Submission No 38

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Catholic Bishops of New South Wales and the Bishops of the Australasian- Middle East Christian Apostolic Churches

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SUBMISSION TO THE STANDING COMMITTEE ON LAW AND JUSTICE FROM THE CATHOLIC BISHOPS OF NEW SOUTH WALES AND THE BISHOPS OF THE AUSTRALASIAN-MIDDLE EAST CHRISTIAN APOSTOLIC CHURCHES

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Introduction

Introductory comments

The 'sanctity of life' principle rests upon two complementary sources: faith and reason.

In secular philosophy the principle refers to the ‘sacredness’, ‘dignity’ or preciousness of human beings. This worth is said to be intrinsic to human beings and so cannot be taken away or volunteered away. It is the basis of the ‘right to life’ and equal treatment of human beings. The right to life likewise is inviolable, inalienable and ‘non-derogable’, that is it may not be denied by any state, group or individual nor surrendered by any individual.

It is important to note that the sanctity of life principle has long informed Hippocratic ethics—the Hippocratic Oath specifically excludes giving anyone a poison even if asked—and has been observed in the best traditions of healthcare as stated in codes of medical and nursing ethics down the centuries to today. It has been part of the common morality of the great civilisations, is expressed in the best secular philosophies as in the world religions, informs the common law and has been restated in international human rights instruments.

In Judeo-Christian faith, as in some other religions, human beings are said to be “created in the image and likeness of God” and destined to God as their ultimate goal. For Christians the belief that in Jesus Christ God became a human person, who suffered, died and rose for the salvation of humankind, endows humanity with an even greater dignity. On both counts the dignity of the human person (and the sanctity of human life and the right to life) is prior to the state rather than granted by the state. It is neither dependent on good health nor diminished when it fades. God is the author of life and commands “you shall not kill”.

For this reason, the Catholic and Orthodox faiths reject all forms of euthanasia and assisted suicide. The *Catechism of the Catholic Church* states:

> *“Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable. Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.”*[1]

This does not mean that life must be prolonged in all circumstances. Again, in accordance with Hippocratic and other sound secular ethics, the Christian wisdom is that it is legitimate to discontinue medical procedures that are ineffective or overly burdensome or disproportionate to the expected outcome. Such acceptance of death is part of good end-of-life care.

The fundamental shift in thinking assumed in the *Voluntary Assisted Dying Bill 2021* should not be underestimated: it marks a radical departure from one of the foundational principles of our civilisation and society.

Euthanasia and assisted suicide are referred to by their proponents as acts of 'compassion.' The word 'compassion' means to 'suffer with.' True compassion, therefore, is about sharing another's pain, not killing the person who is suffering. It is a test of our love, requiring the investment of time, companionship, prayer and hope in the person who is suffering. It is costly but vital to a good society.

Euthanasia and assisted suicide are not just private matters, because they draw medical professionals, lawyers, regulators and the whole community to the bedside. Laws that allow the killing of a certain class of people, or the provision of assistance for them to die, ask us all to agree that some people are better off dead and that our laws and health professionals should give them the assistance and equipment to make that happen.

Such laws have a devastating effect on society because once we accept that some people can be killed, we begin to question whether more people also might be killed.

This is not so much about exposing the danger of the 'slippery slope', for which there is growing evidence in various jurisdictions, but more about revealing the flow of any argument in favour of the legalisation of euthanasia and assisted suicide.

Undermining the key principles that doctors never kill patients and that our state does not sanction killing innocent people fundamentally and permanently alters the doctor-patient relationship and our justice system.

It separates us into two classes of people.

The lives of the first class of people are considered sacred and to be treasured. Their right to life is 'inalienable' and anyone who seeks to end the life of such a person is subject to the criminal law. Society also tries to stop their deaths from self-harm through suicide prevention programmes, clinics and help lines. This class of people, if they are feeling suicidal, are protected and treated and assisted. Their life is protected by homicide laws, medical practices, government spending and social attitudes.

The lives of the second class of people are not respected in the same way and are deemed no longer worth living. The state sanctions their deaths and the medical and legal professions facilitate their killing. Medical professionals are free to suggest they should end their lives and give them access to the means to do so. Instead of a suicide prevention programme, there are government-funded 'navigators' to facilitate their access to lethal drugs. Their treatable depression is ignored and they are not protected by homicide laws, medical practice, government spending or social attitudes.

As St John Paul II wrote:

> *"These people are very often isolated by their families and by society, which are organized almost exclusively on the basis of criteria of productive efficiency, according to which a hopelessly impaired life no longer has any value."*[2]

This does not make for a good society. Our laws should not tell our sick and vulnerable that we believe they would be better off dead or that our society would be better off if they were dead.

For this reason, our primary submission is that the Bill should be voted down and not allowed to pass into law.

We note, however, that the Terms of Reference for this inquiry are limited to the provisions of the Bill and for that reason, the remainder of this submission will focus on those provisions, with terms used in this submission having the same meaning as given in the Bill (unless otherwise defined.) In commenting on the provisions of the Bill, we are in no way endorsing the practice of euthanasia or of assisted suicide or condoning its legalisation in any form in this state.

Executive Summary

The 'sanctity of life' or right to life is the premise of all other human rights and responsibilities and so can never be surrendered or rightly taken away. It is not recognition by the State that endows this right; it is inherent to the dignity of the human person and prior to the State. It is the role of the State to protect human life above all other interests. Any law that only recognises the sanctity of or right to life in some circumstances, and allows its taking in others, will always be unjust. The *Voluntary Assisted Dying Bill 2021* (**Bill**) is an unjust bill, because it separates people into two tiers: those whose lives we fight to save, and those whose lives we regard as not worth living.

We oppose this Bill, and ask the Committee to reject it. It is an extreme Bill, which goes far beyond euthanasia and assisted suicide laws in other jurisdictions.

