# SUBMISSION TO THE ACT GOVERNMENT

## COMMUNITY CONSULTATION

## ON

## VOLUNTARY ASSISTED DYING

## From Dying with Dignity ACT Inc.

## DUE DATE 6 APRIL 2023

The ACT Government acknowledges Canberrans who have experienced, or are experiencing, unbearable end of life suffering in the face of illness, disease and medical conditions. We also acknowledge the hardships and grief experienced by their loved ones and carers. We are committed to listening, learning and understanding from these experiences in developing our approach to voluntary assisted dying in the ACT.

## TERMS OF REFERENCE

### 1. WHO SHOULD HAVE ACCESS TO VAD?

**DWDACT Inc. Answer: Anyone who asks for it.**

**Rationale**: Dying with Dignity ACT Inc. is making a submission to the ACT Government on the matter that the Government calls Voluntary Assisted Dying because it has the aims stated below, which it wishes to see achieved in the ACT. We see the current legal situation in relation to VAD as being based on Sections 16 and 17 of the ACT Crimes Act.

We see the legislation developed in the Australian States as merely providing an exception to these sections for dying individuals, which is not consistent with our aims. Achievement of our aims would remove these punitive sections (Sections 16 and 17 of the ACT Crimes Act) in our law for everyone. People die badly everywhere because these laws have been legislated everywhere in some form or another. We do not accept that the law should penalize people who want to die, no matter what their reason is for wanting to die.

The current law, as stated in Sections 16 and 17 of the Crimes Act, is the last vestige of capital punishment i.e. using death as a way to punish people for the wrongdoing of murdering themselves. The refusal to assist people to die inevitably results in the cruel deaths of ACT citizens each year (65 in 2021). The current law (S16 and 17 in the Crimes Act) reflects pre Darwinian thought equivalent to the medieval punishment of thieves by death. The law in most areas has moved on since then and this one should too. Most people want to live for as long as possible and therefore the law is not fit for purpose. Using the small minority who don't; 1.5-3 percent annually of the people who die, to threaten and shame the majority into staying alive is cruel and inhuman for us all. It's cruel to those who have to undertake the dreadful act of hanging, gassing, drowning themselves and cruel to everyone else because we as a community have to live with this barbarism thinking wrongly that it is an inevitable fact of life.

No-one asks to be born. Life is imposed on us by our parents who, in Australia, are free to conceive as many children as they like. Therefore we believe that, in turn, people should be free to end their lives safely and with the support of their community, when they choose. If people cannot freely end their own lives, the law acts as a prison guard, and life becomes a prison from which they can only escape by violent means such as hanging, drowning etc or dying by disease.

DWDACT AIMS

*Preamble*

We assert that our bodies belong to us as individuals and that we have the right to determine the circumstances of our dying & death as we have in the rest of our lives. We expect our community to support our wishes and provide the facilities required to enable us to have the death of our choice.

*Aims*

1. To work with the ACT community to create the legal environment in which all adult ACT & region residents can die with dignity at a time and place of their choice with the degree of assistance that they determine is appropriate.
2. To promote the concept of an elective death as an alternative to concepts of ‘suicide’ or ‘voluntary euthanasia’ and to encourage support for elective death on Medicare.
3. To promote the idea that those who want to shorten their lives should be able to have a peaceful death.
4. To encourage the use of medication that would provide people with a peaceful, pain free, quick death.
5. To educate the community about the role and work of medical professionals & carers for the dying and to work for their legal protection if they assist a person who has made a reasoned choice to die.

6. To encourage & educate people about dying and death so that they will be fully informed about what will happen to them when they die and to encourage participation in courses which allow people to celebrate their lives, to grieve the loss of their lives and to think positively about death.
7. To support and encourage other like-minded organizations in Australia and internationally to create a legal environment in which people can die with dignity at a time and place of their choice with the degree of assistance that they determine is appropriate.
8. To promote the addition of a right in Human Rights law to a peaceful, pain free, quick death at the time and place of the individual's choice with the degree of assistance that s/he determines is appropriate.

In stating that anyone who asks for it should be able to access an assisted death we exclude those who do not want it. Everyone who asks for it including those who, for example, ask through a Living Will or Power of Attorney should be able to access it when they want it. DWDACT Inc. does not accept the age, health, expectations of death, and residence qualifications that exist in the legislation in the Australian states. The only qualification we believe is an absolute requirement is that the death is freely elected.

