LEGISLATIVE COUNCIL

Tuesday 12 October 1993

The PRESIDENT (Hon. G.L. Bruce) took the Chair at 2.15 p.m. and read prayers.

JOINT PARLIAMENTARY SERVICE COMMITTEE

The PRESIDENT: I lay upon the table the report of the committee for 1992-93.

PAPERS TABLED

The following papers were laid on the table:

By the Attorney-General (Hon. C.J. Sumner)—

Reports, 1992-93—
- Construction Industry Long Service Leave Board.
- Country Fire Service.
- Metropolitan Fire Service.
- South Australian Commissioner of Police.
- Promotion and Grievance Appeals Tribunal.
- SA State Emergency Service.
- Technology Development Corporation.

Construction Industry Long Service Leave Board—
- Estimate of Liability as at 30 June 1993.

Regulation under the following Act—
- Summary Procedure Act 1921—Industrial Offences Exemptions.

By the Minister of Transport Development (Hon. Barbara Wiese)—

Reports, 1992-93—
- Dental Board of South Australia.
- Medical Board of South Australia.

Regulation under the following Act—
- Motor Vehicles Act 1959—National Points Demerit Scheme.

By the Minister for the Arts and Cultural Heritage (Hon. Anne Levy)—

History Trust of South Australia—Report, 1992-93.

Tertiary Education Act 1986—Report on Operations of the Act, 1992-93.

Corporation By-laws—

City of Enfield—
- No. 1—Traffic—One Way Streets—Traffic Signs.
- No. 2—Load Limit.
- No. 3—Streets, Roads, Footways and Public Places.
- No. 4—Waste Management—Garbage Removal.
- No. 5—Flammable Undergrowth.
- No. 6—Caravans, Vehicles and Tents, etc.
- No. 7—Parklands, Reserves and Playgrounds.
- No. 8—Keeping Animals and Birds.
- No. 9—Bees.
- No. 10—Dogs.
- No. 11—Permits and Penalties.
- No. 12—Moveable Signs.
- No. 13—Repeal of By-laws.

QUESTION TIME

INTENSIVE SPEECH AND LANGUAGE DISORDER UNIT

The Hon. R.I. LUCAS: I seek leave to make an explanation before asking the Minister, representing the Minister of Education, a question about the Intensive Speech and Language Disorder Unit (ISLU).

Leave granted.

The Hon. R.I. LUCAS: My office has been contacted by a number of parents who are very concerned by what they see as cutbacks to services for pre-school children who attend the Intensive Speech and Language Disorder Unit at the Crippled Children's Association at Regency Park. At present, 12 students with speech and language disorders attend the ISLU and receive the equivalent of four full school days a week in sessions. Under the proposed changes, in 1994 the ISLU will be transferred from the Education Department to the control of the Children's Services Office and moved from Regency Park to two new locations within the suburbs. More importantly, the children who attend the unit will have their session times halved so as to comply with CSO guidelines on maximum sessional times for kindergarten students: that is, four half-day sessions per week.

Parents are understandably furious about the halving of session times, particularly in view of what they claim have been outstanding achievements by the ISLU over recent years. They say that, in the 10 years during which the ISLU has been running, it has had an 80 per cent success rate in integrating children with speech and language disorders into the regular school system. They fear that if sessional times are halved their children will face unnecessary learning difficulties when they reach school. These parents believe that this hard-hearted cut back by the Arnold Government is just another example of the results of the Labor Government's State Bank disaster. My questions are:

1. Does the Minister believe that the same quality of education and assistance can be provided to these children by cutting by half their teaching time?

2. What will be the savings of moving the unit out of Regency Park and halving students' session times? Will the Minister be redirecting these savings to school-based speech pathology services to cater for the anticipated increased problems at this level?

The Hon. ANNE LEVY: I will refer those questions to my colleague in another place and bring back a reply.

MABO

The Hon. K.T. GRIFFIN: I seek leave to make an explanation before asking the Attorney-General a question about the Mabo negotiations.

Leave granted.

The Hon. K.T. GRIFFIN: The reports indicate that the South Australian Government is involved in the current round of negotiations with the Commonwealth Government and the Governments of other States except Western Australia on the legislative package to address the consequences of the High Court decision. As I understand it, the package currently under discussion provides that, in relation to South Australia, compensation for overriding native title rights will be shared 75 per cent by the Commonwealth and 25 per cent by the State in the first three years, and thereafter all compensation will be paid by the State. There is no indication of the likely cost, but for South Australia the cost is potentially substantial.

I also understand that the legal costs of establishing native title rights before the relevant tribunal will be shared 50-50 by the Commonwealth and the State, although it is not clear whether the offer applies to the costs of not only applicants but also the Crown and other parties. In addition, I understand that, under the current negotiations, State tribunals will be permitted to deal with claims but only if they act within criteria established by the Commonwealth. So, in effect, the Commonwealth sets the parameters for its operation. There

is to be no time limit on claims to native title rights, and that will necessarily create a great deal of uncertainty. A number of bodies and individuals have expressed to me their continuing concern about a lack of resolution to the problem, and there is continuing uncertainty over security of title, which again necessarily impacts upon business confidence. My questions to the Attorney-General are as follows:

1. Has the State Government agreed to the compensation and costs components of the legislative package?

2. Has the State Government agreed that there should be no time limits on claims for the recognition of native title rights?

3. Has the State Government agreed to the formation of a State tribunal and, if it has, what form is it proposed that this will take?

4. What other matters have been agreed by the State Government, and when is State legislation expected to be available for the scrutiny?

The Hon. C.J. SUMNER: I cannot answer those questions: the matter is still being negotiated between this State Government and other State Governments and the Commonwealth. I understand that, at least amongst the cooperating States, agreement is close.

These issues have been canvassed in one way or another in the media and been the subject of negotiation, and I am sure that the honourable member is aware of that. If he was not aware of it from the media, no doubt he has ascertained the situation from interstate colleagues of a similar political persuasion and is therefore aware of the issues that still have to be resolved. There is no point in my commenting on the issues that remain outstanding.

The only thing I would say is that the lack of resolution of this matter is of concern. But who is responsible for that? The Commonwealth, through the Prime Minister, tried to get negotiations going and an agreement with the States on this issue some months ago. He had the cooperation of South Australia, Queensland, New South Wales under a Liberal Government and the Northern Territory under a Liberal/National Party Government, but he did not have the cooperation of Victoria or of Western Australia. They refused to play at that stage, so it was extremely difficult to get a national solution to the problem. Now, after not having had anything to do with it for months, of his own decision the Premier of Western Australia, Richard Court, is claiming that he has not been consulted. He did not want to know anything about a national solution to the Mabo problem until it appeared that he was not being included in the discussions.

I am pleased that Victoria has now agreed to come into the discussions to try to resolve the matter, and I hope that eventually Western Australia will do the same. It has always been the Government's and my view that the problems of Mabo should be resolved on a national basis by legislation and principles that apply to the nation as a whole and that that should be achieved by appropriate agreements between the Commonwealth and the States. We have been pressing for that for many months, so the lack of resolution of this issue cannot be laid at the feet of the South Australian Government or of the Commonwealth Government. Those who have been difficult to get on with in this matter have been the Liberal Governments in Victoria and Western Australia. A bipartisan approach to this issue could have been developed much earlier had Victoria and Western Australia adopted the cooperative approach taken by New South Wales and the Northern Territory at the beginning of the negotiations in Tasmania.

Obviously this matter has to be resolved as quickly as possible for reasons of certainty, and the South Australian Government has been working to achieve that through a national cooperative solution. Some of the conservative commentators, who are probably closer to the Hon. Mr Griffin than to me, have been advocating that we should not do anything about Mabo; we should just let the thing be resolved through the courts. That point of view has been put forward from time to time. That is not this Government's position. We believe that the issue has to be faced at this time, that there has to be a national solution that recognises but does not override the High Court decision and that provides certainty in the manner in which native titles are dealt with in future.

The matter is still the subject of negotiation. I am sure that when those negotiations are concluded, the honourable member will get answers to his questions.

The Hon. K.T. GRIFFIN: As a supplementary question, are we to take it from the Attorney-General's answer that the State Government has not yet made any agreement in respect of any of the components to which I have referred?

The Hon. C.J. SUMNER: You cannot assume that, because the Premier has been handling the negotiations on Mabo, as have the Premiers of other States, and I am not up to date with the exact state of play in the negotiations. However, even if I were, I do not think it would be appropriate to comment because the negotiations are still proceeding.

TAXI INDUSTRY

The Hon. DIANA LAIDLAW: I seek leave to make an explanation before asking the Minister of Transport Development a question about a *de facto* taxi industry.

Leave granted.

The Hon. DIANA LAIDLAW: Taxi drivers and owners are preparing to stop work and demonstrate *en masse* outside Parliament House because they tell me they are so angry with the Government's refusal to stop the development of a *de facto* taxi industry operating in Adelaide. For two years the South Australian Taxi Industry Association has been asking the Government to enforce the specific conditions under which charter buses and limousine buses are licensed to operate under section 4b of the Road Traffic Act.

Over the period, the taxi industry has witnessed an increase from one to 10 in the number of limousine buses now operating illegally as taxis. These vehicles are illegally equipped with taxi meters and roof signs similar to a taxi sign and are illegally plying for business from designated taxi stands. Legal advice also suggests that the operation of these vehicles as taxis constitutes a breach of section 56 of the Fair Trading Act insofar as these activities, which are calculated or at least likely to deceive members of the public into believing that the vehicle is a taxi and operates on the same fare basis as a taxi. Taxi drivers and owners have run out of patience with the Minister and the Government. They want something done—anything done—to address their concerns. My questions are:

1. Does the Minister accept that the Government's failure to enforce the licence conditions under which charter buses or limousine buses can operate has led to the establishment of a *de facto* taxi industry in Adelaide?

2. As taxi owners are now paying up to $120 000 for a taxi plate whereas owners of limousine or charter buses pay no similar up-front sum to operate, does the Minister accept that

taxi owners have reason to be upset about the manner in which some charter buses or limousine buses are operating illegally in Adelaide?

3. Why has the Minister not yet agreed to meet with representatives of the taxi industry on this matter following an urgent plea by the President of the South Australian Taxi Industry Association, Mr Savas, in his letter to the Minister of 27 September, a copy of which incidentally was forwarded to me not by the association but by a representative taxi company?

The Hon. BARBARA WIESE: This matter has quite a history and essentially it dates back to the period during which my predecessor took certain steps to deregulate the taxi industry to some extent and to provide for a diversity of service to the public. I believe that the former Minister took appropriate steps at that time to try to bring about a situation in Adelaide where new opportunities could be provided for people to have access to service beyond the traditional taxi service which has been available in Adelaide, largely unchanged, for about 40 years.

It was important that such steps should have been taken at the time to give a bit of a 'gee along' to members of the traditional taxi industry who I believe have developed a complacent attitude over the years because of the very high level of protection that exists within the taxi industry in Adelaide. There must be a level of protection for the taxi industry in view of the costs that are involved in becoming a member of that industry and in order to ensure that there is a certain standard of service provided to members of the public. However, that should not be used as a means of sitting back and enjoying the fruits of an industry without proper attention being paid to high standards of service to members of the public. An element of complacency developed in the taxi industry owing to that protection. The measures to deregulate the industry, which were not welcomed by some members of the industry, but warmly welcomed by others, have led to an improvement in service.

This has led to the introduction in Adelaide of a new taxi company in Adelaide which has adopted higher standards in a range of areas over and above previous taxi companies, and that in turn is having an impact on the pre-existing companies and the standards of service that they have offered. Part of that plan was for mini-bus services, etc., to also be involved in the provision of transport for the community, and there has been the development of a hire car industry in this State, and people have set up small mini-bus services which are filling a gap within the market.

Some members of the taxi industry have opposed these moves from the very outset and have been determined to do whatever they can to stop some of those players. There is one company in particular about which the Metropolitan Taxi Cab Board and the Office of Transport Policy and Planning have received complaints over a period. Some of the complaints that have been received about that company have probably been warranted, but on the other hand many complaints have been received from that company about members of the taxi industry with respect to the sorts of attacks that it has allegedly received, both physical and in other ways, from members of the industry.

So, there is a conflict which is difficult to resolve, but I can assure the honourable member that, when information that is of sufficient standing is available that would enable either the Metropolitan Taxi Cab Board or the Office of Transport Policy and Planning to take action under the legislation under which various licences have been provided, such action has been taken. But to some extent it requires cooperation on the part of people within the industry to ensure that the industry runs smoothly and that members of the public are assured of a reasonable standard of service.

In some cases when complaints have been made they have been of such a generalised nature that it has not been possible to take action. Some complaints are made to the Metropolitan Taxi Cab Board, for example, which it does not have the power to do anything about. One of the issues, I know, that has been of some concern to people in the taxi cab industry is the alleged behaviour of at least one company using taxi stands which are provided for the traditional industry and not for bus services. The Metropolitan Taxi Cab Board does not have power over that matter: its inspectors do not have the power to move those buses on. It is a matter for City Council inspectors or for the police, and it requires members of the taxi cab industry to make appropriate complaints to the appropriate authorities in order to bring about the change that is necessary.

On the other hand, there is a member of the South Australian Taxi Association (the organisation to which the honourable member refers) which has recently made complaints to me, about which she has received a copy of some correspondence and which is actually a member of the Metropolitan Taxi Cab Board. I would have thought that if there were actions that could be taken by the board and if sufficient information could be provided to the board in the areas in which it has jurisdiction those matters would be taken up and acted upon.

This is a complicated issue, and I am quite sure that the Hon. Ms Laidlaw knows as well as I do that the taxi cab industry in this State, as is probably the case in most parts of Australia, is a very factionalised industry and it is very difficult to sort through the various issues as they arise.

However, we are doing the best we possibly can. Certainly, officers of the Office of Transport Policy and Planning have been in touch with representatives of the South Australian Taxi Association since the most recent correspondence came to me and discussions have been held. I know that the matter has also been taken up with the Metropolitan Taxi Cab Board.

I am hoping that some of the issues that have been raised, if there is sufficient information upon which to act, will be taken up with the appropriate authorities and that we might get members of the industry—whether they be licensed by the board or through the Road Traffic Act—to treat these matters seriously and take an approach based much more upon 'Live and let live' and 'Let's do the best we can to provide a diversity of service to the public.'