The submission discusses particularly troubling aspects of the Bill under the following themes:

- **Choice of language**. The Bill adopts euphemistic language used by euthanasia and assisted suicide advocates that seeks to mask the reality of what the law permits: homicide and the aiding and abetting of suicide, until now part of the criminal law.
- **Access to healthcare.** There are many areas of NSW, particularly regional, rural and remote parts of the state that do not have access to basic healthcare, let alone access to high quality palliative care. The Parliament should focus on ensuring everyone has equal access to healthcare and every dying person access to palliative care rather than prioritising the false choice of euthanasia and assisted suicide.
- **Eligibility.** The eligibility criteria, particularly surrounding decision-making capacity and voluntariness, are lax and would allow for the deaths of many vulnerable persons.
- **Process.** There are many aspects of the process that are liable to abuse, placing already vulnerable persons at risk and placing other people beyond scrutiny.
- **Conscience protections.** The Bill provides an egregious attack on the conscience rights of individual medical practitioners and faith-based institutions. These provisions are not amenable to amendment and must be deleted in their entirety if conscience rights are to be protected.
- **Enforcement.** It is alarming that many of the enforcement provisions of the Bill favour protection of medical professionals and others involved in the process, rather than protection of the vulnerable under the Bill.
- **Review.** The ability of the Supreme Court to review decisions made under the Bill is so limited as to allow it almost no review role at all. The role of the Supreme Court needs to be expanded.
- **Transparency and accountability.** There are many provisions in the Bill that attempt to shroud the process in secrecy, even deception, and shield it from public scrutiny and accountability.

This is an extreme Bill. Its provisions put our most vulnerable at risk and seeks to protect malfeasance through secrecy and protection from liability. It is our submission that no end of amendments to this Bill can make it safe because euthanasia and assisted suicide laws are, by their nature, unsafe. The Bill must be rejected in its totality. If it survives, it requires major revision.

Recommendations

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2.	Section 12 should be deleted.	11
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5.	Sections 28(1)(b) and 28(1)(c) should be amended to require referral for treatment options in addition to the provision of information about treatment options for patients deemed to meet the eligibility criteria for euthanasia and assisted suicide.	12
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14.	Section 18 should include a requirement that the coordinating practitioner and consulting practitioner be independent of each other.	16

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16.	Section 19(3)(b) should be deleted, as should similar sections 48(3)(b) and 57(3)(b).	17
17.	Section 26(2) should be amended to require a referral to a medical practitioner with a specialist qualification in the disease, illness or medical condition suffered by the patient. A similar amendment should be made to section 37(2).	17
18.	Section 27(2) should be amended to require a coordinating practitioner to have regard to prior medical history and seek a referral to a multidisciplinary team of professionals and a requirement to consult anyone who might have standing under section 108(c). A similar amendment should be made to section 38(2).	18
19.	Section 28(j) should be amended to require a treating practitioner to be notified that a patient has requested euthanasia or assisted suicide.	18
20.	Section 30(4)(i) should be amended to ensure that all referrals made under section 26(2) or 27(2) be included in the first assessment report and that a coordinating practitioner who went against the advice contained in the referral give written reasons as to why. A similar amendment should be made to section 41(4)(j).	19
21.	Section 36(3) should be amended to make it clear that the consulting practitioner may not have regard to information prepared by, or at the instigation of, the coordinating practitioner in making their assessment.	19
22.	Section 43(4) should be amended to exclude the ability for those who would be an ineligible witnesses (as outlined in section 44(1)(b)) from being able to sign a written declaration on behalf of the patient.	19
23.	Section 60(6) should be amended to exclude the ability for those who would be an ineligible witnesses (as outlined in section 44(1)(b)) from being able be the necessary witness to a practitioner-administered lethal substance.	19
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33.	Section 9 should be amended to make it clear that a health practitioner may withdraw from the euthanasia or assisted suicide process at any time.	22
34.	Section 21(5)(b) should be deleted.	22
35.	Section 23(2)(h) and the similar sections 32(5) and 34(2)(e) should be deleted.	23
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Choice of language

The Bill adopts euphemistic language used by euthanasia and assisted suicide advocates that seeks to mask the reality of what such a law would permit. The Bill should be clear about the intention of the resulting change in the law - to overturn our long-standing criminal laws pertaining to homicide and the aiding and abetting of suicide.

Section 1 – Name of Act

The Bill should be renamed as the *Euthanasia and Assisted Suicide Bill 2021*.

Section 1 states that, if passed, the Bill is to be called the *Voluntary Assisted Dying Act 2021*. 'Voluntary assisted dying' is euphemistic language used to make the practice less intelligible and more palatable. This is understandable for lobby groups but the Parliament should be honest about what its laws actually do.

What is now the *Abortion Law Reform Act 2019* (NSW) was first tabled in Parliament as the *Reproductive Health Care Reform Bill 2019* (NSW.) During the debate, an amendment to better reflect the practice the bill was enshrined into law.

Section 12 – Voluntary assisted dying not suicide

Section 12 should be deleted.

Section 12 states that a person who dies as a result of the administration of a prescribed substance in accordance with the Bill does not die from suicide. This is an attempt to create a legal fiction and should not be contained in the law. The Bill deals with matters of homicide and suicide and the language of the Bill should reflect this.

Section 1A.1 – Births, Deaths and Marriages Registration Act 1995 No 62

The new section 43(3)(a) of the *Births, Deaths and Marriages Registration Act 1995 No 62* (NSW) proposed in section 1A.1 should be deleted.

This provision requires that a person's underlying illness that made the person eligible for euthanasia or assisted suicide be listed as the cause of death, rather than the administration of a lethal substance. The purpose of a death certificate is to accurately record, among other things, the cause of a person's death and so should reflect that the cause of death was a lethal drug, either self-administered or practitioner-administered. False record-keeping would not only tell a deceptive story about a person's death but also make serious research into the circumstances and effects on these deaths impossible.