DWDACT Inc. prefers to use the term 'elective death' rather than 'voluntary assisted dying' because the term elective death is consistent with the existing health terminology of 'elective surgery'.

## 2. WHAT SHOULD THE PROCESS BE LIKE?

**DWDACT Inc. Answer:** DWDACT Inc. was formed in 2012 for the purpose of achieving the aims stated above. It sees law reform as imperative for many reasons including firstly the punitive nature of the current religious observance expressed in the law that is designed to frighten and or shame most people out of ending their lives by making examples of those who do end their lives by forcing them to hang, drown or gas themselves, thus forcing people to live until they die of disease; and secondly the many human rights breaches that ACT citizens suffer as a result of the current law (Sections 16 and 17 of the ACT Crimes Act) which is the last vestige of capital punishment.

**1.** We propose that the first matter that the ACT Legislative Assembly should address is to reform Sections 16 and 17 of The Crime Act along the following lines.

16 *The rule of law that it is an offence for a person to commit, or to attempt to commit, suicide is abolished*. Add the following sentence to s16: **FROM THE DATE OF EFFECT OF THIS ACT THE WORD 'SUICIDE' WILL BE REPLACED BY THE TERM, 'AN ELECTIVE DEATH'.**

Replace 17 (a) a *person who aids or abets the suicide or attempted suicide of another person is guilty of an offence punishable, on conviction, by imprisonment for 10 years.'* with

**A PERSON WHO ELECTS DEATH CAN BE PROVIDED WITH THE MEANS TO UNDERTAKE A PEACEFUL DEATH UNDER THE FOLLOWING SPECIFIED CONDITIONS;**

1. **THE DEATH MUST OCCUR WITHIN AN ELECTIVE DEATH UNIT IN OR LINKED TO A CANBERRA HOSPITAL.**
2. **IT CAN ONLY BE PROVIDED AFTER COUNSELLING AND PREPARATION FOR DEATH IN ROOMS PROVIDED FOR THE SPECIFIC PURPOSE OF AN ELECTIVE DEATH TO BE UNDERTAKEN INDEPENDENTLY WITHOUT THE HELP OF OTHER PEOPLE.**
3. **THE DEATH ELECTOR WOULD USUALLY (WE KNOW THAT VERY FEW YOUNG PEOPLE WISH TO END THEIR LIVES SO THIS WOULD USUALLY BE THE CASE) BE AN ADULT ACT CITIZEN WHO MUST PROVIDE A) A REASON FOR THE WISH FOR DEATH, B) BE PREPARED TO LISTEN TO OFFERS OF HELP WITH THEIR LIFE CIRCUMSTANCES C) UNDERTAKE A COOLING OFF PERIOD.**

4. **ON DIAGNOSIS OF A TERMINAL ILLNESS OR OTHER DEBILITATING CONDITION, ILL PEOPLE MAY REQUEST A REFERRAL FROM THEIR DOCTORS TO THE ELECTIVE DEATH UNIT FOR AN ELECTIVE DEATH AT THE TIME OF THEIR CHOICE. THEY MAY ACCESS THE COUNSELLING SERVICES OF THE ELECTIVE DEATH UNIT IF THEY WISH.**
5. **THE ELECTIVE DEATH UNIT WILL MAINTAIN RECORDS OF THE REASONS FOR PEOPLE REQUESTING AN ELECTIVE DEATH AND REPORT REGULARLY TO THE ACT LEGISLATIVE ASSEMBLY ON THEIR FINDINGS.**
6. **THE HEALTH DIRECTORATE WILL CO-ORDINATE PUBLIC AND PRIVATE HEALTH SYSTEMS TO LINK INTO THE ELECTIVE DEATH UNIT SO THAT THEY CAN REFER CLIENTS TO IT.**

*A person 'who incites or counsels another person to ELECT DEATH and the other person commits or attempts to ELECT DEATH as a consequence of that incitement or counselling is guilty of an offence punishable on conviction, by imprisonment for 10 years.'*

It is also *'lawful for a person to use the force that is reasonable to prevent the DEATH of another person or any act that the person believes on reasonable grounds, would, if committed, result in the DEATH of another person* **WHERE THE PERSON DOES NOT UNDERTAKE THE ELECTED DEATH WITHIN THE ELECTIVE DEATH UNIT.'**

**2.** DWDACT Inc. recommends that the ACT government adopts the following principles that should inform the process undertaken to provide support for a request for assisted dying. Combined with the Elective Death Unit these principles will establish the best customer service for people who wish to die.

