over my lifetime. I remember very clearly family friends of my parents who had a son who was in a car accident. He was on life support, and it seemed to me — I do not know; I was fairly young at the time — that he was on life support for years. I am not sure exactly what that period of time was, but I know that for that family it was a time of limbo, a time when they would visit him weekly. Then there came a period when they were asked by the medical professionals to turn that machine off. That was a heart-wrenching decision for his parents to make, and they then grieved once again. As they had grieved at the time of the accident, they then grieved again quite some time later when their son's machine was turned off and he finally passed away. I can remember my sister, my brother and I all saying to our parents at the time, 'Please don't let that happen to us. Don't keep us on machines. Turn the machines off straightaway. We wouldn't want to live the life that that young person had been living'.

What this bill does is take those decisions away from parents, such as the heart-wrenching decision to turn a machine off if a young person has already put in place an advance care directive that they do not want to be

kept on life support machines. I have also seen a family where their mother was on a life support machine for some time, and the doctors came to them and said, 'Your mother's brain dead. She's not going to recover. We think it's time to turn the machine off'. That family made the heart-wrenching decision to turn the machine off, and their mother lived. This family would not have had to make that decision if that decision had actually been made by the person themselves, when they were lucid, about how they wanted to be treated at the end of their life.

I think it is really, really important to take the emotion that has been instilled into some of the debate today around euthanasia out of this debate and look at this purely as what it is: it is about an advance care directive, about what the individual wants, not what other people want. It is about how the individual wants to be treated at the end of their life. That may be to have every intervention possible, or it may not be.

I had a father who believed very strongly in euthanasia, and I thought I did too until one night, towards the end of his life, he begged me to get the doctors just to put him to sleep. I could not have made that decision. I know that it was very selfish of me — that faced with that decision I would have made every choice to preserve his life, even though he was in horrendous pain, because while he was there he was still there. I could not have made that choice, even knowing that that was what he wanted. If there had been an advance care directive in place and euthanasia had been available to him, perhaps we might have lost Dad a few weeks earlier than we did, but that would have been his decision.

That is not to say that I will support a bill on euthanasia if it comes before the house; every piece of legislation has to be considered on its merits, and we have not seen any legislation towards that yet. But it is important to note that this bill is not about euthanasia. This is just about the directives of an individual — about how they want their medical treatment to be administered towards the end of their life. I think that is an individual's right.

There are some problems with this bill, and that is why the opposition is moving amendments. I would urge all members of this parliament to support those amendments and improve some of the problems that do exist in this piece of legislation.

Ms MIKAKOS (Minister for Families and Children) — I begin firstly by thanking members for their respective contributions. In a debate that is really a challenging one for members — I know that for some

members it is actually quite a raw subject — members have really made quite heartfelt contributions. I think that on the whole the debate has been a very respectful one, and I am therefore grateful for members indicating their respective views. I also take this opportunity to indicate that there are some members here who have looked at this issue in considerable depth, who have researched the issue, particularly those who have been part of the Legislative Council Standing Committee on Legal and Social Issues, which has considered the issues around dying more broadly.

I think it is important to make it clear what this bill is about and what it is not about. In practice Victoria was already a world leader in implementing advance care planning, but currently the law does not support this critical work. Every public hospital in Victoria is already required to have an advance care planning program, so the bill seeks to ensure that Victorian laws support contemporary practice and high-quality care already provided in our hospitals. In contemporising Victorian law the bill recognises that people should be supported to make their own medical treatment decisions for as long as they are able. The bill also seeks to introduce a contemporary understanding of capacity in accordance with current clinical research and practice, and it recognises that people may be able to make decisions about some things and not others and that loss of capacity may be temporary.

The bill does not alter what constitutes lawful medical treatment. The Standing Committee on Legal and Social Issues explicitly stated that a person should not be able to request physician-assisted dying in an advance care directive. This means that there is no overlap between this bill and the committee's recommendation about physician-assisted dying. I make the point also that there are five other jurisdictions in Australia that have statutory recognition of advance care directives, and none of these jurisdictions have legalised physician-assisted dying.

We need to be very clear about what this bill is about and is not about, because I think a number of members in their contributions have sought to suggest that somehow this bill is part of a broader reform. As a government we have said we will consider the other, broader recommendations from the legal and social issues committee and will provide a response within the normal time frame.

This bill does implement recommendations 47 and 48, which are the two recommendations relating to legislation for advance care planning. The bill does not implement the standing committee's recommendation 49 — that Victoria legalise

physician-assisted dying. I think we just need to be very clear about what it is that we are debating here, as some members are seeking to suggest that the scope of this bill goes in fact beyond what it is about. In the course of the government's consultations about this bill we also made a commitment to put some things on the record, and I will attempt to do that in summing up. Obviously there will be an opportunity to go into more detail about these matters in the committee stage.

In relation to the issue of a scheduled form and prescribed information, it has been suggested that during the process of advance care planning people should be provided with prescribed information and that a prescribed form should be created to ensure that this information is available to people. Some stakeholders have pointed out that prescribed forms can deter people from creating an advance care directive as they can limit a person's ability to express themselves in a way in which they feel comfortable. Health services already conduct advance care planning across Victoria, and this involves providing information that is tailored to each person's needs rather than just providing them with a generic form. Health practitioners have professional obligations to provide appropriate information to people and currently do so.

Nonetheless in partnership with the Office of the Public Advocate, the Department of Health and Human Services will develop a generic form for an advance care directive, which people may use if they choose to, as well as explanatory material to guide people through the development of an advance care directive and key considerations when appointing a medical treatment decision-maker. The form will include an explanation of the witnessing requirements and what is meant by certifying that a person understands the nature and effect of each statement in their advance care directive. This will include recognising that in order to understand the nature and effect of each statement in an advance care directive a person must understand the nature, consequences and risks of consenting to or refusing treatments and that alternative treatments or courses of action have been considered.

The information developed will also include an explanation of when and how an advance care directive will come into effect. For example, the information will clarify that an advance care directive only comes into effect when a person does not have decision-making capacity. This will include an explanation that, wherever possible, a person should make their own decision and this will always take effect before a health practitioner turns to an advance care directive. This includes, for example, making informed decisions prior to undergoing surgery.

The bill provides that a medical treatment decision-maker must sign their appointment and state that they understand their role and have read any advance care directive. The generic form will provide information about the role of the medical treatment decision-maker. The information will include details about how instructional directives and values directives operate as well as advice about who should be provided with a copy of an advance care directive and about the process of challenging an advance care directive at the Victorian Civil and Administrative Tribunal (VCAT).

In terms of the witnessing requirements, it has been suggested that a medical practitioner should also certify that they have provided sufficient medical advice. This concern was raised in relation to people basing their decisions on incorrect information. The witnessing requirements already in the bill will provide a significantly stronger witnessing safeguard than other jurisdictions in Australia. For example, in South Australia an advance care directive does not need to be witnessed by a medical practitioner; the person only needs to understand what an advance care directive is and the consequences of giving one. It is not clear why the requirement that a person understand the nature and effect of each statement in their directive would be interpreted so narrowly as to allow a person to base a decision on incorrect information. An ordinary interpretation of understanding the nature and effect of a statement would include an accurate understanding of the treatment being consented to or refused and its likely effects.

The second-reading speech provides that a person should understand the sort of treatment that will or will not be provided in accordance with their advance care directive. If the person does not have the information to understand the treatment, they will not have understood the nature and effect of each statement in their directive. So, as described, guidance will be developed during the implementation of the bill to ensure that medical practitioners understand their obligations when witnessing an advance care directive.

In relation to applications to VCAT, there has been some significant time devoted by Ms Wooldridge in her contribution to this issue, and there are a number of amendments that have been proposed, as I understand it, by the opposition relating to this matter. What I can say is that concerns have been raised that the circumstances in which a person may apply to VCAT are not sufficiently clear. The detailed guidance material that I referred to earlier on making an advance care directive will include an explanation of who may apply to VCAT and when they may do so.

In relation to additional grounds for departing from an advance care directive, it has been suggested that additional grounds should be added to allow a health practitioner to depart from an advance care directive where the circumstances are not anticipated or the advance care directive is based on incorrect information or assumptions. Stakeholders have expressed significant concerns about provisions allowing health practitioners to disregard an advance care directive. Concerns were raised by people creating advance care directives who were worried that their preferences and values would not be respected and they would not receive the treatment that they want. Concerns were also raised by health practitioners who recognised that creating a range of exclusions will create significant uncertainty and that they will be left making difficult decisions about whether or not an advance care directive should apply.

The bill clearly provides that a health practitioner may not follow an advance care directive if circumstances have changed and the application of the directive would no longer be consistent with the person's preferences and values. This would include the development of new medical treatments or unforeseen circumstances arising, such as an unexpected change in prognosis, and I certainly hope that I have helped to clear this issue up and make this very clear.

In terms of the additional requirements for practitioners to apply to VCAT, it has been suggested that additional mandatory notification to the public advocate or application to VCAT be included in the bill when a medical treatment decision-maker is acting contrary to the person's preferences and values. It is noted that the most effective and efficient way to resolve disputes is locally at the health service level. Our health services already have dispute resolution processes and resolve the vast majority of disputes effectively. Requiring notification or applications to VCAT would significantly slow this process down and may create unnecessary obstacles. The bill will allow VCAT to remove a medical treatment decision-maker who is acting contrary to a person's preferences and values, and VCAT may appoint a guardian under the Guardianship and Administration Act 1986 if they believe this is a necessary step.

In relation to treatment during dispute resolution, it has been suggested that additional provisions should be included in the bill that allow a health practitioner to treat a person while a dispute is being resolved at VCAT. Such provisions do not exist currently. VCAT makes interim orders regarding ongoing treatment shortly following an application being made. In doing so, VCAT determines if treatment is necessary and

whether providing or not providing the treatment before a determination would cause the least amount of harm. This allows VCAT to consider the circumstances in each individual case. Creating a general provision may have unintended consequences. Stakeholders have not raised concerns that people are denied treatment when applications are made to VCAT. Further, clause 53 of the bill allows medical treatment to be provided in an emergency without consent.

In relation to revoking a medical treatment decision-maker's authority, concerns have been raised about VCAT's capacity to revoke a medical treatment decision-maker's authority. Part 3 allows VCAT to revoke or vary the appointment of the medical treatment decision-maker. Clause 66 allows VCAT to declare a person is not a medical treatment decision-maker, including a non-appointed decision-maker. Given that only some medical treatment decision-makers are appointed, it would not be appropriate to provide that their power is revoked under clause 66. VCAT will continue to have the power under the Guardianship and Administration Act 1986 to appoint a guardian to make medical treatment decisions. If VCAT has revoked an appointed medical treatment decision-maker's power or declared a person not to be a medical treatment decision-maker, they could also appoint a guardian to make medical treatment decisions.

In relation to advance care directives and medical treatment decision-makers in an emergency, concerns have been raised that emergency treatment will be delayed to search for an advance care directive. It is noted that clause 53 of the bill allows emergency treatment to be provided without consent. Clause 50 only requires that a medical practitioner make reasonable efforts in the circumstances to ascertain if a person has an advance care directive or medical treatment decision-maker. Given that consent is not required and urgent treatment is necessary, there would be no reason to delay treatment to search for an advance care directive in an emergency. Despite this, if an advance care directive is readily available, it should not be ignored just because it is an emergency.

The issue is illustrated by the following examples: if a person collapses whilst walking alone in a park and paramedics attend and would like to perform CPR, it would be entirely unreasonable in the circumstances to delay treatment to look for an advance care directive before providing CPR; or if a person collapses in a nursing home and the nursing home provides paramedics with an advance care directive when they arrive, there is no reason to ignore the advance care directive.

Stakeholders have raised concerns that without a clear statement that a known advance care directive should be complied with, their advance care directives will be ignored in an emergency and they will not be provided with treatment that is consistent with their preferences and values. We would want to clarify that the requirement to make reasonable efforts in the circumstances to locate an advance care directive or medical treatment decision-maker does not include delaying urgently required treatment and that this would be unreasonable.

In summing up, I think it was important to put some of these things on the record, particularly as these issues did come out of the course of stakeholder consultations, and I am sure I will have the opportunity in the committee stage to provide further clarity to the community and to the chamber. But I certainly commend the bill to the house, and I say in doing so that this is obviously one of the most complex issues in terms of the issues of dying more broadly, and I do hope that we can continue to deal with this piece of legislation in the respectful way that we have undertaken the debate so far.

Motion agreed to.

Read second time.

Committed.

Committee

Clause 1

The DEPUTY PRESIDENT — Order! I believe the government, the opposition and the Greens have separate proposed amendments to this bill. Ms Hartland's and Ms Mikakos's amendments have been circulated, so I ask Ms Wooldridge if she can now circulate her amendments.

Ms WOOLDRIDGE (Eastern Metropolitan) — I ask that my amendments be circulated.

Mr FINN (Western Metropolitan) — I have just one question, and that is: is this bill preparing us for a bill to legalise euthanasia?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Mr Finn, for your question. I think I actually addressed this point in my summing up very clearly — that is, that this is a bill about advancing or updating our existing regime in relation to advance care planning. There is no overlap between this bill and the Standing Committee on Legal and Social Issues recommendation about physician-assisted dying. In fact

the committee explicitly stated that a person should not be able to request physician-assisted dying in an advance care directive. I made the point further that there are five other jurisdictions in Australia that have statutory recognition of advance care directives. None of these jurisdictions have legalised physician-assisted dying.

This bill stands in its own right. It is a bill that is significant in terms of providing people with greater clarity around their advance care directives. As I advised the house on a previous occasion when I had a question in question time about this matter and how we are going to respond to the committee's report, I did indicate to the house at that time that the government intends to respond to that report within the usual time frame, so we will have more to say about our response to the recommendations of that committee report. But certainly this bill stands in its own right and is not a precursor in any way to what may or may not come into the future.

Mr ONDARCHIE (Northern Metropolitan) — Minister, just picking up Mr Finn's question — and I do understand that you indicated this is not a precursor — as you would understand, we have had many letters and many emails about this piece of legislation with a community concern the government is then going to follow this with a bill on euthanasia. Will you satisfy those concerns today by ruling out the government will introduce a bill on euthanasia?