Access to healthcare

Article 12 of the International Covenant on Economic, Social and Cultural Rights provides for "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and obligates State parties, among other things, to create the "conditions which would assure to all medical service and medical attention in the event of sickness."[3]

The UN Committee on Economic, Social and Cultural Rights has said this includes a specific obligation on State parties to ensure access to palliative health services[4].

However, New South Wales currently does not live up to these obligations. Evidence before the ongoing Health Portfolio Committee Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW, has highlighted the egregious lack of healthcare, including oncology, radiation, allied health, mental health and palliative care, in non-metropolitan regions of NSW.

In terms of palliative care, NSW has 1.1 full-time equivalent (FTE) palliative medicine physicians per 100,000 population[5]. This is around half of the benchmark of 2.0 FTE palliative medicine physicians per 100,000 population recommended by Palliative Care Australia[6].

Section 4 - Principles

The reference to "voluntary assisted dying" in section 4(1)(i) should be replaced with healthcare.

Section 4(1)(i) currently states, as a principle of the Bill, that "a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region."

The public hearings for the Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW running in the Parliament will continue until the end of this year. Evidence already received by the Committee so far has demonstrated the inequality of access in terms of basic healthcare and end-of-life care. It would be extraordinary if the Parliament, through section 4(1)(i), committed itself to the principle of equal access to euthanasia and assisted suicide so that people suffering from a terminal illness might be able to end their lives without equally committing itself to the principle of equal access to the necessary healthcare to assist them to live in comfort, and die with dignity.

Section 28 – Information to be provided if patient assessed as meeting eligibility criteria

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Sections 28(1)(b) and 28(1)(c) should be amended to require referral for treatment options in addition to the provision of information about treatment options for patients deemed to meet the eligibility criteria for euthanasia and assisted suicide.

Section 28(1)(b) requires that a coordinating practitioner provide a patient with information about the treatment options that would be considered 'standard care' for their disease, illness or medical treatment and the likely outcomes of that treatment. In a similar fashion, section 28(1)(c) requires a coordinating

practitioner to provide information about palliative care and treatment options available to the patient and the likely outcomes of that care and treatment.

The provision of information to a patient is not sufficient; the patient must also be offered a referral for any such care and treatment. Likewise it is essential that the coordinating practitioner be a specialist in the patient's particular condition.

Under the *Voluntary Assisted Dying Bill 2017* (NSW), rejected by the Legislative Council on 16 November 2017, the coordinating practitioner (named the 'primary medical practitioner' under that bill) was required to offer to refer the patient to a palliative care specialist, not simply provide information about palliative care. Under that same bill, a referral for 'standard care' for their disease, illness or medical treatment was not necessary, given that the primary medical practitioner under that bill was required to be a specialist in the patient's condition. This safeguard has been removed in the current Bill before Parliament.

Section 180 – Standard about access to voluntary assisted dying

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Section 180 should either be deleted or amended to require the access standard to address access to all forms of healthcare, rather than focusing on access to euthanasia and assisted dying.

As noted above in relation to section 4(1)(i), the ongoing Health Portfolio Committee Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW has highlighted the lack of basic healthcare and end-of-life care in rural, regional and remote parts of the state. Any access standard issued by the Health Secretary and facilitated by the Ministry of Health must address the need for equal access to healthcare and palliative care in non-metropolitan NSW. It would be immoral to propose that the only 'equality of access' for those in regional, rural and remote NSW would be with respect to lethal drugs and not actual medical treatment.

Eligibility

The eligibility criteria, particularly as they pertain to decision-making capacity, are too broad and liable to abuse or mistake that will lead to wrongful deaths.

Section 6 – Decision-making capacity

References to 'voluntary assisted dying' in section 6(1) should be deleted.

Section 6(1) should also be amended to require a compulsory mental health assessment to ensure decision-making capacity.

Section 6(2)(b) should be amended to reverse the statutory presumption of capacity.

Section 6(1) seeks to define decision-making capacity with respect to voluntary assisted dying. However, decision-making capacity cannot be compartmentalised to only deal with a request for euthanasia or assisted suicide, but rather assessed more holistically.

The *Voluntary Assisted Dying Bill 2017* (NSW), rejected by the Legislative Council on 16 November 2017, required a patient to be examined by a qualified psychiatrist or psychologist after they made a first request for euthanasia or assisted suicide. This mental health safeguard has been removed in the Bill currently before Parliament and should be reinstated.

Further, in providing for a presumption of decision-making capacity "unless the patient is shown not to have the capacity," section 6(2)(b) fails to offer any detail about how a lack of decision-making capacity might be shown and who might be consulted in the process for capacity to be determined. It also places no obligation on the medical professional to make inquiries about decision-making capacity or to seek access to existing medical records. If anything, it incentivises the medical practitioner not to make any inquiries about capacity so as to avoid receiving any information that might challenge the presumption of capacity. The Law Society of New South Wales has commented that it is very difficult to prove that a person lacks legal capacity[7]. Given the centrality of decision-making capacity to any so-called 'voluntary' assisted dying process, the presumption should be reversed such that capacity must be demonstrated, rather than presumed.

Section 16 – Eligibility criteria

Section 16(1)(d)(iii) should be deleted.

Section 16(1)(d)(iii) includes an eligibility requirement that the disease, illness or medical condition suffered by the person "is causing suffering to the person that cannot be relieved in a way the person considers tolerable."

The test is subjective and so is not capable of any challenge, no matter how irrational or unreasonable that judgment may be. For this reason, it has no legal effect and its presence in the Bill might indicate that it is a safeguard when in reality, that is not the case.

Section 17 – Residency exemptions

Section 17 should be deleted.

The residency requirements in the Bill are already quite lax, with a person only required to be ordinarily resident in NSW for 12 months before making a request for euthanasia or assisted suicide.