**PRINCIPLES THAT JUSTIFY AN ELECTIVE DEATH**

- It is the responsibility of government (and therefore the whole community) to ensure that everyone dies well.
- A good health system guarantees a good death.
- Elective death is defined as a voluntary decision to shorten one's own life. An elective death is a peaceful, pain free, and quick death.
- A civilized society respects the rights of its citizens to die at the time of their choice.
- To elect death is a legitimate goal for people to have. Like birth, death should be a matter of individual choice and the state should support the individual's choice for the same reason.
- The purpose of an elective death is to provide citizens with a peaceful death, free of glorification of suffering, and ultimately, to create a more peaceful world for us all.

**3. IMPLEMENTATION OF THE PRINCIPLES**

To ensure these principles are implemented we suggest that the process of giving assistance to those who wish to die should be managed by the establishment of one or more elective death unit/s, depending on demand, which can be contacted directly by those who wish to die.

**AN ELECTIVE DEATH UNIT**

1. An Elective Death unit would be well-publicized in or linked to a local hospital. The most effective medication would be purchased by the hospital and managed safely like all other medications in hospitals. It would be made available to the EDU staff as required.
2. The Elective Death Unit would have;
    a. a 24 hour a day service with the resources to make professional personal, financial, and relationship counselling available to clients as well as immediate access to police, the coroner, organ donation and funeral services;

b. an education facility designed for all members of the community and targeted for specific age groups and their particular stage of life needs to educate and inform people about death; to assist people to let go of life, to understand what death is and to prepare themselves for death;

c. rooms with the facilities to assist those wanting an elective death to die comfortably in the presence of people they select;

d. facilities to enable a peaceful, pain free and quick death to be undertaken in most cases independently of the help of other people.

3. The Elective Death Unit would provide any adult ACT citizen with an elective death following—

   a. provision of a reason for the wish for death,

   b. offers of help through counselling or other assistance as needed,

   c. a cooling off period negotiated with the person wanting to die. The decision to die would be as respected as the decision to live.

4. On diagnosis of a terminal illness or a protracted chronic disease, those people diagnosed may request a referral from their doctors to the Elective Death unit for an elective death at the time of their choice. Accessing the counselling services of the Elective Death Unit would be a matter for them.

5. The Elective Death unit would be required to maintain records of the reasons for people requesting an elective death and report regularly to the Assembly on their findings.

6. The ACT Government would co-ordinate public and private health systems to link into the Elective Death unit so that they can refer clients to it.

## 3. WHAT ROLE SHOULD HEALTH PROFESSIONALS PLAY?

**DWDACT Inc. Answer:** DWDACT Inc. proposes the Elective Death Unit as the most suitable model for the ACT because of its size and the accessibility of most places for most people. We suggest that the unit or units should be linked to a hospital/s for security of the drugs and possibly for staff co-ordination if the EDU were not able to operate full time given the small numbers of people who die in the ACT (2,207 in 2021).

We believe that the role assigned to doctors by legislation in the Australian states is not suitable for the Elective Death model. The Elective Death model does not confine itself to the terminally ill so the diagnosis of doctors is not important except for those who have received information from their doctors that they are dying and wish to make a choice of an elective death. Information we have received from DWDV also indicates that people who are unable to find a doctor who will give them an assessment that would make them eligible for an assisted death are put into an impossible situation by these doctors. ACT citizens should feel confident that if they go to a place to die the people in that place will be supportive and that their last hours will be peaceful, not made stressful and miserable because they cannot find the support they are looking for.

DWDACT Inc. sees Counsellors as important health professionals in the elective death model for many reasons. They would be needed to counsel those who wish to die because they do not want to live any longer. They would also be better able to assess that those who wish to die as a result of a disease are actually ready to die. They could act as witnesses. Their counselling experience would make them better able than doctors, for example, to assess the state of mind of those who would be clients of the Elective Death unit. They would also be able to provide grief counselling for relatives and friends of the death elector.

Doctors would refer to the Elective Death Unit those of their patients, who have received confirmation that they have a terminal illness from tests they have requested. People would take a referral from their doctors to the Elective Death Unit to die there. An elective death should be seen as a health matter that patients can discuss with their doctors. Given that this model does not require doctors to carry out an elective death there is no reason why it should not be discussed with their doctors. The referral can be an option like any other referral patients might get from their doctors.