Ms MIKAKOS (Minister for Families and Children) — I think it is important that we do focus in the course of the committee stage on what is within the scope of this bill. If we look at the purposes clause of this bill, it is very clear what this bill is about, and it is about advance care directives. The committee stages on other bills are not for the purpose of ruling anything in or out. That is a question that you can put to the government in question time; it is not a question to put to the government in the course of a debate on advance care directives.

I think I have made it very clear on a number of occasions, including today when I responded to a question from Ms Patten very recently, that the government intends to respond to the committee's report within the usual time frame, so we will have more to say about our response to that report at that time.

Mr ONDARCHIE (Northern Metropolitan) — Minister, I understand fully what this bill is. I heard your closing comments, but my question goes more to your opportunity to alleviate the concerns of the

community, who wrote to us in the context of this bill concerned about this as a step towards the government legalising euthanasia. Residents and constituents in both of our electorates have raised these concerns, so I ask that by way of satisfying those concerns so we can deal with bill.

Ms MIKAKOS (Minister for Families and Children) — Mr Ondarchie, I think I have responded to your question already, as I did to Mr Finn's question. As I said, we will respond to the committee's report in due course. This is a bill that stands in its own right. What is in scope here is to consider the detail of this bill today, including the very considerable safeguards that are included in this bill in terms of how advance care directives will work. What I can say to the community is that we are obviously considering the detail of the legal and social issues committee report and we will be responding to it in due course.

Ms WOOLDRIDGE (Eastern Metropolitan) — I have a number of questions on a number of detailed clauses, so just a couple of general questions on clause 1 in the context of the overall bill. A number of stakeholders have highlighted that there are significant extra resources required. There are additional roles for the public advocate. There are additional responsibilities for the Victorian Civil and Administrative Tribunal (VCAT). Could you please outline what additional resources are going to be made available for these two organisations and if there is other funding to support the effective implementation of the bill if it should pass?

Ms MIKAKOS (Minister for Families and Children) — I thank the member for her question in relation to this issue of resources. I can advise the member the advice that I have is that the Office of the Public Advocate — the OPA — will be assisted with additional funding of \$500 000 per annum recurrent for its additional role. In addition to that, the department is being provided with \$1 million over two years in additional funding to provide for an information awareness campaign that will be developed in the lead-up to the commencement of the new legislation. This will include updated information on the Better Health Channel, the Clinicians Health Channel and on the Office of the Public Advocate website. A generic form, as I referred to in my summing up, will be developed and available on these websites that will guide people through the key considerations and questions in undertaking advance care planning. Through their information and advice line the Office of the Public Advocate will also play an ongoing role assisting people with the legal requirements of advance care directives and appointments. In respect of VCAT, I

can advise the member the advice that I have is that the department is in discussions with VCAT in relation to the issue of resources at present.

Ms WOOLDRIDGE (Eastern Metropolitan) — Thank you, Minister. That goes a bit to my next question. Practically every organisation I talked to outlined how important it is that the community is educated to make sure these advance care directives can be effectively implemented. From your response so far, it looks like there are quite a lot of web-based resources through the Better Health Channel, Clinicians Health Channel and the OPA website. The OPA does have some. My concern would be that is going to have a narrow reach rather than a broad reach. Will there be any education through, say, Palliative Care Victoria, the Victorian Council of Social Service, the Council on the Ageing or some of the other organisations that are perhaps more membership based and more able to get broad messages out rather than a ‘We’ll build it and hope that they come and have a look’ approach?

Ms MIKAKOS (Minister for Families and Children) — I thank Ms Wooldridge for her question. I am advised that there will be education resources that will be available. That material will be widely disseminated through the medical profession.

The government already supports training and education resources on advance care planning through the Advance Care Planning Implementation Advisory Group. I am advised that the Australian Medical Association (AMA) and the Office of the Public Advocate are both members of that advisory group. Most recently the AMA has been supported to provide a resource guide for doctors, so they will obviously be able to then provide that information to their patients. Similarly, the Royal Children’s Hospital has been supported to develop a thinking ahead resource for health practitioners working with very sick children and their families, so there will be a range of resources that will be developed in relation to these issues. Certainly the department can ensure that some of the membership-based organisations that you referred to, Ms Wooldridge, do get access to these types of materials and resources.

Ms WOOLDRIDGE (Eastern Metropolitan) — Could you also confirm if these will be translated into other languages to address the issues that have been raised by some members of multicultural communities about having some genuine understanding and information in relation to this?

Ms MIKAKOS (Minister for Families and Children) — Yes, I am advised that materials will be translated consistent with what occurs with all end-of-life care.

Ms WOOLDRIDGE (Eastern Metropolitan) — I am also interested to know about what evaluation the government plans in relation to the impact and the effectiveness of the bill, including what data collection will be done to be able to measure that impact.

Ms MIKAKOS (Minister for Families and Children) — I am advised that data is already collected in health services about the percentage of people over the age of 65 who have an advance care plan and/or a substitute decision-maker. Health services are also reporting on the use of advance care plans as part of their mortality and morbidity, safety and quality review committees. It is intended that further work will be done with the Office of the Public Advocate to evaluate the impact of the new role of the support person and the preferences and values test. The advance care planning strategy sets out seven priorities that health services measure the advance care planning activity against.

It will be important to monitor the patterns of advance care planning in health services and general practices, including how they guide clinical practices in line with people’s stated preferences and values. This will be done through existing data monitoring as well as qualitative information collected from people who have made an advance care directive and the medical treatment decision-makers to guide ongoing improvements in the resources and information developed.

Ms WOOLDRIDGE (Eastern Metropolitan) — Thank you, Minister. Often bills which are very significant like this might have legislated that there is a review in three or four years and that that will be made public. Can you give me a time frame for that review process? What you have said in your response is that it will be ongoing, which to me sounds a little bit like a catch-all, which may or may not happen. So is there a time frame to definitively look at this bill, or is it your expectation it will just roll forward?

Ms MIKAKOS (Minister for Families and Children) — The member would be aware that there are no set time frames set out in this bill. In fact that is quite frequently the case with many bills that come to the Parliament. As I explained in answering the member’s previous question, there will officially be a whole set of data that is collected that will enable ongoing monitoring and evaluation of the legislation as we go forward.

Ms WOOLDRIDGE (Eastern Metropolitan) — Perhaps the minister could assist with how anyone then, other than the government, will know the impact of this bill. Is there any plan to publish the data that is collected, to make that available or to report that through annual reports? How will anyone other than those who receive the data have any ability to assess the impact of this bill?

Ms MIKAKOS (Minister for Families and Children) — I thank the member for her question. I am advised that hospitals will publish in their statement of priorities the percentage of patients who have an advance care plan. In addition to this, it is expected that the Office of the Public Advocate will also publish information in its annual report regarding issues such as the frequency of contact from the community — inquiries they receive from the community — about this, including also the number of substitute decision-makers.

Ms HARTLAND (Western Metropolitan) — I have got a few general questions before we get into clauses. Following up on Ms Wooldridge's question about resources, I am particularly concerned about interpreters. You have stated that information will be in other languages, but someone for whom English is not their first language, especially if they are quite elderly, will actually need the assistance of a professional interpreter, I think, rather than just a family member. How will they be able to access that, especially as many hospitals now do not have permanent interpreters? They often bring them in.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland, for your very good question. I can advise you that interpreter services for advance care planning in public hospitals are already covered and funded by the interpreter service. This will continue. GPs also have access to commonwealth interpreter funding and can use this to create advance care directives. The small number who might be in private hospitals may need to pay for an interpreter, but certainly in the public hospital system they will be covered.

Ms HARTLAND (Western Metropolitan) — Will that be a face-to-face interpreter service or an interpreter service over the phone? I just think that this is such a delicate and difficult issue that if it is not face to face it could actually be lacking.

Ms MIKAKOS (Minister for Families and Children) — I am advised it will be a face-to-face interpreter.

Ms HARTLAND (Western Metropolitan) — I have other questions around resources. Obviously you have talked about an education campaign that the government will run. Do you have any vision at this stage of what that will look like, especially for the culturally and linguistically diverse (CALD) community — using SBS et cetera? Is there an overall plan as yet, or is that to be devised?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland, for your question. I am advised that there will be some advertising and that will also extend to various ethnic communities. In relation to the other types of resources that will be developed and made available to our various CALD communities, the advice I have is that Northern Health at the moment have developed a range of resources for CALD communities in relation to advance care planning. It is translated material, and that is also being made available to other health networks. The resources they have developed go further than translated material; it also relates to the training of interpreters in working with patients around these issues. In addition to this, there is work through Palliative Care Victoria targeted to CALD communities as well. In relation to Indigenous people, advance care planning has been developed as well.

Ms HARTLAND (Western Metropolitan) — I have one last question. Obviously there is a fair amount of lead time between the passing of the bill and its actual start date. In that time I am presuming there will need to be a set of regulations and a practice guide developed. Can you outline how that is going to be done, who will be consulted on that and how you might believe it will be implemented?

Ms MIKAKOS (Minister for Families and Children) — Ms Hartland, obviously it is going to be important to work with key stakeholders across the sector about the obligations of the bill. The bill includes a number of significant changes for the community and the health workforce. Appropriate guidelines and educative materials will need to be developed prior to the commencement of the bill. Health practitioners and health services will also need to be given sufficient time to understand their new obligations and to implement new systems to ensure that these obligations are met.

In relation to your subsequent query in regard to regulations, the advice I have is that the regulations will go to issues around children.

Dr CARLING-JENKINS (Western Metropolitan) — I would just like to follow up on points raised by both Ms Wooldridge and Ms Hartland. They have raised some really good points around data collection, review resources and practice guidelines. As you have indicated, Minister, this indicates a shift for medical professionals and for health services, so I am just wondering in the preparation of this bill what kind of training will be offered and also what kind of supervision will be offered, because obviously this is something that is a part of training for social workers, for doctors et cetera — the supervision over the implementation of these guidelines. I guess I am going to the heart of safeguards with this question as well.

Ms MIKAKOS (Minister for Families and Children) — Thank you for your question, Dr Carling-Jenkins. In relation to the issue of training, I am advised that there will be further training for medical practitioners. In fact there is already training in place, because these processes already apply in terms of advance care directives (ACDs), but there will be further training given the new legislation here. In particular the Office of the Public Advocate will be involved in training and education for health practitioners. Further, it is expected that the Australian Medical Association (AMA) will also be involved in providing information sessions for their members as well, so there will be a range of training opportunities. In terms of supervision, given that this is not a change — it is in fact current practice that applies — obviously the normal processes of supervision would apply as they currently apply to the medical profession.

Clause agreed to.

Clause 2

Ms WOOLDRIDGE (Eastern Metropolitan) — Could I just get some clarity from the minister in terms of the time frame and whether it is expected to work to that March 2018 date for this to become valid or whether she thinks that might happen sooner than that? Can you give some confirmation around the time?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. The bill includes a default commencement date of 12 March 2018. The bill includes a number of significant changes for the community and the health workforce. Appropriate guidelines and educative materials will need to be developed prior to the commencement of the bill. Health practitioners and health services will also need to be given sufficient time to understand their new obligations and implement new systems to ensure that these obligations are met.

Rushing the implementation of the bill creates risks that advance care directives will not be properly understood and may not be properly used or respected. This could have tragic consequences for people who have recorded their preferences and values and are expecting a particular outcome. I guess in answer to your question we are working towards that default commencement date.

Clause agreed to.

Clause 3

Ms MIKAKOS (Minister for Families and Children) — I move:

1. Clause 3, page 10, lines 16 to 34, omit all the words and expressions on these lines and insert—

“*significant treatment* means any medical treatment of a person that involves any of the following—

- (a) a significant degree of bodily intrusion;
- (b) a significant risk to the person;
- (c) significant side effects;
- (d) significant distress to the person;”.

This amendment relates to clause 3. Can I just explain to the house that following the introduction of the bill some stakeholders, whilst supportive of the bill, raised concerns about the application of particular provisions, and so there are in fact three government house amendments proposed to clarify the effect of specific provisions in the bill and address concerns raised by stakeholders.

The bill provides sufficiently prescriptive information to guide medical practice whilst still being sufficiently broad to cover the array of medical treatment decisions and circumstances it must govern. The bill aims to clarify the rights of people to make decisions about their current and future medical treatment and the obligations and protections of health practitioners.

In relation to the first amendment, it will clarify the definition of ‘significant treatment’ set out in clause 3. Currently the definition includes four points that define what makes treatment significant. After each point there is an example of what this may include. Whilst these examples were included to aid interpretation, it is clear that they are causing confusion rather than providing clarification, and this amendment will remove the examples.

The definition of ‘significant treatment’ is required to be used in very limited circumstances under the bill to

identify when the role of the public advocate in medical treatment decision-making is triggered under clauses 62 and 63. These provisions were developed to ensure safeguards for vulnerable people, and the proposed amendment will not alter the application of the definition in these provisions. Clinical guidelines will be developed in consultation with health practitioners during the implementation of the bill to identify specific significant treatments.

Ms WOOLDRIDGE (Eastern Metropolitan) — I thank Ms Mikakos for the amendment. I like the euphemism of ‘stakeholders’ because while there were others who raised it, I think it is fair to say that in the coalition’s negotiations with the government it was agreed that this amendment needed to be made. The original definition, with an example of a significant degree of bodily intrusion such as an internal examination, raised questions about procedures as simple as looking in someone’s mouth or down at someone’s tonsils. Some of the questions that could have been raised by the examples are clarified by their removal. The coalition is very pleased that our recommended definition has been taken on by the government and agreed, and on that basis we will be supporting the amendment.

Ms HARTLAND (Western Metropolitan) — The Greens will be supporting the amendment.

Ms MIKAKOS (Minister for Families and Children) — I thank Ms Wooldridge for her support. Can I just indicate to the house that the coalition is a stakeholder and I am very pleased that it is supportive of this amendment.

Amendment agreed to.

Ms WOOLDRIDGE (Eastern Metropolitan) — Ms Mikakos, I raised in the course of the debate the concern of Palliative Care Victoria about the definition of palliative care which in this context defines palliative care as including the following: ‘the provision of reasonable medical treatment for the relief of pain, suffering and discomfort’ and ‘the reasonable provision of food and water’. Palliative Care Victoria are of the view that that is not a helpful definition because it is narrower than the range of services that palliative care support provides, and they actually sought that this definition be changed to call it what it is, which is the provision of reasonable medical treatment and the provision of food and water, rather than it being defined to that extent. Could you just speak to the concerns of Palliative Care Victoria about that narrow definition and why it needed to be presented in that way?