Given that euthanasia and assisted suicide are now legal and people can access lethal drugs in all Australian states other than NSW, there is no practical need for a residency exemption.

Process

There are many aspects of the process for euthanasia and assisted suicide outlined in the Bill that fail to protect the person making the request for euthanasia or assisted suicide. Unless these are remedied, vulnerable persons are placed at risk of wrongful deaths.

Section 10 – Health care worker not to initiate discussion about voluntary assisted dying

Sections 10(2) and 10(3) should be deleted.

Sections 10(2) and 10(3) allow medical practitioners and other health care workers to initiate discussions with a patient about euthanasia or assisted dying and suggest these to the patient. In doing so, they undermine supposed prohibition against health care workers suggesting euthanasia and assisted suicide to their patients.

The prohibition on medical professionals suggesting euthanasia or assisted suicide to their patients is an important safeguard as it recognises the vulnerability of very sick people, the power disparity between a doctor and patient, and the significant ability for a doctor to influence their patient's choices. It also recognises that when a doctor provides information about a proposed course of action to a patient, it is often viewed by the patient as a recommendation, or 'the right thing to do'.

Sections 10(2) and 10(3) provide that a medical practitioner or other health care worker suggesting euthanasia or assisted suicide to a patient must simultaneously provide information about treatment options and palliative care. However, a breach of these obligations would be impossible to prove without a recording.

It is noteworthy that the *Voluntary Assisted Dying Act 2017* (Vic) includes a prohibition on medical practitioners and other health care workers initiating discussions about euthanasia and assisted suicide with their patients.

Section 18 – Eligibility to act as a coordinating practitioner or consulting practitioner

Section 18 should include a requirement that the coordinating practitioner be a specialist in the disease, illness or medical condition suffered by the patient.

Section 18 should also include a requirement that the coordinating practitioner and consulting practitioner be independent of each other.

Section 25(2) requires a coordinating practitioner to make a decision about a patient's eligibility for euthanasia and assisted suicide against the eligibility criteria, and section 28(1) requires a coordinating practitioner to give a patient, among other things, information about their diagnosis and prognosis, treatment options and the likely outcomes of that treatment, and palliative care treatment and the likely outcomes of that treatment. However, with the coordinating practitioner not required to be a specialist in the patient's medical condition, it is unlikely that the coordinating practitioner will be able to give this

information accurately. Patients should be examined by a relevant specialist and have the specialist provide them with information before making a decision about ending their lives.

The safeguard of a specialist practitioner was contained in the *Voluntary Assisted Dying Bill 2017* (NSW) and has been removed in the Bill currently before Parliament.

Another safeguard that was contained in the *Voluntary Assisted Dying Bill 2017* (NSW) was that the coordinating and consulting practitioners needed to be independent of each other. This has also been removed from the Bill before Parliament and should be reinstated.

Section 19 – Person may make first request to medical practitioner

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Section 19(2)(c) should be deleted, as should similar section 48(2)(b). As a consequence, sections 23(2)(d) and 182 should also be deleted.

Section 19(3)(b) should be deleted, as should similar sections 48(3)(b) and 57(3)(b).

Requests for euthanasia or assisted suicide should not be able to be made using audiovisual means, ie via telehealth. The coordinating practitioner and the consulting practitioner need to assess the patient against the eligibility criteria, including making a diagnosis and assessing prognosis. It should not be possible for this to occur without the practitioners ever meeting or physically examining the patient.

Additionally, the coordinating practitioner and the consulting practitioner need to make an assessment about voluntariness. The NSW Legislative Council Committee Inquiry into Elder Abuse in NSW heard evidence that the medical profession has been slow to identify and manage elder abuse[8]. Elder abuse will be even more difficult to detect when a patient is not physically present.

Section 19(3)(b) allows for a request for euthanasia or assisted suicide to be made by non-verbal means, including 'gestures.' These gestures are not specified and it is not clear how the interpretation of these gestures by a coordinating practitioner could be challenged, given that there is no requirement for the gestures to be recorded in any manner.

The *Voluntary Assisted Dying Bill 2017* (NSW) required that all non-written requests for euthanasia or assisted suicide and all requests made with the assistance of an interpreter be filmed so that they could be subject to scrutiny. The Bill currently before Parliament removes this safeguard, while at the same time extending the provision to allow death to be requested using gestures.

Section 26 – Referral to another medical practitioner for opinion – disease, illness or medical condition

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Section 26(2) should be amended to require a referral to a medical practitioner with a specialist qualification in the disease, illness or medical condition suffered by the patient. A similar amendment should be made to section 37(2).

Section 26(2) requires a coordinating practitioner who is unable to decide whether a patient has a disease, illness or medical condition that meets the requirements of section 16(1)(d) to be referred to "a medical practitioner who has the appropriate skills and training to make a decision about the matter."

The requirement should be that a patient is referred to a specialist in their disease, illness or condition so that the matter can be assessed by someone with the appropriate expertise.

Section 27 – Referral for opinion – other matters

Section 27(2) should be amended to require a coordinating practitioner to have regard to prior medical history and seek a referral to a multidisciplinary team of professionals and a requirement to consult anyone who might have standing under section 108(c). A similar amendment should be made to section 38(2).

Section 27(2)(a) requires a coordinating practitioner who is unable to decide whether a patient has decision-making capacity to "a psychiatrist or another registered health practitioner who has the appropriate skills and training to make a decision about the matter."

Section 27(2)(b) requires a coordinating practitioner who is unable to decide whether a patient is not acting voluntarily or is acting under duress or pressure to refer the patient to "a psychiatrist or another registered health practitioner or person who has the appropriate skills and training to make a decision about the matter."