It seems to me that many members of the industry simply want to prevent a diversity of service being provided in the community, and that is just not good enough. The fact is that the community wants a more diverse service and if people can fill a gap then they must be allowed to do so. Some of the people who are complaining about some of these issues should get down to doing something about the sort of service that they provide to members of the public instead of trying to keep people out of the industry. If they improved the level of service and if they thought a little more creatively about the ways in which they provide a service to the public there would be more work for everyone and a much better situation. As to the specific issues that have been raised in recent times, they are receiving attention and I hope that they can be resolved satisfactorily, but it will take the cooperation of all parties involved.

The Hon. DIANA LAIDLAW: As a supplementary question, in view of the Minister's remarks about 'Live and let live', is she indicating that inspectors are not keen about, and will not diligently enforce, conditions under which limousine buses are licensed—that is, that they have no meter, no sign and that they do not ply from taxi stands? If not, is she indicating that she and her Government are prepared for further deregulation in the taxi industry?

The Hon. BARBARA WIESE: I made it quite clear that the authorities that exist will do what they are able to do under the powers that they have available to them when they have sufficient information to act on various matters. I also indicated that it is necessary to receive cooperation from people within the industry to achieve some of the outcomes that are desired by people within the industry if there are breaches of the licences under which people are operating. It is a complicated issue; I will not go through every single conversation that has been held with all these individuals about all these matters. However, what I will say and what I have said is that those who have authority in particular areas will do what they are empowered to do when they have evidence upon which to act and that I am very hopeful that, with some cooperation, members of the industry—however they have obtained their licences or under whatever authority they are licensed—will take a responsible approach to the rights of others to operate within the industry as well.

OAKLANDS PARK DRIVING CENTRE

The Hon. I. GILFILLAN: I seek leave to make an explanation before asking the Minister of Transport Development a question about the closure of the Oaklands Park Driving Centre.

Leave granted.

The Hon. I. GILFILLAN: On 13 December 1990 I asked a question relating to the long-term life and proposed use of the Road Safety Centre at Oaklands Park. I received an answer from the Hon. Anne Levy, dated 12 February 1991, which states, in part:

> My colleague the Minister of Transport has advised that the Government has no intention of closing the Oaklands Park Road Safety Centre and that the use of the centre has recently increased with practical driving tests now being conducted from the centre.

Further details are provided in the answer, and I refer members to it if they want to find out a little more about what was promised would go ahead. It was indicated, at that time, that an area of land might be sold off but without affecting in any way the use of the centre.

However, it has come to my attention this week that this undertaking has been breached and that plans for the closure of the centre and its redevelopment are well in hand. In fact, I have been advised that, at a meeting with interested parties tonight, consultants, Hassall & Partners, will unveil plans for a 37 block subdivision of the site. Residents, road safety authorities and driving instructors are adamant that the safety centre is much too valuable to the community for it to be lost. The centre is heavily utilised, and local residents say that it is not unusual to see driver training being carried out at 7 a.m. and 6 p.m.

Experts contend that the first 10 hours of driver instruction are the most crucial in the development of safe driving techniques and attitudes. In this respect, the road safety centre at Oaklands Park plays a vital role in creating greater safety on our roads. Most of the drivers who are trained are young learners for whom a controlled environment is the best possible start to their driving career. This basic training has obvious benefits for the State as a whole: the more graduates of the centre we have on our roads the less the risk of accident, and that immediately flows on to lower costs to the community for injury and damage, which, one would imagine, is self-evident.

This threatened closure comes hot on the heels of the regrettable recent shut-down of the bicycle rider education program at the centre, which was run by local service clubs because of a lack of Government funding. My questions are:

1. Does the Minister deny that the centre is being closed down?

2. If the centre is being closed down, what is the reason, and why has the Government's attitude changed from the reply that it gave in 1991?

3. Does the Minister agree that, rather than closing down such a facility, more drivers should be encouraged to use it to contribute to greater overall safety on our roads?

4. Was the Oaklands Park Road Safety Centre infrastructure funded by a levy on drivers licence fees? If that is so, the facility belongs to the community and should not be sold off to boost general revenue.

The Hon. BARBARA WIESE: The Government has no intention of closing down the Oaklands Park Road Safety Centre. From what I can gather from the selective quotes from the former Minister's reply, the situation does not seem to have changed very much since that time. Part of the road safety centre is being kept for its traditional use, but an area of land in that parcel has been identified as surplus to the needs of the Department of Road Transport. It was handed over some time ago to the Department of Environment and Natural Resources, the agency responsible for the sale of surplus Government land. That parcel of land is, therefore, now out of the control of the Department of Road Transport.

As I understand it, the department which is now responsible for that parcel of land has employed consultants to assist in identifying the most appropriate use for that land, and consultations have been held with the local community about some of the options. There have been public meetings, the most recent of which I understand took place last weekend, to enable consultation with local residents about their views on the matter and their preferences for the future. So, that matter is proceeding and is being undertaken by another department.

Regarding the section of the road safety centre that is to be retained by the Department of Road Transport, that land will be used for various purposes, many of those functions having been undertaken on that site over a number of years. However, the reason why the entire property is no longer required by the department for these purposes is that it is now the view that it is desirable for more driver training to take place on road rather than off road, so that people who are learning to drive do so in the sorts of situations that they would have to encounter when they become a licensed driver. It is believed that, if people are put into what might be termed real life experiences, they will be more likely to acquire the skills they will need for the future quicker and more competently. These are the trends in the driver training area. This means that some of the property will be required in the future to continue with some of these driver training programs, but some of the property will not be needed. The matter of the disposal of that land and its future use is, as I said, being handled by the Department of Environment and Natural Resources.

The Hon. I. GILFILLAN: I ask a supplementary question: what proportion of the centre is to be retained as opposed to the proportion that is to be sold?

The Hon. BARBARA WIESE: I cannot answer that question specifically, but I think it is about half. However, I will seek information on the exact proportion so that the honourable member is briefed on that. This matter has been under consideration for some time. Local members in the area have been kept informed, and I know that they have been involved in some of the public consultations that are taking place in that suburb.

STATE GOVERNMENT INSURANCE COMMISSION

The Hon. L.H. DAVIS: I seek leave to make an explanation before asking the Minister of Public Sector Reform a question about replies to questions.

Leave granted.

The Hon. L.H. DAVIS: On 17 August I placed a question on notice regarding SGIC and its subsidiaries and the holdings that those companies had in shares, convertible notes, preference shares and shares in unlisted companies, business undertakings or partnerships as at 30 June 1992 and 30 June 1993. After 56 days, eight weeks and two months since that important question was asked, no answer has been given. If a sharebroker were asked by a client to provide such basic information, it would be able to be provided overnight within 24 hours. SGIC would certainly be in a position to provide that answer within 24 hours.

This is not the first time in the past 12 months that SGIC has ignored the provision of an answer to a straightforward question, notwithstanding the review by the Government Management Board, which was most critical of SGIC and its administration, and this seems to suggest that there has been very little change in culture and attitude at SGIC. My questions to Minister are:

1. Will the Minister of Public Sector Reform—and I am not sure what he does under that title—immediately investigate why SGIC senior management has held Parliament in contempt and sought to avoid parliamentary scrutiny by failing to provide an answer to such a straightforward question?

2. Will the Minister ensure an answer is provided to this question no later than Thursday this week?

The Hon. C.J. SUMNER: I will not respond to the honourable member's provocation and take up Question Time, which members would no doubt resent losing. The Premier and I have made a number of statements on the question of public sector reform over the past 12 months.

The Hon. L.H. Davis: Why don't you do something about it instead of just making statements?

The Hon. C.J. SUMNER: We have. I assume only that the honourable member does not take an interest in these matters except when he comes into this Council and decides off the top of his head without any knowledge to ask questions and to make allegations about what is happening in public sector reform. In fact, what you have seen in this State over the past 12 months is probably the most comprehensive set of changes and proposals in the public sector that you would have seen for many years.

The Hon. L.H. Davis: The E&WS Department?

The Hon. C.J. SUMNER: Well, that's one of them, yes.

The Hon. L.H. Davis interjecting:

The PRESIDENT: Order!

The Hon. C.J. SUMNER: And a large number of other initiatives have been fully outlined in the Premier's economic statement, my subsequent public sector reform statement and in the statement the Premier gave prior to the budget. Work is progressing on all those matters, namely, citizens charter, customer service, etc. So, as I said, I should not be provoked into responding to that matter and taking up members' Question Time, given that what has happened in public sector reform is on the record. With respect to the honourable member's specific question, it is a question that was referred to the Treasurer by the honourable member, and I will chase it up with the Treasurer and see when a reply can be provided.

QUEEN ELIZABETH HOSPITAL

The Hon. BERNICE PFITZNER: I seek leave to make a brief explanation before asking the Minister representing the Minister of Health a question about the health services at the Queen Elizabeth Hospital.

Leave granted.

The Hon. BERNICE PFITZNER: It is reported that the health services have been deteriorating at the Queen Elizabeth Hospital because of lack of funds. The Chairperson of the hospital's Medical Staff Society, Professor Horowitz, states that there is a 5 per cent cut in the hospital funding this year, which amounts to a loss of $6 million. The Queen Elizabeth Hospital services a community which is traditionally comprised of Labor supporters. The community expects this Government would look after its supporters. However, this does not appear to be so as the medical equipment has deteriorated so that it is now functioning at a level of approximately 50 per cent—in particular, the equipment in the x-ray department, the cardiac catheter laboratory and that used for epileptic patients.

To compound this situation, the Minister signed an agreement with his Federal colleague which placed a quota on the number of private patients allowed in public hospitals. For the Queen Elizabeth Hospital, if the number of private patients exceeds 14 per cent of the total hospital patients, the hospital will be penalised. Previously, the Queen Elizabeth Hospital was able to increase its private patient percentage and, therefore, increase hospital funds and the hospital's capability to fund itself for additional equipment. Further, to add insult to injury, the other two large public hospitals, that is, the Royal Adelaide Hospital and the Flinders Medical Centre, have been given a higher private patient quota. I understand that is at 24 per cent, and that gives those hospitals greater power for increasing funds to benefit the hospital.

Thus, in the area of the Queen Elizabeth Hospital, there is a local community that is aging, of low income and shown to be more prone to strokes and respiratory disease—an area which is the Labor heartland but which is discriminated against when it comes to Government funding. My questions to the Minister are:

1. If the Government's oft-used phrase of 'social justice' is applied to the community using the Queen Elizabeth Hospital services, does the Minister believe that he has provided adequate funding to address that philosophy for this particular western community and, if not, why not?

2. Will the Minister look into the need to upgrade the medical equipment so that the present equipment will be fully functional?

3. Did the Minister realise, when the private patient quota was agreed with the Federal Government, that it would limit the hospital's ability to obtain extra funds to cope with the Government's cut in funding?

4. Can the Queen Elizabeth Hospital's private patient quota be revised so that it is at least equal to the quota of the Royal Adelaide Hospital and the Flinders Medical Centre?

The Hon. BARBARA WIESE: I will refer those questions to my colleague in another place bring back a reply.

WHISTLEBLOWERS

The Hon. M.J. ELLIOTT: I seek leave to make a brief explanation before asking the Attorney-General a question about whistleblowers.

Leave granted.

The Hon. M.J. ELLIOTT: This question relates to the State Government's commitment to protecting whistleblowers. It arises out of recent publicity given to the case of Jack King, a 64-year-old chemical engineer who has gone public after being labelled as paranoid as a result of blowing the whistle on serious pollution problems threatening South Australia's marine environment. When the Attorney-General introduced whistleblowers' legislation in this Council in November last year, he said the Government was of the opinion that action must be taken in order to provide protection for those who disclose information in the public interest. But, while the legislation includes the right for whistleblowers to seek redress for victimisation, in this case the Government itself stands accused of failing to protect—and, in fact, victimising—a whistleblower.

The case of Mr King is a complicated one, but I will attempt to summarise the salient points as they have been relayed to me. Mr King says that, as a marine pollution engineer for the South Australian Department of Environment and Planning in the mid 1980s, he was stymied from detailing to Cabinet his concerns about the pollution caused by the Port Pirie lead smelter in proposed marine environment protection legislation. In fact, I understand he spoke to several people, in order up the chain, and in each case met brick walls. CSIRO investigations had found the smelter had been responsible for discharging lead, cadmium and toxic heavy metals into the sensitive Spencer Gulf and the surrounding marine environment.

Mr King says his protests to the Minister and Commissioner for Public Employment fell on deaf ears and led him to go to the media with his concerns. What has resulted is victimisation, discrimination and a blatant denial of justice, Mr King says. His job vanished in a departmental reorganisation. He was subsequently forced to undergo a psychological examination which alleged he was a 'grandiose, obsessive paranoid'. Mr King says he subsequently lost his job and, although seconded to the E&WS Department, he is continually denied jobs he has applied for, despite an independent assessment by a leading psychiatrist in this State which found no evidence to support the Government's claims.

The Hon. C.J. Sumner: Didn't he go to court on that?

The Hon. M.J. ELLIOTT: Just let me finish. Mr King believes he has been the victim of a misuse of psychiatry aimed at marginalising him for revealing a situation where a body corporate had been involved in conduct that caused a substantial risk to the environment and to public health. He says he has revealed his concerns to the present and previous Premiers, without any adequate response. My questions to the Attorney-General are:

1. I am aware that this case occurred before the introduction of the Whistleblowers Protection Act, but would the legislation protect people in Mr King's situation, where psychiatry has been used to marginalise them?

2. Will the Government further investigate this case?

The Hon. C.J. SUMNER: The honourable member has made certain assertions—

The Hon. M.J. Elliott: They are all accurate.

The Hon. C.J. SUMNER: You've alleged that the Government has been engaged in the misuse of psychiatry. That allegation has been made, and I would have thought that it was a serious allegation. I would be very much surprised if the Government had engaged in that practice in any way.

The Hon. M.J. Elliott interjecting:

The Hon. C.J. SUMNER: The whistleblowers legislation is in place, but the normal provisions of statutory interpretation would protect those who blow the whistle in future. It may not cover Mr King's case, but he can no doubt seek his own legal advice on that. As I understood it, this matter found its way to the court.

The Hon. M.J. Elliott: Under the GME Act.