Ms MIKAKOS (Minister for Families and Children) — I thank Ms Wooldridge for her question. I understand Ms Hartland had similar concerns in relation to palliative care, and I hope I will be able to acquit the questions from both members. The advice that I have is that the definition of palliative care in this bill is the same definition that was included in the Medical Treatment Act 1988. This definition is already widely used and understood and has been judicially considered and further defined.

The bill defines palliative care as including ‘the provision of reasonable medical treatment for the relief of pain, suffering and discomfort’ and ‘the reasonable provision of food and water’. It does not include artificial nutrition and hydration via percutaneous endoscopic gastrostomy feeding, which is considered medical treatment.

The bill provides a relatively narrow definition of palliative care in order to allow health practitioners to be able to provide palliative care without consent but not extend this to other treatments and interventions. In this way the bill balances potential situations where a health practitioner may be forced to do nothing when a patient is experiencing considerable pain or suffering or may seek continued curative treatments as the only option if palliative care is refused. While these situations may be infrequent, they would be highly distressing for both health practitioners and families if they were required to stand idle while a person suffered.

This definition applies only to the bill. It is acknowledged that palliative care covers a range of interventions that aim to promote quality of life and comfort care, including person-centred and family-centred care and physiological and/or spiritual support. In fact the government’s recently released *Victoria’s end of life and palliative care framework* described palliative care as:

an approach to care that improves the quality of life of people and their families who are facing the problems associated with a progressive illness. It does this by preventing and relieving suffering through early identification and assessment, by treating pain and other physical, psychosocial and spiritual problems and by addressing practical issues.

It is this framework that will guide end-of-life and palliative care delivery in the community and in health services.

The definition in the bill aims to ensure people are provided with relief for pain, suffering and discomfort rather than be a guideline for the development of palliative care service delivery. This approach was taken because many health practitioners and consumer groups working with family members making medical

treatment decisions on behalf of someone expressed unease about people refusing palliative care in advance. This was due to concerns that a person cannot always fully appreciate the need for pain and symptom relief in advance until they are actually experiencing the pain or symptoms, and this might be at a point where they do not have decision-making capacity to consent to pain or symptom relief.

Indeed there is a considerable body of research that suggests an existing medical culture that defaults to overtreatment and aggressive treatments to cure, even when this is futile, rather than providing palliative care. Allowing palliative care to be refused in advance may have an unintended consequence of overburdensome or increasingly non-beneficial treatment continuing to be provided by clinicians.

Ms WOOLDRIDGE (Eastern Metropolitan) — You did touch on the fact that food and water other than by mouth is regarded as medical treatment. I just have a question regarding the fact that people may not assume that that is the case; it is a Supreme Court interpretation. Can you say whether that issue, because it is such a vital part in terms of this, is expected to be included in the information guide that you mentioned earlier in terms of the resources and the materials on the web and information for people filling in advance care directives?

Ms MIKAKOS (Minister for Families and Children) — Thank you. Again I understand that Ms Hartland had similar questions. You are clearly in sync here, Ms Hartland and Ms Wooldridge, in relation to these questions. I hope that this can address the queries of both of you in relation to these issues. The advice that I have is that the Supreme Court has interpreted the definition of palliative care in the Medical Treatment Act 1988, which is the same as the definition in this bill, to only apply to care that is not meant to treat or cure a person but to alleviate pain and suffering when the patient is dying. Palliative care does not include the administration of artificial nutrition and hydration; this is medical treatment.

Ms WOOLDRIDGE (Eastern Metropolitan) — My question was: will that be explicitly provided in the information on the web so that people seeking to use this will be informed of that?

Ms MIKAKOS (Minister for Families and Children) — My advice is that, yes, in fact that will be the case.

Amended clause agreed to.

Clause 4

Ms HARTLAND (Western Metropolitan) — I have a question on clause 4, ‘Decision-making capacity’. Can the government confirm that when someone is under a guardianship order that person may still be considered capable of making medical decisions?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland, for your question. I am advised that a person would only be put under a guardianship order by VCAT under the Guardianship and Administration Act 1986 if there was a need for an order because the person is unable to make reasonable judgements about the matters for which the order is made. Given these requirements, a guardianship order would not be made unless the person did not have capacity to make the medical treatment decisions themselves. Clause 4(2) outlines that an adult is presumed to have decision-making capacity unless there is ‘evidence to the contrary’. If a guardianship order is in place, this is likely to constitute ‘evidence to the contrary’. It is, however, noted that even if the person is deemed not to have capacity and a guardian is making decisions on their behalf, the bill requires guardians to make decisions that are consistent with the person’s preferences and values. The guardian would be expected to discuss the decision with the person.

Clause agreed to.

Clause 5

Ms WOOLDRIDGE (Eastern Metropolitan) — My question on clause 5 in relation to VCAT orders and who can apply to VCAT is: can a patient themselves appeal to VCAT if they believe they have decision-making capacity?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. The bill intends to ensure people’s preferences and values about medical treatment are respected, and wherever possible people should be making medical treatment decisions themselves. Clause 4(2) sets out that an adult is presumed to have decision-making capacity unless there is evidence to the contrary. The bill provides that a person with a special interest may apply to VCAT to challenge a health practitioner’s opinion that a person does not have capacity. The person directly affected by an opinion would clearly have a special interest in their own affairs, and it would be expected that VCAT would consider them an eligible applicant as defined by the bill.

Clause agreed to.

Clause 6

Ms WOOLDRIDGE (Eastern Metropolitan) — I am not sure if it is comfortably here, but this was the context in which it was presented to me. It is just the question of organ donation and the relationship between a commitment to organ donation and how that interacts with an advance care directive, whether that be an instructional directive or a values directive.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that a decision to donate organs is not a medical treatment decision, and there is already a national scheme through which a person can consent to and register for an organ donation. The national Organ and Tissue Authority was established under the Australian Organ and Tissue Donation and Transplantation Authority Act 2008 to develop a nationally coordinated approach to organ and tissue donation for transplantation, in liaison with states and territories, consumers, clinicians and the community. Victorians will continue to be encouraged to make their organ donation wishes known through this national scheme.

Clause agreed to; clauses 7 to 11 agreed to.

Clause 12

Ms HARTLAND (Western Metropolitan) — Some of what I am going to ask has already been answered, so I will try to condense it down, but I am particularly interested in how the template for advance care directives is going to be organised, especially in regard to the institutional directive as well as other formal requirements. Will the government be setting in regulation a standard template or provide guidelines to health professionals in regard to that template?

Ms MIKAKOS (Minister for Families and Children) — Both, in fact. The government will not be regulating a standard template but will develop a generic form that people can use. On this issue we received clear feedback from members of the public that a prescribed form would narrow the focus of health practitioners, who would look to the form and nothing else. This has been the experience for some people in relation to a loved one refusing treatment that was not on a refusal-of-treatment certificate, for example.

The bill aims to encourage health practitioners to recognise and understand people's preferences and values. Using a prescribed form would only limit the ability of people to make an advance care directive and narrow this focus. As part of the planning for the implementation of the bill this will include a suggested form which will be developed and will include

user-friendly instructions and tips about making a helpful and valid advance care directive.

Clause agreed to.

Clause 13

Ms WOOLDRIDGE (Eastern Metropolitan) — This really relates to the question of people aged under the age of 18 giving advance care directives. I suppose my first question is: what safeguards are in place to make sure that children and young people who are making advance care directives are doing so with the full knowledge and understanding of what they are committing to and potentially not being coerced by parents who may have a particular view or a particular perspective that they are trying to enforce on their children?

Ms MIKAKOS (Minister for Families and Children) — Thank you for your question, Ms Wooldridge. Obviously this is a question that is very dear to my heart — to make sure that children are adequately protected. I can advise you that medical treatment decisions are made by and on behalf of children every day. There is no reason to discriminate against children simply based on their age.

The law already recognises that if a child has capacity, they should be able to make their own medical treatment decisions. The bill similarly recognises that if a child has capacity, they should be able to make the same decisions in advance. It would be arbitrary to limit who can make an advance care directive based solely on a person's age, so the bill will allow a person under the age of 18 who has capacity to make an advance care directive to appoint a support person. The bill will not allow a child to appoint a medical treatment decision-maker. A person with parental responsibility currently makes medical treatment decisions for a child who does not have capacity, and the bill will not change this. If a child makes a valid instructional directive, though, a health practitioner will be required to act in accordance with this rather than turning to the medical treatment decision-maker under clauses 13 and 31.

In relation to safeguards specifically, I can advise you that in order to manage the varying degrees of capacity amongst young people of the same or similar age, the presumption of capacity that applies to adults in the bill will not apply to children. This means that before a child is able to make an advance care directive they will need to show decision-making capacity as outlined in the test in the bill. The child's capacity will be assessed based on the four-part test in the bill, which requires a child to be able to understand the information relevant

to the decision and the effect of the decision, retain that information to the extent necessary to make that decision, use or weigh that information as part of the process of making the decision and communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

In addition, a child's advance care directive will need to be witnessed by a medical practitioner or psychologist with training and experience in assessing the cognitive, emotional and social development and capacities of children and adolescents. They will certify that the child appears to have decision-making capacity and that they appear to understand the nature and consequences of making an advance care directive under clauses 4 and 17.

Mr FINN (Western Metropolitan) — As I foreshadowed in my contribution to the second-reading debate, I am very concerned about the impact this legislation will have on intellectually disabled people, particularly people with disorders such as autism, because it is extremely difficult to judge capacity. I would like to know from the minister what safeguards are in place to protect these people from those who may seek to harm them with regard to this legislation.

Ms MIKAKOS (Minister for Families and Children) — I thank Mr Finn for his concern for people with disabilities. I can advise him and the chamber that the bill shortens the list of people responsible currently contained in the Guardianship and Administration Act 1986 and it adds the requirement that a person has a close and continuing relationship with the person that they are making the decision for. If a person has not appointed a medical treatment decision-maker and VCAT has not appointed a guardian, the first of the following with a close and continuing relationship with the person will be their medical treatment decision-maker: a spouse or domestic partner, a primary carer, an adult child, parent or an adult sibling. If there is no-one available from the list that I have just referred to, then the public advocate will act as the decision-maker of last resort for significant treatment. If routine treatment is required and there is no medical treatment decision-maker available, a health practitioner may proceed without consent. These provisions ensure that people will receive treatment in a timely manner and that there is appropriate oversight from the public advocate for the provision of significant treatment for those people who may be vulnerable. I understand that Dr Rachel Carling-Jenkins had also expressed similar concerns in her contribution.

Ms HARTLAND (Western Metropolitan) — A further follow-up question on that. That is quite an expansive list. If none of those people is available, how is it then triggered for the Office of the Public Advocate to take over that role?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland, for your further query on this. The advice that I have is if there is no-one available from that list that I referred to earlier, then it would be the medical professional, because in the absence of someone to provide that consent, they would be contacting the Office of the Public Advocate who would then act as the decision-maker of last resort for significant treatment.

Mr FINN (Western Metropolitan) — We have had instances both in Australia and overseas where medical practitioners and nurses have taken it upon themselves to become judge and executioner of the elderly and of people with disabilities. What safeguard, in the instance that you have just referred to, is in place to protect people with a disability or the aged person from such a person with foul intent?

Ms MIKAKOS (Minister for Families and Children) — Mr Finn, thank you for your question. Obviously it is important to say at the outset that doctors and nurses every day work incredibly hard to keep people alive, and I think it is important to acknowledge that they are very honourable in their intentions and work incredibly hard to keep people alive regardless of their degree of vulnerability in the community. I say that because I know that many of us have been so impressed by medical professionals over the years in terms of their dealings with members of our families, colleagues and others.

Obviously there are safeguards and protections in place. In terms of ensuring that there are protections in place for vulnerable people, in creating a new legal document for people to express their preferences and values and placing a greater emphasis on respecting people's decisions more generally, the bill will help to ensure that people receive medical treatment that is consistent with their views. This will limit family members from imposing their values on vulnerable people, for example. The bill also creates new explicit protections at clauses 14, 15, 41 and 42, which create new offences to prevent people from abusing new legal instruments or misrepresenting a person's preferences and values. Further, if a medical treatment decision-maker refuses significant treatment in circumstances where the person's preferences and values are not known, a health practitioner is required to notify the public advocate, who will assess the reasonableness of this refusal.

As I indicated earlier, the list of potential medical treatment decision-makers is shorter than in the Guardianship and Administration Act 1986 and creates an additional requirement of a close and continuing relationship. This will ensure that distant relatives, for example, will no longer have the power to make medical treatment decisions for people they hardly know. If there is no medical treatment decision-maker, the public advocate will automatically be the decision-maker of last resort for significant treatment and can protect the person's personal and social wellbeing. I guess in relation to the point that Mr Finn is making about medical practitioners taking action in an illegal manner that is completely outside the scope here, it ultimately is an assault and obviously that does attract criminal sanctions.

Mr FINN (Western Metropolitan) — I fully accept the point that the minister makes about doctors and nurses. They are overwhelmingly an extraordinary group of people who are dedicated to the wellbeing of humanity. But what I am really keen to know is, if a medical practitioner unlawfully refuses treatment to a person with a disability, why does the minister think that that medical practitioner would then notify the public advocate?

Ms MIKAKOS (Minister for Families and Children) — Thank you for your question, Mr Finn. I am advised that a doctor has a duty of care to provide appropriate treatment; failure to do so may constitute negligence. Obviously if a doctor was to take some overt action, as you are suggesting in your hypothetical, and a patient was to die, then that is clearly a criminal matter. This bill does not make that legal.

Mr FINN (Western Metropolitan) — I am not for a moment suggesting that it is making it legal. In your previous answer you said that any medical practitioner who refuses medical treatment to a person with a disability must justify that to the public advocate. What I am asking is: what makes the minister think that if somebody is doing something outside the scope of the law, they would then turn around and notify the public advocate about what they are doing? I would have thought that that is a long bow to draw, to say the very least. In a situation where we have somebody who is acting outside the law, what possibly would make anybody think that they would notify the public advocate of their actions — or inactions, in this case?