These referrals are insufficient and do not take into account the multidisciplinary nature of matters of consent and voluntariness, nor does it require a coordinating practitioner to review previous medical history for indication of decision-making capacity, pressure or duress. It also does not adequately take into account the prospect that family members or others close to a patient might be able to offer insight as to whether a patient is acting under pressure or duress, or indeed whether a family member consulted pursuant to section 27(2)(b) might be the cause of the pressure or duress and so properly be ineligible.

The sections should require a multidisciplinary team that includes a legal professional and the patient's treating practitioner to assess capacity and voluntariness when it is in doubt, and for information to actively be sought from any person who might have standing under section 108(c).

Section 28 – Information to be provided if patient assessed as meeting eligibility criteria

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Section 28(j) should be amended to require a treating practitioner to be notified that a patient has requested euthanasia or assisted suicide.

The inclusion of an obligation that a patient's treating practitioner be notified of the patient's request for euthanasia or assisted suicide is an important safeguard in this process, because the treating practitioner would likely have information relevant to the patient's request. Additionally, mandatory notification would give the practitioner the ability to seek a review under Part 6 of the Bill.

Section 30 – Recording and notification of outcome of first assessment

Section 30(4)(i) should be amended to ensure that all referrals, if more than one, made under section 26(2) or 27(2) be included in the first assessment report and that a coordinating practitioner who went against the advice contained in the referral give written reasons as to why. A similar amendment should be made to section 41(4)(j).

Sections 26(2) and 27(2) provide for referrals to be made when the coordinating practitioner is uncertain as to certain eligibility requirements, but do not obligate the coordinating practitioner to then follow that advice. If a coordinating practitioner decides to act against what is contained in a referral, then he/she should provide a record of why that is the case.

Section 36 – Consulting assessment

Section 36(3) should be amended to make it clear that the consulting practitioner may not have regard to information prepared by, or at the instigation of, the coordinating practitioner in making their assessment.

As outlined above, the Bill currently before Parliament dispenses with the independence requirement between the coordinating and consulting practitioners that was present in the *Voluntary Assisted Dying Bill 2017*. While section 36(2)(b) requires that the decision be made independently of the coordinating practitioner, it should be made clear that this means that the coordinating practitioner cannot use section 36(3) to circumvent this requirement of independent advice.

Section 43 – Patient assessed as eligible may make a written declaration

Section 43(4) should be amended to exclude the ability for those who would be an ineligible witnesses (as outlined in section 44(1)(b)) from being able to sign a written declaration on behalf of the patient.

If a patient is unable to sign a written declaration to access euthanasia or assisted suicide, there should be a safeguard that requires the written declaration to be signed by someone other than a person who may have influence over the patient, or who may benefit from their death.

Section 60 – Practitioner administration

Section 60(6) should be amended to exclude the ability for those who would be an ineligible witnesses (as outlined in section 44(1)(b)) from being able be the necessary witness to a practitioner-administered lethal substance.

If having a witness to a doctor providing a lethal injection to a patient is intended to be a safeguard, then this should exclude anyone who may have influence over the patient, or who may benefit from their death.

Section 73 – Information to be given before prescribing substance

Section 73(2) should be amended to require information to be provided to the patient about the ways in which they can revoke their self-administration decision.

Section 73(3) should be amended to require information to be provided to the patient about the ways in which they can revoke their practitioner administration decision.

Section 73(2)(b) provides that a patient must be informed that they are not under an obligation to obtain the assisted suicide drugs, section 73(2)(c) provides that a patient must be informed that they are not under an obligation to self-administer the assisted suicide drugs and section 73(3)(b) provides that a patient must be informed that they are not under an obligation to have the substance administered. However, these clauses stop short of requiring the coordinating practitioner to provide information about how to formally revoke the self-administration or practitioner administration request. This information should be required so that a patient knows how to record any change of mind.

Section 188 – Interpreters

Section 188(1)(b) should be amended to require interpreters to be independent from the coordinating and consulting practitioners.

Section 190 – Review of Act

Section 190(2) should be deleted.

Section 190(2) seeks to require certain aspects of the Act to be included in a review. There is no reason to prioritise these areas of review and doing so risks steering a review in the direction of expansion (as has been the case for euthanasia and assisted suicide laws in all other jurisdictions.) The section should therefore be deleted.

Schedule 1 - Dictionary

The definition of 'designated period' should be amended to extend the minimum period between first and final request.

The definition of 'family member' should be broadened to include uncles, aunts, cousins, nieces and nephews.

The definition of 'pressure or duress' should be expanded to include the common law definition of duress.

A five-day period between the first and final request for euthanasia or assisted suicide is too short and should be extended. Not only does it limit the ability for notification of, and consultation with, the treating practitioner, family members and other interested parties, it also does not provide sufficient time for mental health practitioners and palliative care specialists to assist the patient. Additionally, a

five-day period limits the ability of the Supreme Court review provisions in Part 6 to provide any real oversight or protection, because a review can only be initiated after a first request is made.

NSW has a large, multicultural community and the narrow definition of 'family member' does not adequately take into consideration the importance of extended families, particularly for culturally and linguistically diverse communities. The definition should be extended.

The definition of 'pressure or duress' as inclusive of abuse, coercion, intimidation, threats and undue influence is too narrow, as it appears to require evidence of unlawful action and does not allow for more subtle and even lawful forms of pressure or duress.

For example, the NSW Parliament Legislative Council General Purpose Standing Committee No. 2 Report on Elder Abuse recognised that a common factor in elder abuse was the dependence by the victim on the perpetrator for day-to-day needs[9]. Applied to the circumstances considered by the Bill, there should be a recognition of the opportunity for subtle pressure to be exerted by those with carer responsibilities.

Additionally, there is a growing recognition of 'lawful act duress' in the common law that does not require the presence or threat of unlawful action in order for duress to be established. The Bill should also recognise the existence of 'lawful act duress' and expand this definition accordingly.