The Hon. C.J. SUMNER: I think it found its way to the Supreme Court. I note that the honourable member, in his recitation of facts, conveniently left out what I would have thought was a salient fact, namely, that Mr King had taken his case to the Supreme Court. It is all very well to say that there was no whistleblowers legislation in place then—

The Hon. M.J. Elliott: There was not.

The Hon. C.J. SUMNER: That is right, but that is hardly the point. The point I make is that you made a series of statements which you allege are all correct. I cannot say whether they are or not, although I would be extremely surprised if the allegation about the misuse of psychiatry was correct. However, it is also true that in your recitation of what you say are the facts in relation to Mr King, you have been very selective. You have not—

The Hon. M.J. Elliott interjecting:

The Hon. C.J. SUMNER: I am not making any comment on the substance of the matter; I am merely commenting on your allegation. You have come into this place and made a series of allegations which you say are facts when clearly you have left out a relevant and salient fact, namely, that Mr King at one point took his case to the Supreme Court and was not successful. Whatever one's view of that may be, I should have thought that was a relevant fact to place before the Council when the honourable member is coming in and asserting that everything in his explanation is correct.

The Hon. M.J. Elliott interjecting:

The Hon. C.J. SUMNER: Mr King's case has been around for some time. Although the Crown Solicitor has been involved in representing the Government from time to time, it is not a matter in which I have had great personal involvement, if any. I will examine the questions posed by the honourable member and see whether anything further can be added to what has already been said and what is already known about Mr King's circumstances. I can only suggest that if Mr King is still concerned, he has the right to seek legal advice on any remedy that might be available to him.

INDUSTRIAL RELATIONS

The Hon. K.T. GRIFFIN: I seek leave to make an explanation before asking the Attorney-General a question about industrial relations.

Leave granted.

The Hon. K.T. GRIFFIN: The Federal Minister for Industrial Relations, Mr Brereton, has backed off his original commitments to open up the industrial relations system in so far as it relates to enterprise bargaining being available to non-unionised workers. Now, as a result of union pressure, he has a package which puts even more hurdles in the way of employers and employees who want to negotiate an enterprise agreement without union involvement.

Mr Brereton has said that in legislating for his pro-union package, the Commonwealth will rely on the corporations power and the external affairs power under the Australian Constitution to endeavour to give the package the necessary validity.

Victoria, New South Wales and the Labor Government in Queensland say that they will challenge the validity of the package, expressing grave concern about the Commonwealth's attempt to override State laws and to use these constitutional pegs on which to hang the Commonwealth's package. My questions to the Attorney-General are:

1. Will the South Australian Government join those three States in challenging the validity of the Commonwealth's package? If not, why not?

2. Otherwise, does the South Australian Government support the deal between the Commonwealth and the ACTU?

The Hon. C.J. SUMNER: It is premature to consider the Government's attitude to this matter, as I suspect it is for the States of Victoria, New South Wales and Queensland. I do not think anyone has yet sighted the legislation. It has not yet been introduced into the Federal Parliament, let alone been passed by it. Until that occurs, there is no matter specifically before us.

I do not propose to make generalised statements whether South Australia will challenge legislation until I know exactly what that legislation is and see the basis for it. Obviously, South Australia would then consider the issue as it does normally in these matters, usually after consultation with other States which might be affected. I have not seen the statements from Victoria, New South Wales or Queensland, so I am not in a position to comment on them. More particularly, we have not seen the legislation. Until we do, I will not indicate what view the South Australian Government may take on this matter.

RURAL SCHOOLS

In reply to **Hon. M.J. ELLIOTT** (11 August).

The Hon. ANNE LEVY: The Minister of Education, Employment and Training has provided the following response:

1. Special provision has already been made to take into consideration the needs of rural schools for the 1994 staffing exercise. Additional salaries have been provided for small rural schools to offset reduced staffing caused by enrolment loss. The proportion of social justice salaries for rural schools in comparison with metropolitan schools has increased and the new distribution of resources under Priority Country Education funding will allow greater flexibility for rural schools to employ appropriate staff.

2. The effect of rural poverty has already been analysed for both staffing of schools and placement points for teachers seeking transfer. This has revealed a change in the proportion of rural schools receiving increased staffing and complexity points.

As greater emphasis is placed on the percentage of School Card students in a school than on the total student enrolment and as this is averaged over a three year period, a number of rural schools are emerging as more complex schools which attract greatest support.

3. Staff in the Statistics Unit are at present considering a range of options including Social Justice factors which will determine resourcing issues for schools. The recommendation of the review will be implemented for the 1994-95 staffing exercise.

WOMEN'S INFORMATION SWITCHBOARD

In reply to **Hon. J.F. STEFANI** (24 August).

The Hon. ANNE LEVY: Further to the response given to the honourable member on 24 August, I provide the following additional information concerning the position of Information Officer at the Women's Information Switchboard:

1. The position was advertised in the Notice of Vacancies on 21 July, 1993 (Vacancy No. 931), and closed on 6 August. The notice was aimed at people from Non-English Speaking Backgrounds, with languages in Spanish, Khmer or Italian.

The Panel selected three people for interview on 30 August, 1993. An appointment has been made and the person selected is fluent in Spanish, English and also has language skills in Italian, Serbo.Croatian, Portuguese, Polish and Russian.

2. Those interviewed were all bi-lingual. The position will be aimed at women from Non-English Speaking Backgrounds, particularly Spanish speaking women.

The successful applicant will commence duties in mid-October.

A radio program on 5EBI aimed at Spanish speaking women will commence as soon as practicable after duties are taken up.

PUBLIC SECTOR ADVERTISING

In reply to **Hon. PETER DUNN** (5 August).

The Hon. BARBARA WIESE: The Minister of State Services has provided the following response:

The aim of the master media agency scheme, which came into operation on 1 July this year, is to reduce the amount spent by Government agencies on media advertising without adversely affecting the impact of that advertising.

The provision of notice of features is a normal practice within the advertising and media industries. The reason that the two master media agencies request publishers to give them a minimum of three weeks notice of features and supplements is so that the master agencies can notify all Government advertisers of these opportunities. Sometimes the media is able to give more notice. At other times, they are able to give less.

Publishers may still contact Government advertisers direct, if they wish. However this service is provided free of charge by the two master media agencies, Charterhouse and Young and Rubicam.

It has been suggested by The Honourable Member that the master media agency scheme is causing unnecessary delays to publications with respect to typesetting and planning of features. State Services Department, which administers the scheme, is unaware of any such delays. The majority of advertisements placed with Charterhouse are typeset by Charterhouse, and since their appointment, they have not missed any agreed deadlines.

It is not true that the master media agencies must now view all advertising before it is placed with the media. The agencies are only placement agencies. A number of Government agencies produce their own material and dispatch it directly to the publishers. There is no production delay through this material having to go through a third party. Those agencies who choose to use the production facilities of the master media agencies do so for reasons of cost savings and service. Once again, no deadlines have been missed.

The following are some of the cost savings and other benefits of the master media agency scheme:

1. Government agencies are expected to make savings in the order of $2 million per annum under the master media agency scheme.

2. These savings will be made through:

2.1 Lower rates negotiated with the media due to the bulk purchasing power of the master media agencies on behalf of Government.

2.2 In campaign advertising, the bulk volume of Government advertising is added to the total volume of Equmedia, the largest media buying consortium in Australia. This results in larger discounts still.

2.3 In addition to lower rates, further advantages can be negotiated for each individual buy.

2.4 In non-campaign advertising, in addition to lower rates, cost savings can be achieved through using smaller advertisements, through using composite ads where appropriate, and through using more cost effective placement options.

2.5 In non-campaign advertising, there are large savings made through much less costly production charges.

3. Other advantages of the master media agency scheme include:

3.1 Qualitative benefits such as:

· advertising rate protection
· placement guarantees
· bonus airtime and space
· no charge sponsorships
· promotional extensions
· waiving of positional loadings
· free monitoring services

These qualitative benefits will improve the impact and the efficiency of advertising.

3.2 Tighter control of Government advertising expenditure through a centralised system that monitors the advertising spent across all departments. The State Services Department will report regularly to the Minister of State Services on the operation of the scheme.

PRIMARY INDUSTRIES DEPARTMENT

In reply to **Hon. J.F. STEFANI** (11 August).

The Hon. BARBARA WIESE: The Minister of Primary Industries has provided the following responses:

1. The annual cost to the Department of Primary Industries of the lease of the office space in the Grenfell Centre is $2 024 117.70.

2. The current lease period for Primary Industries office space is until 31.5.95. The Government has not renewed its accommodation lease recently.

3. The first senior staff placement in a region occurred in July of 1993 with the appointment of the General Manager Forests, to Mount Gambier.

4. Three more senior staff members are to be deployed to regional centres. The General Manager Horticulture, is located at Lenswood as at the 23rd August, 1993. The General Manager Livestock is located at Flaxely. The position of General Manager Field Crops is currently awaiting a permanent appointment. However, when this occurs this position will be located at Clare.

HORTICULTURE INDUSTRY

In reply to **Hon. M.J. ELLIOTT** (25 August).

The Hon. BARBARA WIESE: The Minister of Primary Industries has provided the following responses:

The Magistrate's judgement on this case is being considered by Primary Industries (SA), in particular the new Chief Inspector under the Fruit and Plant Protection Act 1992, who has been appointed after this case went to court.

It is not clear that the current inspection service needs overhauling as a result of this case, and the Minister of Primary Industries has asked for advice from the Crown Solicitor as to the implications for the Fruit and Plant Protection Act, if any, and the inspection service and its procedures.

The Chief Inspector has already begun discussions with the horticultural industry as to the nature of services which can accelerate industry development in South Australia. In this context, the operations of the inspection service and reduction of costs to industry for services which are provided, not for any SA Government benefit, but as required for the movement of produce into another State, are being considered.

In relation to the specific questions the Minister of Primary Industries advises:

1. Yes, if advice from the Crown Solicitor suggests that it is necessary as a result of this decision.

2. It is too early to consider what options need to be assessed. It will have to await advice from the Crown Solicitor.

3. Inspectors are GME Act employees. Some improved flexibility of hours may be possible under that Act.

4. Primary Industries SA is continually seeking ways of improving the cost-effectiveness of its services.

EGGS

In reply to **Hon. M.J. ELLIOTT** (5 August).

The Hon. BARBARA WIESE:

1. The Minister of Primary Industries is aware of the current problems in the egg industry. Officers in Primary Industries (SA) monitor conditions in the industry and will continue to do so while the industry is adjusting to a deregulated environment.

2. The low prices to producers are the result of continuing competition for market share. In a deregulated market the Government has little influence over the business decisions of participants in the industry.

3. A range of financial assistance measures has been announced by the Minister of Primary Industries which are available through Rural Finance and Development, Primary Industries (SA). All eligible producers in SA can apply for interest rate subsidies, grants for financial/management advice, commercial rural loans and re-establishment grants. Anyone requiring information about these packages should contact the Rural Finance and Development in Primary Industries, South Australia.

4. The Minister does not consider that regulating the industry in South Australia would have a beneficial effect on farm gate egg prices. The pricing arrangements in the dairy industry are included in the Dairy Industry Act 1992 and are effective because there is national agreement regarding milk prices. The egg industries in Victoria and New South Wales are deregulated and there is no national agreement on egg pricing. There is nothing to stop eggs from those States being sold in South Australia. Any attempt to set egg prices administratively would be unlikely to succeed because higher egg prices in South Australia would cause retailers to source cheaper eggs from other States and result in local producers losing market share.

ALICE SPRINGS-DARWIN RAILWAY

In reply to **Hon. DIANA LAIDLAW** (18 August).

The Hon. BARBARA WIESE: The Commonwealth Government has established a 'committee of eminent Australians' to examine and report upon ways in which the Commonwealth and Northern Territory Governments might foster the development of Darwin and its immediate region as Australia's northern link to East Asia.

The Committee is to be chaired by Mr Neville Wran, QC. The other members are Lady (Jessie) Kearney, Dr Stephen Fitzgerald and Mr Geoff Stewart.

Funding of $2 million for each of 1993-94 and 1994-95 was provided in the recent Federal budget.

The Committee is to identify and report to the Commonwealth and Northern Territory Governments on:

· the feasibility and potential for Darwin to develop as Australia's northern link to East Asia and as a commercial centre from which Australian business and trade with the region can be enhanced;

· social and economic impediments to the realisation of Darwin's potential to become a major commercial centre providing a business and trade interface with East Asia;

· strategies and policies to be adopted by the two Governments to take full advantage of Darwin's proximity to East Asia, particularly in the context of Australia's national commitment to the strengthening of its trading and cultural relations within the region.

It is expected that the Committee will consult with the local community and where appropriate establish working groups to assist it in its task. It will be authorised, where necessary, to undertake or commission research into factors and issues relevant to the inquiry.

The South Australian Government will monitor the work of the Committee and request involvement where the interests of the State may be affected.

The Committee will present its report to the Commonwealth and Northern Territory Governments.

STATE TRANSPORT AUTHORITY

In reply to **Hon. DIANA LAIDLAW** (8 September).

The Hon. BARBARA WIESE: The modal breakdown of the 800 000 passenger journey decline in public transport anticipated to occur during 1993-94 is as follows:

Bus	-660 000 passenger journeys
Train	-120 000 passenger journeys
Tram	- 20 000 passenger journeys
Total	-800 000 passenger journeys

This projected decline of 800 000 passenger journeys was made by the Authority in July this year and represents a decrease of 1.6 per cent, which is considerably less than the 7.0 per cent and the 7.1 per

cent declines experienced respectively during the previous two financial years 1992-93 and 1991-92.

However, in August this year a 5.1 per cent increase in patronage was experienced, and this, together with the developments occurring on the rail system, and the recently announced new Transit Link services suggests that an even better result than this 1.6 per cent decrease may be achieved.

PUBLIC SECTOR ACCOMMODATION

In reply to **Hon. DIANA LAIDLAW** (10 August).

The Hon. BARBARA WIESE: There is no capital cost associated with the relocation of the Minister of Transport Development's Office and the Office of Transport Policy and Planning to the SGIC Building. The cost of the move will be met by the incentives made available by SGIC for taking up the whole of the 12th floor as a tenant, and the Valuer General has approved the arrangement. The incentive negotiated is the same as that which would have been offered by SGIC to attract a private tenant to occupy the whole of the 12th floor.