Ms MIKAKOS (Minister for Families and Children) — Mr Finn, I think we have already covered this issue. The point of the Office of the Public Advocate is that they are a decision-maker of last resort where there is no medical treatment decision-maker. It

is in those circumstances that the medical professional would then consult the public advocate to act automatically as the decision-maker of last resort for significant treatment and to act in the person's best interests. You are really canvassing, Mr Finn, hypothetical examples of a medical professional acting completely outside the bounds of this legislation. As I said, there are consequences — both at a professional level, in terms of potential negligence of a doctor outside his or her duty of care, and similarly matters that lead to a person's death may well have criminal sanctions attached to them as well. I think they are ultimately the ultimate safeguard.

Clause agreed to.

Clause 14

Ms WOOLDRIDGE (Eastern Metropolitan) — Just a clarification: we did raise this in the course of the consultation, but it would be good to get the response on the record. Clause 14 says that:

A person must not, by dishonesty or undue influence, induce another person to give an advance care directive.

My question is on why it only relates to the giving of an advance care directive and not also to what is included or not included in the advance care directive. It relates to the process as opposed to the content. Would the content already be covered, or why is that excluded?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge, for your question. I have been reminded that I may have addressed this point in my summing up earlier. I know it was a long summing up; you had to listen carefully. I am advised that is intended to cover both — that the offence does include undue influence or dishonesty to induce a person to include or not include things in their advance care directive.

Clause agreed to; clause 15 agreed to.

Clause 16

Ms WOOLDRIDGE (Eastern Metropolitan) — Here seems as good a place as any just to ask about a central database and a requirement for where an advance care directive can be or should be held. One of the things that was repeatedly raised by the stakeholders that I consulted with was the ease of access to this information, because there are certainly a lot of requirements for reasonable efforts and all of those sorts of things, but there is no central database or central holding of these advance care plans. I am wondering if you could just comment on why there is

the absence of a centralised register and what efforts, if any — and I know the bill does allow for them to be registered on the medical record for residential aged care, but that is obviously quite a subset of the overall population who might be holding out — might be made to help ensure, if an individual has an advance care directive, that medical professionals have access to them.

Ms MIKAKOS (Minister for Families and Children) — Ms Wooldridge, I am advised that people will not be required to place their advance care directives on a central register. This would inhibit people’s ability to amend or revoke their advance care directive and would create an additional administrative burden for people making advance care directives. A central register would also not necessarily make it easier for a health practitioner to access an advance care directive. The register would need to be open 24 hours a day, and privacy concerns would inhibit any rapid release of information.

The bill requires that health services take reasonable steps to ascertain whether a patient has an advance care directive and to place this on the patient’s clinical record under clause 98. This is consistent with the national framework for advance care directives of 2011, which supports including advance care directives in the person’s medical record, as this approach has been shown to be the most reliable way of accessing advance care directives when needed. The framework does not recommend advance care directive registers, noting that the evidence indicates they are not an effective means of ensuring that an advance care directive can be found when needed. The most effective place for an advance care directive to be stored is on a person’s clinical record.

Ms WOOLDRIDGE (Eastern Metropolitan) — Just to explore that a little bit more, what is the evidence? What is that based on? Have there been studies on that? The statements in relation to evidence — where is that from?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that the evidence that I referred to did in fact relate to the *A National Framework for Advance Care Directives*. Further, I am advised that at the end of the framework document there are references to various pieces of research, including international research.

Ms WOOLDRIDGE (Eastern Metropolitan) — Can I also just ask, then, Minister, if there has been any consideration of it being placed onto the My Health Record and in what form?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge, for your question. I am advised the answer is yes. I am further advised that it is already possible for someone to upload their advance care directive onto the My Health Record. In terms of being able to do so in an interactive way online, I am advised that there are discussions occurring with the commonwealth with respect to that.

Clause agreed to.

Clause 17

The DEPUTY PRESIDENT — Order! I believe that Ms Wooldridge and Ms Hartland both have amendments to clause 17. As Ms Hartland’s amendments appeared first in this clause, I will call Ms Hartland to move her amendments 1 to 5, which all relate to a witnessing requirement with respect to home-based palliative care. Ms Hartland’s amendment 1 is a test for her remaining amendments to clause 17.

Ms HARTLAND (Western Metropolitan) — I move:

1. Clause 17, line 27, after “(c)” insert “subject to paragraph (d),”.
2. Clause 17, after line 30 insert—

“(d) in the case of an advance care directive being made by a person receiving home-based palliative care, at least one of the witnesses must be a registered nurse or a registered medical practitioner and must write the qualification of that witness on the document;”.
3. Clause 17, page 23, line 1, omit “(d)” and insert “(e)”.
4. Clause 17, page 23, line 4, omit “(e)” and insert “(f)”.
5. Clause 17, after line 26 insert—

“(4) In this section, *registered nurse* means a person registered in Division 1 of the Register of Nurses kept by the Nursing and Midwifery Board of Australia under the Health Practitioner Regulation National Law, other than as a student.”.

I did speak extensively on this during my speech in the second-reading debate, but just to reclarify, I note that I believe this is a situation that would rarely happen. It is for people in rural areas where the main person they see is their palliative care nurse or district nurse. We are talking about registered nurses being able to be a person who can witness the advance care directive. We think these are fairly simple, fairly straightforward amendments. We are hoping that the house will consider them seriously and vote for the amendments.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland. In indicating to the house that the government will not be supporting Ms Hartland's amendments I do want to give an explanation. The bill requires a medical practitioner to witness advance care directives in all circumstances, including the amendment or revocation of an advance care directive. Given the importance of the witnessing requirement in acting as a safeguard against abuse, it is appropriate, if an advance care directive is being made when a person is in palliative care, that they are being witnessed by those who already understand their role and obligations in witnessing a document.

Witnessing requirements are designed to protect vulnerable people by ensuring that they are freely and voluntarily giving an advance care directive and that they understand what they are doing. A person receiving home-based palliative care is likely to be extremely vulnerable to potential undue influence. Lower requirements for witnessing an advance care directive in emotional and stressful periods for the dying person and their families may create more conflict about the validity of the advance care directive. If a person has capacity while they are receiving palliative care, they should be participating in and formulating their own treatment plan with their health practitioners. A person with capacity can refuse treatment as part of their treatment planning.

Advance care directives should not be confused with a treatment plan. The wishes of the person incorporated into a treatment plan should be followed. It is not clear how receiving home-based palliative care would be defined and when the lower witnessing requirements would take effect. This could cause significant confusion and disputes about the validity of an amendment and whether it was appropriately witnessed.

Ms WOOLDRIDGE (Eastern Metropolitan) — While very sympathetic to the issues that Ms Hartland has put forward, the coalition will not be supporting this amendment. In fact I think it was probably advocacy by the coalition amongst others that narrowed the witnessing requirements, through the amendments that were made in the lower house, to being a registered medical practitioner and excluded otherwise authorised witnesses that the government had originally intended to include in the list. It is our view that it is appropriate that this happens at a medical practitioner level. We supported the amendments in the lower house and believe that while it may be an additional effort or step, given the nature of what is being witnessed through this it is valid and appropriate that that happens with a medical practitioner.

Amendments negated.

The DEPUTY PRESIDENT — Order! I now call on Ms Wooldridge to move her amendment 1, which relates to the certification provided by a registered medical practitioner.

Ms WOOLDRIDGE (Eastern Metropolitan) — I move:

1. Clause 17, page 23, after line 26 insert—

“(4) The registered medical practitioner referred to in subsection (1)(c) must certify on the document that the registered medical practitioner has provided the person giving the advance care directive with professional medical advice sufficient to enable the person to make an informed decision about each statement in the directive.”.

My amendment to clause 17 adds that a registered medical practitioner must certify on the document that the registered medical practitioner has provided the person giving the advance care directive with professional medical advice sufficient to enable the person to make an informed decision about each statement in the directive.

Clause 17(3) already requires that the witness certify on the document at the time of signing that the person giving the advance care directive appears to understand the nature and effect of each statement in the directive, and so this would be a further step. The certification is already happening. The witness — the medical practitioner — will already be writing on that document, and our view is that this adds an extra protection to ensure that a medical practitioner has had that conversation and explored those details. There may be a sense that the medical practitioner is really doing this as a witnessing exercise, and I suppose what this clear and explicit additional subclause would do is make it very clear to that practitioner that this is a professional consultation and that the issues in relation to the content and the substance of the advance care directive need to be engaged and discussed so that they can be confident that an informed decision has been made — hence our support and putting forward of this amendment.

Ms MIKAKOS (Minister for Families and Children) — I wish to indicate to the house that the government is opposing Ms Wooldridge's amendment. I did address this point in my very lengthy summing up earlier, but just to reiterate, this additional witnessing requirement is too onerous and retains medical practitioners' control over medical treatment decision-making at the expense of people's personal autonomy. There are five other jurisdictions in

Australia that give statutory recognition to some form of advance care directive. None of these other jurisdictions requires a doctor to certify that they have provided sufficient advice. Most of them do not even require that the medical practitioner witness the document.

This requirement is likely to discourage doctors from witnessing advance care directives. It creates an unnecessary hurdle to making an advance care directive. Medical practitioners are already required to certify that the person appears to understand the nature and effect of each statement in their advance care directive. If they do not, the medical practitioner could either provide them with advice or not witness the document.

Ms HARTLAND (Western Metropolitan) — I was quite torn by this because I actually understand what Ms Wooldridge is trying to do, but I do actually think it is covered well in other parts of the legislation. I think that it can also be strengthened during that process of where the government will do the practice guidance. So for those reasons the Greens will not be supporting it.

Committee divided on amendment:

Ayes, 19

Atkinson, Mr	O'Donohue, Mr
Bath, Ms (<i>Teller</i>)	Ondarchie, Mr
Bourman, Mr	O'Sullivan, Mr
Carling-Jenkins, Dr	Patten, Ms
Crozier, Ms	Peulich, Mrs
Dalla-Riva, Mr	Ramsay, Mr
Davis, Mr (<i>Teller</i>)	Rich-Phillips, Mr
Finn, Mr	Wooldridge, Ms
Lovell, Ms	Young, Mr
Morris, Mr	

Noes, 19

Barber, Mr	Mulino, Mr
Dalidakis, Mr	Pennicuik, Ms
Dunn, Ms	Pulford, Ms
Eideh, Mr	Purcell, Mr
Elasmar, Mr (<i>Teller</i>)	Shing, Ms (<i>Teller</i>)
Hartland, Ms	Somyurek, Mr
Herbert, Mr	Springle, Ms
Leane, Mr	Symes, Ms
Melhem, Mr	Tierney, Ms
Mikakos, Ms	

Pairs

Fitzherbert, Ms	Jennings, Mr
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Amendment negatived.

Clause agreed to; clause 18 agreed to.

Clause 19

Ms WOOLDRIDGE (Eastern Metropolitan) — I have two questions on clause 19, first of all from Palliative Care Victoria, and this may be evident, but it would be helpful to have it confirmed. Can the minister provide some clear advice on when an advance care directive is valid and when it is activated and whether that will be made clear in the instructions on the website and so on?

Ms MIKAKOS (Minister for Families and Children) — Ms Wooldridge, I am advised that in terms of your question the advance care directive will be valid from the time it is made, assuming all the necessary requirements have been met. In terms of when it will be activated, it will be activated at any time that a medical treatment decision needs to be made and the person does not have the capacity to make the decision.

Ms WOOLDRIDGE (Eastern Metropolitan) — So effectively when a medical practitioner determines that someone does not have capacity, it is then considered to be in operation?

Ms MIKAKOS (Minister for Families and Children) — Yes. A health practitioner obviously must have consent. If there is no capacity to provide that consent, then the health practitioner would be turning to the advance care directive.

Ms WOOLDRIDGE (Eastern Metropolitan) — Also just a further clarification of whether time limits on the duration of advance care directives were considered and how it is thought that these will be kept timely?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that a statutory requirement to review advance care directives would mean that a person's otherwise valid advance care directive could become invalid for no other reason than that they have not reviewed it. This is particularly problematic for people who suffer gradual cognitive decline. This decline may occur over a period of 10 years. They may create an advance care directive at the start of this period, and after 5 years they may no longer have capacity to review their directive. If there were a statutory requirement to review the directive after five years, their directive would be invalid even though it still reflected their preferences and values, and there would be nothing they could do about it.

Existing advance care planning programs in Victoria encourage people to regularly review their advance care plans with their family and health practitioners. The bill

also includes a safeguard at clause 51, which provides that if circumstances have changed so that giving effect to an advance care directive would no longer be consistent with a person's preferences and values, a health practitioner may refuse to comply with the instructional directive.

Clause agreed to.

Clause 20

Ms WOOLDRIDGE (Eastern Metropolitan) — I believe that still the process for revoking or amending is a little confused and unclear — for example, clause 20(1) says:

- (1) An advance care directive may be amended or revoked by complying with the requirements of this Part for the giving of an advance care directive, with any necessary modification.

I am wondering if in some plain English, for the purposes of understanding the bill, you could outline simply how that revocation process or amendment process will occur?

Ms MIKAKOS (Minister for Families and Children) — Essentially, people changing their mind, Ms Wooldridge — is that what you are getting at? If a person changes their mind after they have made their advance care directive, the advice I have is that, given the formal requirements for making an advance care directive, it is not anticipated that a person will make an advance care directive lightly and without thinking through their decisions. If a person with decision-making capacity does change their mind, they may amend or revoke their advance care directive at any time.

There is also a safeguard in the bill that allows VCAT to order that an instructional directive does not apply if circumstances have changed and applying the instructional directive would not be consistent with the person's preferences and values. This may occur, for example, because medical technology has developed or a person's prognosis has changed significantly in an unexpected way. If the time spent applying to VCAT would result in significant deterioration of the person's condition, a health practitioner may refuse to comply with an instructional directive without applying to VCAT under clauses 23 and 51.

Business interrupted pursuant to sessional orders.

Sitting extended pursuant to standing orders.

Sitting suspended 6.31 p.m. until 6.54 p.m.

Ms WOOLDRIDGE (Eastern Metropolitan) — Thank you, Deputy President, for the opportunity to have a quick break. My question in relation to this is: is there a scenario where things can be altered orally? This is a question from the AMA. It is a genuine question that someone may be in a state in and out of consciousness and may be making some calls at that point in time that may vary from what they have written in an advance care directive, so is there an oral override in such situations?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that clause 20 provides that a person must comply with the formal requirements in the bill to vary or revoke their advance care directive. These formal requirements, such as witnessing, provide important safeguards for vulnerable people. Removing the witnessing requirements for varying or revoking an advance care directive would leave people extremely vulnerable to elder abuse and potentially create confusion and conflict between family members about the validity of an advance care plan. Clause 51 provides an important safeguard that allows a health practitioner not to comply with an instructional directive if circumstances have changed and the practical effect of an advance care directive would no longer be consistent with a person's preferences and values.