Consultation with Voluntary Assisted Dying Review Board

The process for euthanasia and assisted suicide should also require a coordinating practitioner to check with the Voluntary Assisted Dying Review Board for any prior requests made by a patient.

The Bill should include a requirement that coordinating practitioners check with the Voluntary Assisted Dying Review Board whether a patient has made a previous request for euthanasia or assisted suicide but was deemed to be ineligible. This would provide some limitation on a patient engaging in 'doctor-shopping' in order to find someone to approve euthanasia or assisted suicide.

Conscience protections

The issue of conscientious objection is of grave concern to all Catholic and Orthodox medical professionals, and others who hold a belief that it is always wrong to take a human life in accordance with the Hippocratic tradition as well as their own faith. Requiring medical professionals or medical institutions to have any role in an action that they believe to be gravely immoral is an unjust imposition on the right to freedom of thought, conscience and belief.

Article 18(3) of the *International Covenant on Civil and Political Rights* states that this freedom "may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."[10] In its General Comment on this article, the UN Human Rights Committee states that any limitations must be "proportionate to the specific need on which they are predicated."[11]

The obligation of a medical professional to violate their conscience in such a way that would make them complicit in a patient's death by requiring them to refer a patient to a doctor willing to administer or prescribe lethal drugs does not meet this test of proportionality, because information about euthanasia and assisted suicide can be accessed or provided in other ways that do not impose upon the consciences of doctors.

Additionally, requiring a faith-based hospital or aged care facility to allow any part of the euthanasia or assisted suicide process on its premises not only undermines the freedoms of religion and conscience, but also the freedom of association, because it insists that there be no aged care facility or hospital in the state where those who do not wish to have any part in euthanasia and assisted suicide. It amounts to a denial of the right of churches and faiths to establish and conduct care institutions in accord with the ethos of that church or faith.

Section 4 - Principles

Section 4(1)(k) should be amended to include respect for conscience.

Freedom of conscience is a key human right, guaranteed under international human rights instruments. There is no reason for its omission from the principles underpinning the Bill.

Section 9 – Registered health practitioner may refuse to participate in voluntary assisted dying

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Section 9 should be amended to make it clear that a health practitioner may withdraw from the euthanasia or assisted suicide process at any time.

The limited conscience protections for individuals contained in the Bill appear to presume that a person who has a conscientious objection to participation will hold such an objection from the beginning of the process. This provision should make clear that a health practitioner is permitted to withdraw from the process at any time for reasons of conscience.

Section 21 – Medical practitioner to accept or refuse first request

Section 21(5)(b) should be deleted.

A medical practitioner should have the right to refuse to participate in any part of a patient's death, including the provision of information about the voluntary assisted dying navigator service or other details about where a patient may find assistance to die. For a medical practitioner opposed to the intentional ending of human life, even providing the information approved by the Health Secretary is an unjust imposition on conscience. Section 21(5)(b) is tantamount to requiring a referral and should be removed.

Section 23 – Medical practitioner to notify Board of first request

Section 23(2)(h) and the similar sections 32(5) and 34(2)(e) should be deleted.

Sections 23(2)(h) and 34(2)(e) have the effect of requiring a medical practitioner to inform the Voluntary Assisted Dying Board every time they conscientiously object to participation in euthanasia or assisted suicide. It is onerous and unjust to require this type of manifestation of conscience.

In a similar fashion, medical practitioners should not be required to inform other medical practitioners of their conscientious objection, as is required by section 32(5).

Section 64 – Transfer of administering practitioner's role

Section 64(2) should be amended so that the original practitioner is not required to transfer the role of administering practitioner if they hold a conscientious objection. A similar amendment should be made to section 116(2).

Conscience rights should be protected at every stage of the euthanasia process. A medical practitioner should not lose conscience protections because their objection was raised later in the process, and so this section should make it clear that a medical practitioner with a conscientious objection is not required to refer the patient to another practitioner.

Part 5, Division 2 – Health care establishments

Sections 90 to 97 inclusive should be deleted, with Part 5, Division 3 (as amended below) to be applicable to all facilities.

Owners and operators of residential aged care facilities should not be forced to allow any aspect of euthanasia or assisted suicide on their premises. As noted above, requiring institutions to allow euthanasia or assisted suicide on their premises infringes on freedoms of belief, conscience and association. It amounts to forcing faith-based care institutions to act against their core beliefs. Section 98 requires that a residential aged care facility that does not provide relevant services (as defined) to publish

that information, such that existing or incoming residents will be aware that euthanasia and assisted suicide are not available. Section 92 then requires that faith-based facilities provide the premises for others to commit euthanasia and assisted suicide.

Sections 92(2), 93(2)(a), 94(2)(a), 95(2)(a), 96(2)(a) and 97(2)(a) place residents at risk because they require an aged care facility to provide access to medical practitioners and others who otherwise do not treat the residents or have any association with the facility to access the premises, prescribe and even administer lethal drugs.

Additionally, the requirement to allow every aspect of the assisted suicide and euthanasia process to occur at a residential aged care facility prevents any person from obtaining residential aged care in a place where they can be assured there will not be lethal drugs administered to patients on site.

Section 99 – Access to information about voluntary assisted dying

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Section 99 should be deleted.

For the reasons previously articulated, owners and operators of hospitals that hold a conscientious objection to euthanasia and assisted suicide should be permitted to refuse any aspect of the process to occur on the premises, including the presence of a voluntary assisted dying care navigator service.

Section 102 – First assessments

Section 102(3) and similar sections 103(3), 104(3), 105(3) and 106(3) should be deleted.

Section 102(2) and the equivalent provision in sections 103-106 inclusive require a hospital to take reasonable steps to facilitate the transfer of a patient in order for them to participate in some aspect of the euthanasia or assisted suicide process. It is a requirement placed upon the hospital, not a decision to be made by it. For this reason, the considerations listed in section 102(3) and the equivalent provision in sections 103-106 are redundant and should be removed. That this language mirrors that in Division 2 indicates an intention to impose a requirement on hospitals to allow euthanasia and assisted suicide on their premises and so it should be removed.