However, there may be some doctors who are unwilling to even refer their patients to the Elective Death Unit. This is another reason why it would be helpful to have the unit linked to a hospital. A back-up doctor could be called in this circumstance to check the medical records of the patient who could take them directly to the EDU or they could be accessed electronically. This would provide a third medical check if required i.e. the patient's doctor, the medical tests and the EDU doctor on call as required.

Staff, who have the task of assisting people to die, should be trained and willing to assist people to die. The Swiss model shows that this role does not require high level medical training. Training to provide support to someone at the end of life and in administration of drugs are all that is required. Staff would not have to have a medical background but, of those in the existing health professions, palliative care nurses have training that is most suitable. Elective Death Unit staff could also go where they were required to go to assist a death. Palliative Care nurses already go into people's homes and a variety of settings to assist them when they are dying. They therefore already have professional experience and skills in dealing with dying people. Because the EDU would be part of the existing ACT health system staff would be employed by the Health system and would be subject to the same professional rules that determined all staff in the ACT Health Department.

People who live in aged care homes should have full knowledge of whether the home is one which will allow elective death staff to assist them to die so this should be required either by legislation or regulation. However, given that the Elective Death model does not require people to be at death's door before they are eligible for an assisted death and given the small size of the ACT it should be possible to access an Elective Death Unit easily by car if circumstances made it necessary.

## 4. WHAT CHECKS AND BALANCES SHOULD BE IN PLAY?

**DWDACT Inc. Answer:**

### Reporting

Because the Elective Death unit centralizes the act of an assisted death with staff who are employed to carry out elective deaths it should be easy to monitor. An administrative officer should be appointed to monitor the number of people who request to die. Their progress through the EDU can be monitored by all staff employed there. That information can be collated and submitted at each stage from request through to death. (See points 5 and 6 of What should the process be like?)

### Checking that health professionals are following the law

With an EDU set up by the Government and an integral part of the ACT Health system, the Assembly should be confident that suitably qualified professional people have been employed who can successfully undertake the tasks required of them. Only people who want to do the task of helping people to die should be employed. A small unit of people who can work together effectively should enable the government to collect any information it requires over and above that already required when someone dies. Constant checking which would delay the process should not be required. (See point 1 of What should the process be like?)

### Reviewing eligibility decisions

The Elective Death model will not require people to appeal a decision made by a doctor because the decision to die is made by the person with professional support from the EDU staff.

### Consequences if someone breaks the law

DWDACT Inc agrees that it should be a crime if—

- a health professional submits a false report about an elective death
- a health professional fails to submit a report about an elective death
- (See point 1 of What should the process be like?) *A person 'who incites or counsels another person to ELECT DEATH and the other person commits or attempts to ELECT DEATH as a consequence of that incitement or counselling is guilty of an offence punishable on conviction, by imprisonment for 10 years.'*

### Protecting people from misusing a lethal substance

With the EDU model the lethal medications used will be kept in a safe place until they are ready to be used. Their use would only occur under the supervision of EDU staff. Those who misused the lethal substance would be subject to existing criminal law. The fact of the EDU would encourage people who wished to end their lives to use it rather than hang, drown or gas themselves or break the law to access illegal substances because they would know that they could achieve their wish for death by going to the EDU.

### Protecting people from ending their lives mistakenly

The Elective Death model is designed to give as much support as possible to those people who wish to end their lives. It is clear that the current attempts to prevent people from taking their lives do not work because as we can see from the statistics 1.5-3% of the people who die each year continue to hang, drown and gas themselves despite all the help offered for over sixty years by organizations such as Lifeline and Beyond Blue etc. The Elective Death model is designed to provide these people with the opportunity to talk about their reasons for their wish to die and to have a peaceful death if that is what they want. It accepts that some people will want to make this choice and does not punish them for it by forcing them to die badly. (See the death statistics for the ACT below)

# APPENDICES

## 1 ABS States and Territories Death statistics

## 2 Laws that govern the way we die in the ACT

## 3 DWDACT Attachment to submission; Responses to ACT Discussion Paper consultation questions

# States and territories

## Deaths registered

Over three-quarters (77.5%) of deaths registered were to usual residents of New South Wales, Victoria and Queensland combined.