If a person has capacity to make a decision about altering an advance care directive, they have capacity to be participating in and formulating their own treatment plan with their health practitioners. A person with capacity can consent to or refuse treatment as part of their treatment planning. Applying an advance care directive in these circumstances is not necessary.

Clause agreed to; clause 21 agreed to.

Clause 22

Ms WOOLDRIDGE (Eastern Metropolitan) — I move:

- 2. Clause 22, lines 23 to 30, omit all the words and expressions on these lines and insert—
 - “(c) whether a statement in an advance care directive should be applicable because the practical effect of the statement would not be consistent with the preferences and values of the person who gave the directive because at least one of the following applies—
 - (i) circumstances have changed since the advance care directive was given;

- (ii) when the person gave the advance care directive, the person did not foresee circumstances that have later arisen;
- (iii) when the person gave the advance care directive, the person relied on incorrect information or made an incorrect assumption;”.

This amendment seeks to allow a VCAT review to be sought where a person who gave a directive relied on incorrect information or made incorrect assumptions or did not foresee the circumstances that have arisen. At present VCAT can consider whether a person relied on incorrect information or made incorrect assumptions for the purposes of deciding whether to revoke, vary or suspend an instructional directive. However, this is not grounds for someone to apply to VCAT in the first place, because it does not come under any of the matters listed in clause 22(1)(a), (b) or (c).

It has been argued that such a provision is unnecessary because, if a person relied on incorrect information or made incorrect assumptions, they would not have met the requirements of clause 13 that they understand the nature and effect of their directives, and thus an ACD would be invalid, which is the grounds on which an order can already be sought from VCAT under clause 22(1). However, we believe that this argument is incorrect. A person can still understand the nature and effect of a directive, and thus their ACD is valid even though they decided to give this directive because of incorrect information or assumptions.

There is a further issue that although an application for an order can be made as to whether circumstances have changed since the advance care directive was made, this does not apply to questions of whether the ACD maker did not foresee or anticipate the circumstances that have arisen. We suggest that the proposed wording makes it clear in each instance that the issue must be such that the practical effect of the statement would not be consistent with the person’s preference or values. This should overcome any concern that may have been held that adding these new grounds could undermine giving effect to a person’s preference or values.

Ms MIKAKOS (Minister for Families and Children) — I indicate to the house that the government will not be supporting Ms Wooldridge’s amendment. In our view this is an attempt to undermine personal autonomy by giving doctors as much power as possible to override a person’s preference and values. The bill recognises that if circumstances have changed and the application of the person’s advance care directive would not be consistent with the person’s preference and values, the directive does not need to be followed.

The second suggested exception does not appear to add anything.

The third suggested exception is misconstrued. The bill requires a person to understand the nature and effect of each statement in their advance care directive. If the directive is based on incorrect information or made on an incorrect assumption, it would not be valid. VCAT may already make orders in relation to the validity of an advance care directive. It is also not clear how a treating health practitioner would be expected to know whether the directive was based on incorrect information or assumptions at the time that treatment is required. This would mean it would simply create uncertainty and provide opportunities for doctors to override a person’s advance care directive. If an advance care directive is validly made and witnessed by a medical practitioner, when the time comes to apply it the health practitioner should feel comfortable following the directive.

Ms HARTLAND (Western Metropolitan) — The Greens will not be supporting this amendment.

Committee divided on amendment:

Ayes, 18

- | | |
|---------------------|----------------------------------|
| Atkinson, Mr | Morris, Mr |
| Bath, Ms | O’Donohue, Mr |
| Bourman, Mr | Ondarchie, Mr |
| Carling-Jenkins, Dr | O’Sullivan, Mr (<i>Teller</i>) |
| Crozier, Ms | Peulich, Mrs |
| Dalla-Riva, Mr | Ramsay, Mr |
| Davis, Mr | Rich-Phillips, Mr |
| Finn, Mr | Wooldridge, Ms |
| Lovell, Ms | Young, Mr (<i>Teller</i>) |

Noes, 20

- | | |
|------------------------------|--------------------------------|
| Barber, Mr (<i>Teller</i>) | Mulino, Mr |
| Dalidakis, Mr | Patten, Ms |
| Dunn, Ms | Pennicuik, Ms |
| Eideh, Mr | Pulford, Ms |
| Elasmar, Mr | Purcell, Mr |
| Hartland, Ms | Shing, Ms |
| Herbert, Mr | Somyurek, Mr (<i>Teller</i>) |
| Leane, Mr | Springle, Ms |
| Melhem, Mr | Symes, Ms |
| Mikakos, Ms | Tierney, Ms |

Pairs

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| Fitzherbert, Ms | Jennings, Mr |
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Amendment negatived.

Ms HARTLAND (Western Metropolitan) — In terms of an application to VCAT by a family member who wants to challenge an advance care directive, what happens in the interim in respect of the provision of treatment? Does the treatment accord with the advance care directive? Is it suspended or does it continue?

Ms MIKAKOS (Minister for Families and Children) — I am advised that if an advance care directive is challenged at VCAT, this will be a matter for VCAT to determine. VCAT already faces these situations in relation to disputes about refusals of treatment or withdrawing consent. It would not be appropriate to provide a blanket position about what should occur in every circumstance. Instead VCAT can make a determination based on the individual facts of the case. VCAT may also make interim orders about matters before the tribunal.

Ms HARTLAND (Western Metropolitan) — It is my understanding that VCAT can also do bedside hearings and they can do very rapid turnaround, so the amount of time could be a matter of a half a day or a day. Am I correct in my understanding?

Ms MIKAKOS (Minister for Families and Children) — I am advised the answer is yes.

Clause agreed to.

Clause 23

Ms WOOLDRIDGE (Eastern Metropolitan) — I move:

3. Clause 23, lines 11 to 21, omit all the words and expressions on these lines and insert—
 - “(b) the practical effect of the instructional directive would no longer be consistent with the preference and values of the person who gave it because at least one of the following applies—
 - (i) circumstances have changed since the advance care directive was given;
 - (ii) when the person gave the advance care directive, the person did not foresee circumstances that have later arisen;
 - (iii) when the person gave the advance care directive, the person relied on incorrect information or made an incorrect assumption.”.

In the context of VCAT it appears that the government rightly intends that if a person does not understand the nature and effect of a statement in an advance care directive or does not have decision-making capacity, that will render the statement or advance care directive invalid because clause 13(a)(ii) has not been fulfilled. However, because clause 23 does not give VCAT a power to make an order declaring that a directive is invalid for one of those reasons, VCAT can only declare that an advance care directive is invalid under clause 22(2)(b)(i) on the ground of a failure to comply with a requirement of the relevant part of the bill.

However, clause 13 makes it clear that complying with a requirement of the relevant part of the bill is something separate to not having capacity or understanding. We seek to move this amendment to allow for that clarification that they can declare an advance care directive invalid.

Ms MIKAKOS (Minister for Families and Children) — I wish to indicate that the government will be opposing Ms Wooldridge’s amendment. I will not go into it in detail again, suffice it to say that it is for the same reasons as I outlined in relation to the previous amendment moved by Ms Wooldridge.

Ms HARTLAND (Western Metropolitan) — The Greens will not be supporting this amendment.

Committee divided on amendment:

Ayes, 18

- | | |
|---------------------|---------------------------------|
| Atkinson, Mr | Morris, Mr |
| Bath, Ms | O’Donohue, Mr (<i>Teller</i>) |
| Bourman, Mr | Ondarchie, Mr (<i>Teller</i>) |
| Carling-Jenkins, Dr | O’Sullivan, Mr |
| Crozier, Ms | Peulich, Mrs |
| Dalla-Riva, Mr | Ramsay, Mr |
| Davis, Mr | Rich-Phillips, Mr |
| Finn, Mr | Wooldridge, Ms |
| Lovell, Ms | Young, Mr |

Noes, 20

- | | |
|-----------------------------|------------------------------|
| Barber, Mr | Mulino, Mr |
| Dalidakis, Mr | Patten, Ms (<i>Teller</i>) |
| Dunn, Ms | Pennicuik, Ms |
| Eideh, Mr | Pulford, Ms |
| Elasmar, Mr | Purcell, Mr |
| Hartland, Ms | Shing, Ms |
| Herbert, Mr | Somyurek, Mr |
| Leane, Mr (<i>Teller</i>) | Springle, Ms |
| Melhem, Mr | Symes, Ms |
| Mikakos, Ms | Tierney, Ms |

Pairs

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| Fitzherbert, Ms | Jennings, Mr |
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Amendment negated.

Clause agreed to; clause 24 agreed to.

Clause 25

Ms WOOLDRIDGE (Eastern Metropolitan) — This is, once again, something I raised over the course of my contribution in relation to some issues raised by both the AMA and the Royal Australasian College of Physicians — that is, how it will be practically feasible to incorporate consent for medical research procedures into an advance care directive before a study has been planned and approved.

Ms MIKAKOS (Minister for Families and Children) — I can advise Ms Wooldridge that it would be the same as providing consent to medical treatment. If a person had provided consent to particular research and there was not sufficient particularity at the time, then obviously appropriate consent would not have been provided. The person would then be effectively providing a values directive. This is intended to capture longitudinal medical research that might apply, for example, in Alzheimer's research where the patient clearly understands that they are doing this with the intention of providing benefit to others as well. That is why this is captured in the bill.

Clause agreed to.

Clause 26

Ms WOOLDRIDGE (Eastern Metropolitan) — My question for the minister is: clause 26 appears to allow a treating medical practitioner to be appointed as a medical treatment decision-maker, which would seem to give rise to conflicts of interest. Can you clarify if that would be allowed under this legislation?

Ms MIKAKOS (Minister for Families and Children) — Sorry, if what would be allowed?

Ms WOOLDRIDGE (Eastern Metropolitan) — That a treating medical practitioner could also be appointed as the medical treatment decision-maker.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge, for your question. I am advised that whilst there is nothing in the bill expressly prohibiting this, it would in fact be a breach of a medical professional's professional obligations to accept this dual role.

Clause agreed to; clauses 27 to 30 agreed to.

Clause 31

Ms WOOLDRIDGE (Eastern Metropolitan) — Essentially the question is: why has the number of support persons been limited to one? Both Palliative Care Victoria and the AMA have raised the issue that it would be valuable to have potentially more than one support person, so I would like to understand the logic on that. The Victorian Council of Social Service has also raised the issue about what education will be provided to support people to be able to be effective in their role, so I will wind those two questions into one.

Ms MIKAKOS (Minister for Families and Children) — I am advised that it is important to recognise that the role of a formally appointed support

person does not prevent others from providing support. One of the key legal effects of the appointment of a support person is that they will have automatic access to medical records. For the sake of hospitals and clarity about a patient's privacy, it was necessary to limit the appointment to one person. It would create significant privacy risks to give too many people access to a patient's records. I am further advised that a support person acts at a time when the person has capacity; if the support person is not available, they may appoint another person. In relation to the issue of education, obviously this will be taken up in the implementation stage in terms of the educational resources that will be produced to educate and inform the community around these legislative changes.

Clause agreed to; clauses 32 to 49 agreed to.

Clause 50

Ms WOOLDRIDGE (Eastern Metropolitan) — Clause 50 requires that a health practitioner must make reasonable efforts in the circumstances to ascertain if the person has either or both an advance care directive or a medical treatment decision-maker. I am wondering if you can outline what constitutes reasonable efforts?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that a health practitioner must obtain consent before providing treatment to a person without capacity. Regardless of specific requirements in the bill, a health practitioner would be expected to make efforts to locate someone to consent to treatment.

The requirement in the bill acknowledges that what constitutes a reasonable effort will depend on the circumstances. This includes the urgency and severity of the treatment and the amount of information the health practitioner has about a patient. Depending on the circumstances it may be reasonable for a health practitioner to check a patient's medical record, ask any family or friends present at the hospital, contact the medical treatment decision-maker, contact a next of kin or emergency contact on the patient's medical record, contact the person's GP or contact any residential care facility or other health facility the person may have attended. These processes are not onerous and would occur as part of good clinical practice.

At the time of appointment a medical treatment decision-maker must certify that they have seen and understood a person's advance care directive. A health facility is also required to place an advance care directive on a person's medical record. It is recognised that this may mean that there will be circumstances in

which an advance care directive is not located; however, some responsibility must be placed on the person who gave the advance care directive to make it known to their health practitioners and their medical treatment decision-maker.

Ms WOOLDRIDGE (Eastern Metropolitan) — Can I just clarify then what is reasonable effort in emergency situations? A scenario might be a paramedic arrives at a beach where someone has come close to drowning. I am just trying to make it real, I suppose. What would they be required to do before they started potential resuscitation activities?

Ms MIKAKOS (Minister for Families and Children) — We can go through many hypotheticals, but in the case of any emergency where there is not enough time to look for an advance care directive or get consent, the advice that I have is that currently medical treatment can be administered without consent in an emergency if it is reasonably necessary to save a person's life, prevent serious damage to the person's health or prevent the person from suffering or continuing to suffer significant pain or distress, and this will not change under the bill. The bill does, however, provide that if a health practitioner is aware of an instruction or directive refusing treatment, the health practitioner cannot provide emergency treatment contrary to this refusal. This will not require a practitioner to look for an advance care directive that is not readily available but does mean that a health practitioner cannot act contrary to an instruction or directive just because it is an emergency under the terms of clause 53. I guess the qualification that I have made there is more relevant to a medical environment rather than a beach situation, but as I said at the outset, there is no change under the bill in relation to medical treatment being administered without consent in that kind of an emergency scenario.

Ms WOOLDRIDGE (Eastern Metropolitan) — Can I try one more scenario just to play this out? There is a drowning victim on the beach. A partner or friend or child is there, and they say, 'I think Mum's got one; I don't know what it says', so there is information that it exists. Is there a requirement to then try to understand what it contains, or once again in that emergency situation can treatment be given even though the existence but not the contents of an advance care directive is known?