Enforcement

It is alarming that many of the enforcement provisions of the Bill favour protection of those medical professionals and others involved in the euthanasia and assisted suicide process, rather than protection of the vulnerable under the Bill. Protections against wrongful homicides or aiding and abetting of suicides should apply equally in this area.

Section 11 – Contravention of Act by registered health practitioner

Section 11 and the similar provision in section 10(5) should be amended to make it clear that this is without prejudice to any other offence or sanction, including those contained in section 124.

It should be clearly stated that a contravention of the Act, that might be seen as unsatisfactory professional conduct or relevant to disciplinary action is without prejudice to any other offence or sanction. The gravity of such a breach of the law should not be minimised.

Section 134 – Who may commence proceedings for simple offence

Section 134 should be amended to allow prosecution to be commenced by the Director of Public Prosecutions

There is no reason why the Health Secretary or their delegate should be the only person with authority to commence a prosecution under the Act. Breaches of the Act will involve a homicide or the aiding and abetting of a suicide and so should be able to be commenced by those responsible for such prosecutions (NSW Police, Director of Public Prosecutions etc.)

Section 135 – Time limit for prosecution of offence

Section 135 should be deleted.

An offence under the Act is either a homicide or the aiding or abetting of a suicide. There is no limitation period on these offences under the criminal law and so the inclusion of a limitation period here is not warranted.

Section 136 – Protections for persons assisting access to voluntary assisted dying or present when substance administered

Section 136 should be amended to make it clear that this is without prejudice to other provisions of the Act.

The protections offered by section 136 must be subject to other provisions of the Bill. The need for this is clear if you consider section 136(b), the protection of a person present when another person self-

administers or is administered a lethal drug, in light of section 124 which prohibits inducement by dishonesty, pressure or duress.

Section 137 – Protection for persons acting in accordance with Act

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Section 137(1)(b) should be deleted.

Section 137(1)(a) provides protection against civil and criminal liability for a person who acts in accordance with the Act, while section 137(1)(b) provides the same protection for a person who reasonably believes that they are acting in accordance with the Act. Ignorance of the law, particularly with respect to matters that deal with the taking of human life, should not be a defence to criminal prosecution or civil action.

Review

The Bill purports to limit severely the jurisdiction of the Supreme Court in terms of its ability to review decisions made by coordinating and consulting practitioners.

Section 109 – Application for review of certain decisions by Supreme Court

Section 109 should be amended to enable all eligibility requirements to be subject to review by the Supreme Court. Consequential amendments to section 113 should also be made.

Section 109 provides that certain decisions of the coordinating and consulting practitioners can be subject to review by the Supreme Court, but these are limited to decisions with respect to residency, decision-making capacity, voluntariness, pressure and duress. The section should provide the ability for all eligibility criteria, including those relating to diagnosis and prognosis, to be subject to Supreme Court review. There is no reason to limit the jurisdiction of the Supreme Court in these matters.

Section 114 – Effect of decision under s 113(a), (c), (e), (f) or (j)

Section 114(1) should be amended to make it clear that if a review application is made on more than one ground of eligibility, all grounds relevant to the application need to be decided by the Supreme Court for the section to be applicable.

Sections 114(2)(b), 114(3)(b) and 114(4)(b) should be deleted.

Section 114(1) appears to assume there will only be one ground of review in a Supreme Court application. For clarity, it should ensure that if a Supreme Court review is initiated on more than one ground, that all grounds must be satisfied before the section is applicable.

Sections 114(2)(b), 114(3)(b) and 114(4)(b) state that, when the Supreme Court substitutes the decision of a coordinating or consulting practitioner, the practitioner is "taken to have made" an assessment that deems a patient eligible for euthanasia or assisted suicide. This is unnecessary and a grave imposition on medical practitioners. The sections should simply note that it was the Supreme Court, and not the practitioner, that made the decision about eligibility.

Section 116 – Coordinating practitioner may refuse to continue in role

Section 116(1) should be amended to allow a consulting practitioner to refuse to continue in their role.

Section 116 allows a coordinating practitioner whose decision has been substituted by the Supreme Court under sections 114(2)(a) or 114(4)(a) to refuse to continue in the role of coordinating practitioner. The same freedom should also be given to a consulting practitioner whose decision has been substituted pursuant to section 114(3)(a).

Transparency and accountability

A number of provisions of the Bill seek to shroud the process in secrecy, preventing public and even Ministerial scrutiny of its operation. Given the gravity of the actions permitted by the Bill, there should be a preference for transparency and accountability, rather than for concealment.

Section 130 – Recording, use or disclosure of information

Section 130 should be deleted.

The severe penalties for disclosure of information obtained under the Act risk dissuading whistleblowers from reporting concerns about malfeasance and malpractice. Section 130 should be deleted in its entirety and the ordinary principles of privacy relating to the health sector should apply. There is no reason for additional secrecy provisions to surround euthanasia and assisted suicide. If anything, there is an argument that the process should be subject to additional scrutiny.

Section 131 – Publication of personal information concerning proceeding before Supreme Court

Section 131 should be deleted.

As outlined above, there is no reason that additional secrecy provisions should surround euthanasia and assisted suicide. The section should be deleted and normal rules surrounding the publication of material before the Supreme Court should apply.

Section 148 – Minister to have access to information

Section 148(2) should be deleted.

There is no reason that the euthanasia and assisted suicide process be shrouded in so much secrecy that even the Health Minister is precluded from having access to all relevant information. By precluding the Health Minister from having access to information, the full operation of the Act is left in the hands of unelected bureaucrats who are not accountable to the general public, which is a risk factor for abuse.