Download

Deaths registered by state and territory of usual residence

| State or territory | 2011 (no.) | 2020 (no.) | 2021 (no.) | 2021 (%) |
|---|---|---|---|---|
| New South Wales | 50,661 | 52,485 | 56,525 | 33.0 |
| Victoria | 36,552 | 41,093 | 42,486 | 24.8 |
| Queensland | 27,414 | 31,367 | 33,858 | 19.7 |
| South Australia | 12,665 | 13,607 | 14,494 | 8.5 |
| Western Australia | 12,724 | 14,993 | 15,891 | 9.3 |
| Tasmania | 4,245 | 4,435 | 4,769 | 2.8 |
| Northern Territory | 964 | 1,141 | 1,211 | 0.7 |
| Australian Capital Territory | 1,700 | 2,162 | 2,207 | 1.3 |
| Australia(a)(b) | 146,932 | 161,300 | 171,469 | 100.0 |

a. All jurisdictions recorded an increase in death registrations in 2021. This follows lower death counts in 2020, after the introduction of public health measures to limit the spread of COVID-19.
b. Includes Other Territories.

Median age at death

## Standardised death rate

The standardised death rate was:

- highest in the Northern Territory (7.2 deaths per 1,000 standard population), followed by Tasmania (5.6)
- lowest in the Australian Capital Territory (4.6).

Over the past ten years, standardised death rates:

- decreased in all states and territories.
- decreased the most in both Tasmania (5.6 deaths from 6.4 in 2011) and the Northern Territory (7.2 deaths from 8.0 in 2011), then New South Wales (5.1 deaths from 5.8 in 2011) and Victoria (4.9 deaths from 5.6 in 2011).

Causes of Death, Australia, 2021 | Australian Bureau of Statistics (abs.gov.au)

Number of suicide deaths, by state or territory of usual residence, 2012-2021 (a)(b)(c)(d)(e)

| | 2012 No. | 2013 No. | 2014 No. | 2015 No. | 2016 No. | 2017 No. | 2018 No. | 2019 No. | 2020 No. | 2021 No. |
|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 727 | 718 | 832 | 839 | 822 | 929 | 940 | 960 | 876 | 880 |
| **Vic (a)** | 514 | 552 | 672 | 686 | 667 | 712 | 691 | 727 | 694 | 675 |
| **Qld** | 631 | 676 | 658 | 761 | 688 | 815 | 805 | 798 | 759 | 783 |
| **SA** | 197 | 203 | 244 | 233 | 221 | 226 | 209 | 249 | 234 | 226 |
| **WA** | 367 | 336 | 367 | 402 | 373 | 418 | 384 | 415 | 381 | 389 |
| **Tas.** | 71 | 74 | 69 | 84 | 93 | 79 | 78 | 106 | 87 | 80 |
| **NT** | 48 | 33 | 56 | 48 | 46 | 51 | 47 | 50 | 51 | 46 |
| **ACT** | 24 | 37 | 38 | 46 | 28 | 59 | 50 | 53 | 57 | 65 |
| **Australia** | 2,579 | 2,629 | 2,937 | 3,100 | 2,939 | 3,290 | 3,205 | 3,358 | 3,139 | 3,144 |

a. To best reflect a more accurate time series, deaths due to suicide are presented by registration year. As a result, some totals may not equal the sum of their components and suicide data presented in this publication may not match that previously published by reference year. Care needs to be taken when interpreting data derived from Victorian coroner referred deaths including suicide. See Technical note: Victorian additional registrations (2013-2016) in the methodology for more information.

b. All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2012 - 2018 (final), 2019 (revised), 2020 and 2021

(preliminary). See the Data quality section of the methodology and Causes of Death Revisions, 2018 Final Data (Technical Note) and 2019 Revised Data (Technical Note) in Causes of Death, Australia, 2020.

c. The data presented for intentional self-harm includes ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to intentional self-harm. See the Deaths due to intentional self-harm (suicide) section of the methodology in this publication.
d. See the Data quality section of the methodology for further information on specific issues related to interpreting time-series and 2021 data
e. See the Classifications and Mortality coding sections of the methodology for further information on coding of 2021 data.

# THE LAWS
# THAT DETERMINE THE WAY WE DIE
**in the**
# Australian Capital Territory

***The way we die in the ACT is determined by Constitutional, Federal and Territory law.***

# THE CONSTITUTION OF AUSTRALIA

DWDACT believes that two sections of the Constitution are relevant to this matter. The Federal Parliament used Section 122 of the Constitution to enact *The Euthanasia Laws Act 1997*.