Ms MIKAKOS (Minister for Families and Children) — I am advised that in that scenario of someone being at the beach, obviously this would not be a relevant requirement in the circumstances; they

would not have the ability to be searching for an advance care directive.

Ms WOOLDRIDGE (Eastern Metropolitan) — Further on clause 50 but on a different topic, the AMA, as I raised in my contribution, have been quite concerned about what they are calling a reverse onus of proof, with automatic determination of contraventions being unprofessional conduct rather than that being an allegation to be investigated — so it is, as they have described it, 'guilty until proven innocent', as opposed to 'innocent until proven guilty'. This is relevant not only to clause 50 but also 60 and 73, where there are penalties in place. Can the minister explain why the onus has been drafted in this way in terms of it being unprofessional conduct rather than it being a trigger for investigation?

Ms MIKAKOS (Minister for Families and Children) — I am advised that the provisions listed do not reverse the onus of proof. The provisions clearly state that it will be unprofessional conduct if a health practitioner contravenes subclause (1). A contravention would still need to be proven for a finding of unprofessional conduct. In order to reverse an onus of proof there must be a clear legislative intent. The bill does not do this; it specifies what will constitute a contravention once this contravention is found. This provision replicates section 36(5) of the South Australian Advance Care Directives Act 2013.

Ms HARTLAND (Western Metropolitan) — I have one final question, and that is around the issue of professional misconduct. Can the minister outline what the consequences are for a doctor who does not comply with an advance care directive or does not consult with the medical decision-maker?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Hartland. I am advised that if a health practitioner is accused of unprofessional conduct, a notification is made to the relevant board. The health practitioner's conduct will then be assessed to determine whether they have indeed failed to comply with an advance care directive or obtain a decision from a medical treatment decision-maker. If a health practitioner is found to have contravened the bill and committed unprofessional conduct, there are a range of options open to the board, and this will depend on the circumstances of the case. For minor issues the practitioner may be required to undertake further training, for example. For very serious cases the practitioner may be deregistered. In consultation with key stakeholders it was recognised that this was a more appropriate response than the criminal offence currently in the Medical Treatment Act 1988. The criminal

offence fails to account for the range of different circumstances that may apply and offers no opportunity for professional learning.

Clause agreed to.

Business interrupted pursuant to standing orders.

Sitting extended pursuant to standing orders.

Heading to clause 51

The DEPUTY PRESIDENT — Order! I call on Ms Wooldridge to move her amendment 4, which proposes to insert additional words in the heading of clause 51. I consider this a test for Ms Wooldridge’s further amendments 5, 6 and 7.

Ms WOOLDRIDGE (Eastern Metropolitan) — I move:

4. Heading to clause 51, after “**directive**” insert “**or a medical treatment decision maker’s decision**”.

In doing this, because it is a test for amendments 5, 6 and 7, I would just like to speak to the content of them at the same time. The first amendment adds grounds for departing from an advance care directive where circumstances were not foreseen or an advance care directive is based on incorrect information and assumptions. Clause 51 rightly allows for a practitioner to not follow an advance care directive where circumstances have changed so that an advance care directive is no longer consistent with the person’s values and there is not time to take the matter to VCAT.

The clause should allow a practitioner to also depart from an advance care directive where there is not time to take the matter to VCAT and a practitioner reasonably suspects the person would not have foreseen or anticipated the circumstances that have actually arisen, or that the person gave the directive relying on incorrect information or making incorrect assumptions. Not foreseeing circumstances is different from circumstances having changed. It is equally important to cover both. Relying on incorrect information or making incorrect assumptions is already a situation in which VCAT can vary a directive under clause 23(b), so it is logical for a practitioner to be able to depart from a directive on those grounds where there is not time to take the matter to VCAT.

The further amendments seek to allow a practitioner to continue to treat despite a refusal to consent by a medical treatment decision-maker where delay would cause serious deterioration until that matter can be resolved by the public advocate or VCAT. So even when a practitioner notifies the public advocate under

clause 62 of a concerning decision by a medical treatment decision-maker or commences an action at VCAT about it under clause 65, the refusal of consent by a medical treatment decision-maker continues to bind the practitioner. Although a practitioner can treat without consent in an emergency, it is not clear whether or when an ongoing deterioration in a patient would constitute an emergency. A provision should be included to put beyond doubt that a practitioner may continue to treat a patient if not treating may result in significant deterioration in a person’s condition.

Ms MIKAKOS (Minister for Families and Children) — I wish to indicate to the chamber that the government will be opposing Ms Wooldridge’s amendments 4, 5, 6 and 7 as they seek to amend clause 51. I am advised that these proposed amendments demonstrate a fundamental misunderstanding about one of the key purposes of the bill. The bill aims to ensure that people receive medical treatment that is consistent with their preferences and values. These amendments provide opportunities to override a person’s preferences and values. The Medical Treatment Act 1988 does not currently allow a medical practitioner to unilaterally override a valid refusal of treatment by a substitute decision-maker. There is no reason to add this, and doing so would be a step backwards in best interest decision-making. VCAT already considers disputes about refusals of treatment and will continue to do so under the bill. VCAT may also make interim orders about whether or not treatment should proceed while they are making a final determination. This decision can be made based on the facts, and simply allowing health practitioners to provide treatment is not appropriate and is unnecessarily broad.

I am further advised that the proposed subclause (2)(a)(ii) is also unworkable. A health practitioner cannot be expected to determine what VCAT is likely to make an order about.

Ms HARTLAND (Western Metropolitan) — The Greens will not be supporting these amendments.

Committee divided on amendment:

Ayes, 18

Atkinson, Mr	Morris, Mr
Bath, Ms	O’Donohue, Mr
Bourman, Mr	Ondarchie, Mr
Carling-Jenkins, Dr	O’Sullivan, Mr
Crozier, Ms (<i>Teller</i>)	Peulich, Mrs
Dalla-Riva, Mr	Ramsay, Mr
Davis, Mr	Rich-Phillips, Mr
Finn, Mr (<i>Teller</i>)	Wooldridge, Ms
Lovell, Ms	Young, Mr

Noes, 20

Barber, Mr	Mulino, Mr
Dalidakis, Mr	Patten, Ms
Dunn, Ms	Pennicuik, Ms (<i>Teller</i>)
Eideh, Mr	Pulford, Ms (<i>Teller</i>)
Elasmar, Mr	Purcell, Mr
Hartland, Ms	Shing, Ms
Herbert, Mr	Somyurek, Mr
Leane, Mr	Springle, Ms
Melhem, Mr	Symes, Ms
Mikakos, Ms	Tierney, Ms

Pairs

Fitzherbert, Ms	Jennings, Mr
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Amendment negatived.

Heading to clause 51 agreed to; clause 51 agreed to.

Clause 52

Ms MIKAKOS (Minister for Families and Children) — I move:

2. Clause 52, page 42, after line 16 insert—

“Note

An instructional directive that is voided and severed from an advance care directive by section 18 is not part of that advance care directive.”.

In moving amendment 2 standing in my name I just wish to explain to the house that what this amendment seeks to do is add a note under clause 52 clearly linking the provisions in clause 18 with clause 52. This note has been added to address concerns that it is not immediately clear that the protections for health practitioners in clause 52 exclude unlawful acts, including euthanasia. Clause 52 provides that health practitioners will not face criminal or civil liability if they act in good faith and without negligence in accordance with an advance care directive or what they relied upon in good faith as an advance care directive. Clause 18 provides that a statement that would require an unlawful act is void and severed from an advance care directive. This amendment will clarify that a health practitioner is not protected if they commit an unlawful act in accordance with a purported statement in an advance care directive.

Ms WOOLDRIDGE (Eastern Metropolitan) — The coalition will be supporting this amendment. This was another issue on which we raised concerns with the government. We think this does make a step. I have a further amendment that we think actually clarifies the situation further, but we will be supporting this amendment.

Ms HARTLAND (Western Metropolitan) — The Greens will be supporting this amendment.

Amendment agreed to.

Ms WOOLDRIDGE (Eastern Metropolitan) — I move:

8. Clause 52, line 31, omit “A” and insert “Subject to subsection (4), a”.
9. Clause 52, page 42, after line 16 insert—

“(4) Nothing in subsection (2) prevents a health practitioner administering medical treatment to a person if the health practitioner believes on reasonable grounds that the person has attempted to commit suicide.”.

As I just mentioned in the earlier consideration of the government’s amendment on clause 52, it is the coalition’s view that, while this note assists, it does not make it explicitly clear, and hence we are moving amendments 8 and 9 in my name, which make it very clear, as the wording of amendment 9 says, that a health practitioner can administer medical treatment — it is not a requirement to provide it, but the option is there to provide it — to a person if the health practitioner believes on reasonable grounds that a person has attempted to commit suicide.

This is obviously a very difficult and concerning situation, and we believe that it is appropriate beyond any reasonable doubt that a medical practitioner can administer life-saving treatment in these circumstances so that things like a suicide note are not seen as a refusal of treatment in the circumstances. We think this is an important addition that does not change the intent but makes very clear the capacity to administer medical treatment in those very difficult and concerning circumstances.

Ms MIKAKOS (Minister for Families and Children) — I wish to advise the committee that the government will be opposing amendments 8 and 9 moved by Ms Wooldridge. Our view is that this provision is unnecessary. Despite what was said in the other place, a suicide note will not constitute a valid refusal of treatment. Clause 53 of the bill allows a health practitioner to provide medical treatment in an emergency to save a person’s life without consent. Given the person will not have validly refused the treatment, a health practitioner will be able to provide treatment. Section 463B of the Crimes Act 1958 already provides that every person is justified to use reasonable force necessary to prevent suicide.

Committee divided on amendments:

Ayes, 18

Atkinson, Mr	Morris, Mr
Bath, Ms	O'Donohue, Mr
Bourman, Mr	Ondarchie, Mr
Carling-Jenkins, Dr (<i>Teller</i>)	O'Sullivan, Mr
Crozier, Ms	Peulich, Mrs
Dalla-Riva, Mr	Ramsay, Mr (<i>Teller</i>)
Davis, Mr	Rich-Phillips, Mr
Finn, Mr	Wooldridge, Ms
Lovell, Ms	Young, Mr

Noes, 20

Barber, Mr	Mulino, Mr
Dalidakis, Mr	Patten, Ms
Dunn, Ms (<i>Teller</i>)	Pennicuik, Ms
Eideh, Mr	Pulford, Ms
Elasmar, Mr	Purcell, Mr
Hartland, Ms	Shing, Ms
Herbert, Mr	Somyurek, Mr
Leane, Mr	Springle, Ms
Melhem, Mr (<i>Teller</i>)	Symes, Ms
Mikakos, Ms	Tierney, Ms

Pairs

Fitzherbert, Ms	Jennings, Mr
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Amendments negated.

Amended clause agreed to.

Clause 53

Ms MIKAKOS (Minister for Families and Children) — I move:

- Clause 53, page 43, line 6, omit "otherwise" and insert "a legally valid and informed refusal of treatment by or under another form of informed consent".

This is my final amendment. Concerns have been raised that the emergency treatment provisions in clause 53 as currently worded would prevent a health practitioner from providing life-saving medical treatment to a person who attempted suicide and had left a note saying they refused medical treatment. These concerns arose because clause 53(2) provides that a health practitioner cannot provide emergency treatment if that particular treatment had been refused through an instructional directive 'or otherwise'. This third amendment clarifies this issue by removing the word 'otherwise' and instead specifically referring to an instructional directive or a valid legal refusal of treatment.

This change will more clearly demonstrate that the bill does not intend to lower the requirements for a lawful refusal of treatment while still recognising that an instructional directive is only one way a person can legally refuse treatment. For example, a person may choose to refuse treatment prior to a surgical procedure

if certain adverse outcomes occurred while they were still sedated. They should continue to be able to do this with their surgeon prior to surgery without having to create an advance care directive. A person should not be required to complete an advance care directive for immediate treatment when they are fully informed and have capacity to make decisions relating to the medical treatment and what outcomes are acceptable to them. This amendment will not alter the policy or legal effect of the bill but will clarify the application of these provisions and address stakeholder concerns.

Ms WOOLDRIDGE (Eastern Metropolitan) — The coalition will be supporting this amendment. This was another issue that I am pleased we were able to raise with the government. The use of the words 'or otherwise' left it very broad and without clarity, and we have been able to come to a position where that can be clarified so that it is very clear when a health practitioner is not permitted to administer medical treatment or a medical research procedure. So we will be supporting this amendment.

Ms HARTLAND (Western Metropolitan) — The Greens will also be supporting this amendment.

Amendment agreed to; amended clause agreed to; clauses 54 to 57 agreed to.

Clause 58

Ms WOOLDRIDGE (Eastern Metropolitan) — I am just seeking some clarification from the minister because, as currently worded, clause 58 is confusing as it requires that a decision must always be obtained or ascertained before a person can be treated. However, some parts of the bill rightly allow treatment without a separate decision — for example, in an emergency situation. As worded, clause 58 could imply that consent must always be obtained, which would contradict those other provisions and may make practitioners reluctant to treat even when the bill expects the practitioner to provide treatment. Can the minister clarify the relationship of clause 58 to other circumstances where a decision does not have to be obtained?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I refer Ms Wooldridge to the language in the clause and specifically subclause (1) that refers to:

... medical treatment to which this Division applies ...

I am advised that the provisions that relate to emergency situations are set out in the previous division of the bill and therefore are not captured by this

division. In other words, clause 58 clearly does cover the circumstances in which consent would be required.

Clause agreed to; clauses 59 and 60 agreed to.

Clause 61

Ms WOOLDRIDGE (Eastern Metropolitan) — I have a question from the cancer council about whether it will be mandatory for health practitioners to notify the public advocate if a medical treatment decision-maker refuses significant treatment against the known preferences and values of the patient. It is not necessarily clear or explicit, so could we have some clarification on that?

Ms MIKAKOS (Minister for Families and Children) — Again I am being reminded that many hours ago now, in the summing up, I did actually refer to this issue. It has been suggested that additional mandatory notification to the public advocate or application to VCAT be included in the bill when a medical treatment decision-maker is acting contrary to the person's preferences and values. The advice that I have is that the most effective and efficient way to resolve disputes is locally at the health service level. Health services already have dispute resolution processes and resolve the vast majority of disputes effectively. Requiring notification or applications to VCAT would significantly slow this process down and may create unnecessary obstacles. The bill will allow VCAT to remove a medical treatment decision-maker who is acting contrary to a person's preferences and values, and VCAT may appoint a guardian under the Guardianship and Administration Act 1986 if they believe this is a necessary step.