The cost of converting a conference room on the 4th floor of the Motor Registration Building for the Chief Executive Officer of the Office of Transport Policy and Planning was $4 950. This conversion allowed the previous CEO, the Director-General of Transport, to remain in his office to be conveniently located in relation to his new duties with the Office of Public Sector Reform. This work was completed in June 1993. A further $3 400 was spent in 1992-93 on attending to various minor occupational health and safety matters on the 4th floor.

ECONOMIC DEVELOPMENT AUTHORITY

In reply to **Hon. BERNICE PFITZNER** (25 August).

The Hon. BARBARA WIESE: The Minister of Business and Regional Development has provided the following responses:

1. The International Business Department of the Economic Development Authority (EDA) is responsible for South Australia's ongoing relationship with Asian business. The Department's objectives include trade promotion, investment attraction and strategic partnering.

A strong emphasis has been placed on both North East and South East Asia, as these regions are seen as being a key focus for South Australian industry.

Specialist officers have been recruited into the Department who have both public and private sector backgrounds and also have spent many years in the Asian region. Some of these officers also possess language skills and hold post-graduate qualifications in international business.

The Department has achieved a number of important milestones in relation to the Asian business environment. It is a serious mistake to assume there is one Asian business culture when in fact there are many Asian business cultures.

Should the honourable member wish to understand more of the EDA's endeavours and achievements it is suggested that contact be made with the General Manager, International Business—Dr Leon Gianneschi (Telephone 210 8339). It must be understood however that officers travel frequently to the Asian market and may not always be available in Adelaide without advance warning. For this reason the EDA is strongly represented on the executive of a number of Asian Chambers of Commerce and enjoys a close association with these groups, particularly the Chinese Chamber of Commerce.

2. The EDA has a substantial range and depth of marketing skills and experience with particular strengths in the following areas:

· communications strategies and publicity;
· market research;
· marketing strategy;
· promotional materials for overseas markets;
· planning and management of overseas trade and investment missions;
· event management—local, national and international;
· personal selling;
· direct marketing;
· displays and exhibitions;
· visitor liaison.

Several officers within the organisation hold tertiary and professional qualifications in marketing disciplines. For the past 5 years the EDA has employed marketing graduates from the Elton Mayo School of Management of the University of South Australia, on a 12 month basis, to work within the International Business Branch.

The EDA retains a public relations consultancy firm and also utilises the marketing expertise of the South Australian Government's representatives in the various overseas locations.

The EDA is a strong advocate for an increased emphasis on marketing in economic development, and its officers contributed to the speaker program for the Australian Marketing Institute's Marketing Week which was held 16-20 August, 1993.

STATE ADMINISTRATION CENTRE

In reply to **Hon. R.I. LUCAS** (28 April).

The Hon. C.J. SUMNER: The Minister of State Services has provided the following response:

The Premier in his Economic Statement advised that the Government was reviewing its priorities for the refurbishment and fitout of the State Administration Centre. This review proposed to achieve a reduction in targeted expenditure in 1993-94 of approximately $5.0 million. This was not a saving of $5.0 million on the project but was a deferral of expenditure through a prolonged refurbishment and fitout program.

Cabinet approved initially the refurbishment of the State Administration Centre at an estimated cost of $18.5 million and at a later stage, the fitout of the building for Government agencies at an estimated cost of $9.393 million, making a total of $27.893 million.

Subsequent to the Economic Statement it was considered more appropriate to not defer the expenditure as proposed due to existing contractual obligations with refurbishment contractors. This provided an opportunity to examine the project and identify a few areas of refinement. In particular, this enabled reconsideration of the building's final occupants by appropriate central agencies. A revised program budget was approved at a total expenditure level of $28.679 million.

Prior to detailed costing of the refurbishment project, the ball park estimate was $15.0 million, excluding fitout requirements.

BENEFICIAL FINANCE

In reply to **Hon. J.F. STEFANI** (7 September).

The Hon. C.J. SUMNER: It would appear from the explanation to the question that at the creditors meeting on 9 June, 1991 Mr De Vries, acting as a proxy for Beneficial Finance suggested a proposal to the creditors, but said that he had to obtain approval of his superiors (presumably in Beneficial Finance), and that the decision 'is being made by the Attorney General's Office, as it has taken charge in Adelaide'.

Obviously, it is not possible to know just what Mr De Vries said or what he meant. However, as neither I nor my Office had any role in the matter, the most likely explanation for any such comment is that:

· Under the Indemnity between the Bank and the Government, and pursuant to directions given under that indemnity, the Bank was required to obtain the consent of a Government officer called 'The Treasurer's representative' before it could settle any matter that was covered by the Indemnity. This requirement was to protect the Government's position under the Indemnity.

· At all relevant times, the Treasurer's Representative was the Assistant Crown Solicitor Commercial in the Crown Solicitor's Office. The Crown Solicitor's Office is a Division of my Department. That officer was stationed in the Bank and worked from there. Whilst he remained at all relevant times an officer of the Crown Solicitor's Office he was responsible to the Treasurer in respect of his role of giving consent.

· In his role as Treasurer's Representative any proposal to settle or resolve or restructure a matter covered by the Indemnity required his prior consent.

· The officer concerned has confirmed that the matter of Tribe & Crisapulli referred to in the question is one which was referred to him at the relevant time in his role as the Treasurer's Representative at the Bank administering the Treasurer's Indemnity.

· It is understood that Mr De Vries was aware that the officer was, as Assistant Crown Solicitor Commercial, an officer of my Department but was apparently mistaken in believing that it was in that capacity that his decisions about State Bank/Beneficial finance matters were being given. Therefore, it would seem that any comment by Mr De Vries about a decision needing to be made by

the Attorney General's Office was probably a reference to that officer in his role as Treasurer's Representative.

HOUSING TRUST PROPERTIES

In reply to **Hon. J.F. STEFANI** (19 August).

The Hon. ANNE LEVY: The Minister of Housing, Urban Development and Local Government Relations has provided the following response:

1.TRUST REGIONS	NUMBER OF TRUST HOMES SOLD 1991-92 FINANCIAL YEAR	NUMBER OF TRUST HOMES SOLD 1992-93 FINANCIAL YEAR
1. WARRADALE	22	19
2. PORT ADELAIDE	55	32
3. ELIZABETH	142	65
4. PORT AUGUSTA	58	53
5. WHYALLA	150	178
6. NOARLUNGA	57	48
7. MOUNT GAMBIER	81	65
8. ADELAIDE	16	9
9. HILLCREST	41	17
10. SALISBURY	111	78
11. GAWLER	69	70
12. THE PARKS	32	28
13. MODBURY	31	13
14. PORT PIRIE	28	13
15. PORT LINCOLN	4	17
16. MURRAY BRIDGE	34	25
TOTALS	931	730

2. Total amount realised for the periods:
   1991-92 Financial Year $42 947 600
   1992-93 Financial Year $33 781 400.

3. TRUST REGIONS	TOTAL NUMBER OF TRUST PROPERTIES ACQUIRED 1991-1992 FINANCIAL YEAR	TOTAL NUMBER OF TRUST PROPERTIES ACQUIRED 1992-93 FINANCIAL YEAR
1. WARRADALE	85	149
2. PORT ADELAIDE	189	129
3. ELIZABETH	1	3
4. PORT AUGUSTA	15	11
5. WHYALLA	3	Nil
6. NOARLUNGA	111	164
7. MOUNT GAMBIER	21	9
8. ADELAIDE	147	67
9. HILLCREST	67	81
10. SALISBURY	Nil	Nil
11. GAWLER	84	74
12. THE PARKS	235	194
13. MODBURY	22	2
14. PORT PIRIE	1	9
15. PORT LINCOLN	29	35
16. MURRAY BRIDGE		11
TOTALS	1054	993

4. Total amount expended by the Housing Trust to acquire properties:
   1991-92 Financial Year $54 721 000
   1992-93 Financial Year $38 784 000

HOUSING TRUST TENANTS

In reply to **Hon. J.F. STEFANI** (18 August)

The Hon. ANNE LEVY: The Minister of Housing, Urban Development and Local Government Relations has advised that the procedure followed by the Housing Trust in the instance of changeover of tenants is as follows:

- Tenants give 14 days notice of intention to terminate;
- Housing Trust officers inspect the property prior to vacation and complete a Property Condition Report;
- Providing the property is not required for redevelopment or other purposes, contractors are engaged to undertake maintenance or upgrade work as identified in the inspection, to bring the property into line with established vacancy standards;
- Contractors commence work, usually on the day after the vacancy occurs;
- The property is ready for tenancy;
- An offer of tenancy is made;
- The tenant to whom the offer was made has 48 hours to accept or reject the offer;
- The Housing Trust and the new tenant enter into a formal tenancy agreement; and
- The tenant winds up previous housing arrangements, (usually also involving tenancy agreements) and moves in.

The average vacancy period in 1991-92 was 20.8 days. The average vacancy period in 1992-93 was 21.7 days. These figures are inflated by the inclusion of properties targeted for redevelopment. At any given point in time the Housing Trust vacancy level is in the order of 1.6 per cent. The vacancy level in the private rental market is currently 4.8 per cent.

The loss of actual rental income incurred by the Housing Trust as a result of tenancy changeovers was in the order of $2.15 million in 1991-92 and $2.3 million in 1992-93. This equates to 1.2 per cent of rents payable. Commercial practise is to allow for annual losses of up to 8 per cent of rents payable as a result of vacancies.

LOCAL GOVERNMENT MEETINGS

In reply to **Hon. J.C. IRWIN** (3 August).

The Hon. ANNE LEVY: The Minister of Housing, Urban Development and Local Government Relations has provided the following response:

1. The Minister is aware of the media reports of a council forming working parties whose proceedings are not open to the public, and has received a complaint about such meetings. The matter is presently being investigated.
2. If any council is using working parties to avoid the public access requirements of the Local Government Act, the Minister will seek to have this practice stopped.
3. Yes.

ROAD CLOSURES

In reply to **Hon. J.C. IRWIN** (11 August)

The Hon. ANNE LEVY: The Minister of Housing, Urban Development and Local Government Relations has provided the following response:

Section 359(1) of the Local Government Act provides for the temporary closure of a road supported by a resolution of a majority of council members.

Section 359(4) provides that a road closure cannot take effect before it has been published in the *Government Gazette* and in a newspaper circulating in the area.

Section 41 of the Local Government Act generally empowers a council by resolution to delegate to a council officer any of its powers, functions or duties under 'this or any other Act', but itemises specific circumstances where a Council may not delegate.

Mr C Catt, City Manager of Noarlunga Council has advised that on Friday 30 July 1993, the South Australian Film Corporation requested the temporary closure of the roads at McLaren Flat between 5.30 am and 6.30 pm on Thursday 5 August 1993 to enable the filming of 'The Battlers' to proceed on schedule.

As one of the roads is the common boundary between the Councils of Happy Valley and Noarlunga, a joint notice of closure was considered desirable as a matter of practicality and expediency.

The Happy Valley Council has received legal advice in reference to Section 359 that a delegation under Section 41 has the effect of the delegatee being the Council, therefore the decision is by a majority. Both Happy Valley and Noarlunga Councils have delegated the right to temporarily close roads to their City Managers.

A condition of the closure was that the residents living on the roads concerned be consulted. Barriers were required to be erected and staffed so that casual users of the roads could be let through between shooting of the film.

Mr Catt was informed that a delay in the approval to close the road would have caused severe inconvenience to the South Australian Film Corporation.

Notice of the temporary road closure pursuant to Section 359(4) was published in the Advertiser of Wednesday 4 August and in the *Gazette* of 5 August 1993.

In summary, the Minister considers that the notice published in both the Advertiser of 4 August and the *Government Gazette* of 5 August 1993 was drawn up and executed on the basis of legal advice and in the absence of contrary advice appears to have been lawfully given pursuant to a delegation under Section 41.

In the matter of due notice, the Minister is satisfied that due notice was given in compliance with Section 359(4) and that in addition, the two Councils took effective steps to ensure that members of the public were consulted and not unduly inconvenienced.

In the circumstances the Minister considers that the two City Managers acted with commendable purpose and goodwill to assist the South Australian Film Corporation to maintain its schedule.

HOUSING, PUBLIC

In reply to **Hon. L.H. DAVIS** (19 August).

The Hon. ANNE LEVY: The Minister of Housing, Urban Development and Local Government Relations has provided the following response:

1. The Federal Government did not offer the South Australian Government any opportunity to consult upon or negotiate the deferment of the Social Housing Subsidy Program.

   While South Australia could have effectively utilised funds from the Social Housing Subsidy Program in the second half of 1993-94, it is the Minister's understanding that the program was deferred because the majority of States were, due to difficulties with the operation of their particular home ownership lending programs, not in a position to take up funds from the program in 1993-94.

   A further factor which may have contributed to delaying the introduction of the scheme was the considerable lead time required for the development of detailed financial modelling and program guidelines at a Commonwealth level.
2. The deferment of the Social Housing Subsidy Program will have no immediate and direct impact on the South Australian public housing program. It has been estimated that in South Australia the Social Housing Subsidy Program could provide up to 1 200 shared equity home ownership opportunities, and further extend access to home ownership for low and moderate income households.

   It is anticipated that these additional home ownership opportunities will, in the longer term, complement public housing initiatives and contribute to achieving an increasingly diversified and co-ordinated range of housing choices for South Australians. While the original expectation was that the program would commence in late 1993-94, work will continue throughout the current year to facilitate the introduction of shared equity products in early 1994-95. In this manner, the actual delay in introducing new shared equity opportunities should be no greater than six months.

BARKER INLET

In reply to **Hon. M. J. ELLIOTT** (19 August).

The Hon. ANNE LEVY: The Minister of Public Infrastructure has advised that consultancies have recently been finalised into the four major Metropolitan Adelaide Wastewater Treatment Plants; Bolivar, Port Adelaide, Glenelg and Christies Beach. The consultants investigated options for landbased disposal of effluent and compared them to the cost and environmental benefits of upgrading the plant with nutrient removal and continued discharging to the marine environment.

The information from these consultancies is too lengthy to include here but, to illustrate a point, using Bolivar as an example, two landbased disposal options were considered. One option was to construct a pipeline to the Virginia Vegetable Triangle for a cost of $40 million. This could achieve 100 per cent re-use of effluent in the summer with continued disposal to the marine environment during winter.