**Section 122: Government of Territories**

The Parliament may make laws for the government of any territory …..and may allow the representation of such territory in either House of the Parliament to the extent and on the terms which it thinks fit.

DWDACT believes this law may be open to challenge by Section 116 of the Constitution. Current law that requires Australians to die of disease was enacted when the Australian Federal parliament was even more populated by religious believers than it is today. Parliamentarians believed that citizens not only belonged to the nation but also that they belong to God and only God can take a life. Generally, this means that we are required to die of disease. Requiring death by disease is part of the religious observance related to the practice of death in most religions.

**Section 116: Commonwealth not to legislate in respect of religion**

The Commonwealth shall not make any law for….. imposing any religious observance….

# ACT LAW

Law in *The Crimes Act 1900* determines how we die in the ACT.

**Suicide**

Section 16 Suicide etc – not an offence

The rule of law that it is an offence to commit, or to attempt to commit, suicide is abolished.

DWDACT suggests that the ACT government add to Section 16 in *The Crimes Act 1900* the following words; *from the enactment of this amendment to the law the act of ending one's life will no longer be called suicide. It will be called an elective death.*

Given that it is no longer a crime to end one's own life it is an error to continue to call the act of doing so 'suicide' which means self-murder, which is a crime.

Section 17 Suicide – aiding etc

(1) A person who aids or abets the suicide or attempted suicide of another person is guilty of an offence punishable, on conviction, by imprisonment for 10 years.

Section 17 (1) of the Crimes Act is intentionally designed to make the act of ending one's own life difficult. The underlying ideological principle behind the law is that only God can take a life and therefore everyone should die of disease. Dying of disease is required for two reasons; 1) ideological; to establish that the death was a result of the action of God or nature and

2) criminal; to establish the innocence of those around the dead body i.e., *that* the person was not murdered by another human being; and to punish any person guilty of causing the death.

Section 17 (1) of the Crimes Act is based on the idea that people should die of 'natural causes' i.e., of the diseases of old age. If they are unwilling to do this they must submit to a lonely, degrading and usually painful manner of death or act unlawfully to obtain a peaceful means of death. Section 17 (1) in effect cancels out the apparent decriminalization of S 16 by denying assistance to die, either with the help of another person or by giving access to appropriate medication.

This idea does not consider the possibility that ACT citizens should be able to undertake their deaths in a safe manner within a modern health system at a time of their choosing.

DWDACT suggests that the ACT government repeal or modify Section 17 (1) with the concept of an elective death unit. DWDACT believes that Section 23 1A of the ACT Self Government Act and Section 17 of the ACT Crimes Act should be repealed and amended. This would mean that an elective death would no longer equate to murder.

**Murder**

(1) A person commits murder if he or she causes the death of another person—

(a) intending to cause the death of any person; or
(b) with reckless indifference to the probability of causing the death of any person

## ACT Human Rights Act

DWDACT suggests that the ACT government should bring *The Crimes Act* law into line with its *Human Rights* Act. We believe that Section 17 (1) of *The Crimes Act* breaches the human rights of ACT citizens. The following ACT *Human Rights* laws make the *Crimes Act* laws a basis for a claim of discrimination**.**

**Section 8 Recognition before the law:** *Everyone has the right to enjoy his or her human rights without distinction or discrimination of any kind.*

Article 26 of the International Covenant on Civil and Political Rights states that 'All persons are equal before the law and are entitled without discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'

Section 17 (1) of *The Crimes Act* imposes a religious observance on everyone by criminalizing anyone who gives assistance to die thus denying ACT citizens the right to die at a time and place of their choice and forcing death by disease on them. **It is therefore both inconsistent with this Human Rights law and discriminatory.**

**Human Right:** *Everyone has the right not to have his reputation unlawfully attacked.*

No one should be called a 'suicide' (a self-murderer) when electing to die is no longer a crime. In retaining the word 'suicide' to describe the act of electing to die, the law itself damages the reputation of anyone who undertakes this act now made lawful by S 16. **It is therefore both inconsistent with this Human Rights law and discriminatory.**

**Human Right:** Protection from torture and cruel, inhuman or degrading treatment: *No-one may be treated or punished in a cruel, inhuman or degrading way*.