Clause agreed to; clauses 62 to 66 agreed to.

Clause 67

Ms WOOLDRIDGE (Eastern Metropolitan) — The issue is about the timeliness of decision-making. This clause in the bill allows the public advocate up to 14 days after receiving notification to apply to VCAT for a review of that decision, and then there is no guarantee on the time at VCAT. I am wondering if you can just provide some advice on what the funding that you told us a number of hours ago was going to the public advocate will enable — and even 14 days is a long period of time to sit with the public advocate — and what sort of time lines we would be expecting and whether that funding will allow that to be expedited.

Secondly, do you have any expectation of time lines for VCAT to actually be able to then consider the case?

There is obviously the gap between something being referred and something being assessed by VCAT, and obviously that can have some ramifications in terms of treatment and the health and wellbeing of the person in question.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that the Office of the Public Advocate (OPA) need the 14-day maximum for very complex cases where collecting sufficient information is required in order to make the best possible decision. The OPA have advised that these types of time frames are rare, but the 14-day time limit is needed in the case of very complex cases. That is of course an outer limit, and the bill does require these decisions to be reached as soon as possible.

Ms WOOLDRIDGE (Eastern Metropolitan) — In regard to VCAT, then — sorry, I may have blanked on the end of that — what is your expectation in terms of VCAT? I know that you said that the funding for VCAT to be able to support these processes was still under discussion, but what is a reasonable expectation of a time frame for a referral from the public advocate to VCAT and for that matter to be considered by VCAT?

Ms MIKAKOS (Minister for Families and Children) — I am advised that in terms of time lines for VCAT the range is expected to be between 12 hours and 14 days — 14 days being again the upper limit. As I explained to Ms Hartland earlier, there is the capacity for VCAT to do bedside hearings to expedite matters. In addition to that, VCAT could obviously still make interim orders in these matters as well.

Ms WOOLDRIDGE (Eastern Metropolitan) — I am just wondering: in the context of referrals to the public advocate and in calculating the \$500 000 per annum additional funding, do you have an estimate or a rough idea of an approximate number of cases per year that the public advocate may be dealing with as a result of this legislation?

Ms MIKAKOS (Minister for Families and Children) — I can advise Ms Wooldridge that the funding I referred to earlier was based on the OPA's request for funding. It was not based on a projected number of cases as such through each year. I can advise the member further that the OPA will be developing a dedicated response to assist health services with these matters, but the additional funding resources that were provided were based on the OPA's advice to the department around additional salary requirements.

Ms WOOLDRIDGE (Eastern Metropolitan) — So is there no estimate of a rough number of additional cases that the OPA might be dealing with as a result of the bill?

Ms MIKAKOS (Minister for Families and Children) — None that I can provide you with.

Clause agreed to; clauses 68 and 69 agreed to.

Clause 70

Ms WOOLDRIDGE (Eastern Metropolitan) — I am interested to get some advice from the minister in relation to the advisory opinion and whether a health practitioner or a medical treatment decision-maker will be able to apply to VCAT for an advisory opinion on an advance care directive or on a treatment decision. That is what it relates to. Just what value does an advisory opinion have? Does it have any status or standing? Why is this a useful mechanism?

Ms MIKAKOS (Minister for Families and Children) — I am advised that an advisory opinion is not legally binding. It is not a final or binding determination of the tribunal; its purpose is to guide the parties. The advantage is that an advisory opinion can be provided by the tribunal in the absence of a dispute between the parties.

Clause agreed to; clauses 71 to 94 agreed to.

Clause 95

Ms WOOLDRIDGE (Eastern Metropolitan) — These are questions raised by Palliative Care Victoria and the cancer council relating to interstate advance care directives. I am seeking some assurance that a valid interstate advance care directive is only recognised as a value directive and not an instructional directive. This is clear in clause 12 but not necessarily in clause 95, which is where we are considering it here and whether and how those two clauses compete.

I will also raise a separate question in the interests of the question and answer process. Will an advance care directive prepared in another country be considered as a values directive in Victoria?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge, for your question. In relation to interstate care directives, I can advise you that they would be value-based directives rather than instructional directives.

In relation to the overseas-based ones that you referred to, they are outside of the scope of the legislation in

terms of our statutory interpretation act requirements in Victoria, but we would expect that a medical practitioner would have regard to such an overseas-based statement. But it obviously would not be legally binding under the provisions of this act.

Clause agreed to; clauses 96 to 105 agreed to.

Clause 106

Ms WOOLDRIDGE (Eastern Metropolitan) — We are nearly through it, which is good news; it has been quite a long but, I think, productive process.

Clause 106 is the commencement of the amendment to the Mental Health Act 2014. A number of organisations have raised some concern about the interaction between the Mental Health Act and this bill, so my question is particularly for mental health practitioners and people with mental illness and their families. Could you articulate specifically for that group what education and information will be put in place so it can be clearly communicated, the relationship between the two bills?

Ms MIKAKOS (Minister for Families and Children) — I thank Ms Wooldridge. I do not propose to go into a big explanation about this part of the bill unless the member has specific questions about the whole scope of it, but clearly the bill is introducing some additional safeguards for the use of electroconvulsive therapy (ECT) and makes consequential amendments to the Mental Health Act 2014 to recognise the bill.

But specifically in regard to the question that Ms Wooldridge has posed to me, the commencement date, as we have addressed, is expected to be 12 March 2018. Extensive work will be undertaken subsequent to the bill's passage to provide appropriate materials and education.

The department is working closely with the OPA to develop an implementation and communication plan to prepare stakeholders for the commencement of the bill. This will include the development of a range of information and educational material to support the community, consumers and providers to understand their rights and obligations under the bill.

Information about the rights of people to receive second opinions and expert assessments and the right to apply to VCAT as a person with a special interest to challenge a decision made by a health practitioner or a medical treatment decision-maker will form part of the communication plan. Obviously the communication material that will be developed specifically relates to

the changes to this part of the bill and the changes relating to the Mental Health Act 2014.

Clause agreed to; clauses 107 to 109 agreed to.

Clause 110

Ms WOOLDRIDGE (Eastern Metropolitan) — I have two questions in relation to this clause. They are both points of clarification really, sought by, once again, different groups. Firstly, is it actually the case, just for clarification, that the opinion of the medical treatment decision-maker should only form part of the tribunal's decision to treat with ECT? Is that actually a fair characterisation of it? Secondly, as psychiatrists are required to assess the direct effect of ECT on a carer, what is the expectation that they will make a reasonable effort to locate a carer — because it may not always be immediately obvious?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that under the provision of the act the view of the medical treatment decision-maker is one of the considerations that the tribunal must consider. There is a long list of considerations set out under subsection (2) of new section 94A that sets out the views that the tribunal would be considering.

Business interrupted pursuant to standing orders.

Sitting extended pursuant to standing orders.

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. In relation to a carer, again the views of a carer are set out in the provisions set out in this new section 94A(2), in terms of the views that the tribunal should have regard to.

I am advised that it is a matter for the tribunal to determine whether they would be making further inquiries about the existence of a carer.

Clause agreed to; clauses 111 to 115 agreed to.

Clause 116

Ms WOOLDRIDGE (Eastern Metropolitan) — This is my last question for the evening, and my question is in relation to the definition. It seems a bit strange that the definition of medical treatment is that it has the same meaning as in the Medical Treatment Planning and Decisions Act 2016 but does not include treatment. So 'medical treatment' is medical treatment without the treatment. Could you perhaps in plain English explain what that actually means?

Ms MIKAKOS (Minister for Families and Children) — Thank you, Ms Wooldridge. I am advised that 'treatment' is a defined term in the Mental Health Act, and therefore the interaction of the provisions makes sense in that context.

In relation to a previous question that the member asked me, I just want to clarify the advice that I have received. I advised the house earlier that it would be a matter for the tribunal to locate the existence of a carer. I am now being advised that the obligation sits with the treating psychiatrist.

Ms WOOLDRIDGE (Eastern Metropolitan) — So they just have to — —

Ms MIKAKOS (Minister for Families and Children) — They would have the obligation to determine whether a carer existed or not.

Clause agreed to; clauses 117 to 161 agreed to.

Reported to house with amendments.

Report adopted.

Third reading

Ms MIKAKOS (Minister for Families and Children) — I move:

That the bill be now read a third time.

Ms WOOLDRIDGE (Eastern Metropolitan) — On the motion, firstly I want to commend the minister and all the participants in the process on an extensive consideration in detail. It is fair to say that we have debated the bill for a number of hours, and we have been able to work through a lot of issues. From the coalition's perspective, we are very pleased that the government made amendments both in the lower house and in this house that were the result of the coalition's initiative, working with stakeholders and identifying what we saw as flaws in the bill.

However, it is very concerning from the coalition's perspective that amendments that we proposed, which we believe were not fundamental policy changes but would have improved the clarity of the bill and helped with its interpretation, have not been supported. It is disappointing that the chamber has not seen fit to support those amendments that we put forward. That being the case, I do want to inform the house that the coalition will have a free vote on the third reading motion before the house.

Ms MIKAKOS (Minister for Families and Children) — I just want to take the opportunity to thank members for their contributions and for the very considered way that I think they have conducted themselves during this very serious debate.

The ACTING PRESIDENT (Mr Melhem) — Order! I would also like to join in thanking all the members now. The question is:

That the bill be now read a third time and do pass.

House divided on question:

Ayes, 30

Atkinson, Mr	Mulino, Mr
Barber, Mr	O'Donohue, Mr
Bath, Ms	O'Sullivan, Mr
Bourman, Mr	Patten, Ms
Crozier, Ms	Pennicuik, Ms
Dalidakis, Mr	Pulford, Ms
Dunn, Ms	Purcell, Mr (<i>Teller</i>)
Eideh, Mr	Ramsay, Mr
Elasmar, Mr	Shing, Ms
Hartland, Ms	Somyurek, Mr (<i>Teller</i>)
Herbert, Mr	Springle, Ms
Leane, Mr	Symes, Ms
Lovell, Ms	Tierney, Ms
Melhem, Mr	Wooldridge, Ms
Mikakos, Ms	Young, Mr

Noes, 7

Carling-Jenkins, Dr (<i>Teller</i>)	Ondarchie, Mr
Dalla-Riva, Mr	Peulich, Mrs
Finn, Mr	Rich-Phillips, Mr
Morris, Mr (<i>Teller</i>)	

Question agreed to.

Read third time.

ADJOURNMENT

Ms TIERNEY (Minister for Training and Skills) — I move:

That the house do now adjourn.

Government procurement policy

Ms LOVELL (Northern Victoria) — My adjournment matter is for the Premier, and it is regarding a procurement policy specifying the purchase of Victorian grown and processed food for the public sector. My request of the Premier is that he be consistent with his statements about keeping jobs in Victoria by ordering trains in Ballarat by creating and implementing a whole-of-government procurement policy to ensure that Victorian grown and processed foods, such as SPC products, are purchased by government departments and agencies, including but

not limited to public hospitals and healthcare services, prisons and schools to protect and create jobs in other regional centres like Shepparton.

The Victorian public sector spends \$10 billion on procurement every year, including food products. The government is well aware that our primary and food manufacturing industries have struggled in recent years and that conditions are still tough. These industries have battled drought and flood, hailstorm issues, a significant dairy crisis and most recently contract insecurity with major clients, which saw Woolworths walk away from a tinned tomato contract they had previously committed to with SPC. Thankfully in this case, after a brief but intense public push, the SPC-Woolworths Homebrand tinned fruit contract was retained and extended. Public support for SPC now and in recent years, when the company struggled, and the groundswell of support for the dairy industry during the dairy crisis are proof that the Victorian public wants to support Victorian industry and business.

In times of trouble and uncertainty the public looks to the government for reassurance, leadership and assistance. One such way the government can provide assistance to the primary and manufacturing industries is via the creation of a procurement policy that requires the public sector to buy Victorian food and products to support local farmers and food processors. This action would give some security to the future of local primary producers, food processors and the many people attached to them, including farmers and their families, small farming communities, employees of food processing companies and employees of associated local businesses.

In recent days the Premier has been talking up a recent government purchase order of trains that are being built in Ballarat, saying he is using taxpayer money to keep jobs in the state and that the state is buying local to keep the benefits of spending local. The Premier's line of using taxpayer money to keep jobs in the state is just empty rhetoric unless he makes commitments to buy local across many more industries than just rail rolling stock producers in Ballarat. The Premier needs to give Victorian famers and food processors such as SPC the same commitment he gave to Ballarat to keep jobs local for the rest of Victoria by implementing a whole-of-government procurement policy for Victorian grown and processed food.

I recall that when in opposition the Labor Party were happy to demand the former Liberal government use local providers for government procurement. I specifically recall Jacinta Allan in the Legislative Assembly pushing for the former government to

purchase only Victorian-made tomato sauce. However, now that Labor is in government the Minister for Agriculture has failed to give a commitment to buy SPC products when directly asked this question by the — —

The PRESIDENT — Order! The member's time has expired.

Compensation legislation

Mr EIDEH (Western Metropolitan) — My adjournment matter is for the Minister for Finance. I know that the Andrews Labor government is committed to protecting the interests of Victorian workers and their families and also to the creation of better road safety for all Victorian road users. When a worker or road user is injured, they should be entitled to appropriate compensation. The Compensation Legislation Amendment Bill 2016 ensures this and more. It strengthens assistance offered to Victorian families affected by road and workplace injury or trauma by improving the benefits payable under the Transport Accident Commission (TAC) and WorkSafe schemes. Importantly for the families of deceased TAC clients, the bill will expand TAC travel and accommodation expenses to allow family members to claim up to \$5000 to attend a funeral service for their loved one. This is a much-needed and much-called for initiative that will ease the burden on grieving families.

The TAC does a great job supporting and compensating Victorians who are injured in road or transport accidents. The TAC will continue this great work and will continue to provide fair, just and affordable compensation for Victorian road users. The creation of the Accident Compensation Conciliation Service is a substantial boost for Victorian workers who sustain injuries at their workplace. Workers compensation has always been a difficult area for all concerned, and creating a statutory body will ensure that all decisions and governance issues are consistent with best practice.