Section 149 – Membership of Board

Section 149 should be amended to require a broad range of professionals to be on the Voluntary Assisted Dying Board.

The Bill, as currently drafted, only requires that a legal practitioner with at least 7 years' professional experience be on the Board.

The *Voluntary Assisted Dying Bill 2017* required membership of the Board to include the State Coroner or their nominee, representatives from the Medical Board of Australia, the Australian Medical Association or the Royal Australasian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists or the Australian Clinical Psychology Association Limited, and Palliative Care NSW. This requirement should be reinstated.

Section 176 – Board to record and keep statistical information

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Section 176 should be amended to require the Voluntary Assisted Dying Board to collect a broader range of statistical information. Section 179 should consequentially be amended to require public reporting of this information.

Section 176, as currently drafted, only requires the Board to collect statistical information about the disease, illness or medical condition of a patient, the age of the patient, and regional residency status of a patient.

In Oregon, often held as an exemplar in assisted suicide regimes, the following information is also collected:

- whether a patient had been given a psychological assessment before they were given a lethal prescription;
- whether a patient had private health insurance;
- a patient's annual income;
- a patient's education level;
- a patient's reasons for requesting assisted suicide; and
- the length of time the doctor had been treating the patient.

The broader range of information is then made public, enabling public scrutiny as to the operation of the law and the people it affects and also allowing academic research. In order to promote transparency and accountability, similar details should be collected and made public by the Board. The public should also be made aware of details of breaches and alleged breaches of the law.

Coronial referral

All euthanasia and assisted suicide deaths should be reported to the NSW Coroner.

The *Voluntary Assisted Dying Bill 2017* required that all euthanasia and assisted suicide deaths be reported to the NSW Coroner. This safeguard has been dispensed with in the Bill currently before Parliament, but this should be reinstated.

Conclusion

The Catholic Bishops of New South Wales and the Bishops of the Australasian-Middle East Apostolic Churches submit that the *Voluntary Assisted Dying Bill 2021* should be rejected by the Committee and the Parliament because it fails in the protection of our most vulnerable elderly and disabled, terminally and chronically ill.

Even those who are determined to vote in favour of euthanasia and assisted suicide should be able to see the extreme nature of this Bill, particularly when viewed alongside the provisions of the *Voluntary Assisted Dying Bill 2017*, which the Legislative Council prudently voted against just four years ago. They should be seeking significant amendments along the lines described above.

This Bill is out-of-step with good medical practice, as well as our duty to care for the weakest amongst us, and must be rejected.

Yours sincerely in Christ,

Most Rev. Anthony Fisher OP
Archbishop of Sydney
Metropolitan of the Province

Most Rev. Terence Brady
Auxiliary Bishop of Sydney

Most Rev. Richard Umbers
Auxiliary Bishop of Sydney

Most Rev. Christopher Prowse
Archbishop of Canberra and Goulburn

Most Rev. Vincent Long OFMConv
Bishop of Parramatta

Most Rev. Brian Mascord
Bishop of Wollongong

Most Rev. Michael Kennedy
Bishop of Armidale

Most Rev. Anthony Randazzo
Bishop of Broken Bay

Most Rev. Gregory Homeming OCD
Bishop of Lismore

Most Rev. Mark Edwards OMI
Bishop of Wagga Wagga

Most Rev. Columba Macbeth-Green OSPPE
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Most Rev. Robert Rabbat
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Most Rev. Antoine-Charbel Tarabay DD
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Most Rev. Amel Shamon Nona, DD
Archbishop of St Thomas the Apostle of the Chaldeans in Australia

Most Rev. Anba Daniel
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Vice-President of the Australasian-Middle East Christian Apostolic Churches

Most Rev. Basilios (Kodseie)
Metropolitan of Antiochian Orthodox Church of Australia, New Zealand and the Philippines

Most Rev. Mor Malatius Malki Malki
Metropolitan Archbishop of the Syrian Orthodox Church

Most Rev. Mar Yakoob Daniel Bolis
Archbishop of the Ancient Church of the East of Australia & New Zealand

Most Rev. Haigazoun Najarian
Primate of The Armenian Apostolic Church of Australia and New Zealand

Most Rev. Georges Casmoussa
Apostolic Visitor, Syriac Catholic Church

Very Rev. Msgr Basil Sousanian
Patriarchal Vicar of the Armenian Catholic in Australia

Rev. Fr. Andrawes Faraj
St Mark's Coptic Catholic Church

[1] Catechism of the Catholic Church (2nd ed.). (1997). Libreria Editrice Vaticana. Paragraph 2277.
[2] John Paul II. Evangelium vitae. 25 March 1995. Available from: https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html, paragraph 64.
[3] UN General Assembly. International Covenant on Economic, Social and Cultural Rights. 16 December 1966. Available from: https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx
[4] Office of the High Commissioner for Human Rights. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). 11 August 2000. Available at: https://www.refworld.org/pdfid/4538838d0.pdf
[5] Australian Institute of Health and Welfare 2021. Palliative care services in Australia. 26 May 2021. Canberra: AIHW. https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia
[6] Palliative Care Australia 2018, Palliative Care 2030 – working towards the future of quality palliative care for all, PCA, Canberra.
[7] Legislative Council General Purpose Standing Committee No. 2. Elder Abuse in New South Wales. 24 June 2016. Available from: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf
[8] Legislative Council General Purpose Standing Committee No. 2. Elder Abuse in New South Wales. 24 June 2016. Available from: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf
[9] Legislative Council General Purpose Standing Committee No. 2. Elder Abuse in New South Wales. 24 June 2016. Available from: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf
[10] UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, 171.
[11] UN Human Rights Committee (HRC), CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion), 30 July 1993, CCPR/C/21/Rev.1/Add.4, available at: https://www.refworld.org/docid/453883fb22.html [accessed 11 November 2021]