Section 16 of *The Crimes Act* makes it lawful for people to end their own lives. DWDACT believes that no one should be forced to hang themselves just because they do not want to live. Making a person who assists someone to die into a criminal inevitably results in people having to die in this and other unacceptable ways. Section 17 (1) forces people who want to die, to die horribly. This is a form of indirect assault by the state. Many people die bad deaths in hospitals, hospices, nursing homes or at home through neglectful treatment or because their particular diseases ravage their bodies. This has been documented systematically over time by many people in Australia and elsewhere. Section 17 (1) is **therefore both inconsistent with this Human Rights law and discriminatory.**

**Human Right:** Right to Liberty and Security of person: *Everyone has the right to liberty and security of person.*

Section 17 (1) of *The Crimes Act* only permits people wanting to die the liberty to undertake the death that S16 gives them by insecure means i.e., self-assault.

The ultimate liberty is freedom from life. Sections 16 and 17 deny people the right to this liberty except by self-assault or disease. **It is therefore both inconsistent with this human rights law and discriminatory.**

> **Human Right:** *Every person has the right not to be arbitrarily deprived of their property.*

DWDACT believes that Section 17 (1) of *The Crimes Act* breaches ACT citizens right not to be arbitrarily deprived of their property as identified in *The Universal Declaration of Human Rights* and the *ACT Human Rights Act.* The most precious property human beings own is their bodies. Due to the exclusion by law of methods of death other than disease human beings lose the ability to manage and dispose of their bodies themselves. Their bodies then become the property of others due to illness deliberately induced by the religious values that underpin the law. Section 17 (1) is **therefore both inconsistent with this Human Rights law and discriminatory.**

# DWDACT Attachment to submission
# Responses to ACT Discussion Paper consultation questions.

| | |
|---|---|
| 1. What should the eligibility criteria be for a person to access voluntary assisted dying? | See Terms of reference 1 |
| 2. What kind of suffering should a person be experiencing or anticipating in order to be eligible to access voluntary assisted dying? | See Terms of reference 1 |
| 3. Should a person be expected to have a specified amount of time left to live in order to be eligible to access voluntary assisted dying? If so, what timeframe should this be? Should there be a different timeframe for different conditions, for example for neurodegenerative disorders? If there is no timeframe required, what should a prognosis be instead? | See Terms of reference 1 |
| 4. How should a person's decision-making capacity be defined or determined in relation to voluntary assisted dying? | See Terms of reference 1 |
| 5. Should voluntary assisted dying be restricted to people above a certain age (for example, people 18 and over)? | See Terms of reference 1 |
| 6. Should a person be an Australian citizen or a long-term resident of Australia to access voluntary assisted dying in the ACT? | See Terms of reference 1 |
| 7. Given every Australian state now has voluntary assisted dying laws, is there any need for voluntary assisted dying in the ACT to be restricted to people who live in or have a close connection to the ACT? | See Terms of reference 1 |
| 8. What process should be in place in the ACT to ensure that an eligible person's access to voluntary assisted dying is safe and effective? | See Terms of reference 2 |
| 9. If a coordinating health professional or consulting health professional declines to be involved in a person's request for voluntary assisted dying, should they be required to take any particular action? | See Terms of reference 2 |
| 10. Should witnesses be required for a person's formal requests for voluntary assisted dying? If so, who should be permitted to be a witness? | See Terms of reference 2 |
| 11. Should the process for seeking access to voluntary assisted dying require that a person take time to reflect (a 'cooling off' period) before accessing voluntary assisted dying? | See Terms of reference 2 |
| 12. Should a person have a choice between self-administration and administration by an administering health professional of a voluntary assisted dying substance? | See Terms of reference 2 |

| | |
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| 13. Should one method of administration be prescribed as the default option, or should methods differ depending on the circumstances? Does this need to be prescribed in legislation, or is it a matter best determined between the registered medical practitioner and patient? | See Terms of reference 2 |
| 14. Are additional safeguards required when an eligible health professional administers the voluntary assisted dying substance (as compared with self-administration) and, if so, what safeguards would be appropriate? | See Terms of reference 2 |
| 15. Should administration of the voluntary assisted dying substance to an eligible person be witnessed by another person? If so, who should be permitted to be a witness? | See Terms of reference 2 |
| 16. What safeguards are necessary to determine whether or not a person has taken the voluntary assisted dying substance, and to return the voluntary assisted dying substance if it has not been taken? | See Terms of reference 4 |
| 17. Who should be permitted to be a person's coordinating health professional or consulting health professional? For example, a registered medical practitioner, a nurse practitioner, or someone else? | See Terms of reference 2 |
| 18. What minimum qualification and training requirements should there be for health professionals engaged in the voluntary assisted dying process? | See Terms of reference 2 |
| 19. Which health professionals should be able to administer the voluntary assisted dying substance? For example, a registered medical practitioner, a nurse practitioner, registered nurse, or someone else? | See Terms of reference 2 |
| 20. Should registered health practitioners or other health professionals be free to initiate a discussion about voluntary assisted dying, providing information alongside other treatment and management options such as palliative care, where appropriate? | See Terms of reference 2 |
| 21. Should health professionals be required to provide certain information to a person who asks about voluntary assisted dying, in addition to providing information about other treatment and management options such as palliative care? | **NA** |
| 22. What categories of persons or professions should be permitted to conscientiously object to being involved in voluntary assisted dying? Should this be limited to registered health | **NA** |