A second option was to construct a pipeline to a 5000 ha afforestation zone 20 kms north of Adelaide at a cost of $170 million. This option was intended to achieve 100 per cent year round disposal of effluent to land.

As can be seen the cost for total landbased disposal is expensive. Also total year round disposal will be difficult if not impossible to achieve particularly during the winter months when irrigation is not required. As the honourable member realises the community will be required to pay for any changes to effluent disposal practise and thus it would be irresponsible to automatically adopt total landbased disposal when lower cost options that may be environmentally sustainable are available.

The honourable member also mentioned the damage to the marine environment caused by a sewage outfall from Port Adelaide which he understood commenced operation in 1978. In fact the outfall that the honourable member refers to is the sludge outfall which pumps digested sludge from the Port Adelaide discharges into the lower reaches of the Port River and has done so since the 1930's.

It is agreed that the sludge outfall has impacted on seagrass. As a consequence of investigations undertaken by the Engineering and Water Supply Department in the late 1980's, a pipeline is now being constructed to collect sludge from Port Adelaide and Glenelg and pump it to Bolivar for air drying and for subsequent beneficial reuse on land.

This pipeline will be commissioned by the end of 1993 and will reduce the nitrogen and phosphorus load discharged from the four metropolitan plants to Gulf St Vincent by at least 10 per cent. It is expected that this step alone will achieve significant improvements in water quality in Gulf St Vincent.

Whilst it would be premature to make a commitment that no effluent from sewage treatment works will be allowed to enter Gulf St Vincent in the future, it is clear that the Government is committed to reducing the impact of sewage treatment works discharges on Gulf St Vincent and is well advanced in the cessation of sludge discharges and is developing proposals for compliance with marine discharge legislation with respect to effluent discharges. This compliance with marine discharge legislation for effluent will either involve landbased disposal or nutrient reduction or a combination of the two.

DEPARTMENTAL MERGER

In reply to **Hon. M.J. ELLIOTT** (24 August).

The Hon. ANNE LEVY: The Minister of Public Infrastructure has advised that Ernst and Young is an international company of good reputation. In carrying out an independent assessment the company would be expected to implement a rigorous process.

In the course of its merger savings assessment the consultant considered factual data provided by ETSA/E&WS in relation to activities in common and the resources deployed in those activities. The company then considered savings potential by examining data on duplication of functions, opportunities for synergy and assumptions as to the scope and feasible timings for implementing efficiencies. In the course of the assessment the consultants carried out lengthy interviews and questioning of executives and analyses of the savings potential. The consultants were able to draw on their very substantial experience in activity reviews aimed at achieving efficiency improvements in both the government and private sectors.

The consultants reached their own view as to appropriate assumptions and savings potential and reported accordingly from the perspective, in their own words, of a 'conservative approach'.

ETSA/E&WS has not yet been invoiced but it is understood that the cost of the study is of the order of $45 000.

FINGER POINT

In reply to **Hon. M.J. ELLIOTT** (8 September).

The Hon. ANNE LEVY: The Minister of Public Infrastructure has advised that during 1986, as part of the hydrogeological investigation prior to plant design, three 50m deep bore holes were drilled at the Finger Point site to determine the porosity and permeability of the limestone strata. The strata was found to be consistent over the full 50m with very low permeability over the full depth. No cavities were found.

All sludges contain a range of heavy metals. The more significant ones are monitored and their concentrations are shown in the following table.

HEAVY METALS FPSTW SLUDGE LAGOON

(All values in mg/l)

Sampled	Cd	Cr	Cu	Pb	Ni	Zn
9/6/92	.002	.056	.282	.057	.038	.442
20/5/93	.003	.077	.613	.112	.079	.900
Average	.003	.067	.448	.085	.059	.671
US EPA Guideline*	.030	.200	.500	.300	.420	1.8

* If level of heavy metals are lower than this guideline sludge can be used for any agricultural purpose.

The quality of the sludge at Finger Point is an excellent quality sludge and falls well within the United States EPA guidelines for general use.

The monitoring of heavy metals in the sludge has not been done on a regular basis. The sludge is not considered to be of any significant environmental risk considering the nature of the limestone strata at the site and as they rapidly complex on to soil particles.

The results of the testing will be made public when they become available.

The whole length of outfall main is patrolled at least once per fortnight to relieve trapped gases and to ensure no leakage is occurring.

The information gained to support the Minister's opinion that this section of pipe requires no urgent attention at this stage is very reliable. Sections of the concrete main have been cut out at several locations and inspections by closed circuit television have been made. The remaining 4km of main was in a sound condition at those representative inspection points at the last inspection (10 June 1986). A further inspection is scheduled to be carried out this year. There have been no leaks on this main detected since the poor 800m section of the main was replaced in 1989.

The results of the heavy metal tests on water from the spring known as FP No 7 will be made public when they become available.

WATER RESOURCES

In reply to **Hon. M.J. ELLIOTT** (26 August).

The Hon. ANNE LEVY: The Minister of Public Infrastructure has advised that the volume of water held and percentage of capacity, rather than level, is the usual measure of reservoir holdings. South Australia's holdings at the end of August 1993 were:

Reservoir	Current Holdings		Last Yrs Holdings	
	Vol (ML)	(%)	Vol (ML)	(%)
Mt Bold	9990	22	41297	90
Happy Valley	8145	64	9518	75
Myponga	25754	96	268000	100
Millbrook	6101	37	13446	81
Kangaroo Creek	10734	56	19000	100
Hope Valley	1837	53	3235	93
Little Para	14035	67	10283	49
South Para	37516	84	33198	74
Barossa	4209	93	4436	98
Warren	3894	82	4770	100
Bundaleer	5227	82	2407	38
Beetaloo	3140	95	3241	53
Baroota	5826	95	3241	53
Tod	7450	65	4963	44

Note: Volumes are measured in megalitres (ML)

For the reservoirs supplying Adelaide with water, this represents 61 per cent of capacity. This is not unusual. Adelaide's reservoirs held less than 61 per cent at the end of August in 1982 and again in 1987. There were no shortages of water in either of those years due to the ability to transfer large volumes of water from the River Murray via the Mannum-Adelaide and Murray Bridge-Onkaparinga pipelines.

Even if there is no further natural inflow to our reservoirs in Spring, there will be no water shortages in Adelaide. The River Murray can supply all our needs.

Water storages in the River Murray system are near full. Dartmouth and Hume reservoirs are 97% and 93% full respectively. South Australia is assured of receiving its full entitlement flow (as provided in the Murray-Darling Basin Agreement) in the River Murray during 1993-94. We are presently receiving well in excess of entitlement flow and this is expected to continue for several more weeks.

Water quality in the River Murray in South Australia is currently very good. This is principally because the high flows originate from the alpine streams of the Great Dividing range. For example the salinity of water at Morgan is currently 250 EC (electrical conductivity units). The median recorded salinity at Morgan over the last ten years has varied from 390 EC to 970 EC.

The honourable member in his lead up to the question, commented on the threat of blue-green algae.

To combat the threat of blue-green algae in the rivers of the Murray-Darling basin, the Murray-Darling Basin Ministerial Council is developing an Algal Management Strategy. A discussion document has been released for public comment. The final strategy is expected to include action in five areas:

- improved flow regimes and flow management;
- reduced nutrient concentrations in the streams and storages of the basin;
- heightened community awareness;
- improved scientific knowledge;
- progressive refinement of the strategy.

CODE OF CONDUCT

The Hon. C.J. SUMNER (Attorney-General): I move:

That the Legislative Review Committee be required to—

1. examine and report on proposals in Australia and elsewhere for the establishment of a code of conduct for members of Parliament; and

2. recommend to Parliament the adoption of a code appropriate to the South Australian Parliament.

Members will recall that during the last parliamentary session the Government announced a number of initiatives designed to ensure high standards of integrity and accountability in the conduct of the public and elected officials in this State. These measures include the enactment of the Public Corporations Act 1993, the Whistleblowers Act 1993, the Members of Parliament (Register of Interests) Amendment Act 1993, the release of the guidelines for ethical conduct for public employees and a code of conduct for public employees, the requirement for ministerial advisers to declare interests and the release of the Cabinet Handbook, including rules relating to conflicts of interest, disclosure of facts and declarations in relation to pecuniary and non-pecuniary benefits.

I have also referred to the need for a code of conduct for members of Parliament. The Government considers that Parliament may wish to adopt a code setting out the standards of conduct to which members should adhere. The Western Australia Royal Commission, in its second report, states that all public officials (and members of Parliament are expressly included within public official) should be bound by such a code. The Electoral and Administrative Review Commission in Queensland has also recommended that elected representatives adopt and adhere to a code of conduct. The New South Wales Parliamentary Joint Committee on the Independent Commission against Corruption currently is working on a reference which includes:

> An examination of the need for and suggestion as to the content of a code of ethics for members of Parliament. This might take into account the provisions already applying to Ministers and suggestions as to how these provisions might be streamlined and incorporated into a more general code which would apply to all members of Parliament.

It is important that members, like public servants, are aware of the legal and ethical responsibilities which attach to the public office which they hold. The New South Wales Speaker, Mr Rozzoli, prepared a submission to the State's Independent Commission against Corruption in which he commented:

> Leadership always brings with it a demand to raise conduct above the standard of those around, to set an example for others to follow.

He further reflected:

> It has become a present day practice in the arenas of public related activity to set down such codes.

I should also add that this is an increasing trend in the private sector, particularly following the excesses of the 1980s. Codes of conduct for company directors, for instance, have

been developed. All of this indicates that a clear perception exists, both in parliamentary circles elsewhere in Australia and in the community, that the standing of this Parliament and its members would be significantly enhanced by the reduction to writing of a set of standards of conduct for members.

There are many important issues which would need to be addressed in such a code by members both here and in another place. The code could cover the following issues:

· respect for the law and the system of Government;

· honest, fair and responsible conduct in the performance of public duties;

· recognition that members of Parliament occupy positions involving significant public trust;

· ensuring that personal conduct does not compromise the performance of official duties;

· conflicts of interest;

· acceptance of gifts;

· engaging in outside employment while a member of Parliament;

· the use of electoral and travel allowances.

Of these, perhaps the most important issue is that relating to conflict of interests. It cannot be too often repeated, whether in the context of public employees or in the context of members of statutory bodies, or in the context of elected representatives, that the public official must be, and must be seen to be, free of any conflict between his or her personal interests and the interests of the public. To retain the confidence of the community we are elected to represent, we must be constantly alert to the need to declare any personal interest which, in the absence of such a declaration, might create an impression that we are acting in our own rather than in the public interest.

While the Members of Parliament (Register of Interests) Act does important work in identifying situations and relationships which affect members and which might be liable to create a situation in which a member faces a conflict, the Act stops short of requiring members to declare each situation or relationship as it arises. To do so would, the Government believes, create onerous and impractical obligations on members. However, the Government recognises that it is important to stress that members should disclose to Parliament interests held by them, as and when those interests become relevant to the business being conducted by Parliament. Relevance must be measured by deciding when the personal interests affect, or may be seen to affect, the member's actions.

The Standing Orders do prohibit members here and in another place from voting upon matters in which members have a direct pecuniary interest. These Standing Orders are based on rules which applied in the House of Commons in the United Kingdom. These rules were interpreted by the Speaker of the House of Commons in 1811 to mean that the interest had to be one which is not held in common with the rest of Her Majesty's subjects. This interpretation is reflected in the Council's Standing Orders. Consequently, no member is actually prevented from voting on public Bills.

A similarly defined constraint prevents members in this place from sitting on a committee, while members in another place are prohibited from sitting on a select committee, if the member 'shall be personally interested in the inquiry before such committee'. It is the Government's view that these provisions do not adequately protect the member from accusations that a conflict of interest exists, or at least from giving an appearance that a conflict of interest exists. This is one matter that needs to be examined by the committee.

One matter which could be considered for inclusion in the code is parliamentary privilege. A joint committee is currently examining the extent of parliamentary privilege. While it is the Government's view that there should be a broad scope given to parliamentary privilege, some rules to guide members in raising matters under privilege may be of use. Unless MPs themselves look at taking steps to curb abuses of privilege, then the community may demand action. That is, it is important for the principle not to be brought into disrepute. In considering a code of conduct for members, Parliament could take the opportunity to examine the sensitive issue of what constitutes proper and appropriate use of parliamentary privilege, having due regard to the need not to abuse. This does not mean support for any legal restraint on parliamentary privilege but suggests that parliamentarians could look at some code of conduct to prevent its abuse. It is important that the privilege is something which members have so as to ensure that they can speak freely on behalf of their electors.

Another matter which needs to be examined is whether the code is purely voluntary and a measuring stick against which MPs and the public can judge the appropriateness of an MP's behaviour or whether there should be more formal sanctions attaching to its breach. The Government is of the view that this issue should be considered by a committee of the Parliament. The Legislative Review Committee comprising members of both Houses would be appropriate and I commend the motion to members.

The Hon. K.T. GRIFFIN secured the adjournment of the debate.

STATUTES AMENDMENT (ATTORNEY-GENERAL'S PORTFOLIO No. 2) BILL

The Hon. C.J. SUMNER (Minister of Public Sector Reform) obtained leave and introduced a Bill for an Act to amend the Criminal Law (Sentencing) Act 1988, the Legal Practitioners Act 1981, the National Crime Authority (State Provisions) Act 1984, the Summary Offences Act 1953, the Trustee Act 1936, the Trustee Companies Act 1988 and the Wrongs Act 1936. Read a first time.

The Hon. C.J. SUMNER: I move:

That this Bill be now read a second time.

This Bill makes a number of amendments to Acts within the Attorney-General's portfolio.

Criminal Law (Sentencing) Act 1988

During the past few months, the Crown Solicitor has been asked to give advice on a number of matters where there has been a mistake made by the sentencing judge in imposing a sentence or non parole period. The Crown Solicitor is of the view that the only options are to imply into the sentencing remarks words to give effect to the judge's intention or to take the matter to the Court of Criminal Appeal.

It would seem to be a waste of resources to lodge an appeal where an administrative error has been made in sentencing. Rather it would be preferable if the Act allowed either the Director of Public Prosecutions or the defendant to call the matter back on before the sentencing judge.

Therefore Clause 5 of the Bill amends the Act to enable the Director of Public Prosecutions or a defendant to call a matter back on before a sentencing judge where an administrative mistake is discovered in the sentence.