In my electorate of Western Metropolitan Region we unfortunately have many incidents of workplace injury and road trauma. Unfortunately with the large and diverse industrial estates and our increasingly busy roads, freeways and ring-roads in Western Metropolitan Region, we suffer a consequent level of workplace and road trauma. My question to the minister is: can he please inform me how this bill will benefit my constituents in Western Metropolitan Region?

The PRESIDENT — Order! It is a lineball one. Really, it does not quite fit the adjournment.

Regional and rural roads

Mr RAMSAY (Western Victoria) — My adjournment matter tonight is for the Minister for Roads and Road Safety, the Honourable Luke Donnellan. The action I am seeking from Mr Donnellan is clarification in relation to the recent announcement by the Turnbull government of matching funds for a regional roads package of \$1.5 billion, which was the money the Turnbull government committed to the east-west link. Supposedly an agreement was reached with the state government for matching funds.

I was in Portland last Monday where I was strongly lobbied for matching funds for the Henty and Princes highways. There has been \$20 million already promised by the Turnbull government, which is seeking \$20 million from the state government for both the Henty Highway and the Princes Highway. So I was somewhat surprised when the Turnbull government announced this package last week that the Victorian government was non-committal.

There were no press releases, no statements and no announcements by the Minister for Roads and Road Safety, yet federal MPs, including Sarah Henderson in Corangamite, have heralded the fact that this is a new agreement that has already identified roads, including \$25 million for the Great Ocean Road with a matching commitment from the state government, making it \$50 million. I ask: is that on top of the \$50 million that had already been reached in a previous arrangement? Does that mean \$100 million for the Great Ocean Road now? The release went on about the duplication of Grubb Road, Ocean Grove, and Midland Highway between Geelong and Bannockburn.

Then Dan Tehan, the federal member for Wannon, talked about a \$40 million upgrade of the Henty Highway and a \$40 million upgrade of the Princes Highway, which cuts across Corangamite, Moyne and Glenelg shires. His release talks about the \$220 million contribution to the Murray Basin rail project, which was previously announced and for which the state government said it would provide \$200 million.

So I am actually at a loss to know if the Andrews government has in fact committed \$1.5 billion matching funding with the commonwealth, and part of that is the \$690 million roads package that the Turnbull government has foreshadowed as an agreement, as well as the announcements, which I have just spoken about, by the federal representatives for Corangamite and Wannon. As I stated, the action I seek from the minister is clarification of what exactly the Andrews government's position is in relation to matching the

\$1.5 billion funding announced by the Turnbull government last week.

Shrine of Remembrance poster competition

Mr ELASMAR (Northern Metropolitan) — My adjournment matter is for the Minister for Veterans, the Honourable John Eren. I understand that in early November a grade 6 primary school student in my electorate was named as a finalist in the Shrine of Remembrance poster competition. While the competition is a fantastic opportunity for our primary school kids to practise and exhibit their artistic skills, it is also a wonderful way for them to learn more about Australia's wartime legacy and the sacrifices made by Australian men and women in the armed forces. My matter is: will the Shrine of Remembrance trust be providing an ongoing artistic poster competition next year, given the success of this one? I am sure that the parents of the 2016 poster competition entrants were thrilled and proud of their children's efforts. It is a great initiative, and I would like to see it on an ongoing basis.

Goulburn-Murray irrigation district

Mr O'SULLIVAN (Northern Victoria) — The action I seek tonight is for the Minister for Water to follow the lead established by The Nationals leader, Peter Walsh, when he was the Minister for Water, in ensuring that there can be no up-water leaving the Goulburn-Murray irrigation district if there is any negative social impact on northern Victorian communities. Just in the last couple of days the Deputy Prime Minister and federal Minister for Agriculture and Water Resources, Barnaby Joyce, wrote to the South Australian Minister for Water and the River Murray and said:

If it was genuinely possible to put an additional 450 gigalitres down the river without hurting people, then none of us would have a problem with it. The reality is that it will.

Even now we have got a situation where the federal government understands that if any of the up-water was to leave Victoria, it would have a massive socio-economic impact on the regional communities of northern Victoria. Under the commonwealth legislation, that up-water cannot be taken if there is a negative social impact, and clearly there would be if any of that water was to be taken away. So what I would really like to see is for the Minister for Water in Victoria to follow the lead of Barnaby Joyce and follow the lead of Peter Walsh when he was the Minister for Water and ensure that that water does not go to South Australia, because it would have a detrimental impact on our communities.

Water is wealth for regional communities. It creates jobs right throughout the northern part of Victoria, and all of those communities up there in northern Victoria are based on the back of agriculture. The water that is used in irrigation up there grows all of the fruit, it grows the vegetables and it grows the grass for our cows to eat to make milk and so forth, so we all rely on that water for production of the food that we eat. If any of that water was to leave the district, it would have a very detrimental impact, and that is why I would like to see the Minister for Water here in Victoria stick to her guns and stick to the guns that Peter Walsh has already established in terms of looking after the water here in Victoria and making sure none of it goes to South Australia.

Long service leave portability

Mr MELHEM (Western Metropolitan) — My adjournment matter is directed to my colleague in the other place the Minister for Industrial Relations, Minister for Local Government and Minister for Aboriginal Affairs, the Honourable Natalie Hutchins. It is in relation to the implementation of the portable long service leave scheme for the community services, security and contract cleaning industries. I commend the Andrews Labor government and the minister for accepting recommendations made by the Economic, Education, Jobs and Skills Committee on the introduction of portable long service leave in the community services, security and contract cleaning industries. I note that the government is currently determining how to make such a scheme viable.

As a member of the committee that made the recommendations, I understand the importance of having a viable portable long service leave scheme in place for these industries in Victoria. It is in the nature of the community services, security and contract cleaning industries that employees are unable to continue working for a single employer long enough to qualify for long service leave. In order then to ensure that employees in these industries are not left disadvantaged, laws need to change to keep pace with how these industries evolve. In that effort, the action I seek is for the minister to provide me with further details regarding the process and development of the Victorian portable long service leave scheme and its implementation.

South Eastern Metropolitan Region constituent

Mrs PEULICH (South Eastern Metropolitan) — The matter I wish to raise is for the attention of the Minister for Health. It is in relation to a 12-year-old girl called Abby Walsh, who is a Dingley Village resident. I

have received representations from her father. Regrettably young Abby has been diagnosed with Ewing's sarcoma in her left cheekbone that is protruding into the eye orbit. She requires treatment and has been receiving some. The next instalment of treatment should begin within two weeks, so this is a time-sensitive matter, and I am asking for the minister to assist because they have hit some hurdles.

Abby's treating oncologists have recommended a particular type of proton beam technology treatment that has been refined to a higher level of effectiveness in the United States than the one available here in Australia. The process for accessing the government's Medical Treatment Overseas program is based on receiving two assessments. Abby basically meets all of the criteria according to one of the assessors, which is the Royal Australian and New Zealand College of Radiologists (RANZCR). She actually meets three out of the four. The Australian and New Zealand Children's Haematology Group has assessed that she meets all four criteria and therefore should be eligible for this program. So on the basis of one assessor — and there is some dispute there, especially from her treating oncologists — Abby Walsh, 12 years of age, cannot access the level of government support in order to access this treatment overseas.

This is an important matter. I am not sure exactly where the fault lies. I am not interested in that; her family is not interested in that. All they seek is the opportunity to have their daughter treated in the United States under this program because they believe that Abby's opportunity for recovery will be much better, according to her treating oncologists. I would just like to quote from one letter:

It is our opinion that the decision from RANZCR is not considering fully the benefits that the proton treatment offers in dosage to critical structures, and that the response contradicts the advice from other medical experts. We also believe that in using the RANZCR panel for advice in making a decision on our application, has resulted in not being in Abby's best interest.

I am asking the minister to review the advice and see what advice she and her department may be able to furnish the family with so that Abby may be able to access this level of government funding or support in order to access treatment which offers her better prospects for a full recovery in view of her age and in view of the fact that there is largely overwhelming agreement, with the exception of one criterion, that this is a special case that I think deserves to be brought to the attention of the minister.

Broadford Community Centre

Ms SYMES (Northern Victoria) — My adjournment matter this evening is for the Minister for Local Government in the other place. It concerns the Broadford Community Centre and the dire need for funding to revitalise this important community asset. The building was the former Broadford Bush Nursing Hospital, which was constructed in 1933 and has immense public value; it is iconic. It is also situated in what might be called a community precinct. It is next to the police station, the new Labor-funded youth centre, the skate park and Mount Piper Kindergarten.

The community centre was gifted to the Mitchell Shire Council in 2016 with an acknowledgement of the extensive works required to restore the building. Following significant governance issues, the service agreement to run the Neighbourhood House program with Broadford Community Centre was terminated and Mitchell Shire Council took over the daily running of the centre in August. It received government funding to ensure the community could continue to access the Neighbourhood House services. Two weeks ago there was a very well attended open day to showcase the many programs on offer and to display their future potential to the community. My kids enjoyed the jumping castle, farm animals and face painting in particular.

I have already had several conversations with community groups that are excited about the prospect of what could be realised at the centre, including the innovative programs and activities to facilitate learning, education and social connectedness, but everyone is just a little bit put off by the state of the building. There has been no significant refurbishment since its early beginnings. I have been there quite a few times and can confirm that it is very obviously a disused hospital. There are unused rooms that were once bathrooms and the original kitchen is still there, despite not being able to be used. The four-bed ward configuration of the building basically means that it cannot provide open and multipurpose spaces for meetings or community gatherings. There is peeling paint and mouldy carpet, and despite the best efforts of staff, the management of the smell is somewhat challenging. All in all the existing infrastructure is unsuitable, inaccessible and outdated, making it completely inadequate to live up to its potential as a thriving community hub.

Mitchell Shire Council has applied for more than half a million dollars from Labor's Growing Suburbs Fund. I know just how important and necessary this money is to the Broadford community. My family have been a part of this awesome community for nearly 12 months

now. I know there are many quality projects across Victoria's growth areas that are vying for funding, but I call on the minister to ensure that the Broadford Community Centre revitalisation project is one of the projects that receives funding under this program.

Hazelwood power station

Ms BATH (Eastern Victoria) — My adjournment matter this evening is directed to the Minister for Energy, Environment and Climate Change, the Honourable Lily D'Ambrosio. The action I seek from the minister is to work with the owners of the Hazelwood power station, Engie and Mitsui, to transition a staged closure of the Hazelwood power station. Over recent days, weeks and months I have spoken to mineworkers, union members, contractors and subcontractors who are facing a black hole of uncertainty at the complete shutdown of the mine on 31 March 2017.

The figure of \$330 000 in terms of a redundancy package is certainly the domain of a select few, not the majority. Speaking with workers, their commentary has been that the younger workers who have been there around 5 to 10 years can look at only about four to six weeks pay, with their super going along with it. Other maintenance contractors, such as electricians, plumbers, and fitter and turners, will receive nothing once the plant closes. Surely this government should and could provide for a phased closure.

There is context to this. In terms of past history, on 27 July 2010 the future of the Hazelwood power station was debated in this Parliament, with Mr Brumby as Premier. In response to a question from the Leader of the Opposition Mr Brumby stated:

Yesterday I announced the government's white paper, and as part of that I have outlined the government's plan for the staged closure of the Hazelwood power station.

The then Premier of Victoria stated:

... the government will engage in discussions with the owners of the Hazelwood power station to ensure that an appropriate framework is agreed going forward.

My comment is: why can it not happen now, if it was going to happen back then?

Also, Mr Peter Hall, my predecessor, made comments on the same date, and he said in relation to the minister's response:

On behalf of those who are experiencing that anxiety currently, I ask the minister: given that Hazelwood provides direct employment for more than 800 persons, will he give a

guarantee that a staged closure will not add to the region's already high unemployment levels?

Morwell has an unemployment rate of 19 per cent. That is about the highest in the state. The Latrobe Valley has an unemployment rate of 10.7 per cent. This will be a crushing blow to this community and the outlying towns, businesses and subcontractors. The ripple effect will be great and overbearing. This government should be able to provide for a staged closure. They committed to it back in 2010, but they have done a backflip. Again I ask the minister to work with the Hazelwood owners for a staged closure.

Responses

Ms TIERNEY (Minister for Training and Skills) — I have a number of adjournment matters raised this evening: Ms Lovell's to the Premier in relation to government procurement policy and in particular the purchase of Victorian grown and processed food; Mr Eideh's to the Minister for Finance, Robin Scott, in relation to proposed changes to the Transport Accident Commission and the impact that that may have in relation to workplace injuries and road trauma in his electorate; Mr Ramsay's to the Minister for Roads and Road Safety, Luke Donnellan, and that was in relation to matching federal and state road funding; and Mr Elasmars to Minister Eren, and that was in relation to the need for an artistic poster competition that currently exists to be ongoing in nature.

Mr O'Sullivan's adjournment matter was directed to the Minister for Water, Lisa Neville, in the other place, and it was in respect of up-water and its socio-economic impact on northern Victorian communities, wanting the minister to take action to ensure that water will stay in Victoria and not move on to South Australia.

Mr Melhem had an adjournment matter that was directed to the Minister for Industrial Relations, Natalie Hutchins, seeking the minister to provide him with further information on the development and indeed the implementation of the provision of portable long service leave.

Mrs Peulich had a matter for the Minister for Health seeking the minister's advice and assistance for a young girl in her electorate, Abby Walsh, who is 12 years old and requiring treatment.

Ms Symes had a matter for the Minister for Local Government seeking funding assistance for the Broadford Community Centre and the Broadford revitalisation project.

Finally, Ms Bath had a matter for the Minister for Energy, Environment and Climate Change calling on the minister to ensure a staged closure of the Hazelwood power station and an appropriate framework for that closure.

I have 22 written responses to adjournment debate matters raised by Mrs Peulich on 23 June; Ms Lovell on 31 August; Ms Tierney on 14 September; Mr Elasmarr, Ms Lovell, Mr Melhem, Mr O'Donohue and Mr Ramsay on 11 October; Mr Davis, Ms Dunn, Mr Finn, Mr Mulino and Mr Purcell on 12 October; Mr Finn, Ms Patten and Mr Ramsay on 13 October; Ms Crozier and Mrs Peulich on 25 October; Mr Eideh and Mr Finn on 26 October; Ms Crozier on 10 November; and Mr Purcell on 11 February 2015.

The PRESIDENT — Order! The house stands adjourned.

House adjourned 9.11 p.m.