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| practitioners? | |
| 23. Should health professionals who conscientiously object or who choose to not participate in the voluntary assisted dying process be required to declare their objection or non-participation to a person who is or may be interested in accessing voluntary assisted dying? | **NA** |
| 24. Should health professionals who conscientiously object to voluntary assisted dying be required to refer a person to other health professionals? Is there anything else that health professionals should be required to do if they conscientiously object, such as provide certain information about voluntary assisted dying? | **NA** |
| 25. Should a health service be permitted to not facilitate voluntary assisted dying at its facilities, for example at a residential aged care facility, a hospital, or accommodation for people with a disability? | See Terms of reference 4 |
| 26. If a health service wishes to not facilitate voluntary assisted dying at its facilities, what is the minimum the provider should be required to do so that a person's access to voluntary assisted dying is not hindered? | **NA** |
| 27. Should information about the Registrar-General's discretion for death certificates under section 44 of the Births Deaths and Marriages Registration Act 1997 (ACT) be made available to families who may require support after a person dies by accessing voluntary assisted dying? | **Yes.** |
| 28. What should be recorded as the cause and manner of death for a person who has died by accessing voluntary assisted dying? | See Terms of reference 2. An elective death or the underlying cause depending of the wishes of the person. |
| 29. What sort of oversight mechanisms are needed to ensure voluntary assisted dying is safe and effective? In particular, should oversight focus more on retrospective compliance or prospective approval? Should oversight mechanisms be independent from government? | See Terms of reference 1,2,3,4 |
| 30. If an oversight body is established, should this body review or approve compliance with key stages in the voluntary assisted dying process as a person is progressing through the process? If so, what should these key stages be? | See Terms of reference 1,2,3,4 |
| 31. Should mechanisms be available to review the decisions of a coordinating health | **NA** |

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| professional or consulting health professional in relation to a person's eligibility to access voluntary assisted dying? If so, what kind of mechanisms, and what aspects of health professionals' decisions should be reviewable? | |
| 32. What protections might be necessary for health professionals, and potentially others, who act in accordance with voluntary assisted dying legislation in good faith and without negligence? | See Terms of reference 1,2,3,4 |
| 33. Should there be specific offences for those who fail to comply with these requirements? | See Terms of reference 4 |
| 34. What other laws might need to change in the ACT to enable effective access to voluntary assisted dying? | See Terms of reference 1 |
| 35. Are there experiences elsewhere in Australia or internationally that the ACT might usefully learn from in the development of its own approach to voluntary assisted dying? | The Elective Death unit model has been drawn from consideration of 25 years of experience, of reading, of travelling to and discussion at WFRTDS conferences in Melbourne, Switzerland (at which I visited Dignitas), Chicago and Cape Town in addition to discussion with Dying with Dignity groups around Australia since 1997 when The Northern Territory Rights of the Terminally Ill Act was discontinued by the Federal Parliament's 1997 Euthanasia Laws Act. |
| 36. Are there any other matters you think should be considered in implementing voluntary assisted dying in the ACT? | It may be that the ACT Legislative Assembly will be tempted to take the models around the states and just follow their lead when changes are made to their laws. In the meantime people will suffer horrible deaths if they decide to do this. Everywhere around the world even where it appears that people are satisfied with the laws their parliaments have made, they are not. In the Netherlands, for example, people are risking their careers and possible gaol terms to help others to die who have not been given permission to die by doctors. In Canada people are challenging the law in relation to mental health and dementia so I suggest to the ACT Legislative Assembly that it would be better to be bold and establish an elective death unit which trusts human beings to know themselves and which is consistent with The ACT Human Rights Act. Let's get it right the first time. |