Recent amendments to the Criminal Law (Sentencing) Act provide for a Court to order the disqualification of a driver's licence or the suspension of a vehicle's registration for the non payment of a court fine relating to the use of a motor vehicle. Following an order by the Court, the Registrar of Motor Vehicles is required to issue a notice advising of the disqualification or suspension.

Clauses 6 and 7 of the Bill provide for the introduction of fees for the issue of the disqualification or suspension notices. The fees will be set by regulation at $19.00.

A minor amendment is also made to the definition of 'appropriate officer' to reflect the change in name from Clerk of Court to Registrar.

Jurisdiction of Courts (Cross-vesting) Act 1987

The Jurisdiction of Courts (Cross-vesting) Act 1987 established a scheme for cross-vesting of jurisdiction between Federal, State and Territory courts. The Act is complemented by reciprocal legislation in the Commonwealth and each State and Territory. The Australian Capital Territory has recently enacted such reciprocal legislation.

Part 3 of the Bill amends the South Australian principal Act to reflect the fact that the Australian Capital Territory now has its own legislation dealing with cross-vesting.

Legal Practitioners Act 1981

In the Legal Practitioners (Reform) Amendment Act 1993, an amendment was made to Section 52 of the principal act dealing with the professional indemnity insurance scheme. The amendment provided for the insurance scheme to be authorised by the Attorney-General rather than promulgated in the Regulations.

The amendment to Section 19 of the Legal Practitioners Act set out in Clause 9 of this Bill is consequential to the earlier amendment as it removes the reference to the regulations.

National Crime Authority (State Provisions) Act 1984

The Chairperson, National Crime Authority, has recommended amendments to the National Crime Authority (State Provisions) Act to bring the legislation up-to-date with the Commonwealth National Crime Authority Act.

The National Crime Authority has conducted a review of the legislation in each jurisdiction and has identified amendments to the National Crime Authority Act that have not been picked up in underpinning legislation. The Authority has identified a number of miscellaneous amendments required to the South Australian legislation. These amendments are set out in Part 5 of the Bill. The most significant amendments are set out in Clause 19 and relate to the insertion of new Sections 18A and 18B. Section 18A will provide that a member of the Authority issuing a summons or notice may include a notation to the effect that disclosure of information about the summons or notice is prohibited except in certain circumstances. Section 18B creates an offence if disclosure is made contrary to the notation.

The other amendments to the Act are largely of a procedural nature.

Summary Offences Act 1953

The Commissioner of Police has recommended that the Summary Offences Act be amended to prohibit the possession of body armour without lawful excuse. Body armour vests are included as prohibited imports under item 29a of schedule 2 of the Customs (Prohibited Imports) Regulations. The authority to sanction the importation of such vests has been delegated by the Minister of Customs to the Commissioner of Police.

It has been the policy of the Commissioner to restrict the importation of body vests. As a consequence, it has become apparent that vests are being imported into South Australia through other States. Materials are also being imported for the manufacture of such vests within Australia.

The Commissioner is concerned that body armour vests, although not dangerous in themselves, may, in the hands of criminals, induce a sense of invincibility the consequences of which may be an increase in violence by armed offenders.

While the Customs (Prohibited Imports) Regulations offer some means of restriction on the availability of body armour, that control is rendered largely ineffective by the manufacture of vests within Australia.

Therefore Part 6 of the Bill amends the Summary Offences Act to make it an offence for a person to possess body armour without the approval in writing of the Commissioner of Police.

Trustee Act 1936

Part 7 of the Bill makes a number of amendments to section 5 of the Trustee Act.

Perpetual Trustees has drawn attention to Section 5(1)(b)(i) of the Act which, in relation to mortgages, defines an authorised investment in terms of 'land in the State.' There are examples in other States where investments in mortgages are not restricted geographically but can be made in relation to land in 'any State or Territory of the Commonwealth.'

In 1987, the Inter-Departmental Committee on Authorised Trustee Investment Status presented its Report to the Government. The Committee recommended that the Authorised Trustee Investment Status of certain first mortgages be expanded to include such mortgages in any State or Territory of the Commonwealth of Australia. The Committee was of the view that, while investing in a mortgage over a property some distance from the investor may be somewhat more difficult, it is not inherently more risky and should therefore not be denied authorised trustee status.

Therefore the Bill inserts a provision to allow for first mortgages over land in 'any State or Territory of the Commonwealth'.

Perpetual Trustees have also advised of a difficulty with the operation of the South Australian Act. Under Section 5(1)(c)(i), a trustee may invest in 'a deposit with any bank carrying on the business of banking in the State.' Under Section 5(9), a bank is defined as 'a body corporate authorised under the Banking Act 1959 and includes the State Bank of South Australia'. However, the effect of those provisions is to rule out investments in deposits, bills etc of the State Bank of New South Wales, and the R & I. Currently, the Perpetual Trustees At Call Fund has investments in these banks.

Treasury has advised that it is not aware of any prudential reason for limiting the definition of an acceptable bank in this way. It is understood that Queensland, New South Wales and Western Australia adopt a definition that is not restricted geographically, or exclusive of, State Banks.

Clause 30(b) of the Bill provides for an amendment to allow any bank operating in Australia to have trustee status, provided it is authorised to carry on the business of banking by a law of the Commonwealth or of a State or Territory.

National Australia Trustees has written requesting that its Common Fund be included in the list of authorised investments under Section 5(1)(g) of the Trustees Act. Treasury has advised that it does not oppose the inclusion of the National Australia Trustees At Call Common Fund as an authorised investment.

Trustee Company Act 1988

Part 8 of the Bill amends the Trustee Company Act by including IOOF Australia Trustees as a trustee company authorised to operate in this State. IOOF Australia Trustees incorporates the business formerly conducted by Farmers Cooperative Executors and Trustees and maintains the business known as Bagots Executor and Trustee Company Limited.

Wrongs Act 1936

In a recent decision of the Full Court of the Supreme Court in Morrison v SGIC Bollen J. quoted from the judgement of Judge Lee in the District Court drawing attention to a defect in Section 35a(4) of the Wrongs Act.

In his judgement, Bollen J. states that the case reveals what appears to be an oversight by the draftsman. He quotes Judge Lee as follows:

> Subsection (4) of Section 35a of the Wrongs Act 1936 abolishes the defence of *volenti non fit injuria* in cases where a presumption of contributory negligence arises under subsection (1)(j) of the section. Subsection (1)(j) creates a presumption of contributory negligence in cases where the driver is impaired by alcohol and the injured person (not being a minor) is a voluntary passenger and is aware of the impairment. Doubtless, due to an oversight by the draftsman, the qualifying words 'not being a minor' deny to a minor the benefit of subsection (4). The plaintiff was a minor at the time of the accident. This means that the defendant's plea of volenti non fit injuria remains one of the issues for determination.

The amendment to Section 35a of the Wrongs Act ensures that the defence of *volenti non fit injuria* will no longer be available against minors.

I commend this Bill to Honourable Members.

I seek leave to have the explanation of the clauses inserted in *Hansard* without my reading it.

Leave granted.

Explanation of Clauses

PART 1

PRELIMINARY

Clause 1: Short title

This clause is formal.

Clause 2: Commencement

This clause is formal.

Clause 3: Interpretation

This clause provides that a reference in this Act to the principal Act is a reference to the Act referred to in the heading to the Part in which the reference occurs.

PART 2

AMENDMENT OF CRIMINAL LAW (SENTENCING) ACT 1988

Clause 4: Amendment of s. 3—Interpretation

This clause amends the definition of 'appropriate officer' to reflect the change in name from Clerk of the Court to Registrar.

Clause 5: Insertion of s. 9a

This clause provides for the insertion of proposed section 9a. Proposed section 9a provides that a court that imposes a sentence on a defendant, or a court of coordinate jurisdiction, may, on application by the Director of Public Prosecutions or the defendant, make such orders as the court is satisfied are required to rectify any error of a technical nature made by the sentencing court in imposing the sentence, or to supply any deficiency or remove any ambiguity in the sentencing order. The Director of Public prosecutions and the defendant are both parties to an application under this proposed section.

Clause 6: Amendment of s. 261a—Driver's licence disqualification for default

This clause amends the principal Act to provide that the cost of issuing a notice of disqualification be added to the amount in respect of which the person is in default. It provides that this may be waived by the appropriate officer in such circumstances as he or she thinks just.

Clause 7: Amendment of s. 61b—Suspension of motor vehicle registration for default by a body corporate

This clause amends the principal Act to provide that the cost of issuing a notice of an order suspending registration be added to the amount in respect of which the company is in default. It provides that this may be waived by the appropriate officer in such circumstances as he or she thinks just.

PART 3

AMENDMENT OF JURISDICTION OF COURTS (CROSS-VESTING) ACT 1987

Clause 8: Amendment of s. 3—Interpretation

This clauses amends section 3 of the principal Act—

- by striking out the definition of 'State' and substituting a new definition of 'State' to include the Northern Territory and the Australian Capital Territory;
- by striking out the definition of 'Territory' and substituting a new definition of 'Territory' that does not include the Northern Territory or the Australian Capital Territory.

PART 4

AMENDMENT OF LEGAL PRACTITIONERS ACT 1981

Clause 9: Amendment of s. 19—Evidence of insurance to be produced to Court

This clause amends section 19 of the principal Act by striking out from subsection (1) 'Where regulations are in force' and substituting 'Where a scheme under section 52 is in force' and by striking out from subsection (1) 'regulations' (second occurring) and substituting 'scheme'. These amendments are consequential on the enactment of the Legal Practitioners (Reform) Amendment Act 1993.

PART 5

AMENDMENT OF NATIONAL CRIME AUTHORITY (STATE PROVISIONS) ACT

The amendments made to the principal Act in this Part are designed to keep the principal Act consistent (except for slightly different drafting styles between the Commonwealth and this State) with the National Crime Authority Act 1984 of the Commonwealth ('the Commonwealth Act'). The majority of the amendments proposed are of a minor drafting nature; for example, throughout the Act, any reference to 'an acting member' is deleted.

Clause 10: Amendment of s. 5—Functions under laws of the State

This clause amends section 5 of the principal Act by inserting after subsection (3) proposed subsection (3A) which provides that the Minister may, with the approval of the Inter-Governmental Committee—

- in a notice under subsection (1) referring the matter to the Authority, state that the reference is related to another reference; or
- in a notice in writing to the Authority, state that a reference already made to the Authority by that Minister is related to another reference.

Clause 11: Amendment of s. 6—Performance of functions

This clause amends section 6 of the principal Act by inserting in subsection (1) 'or any person or authority (other than a law enforcement agency) who is authorised by or under a law of the Commonwealth or of a State to prosecute the offence' after 'agency'.

Clause 12: Amendment of s. 9—Co-operation with law enforcement agencies

This clause amends section 9 of the principal Act by inserting proposed subsection (2) which provides that in performing its special functions, the Authority may coordinate its activities with the activities of authorities and persons in other countries performing functions similar to the functions of the Authority.

Clause 13: Amendment of s. 12—Search warrant

Clause 14: Amendment of s. 13—Application by telephone for search warrants

Clause 15: Amendment of s. 15—Order for delivery to Authority of passport of witness

The amendments made by these clauses to the principal Act are of a minor drafting nature and, for the most part, delete references to 'a member of the Authority' and substitute references to 'a member'.

Clause 16: Amendment of s. 16—Hearings

This clause amends section 16 of the principal Act. Subsection (3) is struck out and proposed subsections (3), (3A), (3B), (3C) and (3D) (which provide for the procedure of hearings by members of the Authority) are substituted.

Subsection (7) is struck out and the proposed substituted subsection (7) provides that where a hearing before the Authority is being held, a person (other than a member or a member of the staff of the Authority approved by the Authority) must not be present at

the hearing unless the person is entitled to be present by reason of a direction given by the Authority under subsection (5) or by reason of subsection (6).

After subsection (9), proposed subsections (9A) and (9B) are inserted. Proposed subsection (9A) provides that subject to proposed subsection (9B), the Chairperson may, in writing, vary or revoke a direction under subsection (9).

Proposed subsection (9B) provides that the Chairperson may not vary or revoke a direction if to do so might prejudice the safety or reputation of a person or prejudice the fair trial of a person who has been or may be charged with an offence.

Clause 17: Amendment of s. 17—Power to summon witnesses and take evidence

Clause 18: Amendment of s. 18—Power to obtain documents

The amendments made by these clauses to the principal Act are of a minor drafting nature and, for the most part, delete references to 'a member of the Authority' and substitute references to 'a member'.

Clause 19: Insertion of ss. 18A and 18B

This clause provides for the insertion of proposed sections 18A and 18B.

Proposed section 18A provides that the member issuing a summons under section 17 or a notice under section 18 must, or may (as the case may be as provided in proposed subsection (2)), include in it a notation to the effect that disclosure of information about the summons or notice, or any official matter connected with it, is prohibited except in the circumstances, if any, specified in the notation. If a notation is included in the summons or notice, it must be accompanied by a written statement setting out the rights and obligations conferred or imposed by proposed section 18B on the person who was served with the summons or notice. In the circumstances set out in proposed subsection (4), after the Authority has concluded the investigation concerned, any notation that was included under proposed section 18A in any summonses or notices relating to the investigation is cancelled by proposed subsection (4). If a notation made under proposed subsection (1) is inconsistent with a direction given under section 16(9), a notation has no effect to the extent of the inconsistency.

Proposed section 18B provides that a person who is served with a summons or notice containing a notation made under proposed section 18A must not disclose the existence of the summons or notice or any information about it or the existence of, or any information about, any official matter connected with the summons or notice. The penalty for a breach of this proposed subsection is a $2 000 fine or imprisonment for one year.

Proposed subsection (1) does not prevent the person from making a disclosure—

- in accordance with the circumstances, if any, specified in the notation; or
- to a legal practitioner for the purpose of obtaining legal advice or representation relating to the summons, notice or matter; or
- to a legal aid officer for the purpose of obtaining assistance under section 27 of the Commonwealth Act relating to the summons, notice or matter; or
- if the person is a body corporate—to an officer or agent of the body corporate to ensure compliance with the summons or notice; or
- if the person is a legal practitioner, to comply with a legal duty of disclosure arising from his or her professional relationship with a client or to obtain the agreement of another person under section 19(3) to the legal practitioner answering a question or producing a document at a hearing before the Authority.

It is an offence for a person to whom a disclosure has been made under this proposed section to disclose relevant information and the penalty is a fine of $2 000 or imprisonment for one year.

Proposed subsection (4) provides that a person to whom information has been lawfully disclosed may disclose that information—

- if the person is an officer or agent of a body corporate referred to in proposed subsection (2)(d)—to another officer or agent of the body corporate for the purpose of ensuring compliance with the summons or notice or to a legal practitioner or legal aid officer;
- If the person is a legal practitioner—to give legal advice, make representations, or obtain assistance under section 27 of the Commonwealth Act, relating to the summons, notice or matter; or
- if the person is a legal aid officer—to obtain legal advice or representation relating to the summons, notice or matter.

Proposed subsection (5) provides that proposed section 18B ceases to apply to a summons or notice after the notation contained in the summons or notice is cancelled by proposed section 18A(4) or 5 years elapse after the issue of the summons or notice, whichever is sooner.

Clause 20: Amendment of s. 19—Failure of witnesses to attend and answer questions

Clause 21: Amendment of s. 20—Warrant for arrest of witness

Clause 22: Amendment of s. 21—Applications to Federal Court of Australia

Clause 23: Amendment of s. 24—Protection of witnesses, etc.

Clause 24: Amendment of s. 25—Contempt of Authority

Clause 25: Amendment of s. 27—Powers of acting members of the Authority

Clause 27: Amendment of s. 29—Protection of members, etc.

Clause 28: Amendment of s. 30—Appointment of Judge as member not to affect tenure, etc.

Clause 29: Amendment of s. 31—Secrecy

The remaining amendments made by these 9 clauses to the principal Act are of a minor drafting nature and are to keep the State Act consistent with the Commonwealth Act.

PART 6

AMENDMENT OF SUMMARY OFFENCES ACT 1953

Clause: Insertion of s. 15A

This clause inserts a new section dealing with body armour. The clause provides that it is an offence to manufacture, sell, distribute, supply or otherwise deal in body armour without the written approval of the Commissioner of Police. It is also an offence to possess or use body armour. The penalty on breach is a division 5 fine or division 5 imprisonment ($4 000 or 2 years). For the purposes of this clause, 'body armour' is defined as apparel designed to resist the penetration of a bullet.

PART 7

AMENDMENT OF TRUSTEE ACT 1936

Clause 31: Amendment of s. 5—Authorised investments

This clause amends section 5 of the principal Act to authorise a trustee to invest trust funds—

- on first legal mortgage of an estate in fee simple in land in any State or Territory of the Commonwealth or of a perpetual lease (granted under a law of this State or the equivalent of such a lease granted under the law of any other State, or a Territory, of the Commonwealth);
- on deposit with any bank authorised by a law of the Commonwealth or of any State or a Territory of the Commonwealth, to carry on the business of banking.

Section 5 is further amended by inserting the common fund of the National Australia Trustees Limited into the list of authorised investments and by striking out the definition of 'bank' from subsection (9).

PART 8

AMENDMENT OF TRUSTEE COMPANIES ACT 1988

Clause: Amendment of Schedule 1—Trustee Companies

This clause amends Schedule 1 of the principal Act by striking out 'Farmers' Co-operative Executors and Trustees Limited' and substituting 'IOOF Australia Trustees Limited'.

PART 9

AMENDMENT OF WRONGS ACT 1936

Clause 32: Amendment of s. 35a—Motor accidents

This clause amends section 35a of the principal Act by striking out subsection (4) and substituting a new subsection (4) that provides that the defence of *volenti non fit injuria* is not available against the injured person where—

- the injured person was (at the time of the accident) a voluntary passenger in or on a motor vehicle; and
- the driver's ability to drive the motor vehicle was impaired in consequence of the consumption of alcohol or a drug and the injured person was aware, or ought to have been aware, of the impairment.

The Hon. K.T. GRIFFIN secured the adjournment of the debate.

APPROPRIATION BILL

Second reading.

The Hon. C.J. SUMNER (Attorney-General): I move:

That this Bill be now read a second time.

As the Bill has been dealt with in another place, I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

On 26 August 1993 the 1993-94 budget papers were tabled in the Council. Those papers detail the essential features of the State's financial position, the status of the State's major financial institutions, the budget context and objectives, revenue measures and major items of expenditure included under the Appropriation Bill. I refer all members to those documents, including the budget speech 1993-94, for a detailed explanation of the Bill.

Clause 1 is formal.

Clause 2 provides for the Bill to operate retrospectively to July 1993. Until the Bill is passed, expenditure is financed from appropriation authority provided by the Supply Acts.

Clause 3 provides relevant definitions.

Clause 4 provides for the issue and application of the sums shown in the schedule to the Bill.

Sub-section (2) makes it clear that appropriation authority provided by Supply Act is superseded by this Bill.

Clause 5 is a new clause designed to ensure that where Parliament has appropriated funds to an agency to enable it to carry out particular functions or duties and those functions or duties become the responsibility of another agency the funds may be used by the responsible agency in accordance with Parliament's original intentions without further appropriation.

Clause 6 provides authority for the Treasurer to issue and apply money from the Hospitals Fund for the provision of facilities in public hospitals.

Clause 7 makes it clear that appropriation authority provided by this Bill is additional to authority provided in other Acts of Parliament (except, of course, in Supply Acts).

Clause 8 sets a limit of $50 million on the amount which the Government may borrow by way of overdraft in 1993-94.

The Hon. R.I. LUCAS secured the adjournment of the debate.

CONSENT TO MEDICAL TREATMENT AND PALLIATIVE CARE BILL

Adjourned debate on second reading.

(Continued from 7 September. Page 324.)

The Hon. R.I. LUCAS (Leader of the Opposition): I spoke earlier this year on this matter and therefore do not intend to take a very long time on it during the second reading debate, although there are just one or two matters that I want to place on the record. There is no doubting that this is an extraordinarily significant piece of legislation. It is controversial at the moment, and I suspect that in years to come it will be seen to have been one of the most controversial pieces of legislation that this Parliament has debated. Certainly, I would see it as one of the more significant pieces of legislation that I have seen in my 11 or 12 years sitting in this Chamber.

It is my view that in the coming years the community will see it to be a significant and controversial piece of legislation as well. I do not believe at the moment that there has been wide debate about the issue. I accept that there has been a long period of time for members of the community to have interested themselves in the debate if they were interested and to have made submissions to the select committee and to have lobbied members of Parliament. Again, it is fair to say that this has not been an issue that has grabbed the media's attention. I know that members of the select committee have tried on occasions to interest the media in this issue, but because the media have not been interested it has therefore not become the subject of wide debate. I think that is a shame for what is an important piece of legislation.

When I spoke in April or May I outlined my general concerns about the legislation and do I not intend to repeat the detail of those concerns, other than to say that perhaps in general terms I am still personally uncomfortable about the notion or the concept of a medical agent being able to make life and death decisions for others in the community. However, my concerns—and if those concerns are shared by others—can be reflected during the Committee stages of this debate.

The only issue I want to address during my contribution on this occasion is the debate on this legislation in relation to the debate that goes on about the role of the Legislative Council, or the second Chamber in our parliamentary system here in South Australia. On occasions people have raised the question of the importance of having a second Chamber in our parliamentary system. There have been some, indeed, who have gone further and argued that the Legislative Council ought to be abolished. Of course, I have taken a view contrary to that; indeed, all my colleagues have taken a contrary view and do not support that particular proposition.

It is only when we have the opportunity to sit back and debate a controversial piece of legislation such as this that we can really see the importance, relevance and need for a second Chamber in our parliamentary system. A number of members in another place took the view in April and May, before the end of the last session, that the select committee had spent many hours and months working on this particular issue; that there was overwhelming support in the House of Assembly for this draft legislation before us; and that, therefore, the Legislative Council should hasten its consideration of the legislation and ensure the passage of the Bill before the end of the last session. For a variety of reasons, that did not eventuate during the last session. Whilst I cannot predict at this stage whether or not the legislation will pass—and, indeed, if it does, in what form—my gut reaction would be that the legislation is likely to pass in some form or another and that it is likely to pass in a form with quite significant amendments being made to the final recommendations of the select committee and the final position of the majority of members in the House of Assembly.

I need to look at only one area, but there are many others. We have the Minister in charge of the Bill in this place, the Hon. Barbara Wiese, moving a package of amendments that will provide for an appeal mechanism of some form in relation to decisions taken by the medical agent. Back in the early part of this year, in the last session, there was no reference at all to an appeal mechanism, and members who were lobbying for support of the Bill with me and other members of the Council certainly believed that proper consideration had been given, all the checks and balances had been put in the legislation and that the Legislative Council should get on with the job and substantially get the Bill through in the form that has been agreed.

So, I want to place on the record only that view: that I believe there is obviously an important role for the Legislative Council—for a second Chamber—in our parliamentary system. Of course, I do not argue that solely in relation to this Bill. However, I do argue that this Bill is a perfect example of how our parliamentary system, with its checks and balances, should work. As it is currently constructed, the Government of the day cannot rush a piece of legislation through one House of Parliament or both Houses of Parliament without proper consideration and consultation,

because there is an opportunity for members to reflect, to discuss matters with each other, and then to consider various amendments to the legislation.

We see in relation to this Bill that some seven or eight members of this Chamber—Liberal, Labor and Democrat—have already listed significant amendments to the legislation as recommended by the select committee and as passed by the House of Assembly. So, over one third of the members in this Chamber of all Parties are moving significant amendments to the legislation that we see before us this afternoon. That is a fair reflection on the way I believe our parliamentary system ought to operate, and I think it is a credit and a tribute to that system and, in particular, to the work of members of all sides of this Chamber.

This is one of those very rare issues where all members would appear to have strongly differing views, and evidently they will be expressing those views freely and fairly during the Committee stages of the legislation. I said in relation to the poker machine debate, where we at least headed down that path a bit, that I think that therefore makes for a very interesting debate in the Legislative Council. I therefore enjoyed that debate and will look forward to this—

The Hon. M.S. Feleppa: I didn't.

The Hon. R.I. LUCAS: The Hon. Mr Feleppa says he didn't, and I understand that. But that is a matter he can take up with his colleagues; I do not intend to be deflected. Finally, I make the point that this will be a very difficult Committee process, because obviously on every amendment 22 members cannot speak—although I imagine on a number of them most of us will. I suspect that we will therefore need many divisions in Committee so that we can establish one way or another where the majority view is on a particular issue. I know that in my Party there are differing views and I know that even within the Government there are differing views on some of the amendments, and maybe there are differing views within the Democrats as well.

With those comments I indicate my support for the second reading of the Bill and look forward to what will be, I am sure, a long and arduous Committee stage.

Bill read a second time.

In Committee.

Clause 1 passed.

Clause 2—'Commencement.'

The Hon. R.I. LUCAS: What is the Government's intention regarding the proclamation of this legislation should it pass the Parliament in the next two weeks?

The Hon. BARBARA WIESE: I understand that, before this legislation is proclaimed, the Minister intends to embark upon a public education program regarding its provisions should it pass the Parliament. Although I cannot be specific about the timetable for that education program, the Government intends that the legislation be proclaimed as soon as possible. The development of an education program that will allow sufficient time for relevant people to become aware of the provisions of the legislation will take some time, so I do not expect it to be proclaimed within the next few months.

The Hon. R.I. LUCAS: On behalf of my colleague the Hon. Mr Griffin, I move:

Page 1, after line 6—Insert subclause as follows:

(2) All provisions of this Act must be brought into operation simultaneously.

I seek the indulgence of the Committee to not finally resolve this debate until my colleague, who is unavoidably out of the Chamber for a brief period, is able to enter the debate. I recall one or two other occasions on which my colleague the Hon. Mr Griffin has moved similar provisions in relation to important legislative matters that the Chamber has debated. It has been his consistent view, and one which I share, that the Minister of the day cannot bring into operation pieces of legislation with which he or she agrees without proclaiming aspects of the legislation over which the Minister has debated long and hard but which the Minister has lost in both Chambers. There have been strongly divided views on this sort of controversial issue, and my colleague the Hon. Mr Griffin has moved similar amendments. I support the Hon. Mr Griffin's amendment.

The Hon. BARBARA WIESE: The Government supports this amendment. It agrees that it is desirable that, in order to maintain the cohesiveness of whatever legislation is passed here, it be brought into force together. Therefore, the amendment is supported.

Amendment carried; clause as amended passed.

Clause 3—'Objects.'

The Hon. CAROLINE SCHAEFER: I move:

Page 1, lines 9 to 11—Leave out 'to allow persons over the age of 16 years to decide freely for themselves on an informed basis whether or not to undergo medical treatment'.

I do not propose to speak for long on this amendment, the aim of which is fairly clear. I have some difficulty with this clause because there are laws that will not allow a person to be an adult until they are 18. For instance, a person may not receive unemployment benefits or be married without parental consent until the age of 18, and they may not drink or vote legally, gamble or be tattooed until the age of 18. Yet, under this Bill, at the age of 16, without consulting their parents, their guardian or anyone else, they may consent to or refuse any form of medical or dental treatment. There seems to be an inconsistency here. I fully realise that many members in this Chamber will not support my amendment, but I believe that it needs to be placed on record that, in my opinion, the consent to or refusal of medical treatment is at least as important as whether one may or may not gamble or be tattooed.

The Hon. M.S. FELEPPA: I wish to raise my concern about the definition of the age of 16 in this legislation. As the honourable member opposite has said, there are a number of areas in which we recognise the age of 16 as a suitable age. The nature of this legislation is extremely important. At 16 years of age, a person can be caught by a degree of emotion. I do not think that any person aged 16 and of sound mind can make a decision such as would be required by this legislation. I hope that the Minister in her response can persuade me to the contrary, because I am concerned not only with this clause but with the following clause in which I will oppose the definition of the age of 16.

The Hon. T.G. ROBERTS: I support the Hon. Caroline Schaefer's amendment for many of the reasons that she has expounded. Many members of the community are concerned about the care of their children. The point has been made that in respect of social security parents are required to be responsible for the care, wellbeing and financial support of their children until the age of 18, and in almost every other area a person is not considered to be an adult until the age of 18. Division 3 brings into question the medical treatment of children. Clause 9 provides:

(1) A medical practitioner may lawfully administer medical treatment to a child if—

(b) the child consents and—

(i) the medical practitioner who administers the treatment is of the opinion that the child is capable of understanding the nature. . .

There will be more debate on this issue as we go down the track, but I agree with the Hon. Caroline Schaefer's argument that, in all other instances, one is not an adult until the age of 18. I accept that it will be argued that children are capable of making such decisions, but that is not recognised in the social security area or in areas such as the making of contracts.

The Hon. CAROLYN PICKLES: The problem is that in this legislation in many cases we are talking about a terminal and very painful illness with people having to undergo intrusive kinds of medical treatment. Anyone who has had anything to do with an association called Canteen—an association comprised of young teenagers who have cancer, many of whom unfortunately die—would be well aware that these young people are very mature and can make decisions about whether or not they should continue with medical treatment that may be painful or intrusive.

This legislation has been in force for approximately 10 years. I see no reason why this case should be any different. The provisions have worked very well. I believe that the people of the age of 16 years should be able to make up their own mind about whether or not they wish to have the kind of medical treatment that can be—

The Hon. M.J. Elliott: They are under the present law.

The Hon. CAROLYN PICKLES: You're quite right, Mr Elliott. I see no reason to change it. I cannot quite understand the objection here. Perhaps some members are not aware that the present law allows that already.

The Hon. R.I. LUCAS: I support the amendment. I suppose every member can give examples of the age of majority, whether it be from 15 years in some legislation, although more generally it is from 16 years through to 18 years, and my colleague the Hon. Carolyn Schaefer has given some examples of that. The most recent debate we have had—and it is not directly applicable to this matter—was our increasing in the tobacco legislation the age of people being able to purchase cigarettes from 16 to 18 years. I concede that those who want to argue the other side of the debate will be able to trot through the statutes and find examples where the ages of 16 and 17 years are used.

I support most of the arguments and, therefore, do not intend to repeat them. The defence that has been used by the Hon. Carolyn Pickles, the Hon. Mr Elliott (by way of interjection), by the Minister in another place and by other advocates is that the old consent legislation included 16 years of age and, therefore, this is just a continuation of the present situation. That tells half the story. In my very first year in this Chamber, when we debated the more controversial aspects of this legislation in the natural death debate of 1983, the question of the age of majority was one of those issues that had to be addressed. It is important that we remind members in this Chamber that 18 years was the age that the majority of members in this Chamber—a good number of whom are still here debating the legislation on this occasion—

The Hon. Carolyn Pickles interjecting:

The Hon. R.I. LUCAS: It is fair to say that you could change your mind if you wanted to. All I am saying is that the defence the Hon. Ms Pickles and others are using is that we should keep 16 years of age, because under the old consent legislation 16 years was the age of majority. I point out that, with regard to the Natural Death Act (again legislation which obviously relates directly to the issue we are debating), the overwhelming majority—although not everybody—supported the provision of 18 years as being the appropriate age of majority for these life and death decisions that have to be taken in relation to this issue. In going back to the statutes in relation to this legislation, I point out that it is important to refer not just to the consent legislation which uses the age of 16 years but to the Natural Death Act which refers to the age of 18 years. That is a powerful argument to support this amendment.

The Hon. BARBARA WIESE: I oppose this amendment, as well. I want to take up a couple of points that were made by the Hon. Mr Lucas. This is now the third occasion that this matter has been debated in this Chamber in the time that I have been a member of Parliament. The first occasion was during the debate on the natural death legislation. It was a very controversial issue at that time. Many community organisations on both sides of the argument presented a case to members of Parliament who ultimately determined that the age of consent at that time should remain at 18 years of age. However, two years later, when we were debating the Medical and Dental Procedures Act, members, in their wisdom, with still a great deal of debate taking place in the community, decided that the age of consent should be dropped to 16 years in making decisions relating to dental and medical treatment. There was enormous debate about these issues during that period. But just in that two year space quite a considerable change in attitude occurred.

So, the legislation that we passed in 1985, which has been in force since that time, has enabled 16 year olds and older to make these decisions and, as far as I am aware, that legislation has functioned very well. I am not aware of concerns being expressed about the legislation not operating appropriately, and it is for that reason that the select committee recommended that the measure should be carried through into this legislation. So, here we are looking at an evolution of views. We started—

The Hon. R.I. Lucas: As they are brought together in one Bill.

The Hon. BARBARA WIESE: It is true that two different issues are brought together in one piece of legislation. I would argue that the issues that are contained in the Natural Death Act should entitle a person, even more so, to have some power over their own life and over decision making than may be the case with respect to such matters as dental treatment.

The Hon. R.I. Lucas interjecting:

The Hon. BARBARA WIESE: You can have another go in a minute. The point that I want to make is that the views of parliamentarians reflect a shift that has taken place over a period of years in the community, and the age of consent that was adopted in 1985 represented that shift over a period of two years. I am aware of no objections relating to the operation of that legislation since then that would lead me to change my view on the age of consent matter. After taking evidence from numerous people within the community, the select committee has recommended that the age of consent for the purposes of this legislation, which combines a number of pieces of legislation, should be set at 16 years, and one of the main reasons for recommending that is that the select committee did not believe that we ought to take a step backwards. To reinstate an 18 year old age limit here, in my view, would be to take a step backwards.

The Hon. M.J. ELLIOTT: I shall be opposing the amendment. We have to acknowledge that any age that we choose in such legislation is ultimately arbitrary. There is no magic switch that flicks over on somebody's birthday, be it

at 15, 16, 17 or 18. It is a matter of deciding at what point we should allow certain decisions to be made by children.

I recall the very loud protests, particularly from country areas, when there was a suggestion that the driving age should go up from 16. Life and death decisions are being made on the road all the time by 16-year-olds. We have decided that we will allow 16-year-old farm lads and girls on Eyre Peninsula among other places to drive sometimes quite big equipment on roads and also cars to visit Port Lincoln or wherever. We have decided that 16-year-olds are capable not only of handling the equipment, but handling it in a competent and sensible way. It is probably a good thing that we decided not to make the same age the age at which they can legally buy alcohol. It is sensible that legally both of those things do not happen on the same day and that we have separated them by two years. As a parent, when do I lose absolute control of my children? There is no magical day when that happens.

The Hon. Diana Laidlaw: How old are they now?

The Hon. M.J. ELLIOTT: My eldest child is approaching 12. I still expect that child to do what she is told—I think the operative word is 'shall', not 'should'—in response to any reasonable request. I know that by the age of 18 she will be an adult in every sense, but there is a gradation. One hopes that children will always take note of what one says as they grow older and that, if they have respect, they will take note of one's wishes. That respect ultimately is commanded, not demanded. It is a matter of deciding when, in all these arbitrary numbers that we go past, we entrench in law that there will be a cut-off.

I do not believe that 16 years in relation to these matters is unreasonable. This is a personal decision. I am assessing it on what I have seen of my children, who are below that age, but one is not far below it, and also nine years of teaching in high schools. There will be some 70-year-olds who will not be capable of doing it and some 12-year-olds who will. I think that 16 in the circumstances is not unreasonable.

The Hon. K.T. GRIFFIN: I do not think that the analogy of driving an expensive piece of equipment on the road is appropriate, because it requires different attributes: it requires manual skills and some intuition about handling a vehicle.

The Hon. Carolyn Pickles: And commonsense.

The Hon. K.T. GRIFFIN: And commonsense, of course, about how to handle a vehicle. However, that is quite different from making a decision whether or not medical treatment will be withheld or applied. As the Hon. Robert Lucas said, there are two different issues here. One is the question of consent to medical and dental treatment and the other is the question of appointing an agent to make a decision to apply or not apply a particular treatment in the event of some life-threatening disease or for some other obvious reason. Therefore, two different issues have to be approached.

A person cannot make a will until the age of 18. Some have described the appointment of a medical agent as the appointment of an agent for the purpose of a living will, but the appointment of an attorney in ordinary circumstances is not permissible until one is aged 18. Those areas could probably be regarded as less serious in importance than areas relating to one's health and well-being. In the context in which this Bill is brought to us, where the two different issues are very much entwined in the one piece of legislation, I shall be supporting the amendment for 18 years of age as the more appropriate point at which persons may make decisions affecting their health.

The Hon. J.C. BURDETT: I support the amendment. I think there is some desirability in having the age of majority uniform as far as possible, unless there are good reasons to the contrary. The age of majority is fixed in the Age of Majority (Reduction) Act 1971. That Act reduced the age of majority from 21 to 18, and that is still the current legislation. There are particular areas where that is departed from. We have heard about driving licences, and even that is a controversial area. However, it is desirable to have the age uniform, if possible.

The Hon. Trevor Griffin referred to the fact that a power of attorney in the ordinary sense can only be made by a person who has attained the age of majority—18 years of age—so why should there be any difference in this instance? I agree that in a number of cases there are reasons for departing from the general age of majority. However, during the debate I have not heard any reasons which I regard as being valid in this matter. Therefore, I consider that it is desirable to retain the uniform age of majority of 18.

The Hon. DIANA LAIDLAW: I oppose the amendment. I served on the select committee that addressed medical and dental procedures. The Hon. Mr Burdett also served on that committee. At that time we determined that 16 was the appropriate age for such decisions. From my earlier experience as shadow Minister with responsibility for community welfare, I know that the age at which children are capable of making any decision is a vexed and arbitrary issue. I met kids of eight years of age who were more worldly than some people of 25. Indeed, all these issues were discussed with my niece, aged 14, who has just been on a school trip to Japan, and she was more than able to make decisions about her own welfare and who to appoint to act as an agent. We are not providing her with that opportunity in this Bill, but some people aged 45 will never have the capacity or the wisdom to make such decisions. It is an arbitrary thing. As one who moved initially for age discrimination in this place, I find these matters difficult. However, having made a decision at an earlier time with regard to the age of 16, I would commend the provision in this Bill which provides for persons over the age of 16 to make decisions about their health and welfare.

The Hon. BERNICE PFITZNER: I oppose the amendment on three counts. The first relates to the Consent to Medical and Dental Procedures Act 1985. The Minister, in his second reading explanation in November 1984, said:

> The report stated that a single piece of legislation should be introduced to provide minors, 16 years or over, with the ability to give as effective consent to medical or dental treatment as an adult can give. This recognises the fact that a minor at 16 is usually able to realise the nature and consequences of any proposed treatment for him. Such legislation would embody general practice and would clarify the common law principle which relates the ability to consent to a person's understanding rather than a particular age.

Further, he said:

> This move would provide clarity for both doctors and patients and would recognise the maturity of 16-year-olds in today's society. As the working party rightly pointed out in its report, under existing legislation a minor of that age is able to consent to sexual intercourse, drive a motor vehicle, be employed and undertake most of life's roles and responsibilities. It is right that such self-determination of their own lives be extended to allow them to make a choice about medical and dental care. If a person is mature enough to seek such care, he or she should not be denied treatment solely because of age.

I support the sentiments in the second reading of that Bill. Secondly, being involved in child development and looking after children I would concur that 16 is an age at which most

children in this society, given full information as to the implication of treatment, whether it be dental treatment, minor treatment or major life supports, do understand such things. Thirdly, I would also like to share with this Council a practical experience that I had, involving a 17 year old who had broken his neck in a football incident and was a paraplegic. He was on life support, for breathing and for all other body functions.

At that stage I was not aware that the Natural Death Act operated at 18 years, and this child very clearly requested all life support to be withdrawn. I would submit that, with more serious medical treatment, a 16 year old person's faculties and abilities are indeed more sharpened than in those situations concerning the pulling out of a tooth. When this 17 year old boy requested that all life support be withdrawn it was done. So, I would oppose the amendment and support the sentiment as drawn out in the Consent to Medical Treatment Bill 1985—that 16 is a suitable age for decisions on such things as medical treatment, be it trivial or be it serious.

The Committee divided on the amendment:

AYES (11)

Burdett, J. C.	Davis, L. H.
Dunn, H. P. K.	Feleppa, M. S.
Griffin, K .T.	Irwin, J. C.
Lucas, R. I.	Roberts, R. R.
Schaefer, C. V.(teller)	Stefani, J. F.
Weatherill, G.	

NOES (10)

Crothers, T.	Elliott, M. J.
Gilfillan, I.	Laidlaw, D. V.
Levy, J. A. W.	Pfitzner, B. S. L.
Pickles, C. A.	Roberts, T. G.
Sumner, C. J.	Wiese, B. J. (teller)

Majority of 1 for the Ayes.

Amendment thus carried; clause as amended passed.

Clause 4—'Interpretation.'

The Hon. BARBARA WIESE: I move:

Page 1—
Line 21—Insert definition as follows:
'administration' of medical treatment includes the prescription or supply of drugs;
Line 21—Leave out the definition of 'adult.'

The insertion of the definition of 'administration' makes clear that administration of medical treatment includes the prescription and supply of drugs. It was intended that this should be the case, but without further clarification it could be argued that it may be interpreted more narrowly to apply, for example, just to administration in the sense of giving an injection, as opposed to prescribing and supplying drugs to a patient capable of administering them himself or herself.

The second amendment, leaving out the definition of 'adult', is really a drafting amendment. It is considered that the definition is unnecessary and somewhat confusing as it stands, particularly when read in conjunction with clause 6, and accordingly the amendment seeks to strike it out.

Amendments carried.

The Hon. CAROLINE SCHAEFER: I move:

Page 2, line 6—leave out '16', insert '18'.

This is consequential on my first amendment. I do not propose to speak to it.

The Hon. BARBARA WIESE: I oppose this amendment. I do so because, although the Council has carried an amendment relating to the age of consent (which the honourable member moved previously), that was essentially an amendment to the objects of the legislation. This amendment now is the first occasion where a substantive amendment is being made to the provisions of the legislation, and I therefore believe it is appropriate that I should indicate opposition with respect to that amendment.

I will not go through the arguments again, but I reiterate that this Bill has sought to preserve provisions which have existed in legislation now for many years and which have conferred rights upon people aged 16 and above to make decisions that are essentially very personal decisions about medical care for themselves. As this first amendment relates to a substantive part of the Bill, it is appropriate to consider the matter again. So I therefore indicate opposition to the amendment.

The Hon. R.I. LUCAS: I think we will have a long debate if, once we establish a principle as to where the numbers in the Chamber are, each and every time we then come back to the same issue we revisit the same debate. It has been a long-established principle in my time here that we have a test case for the views of the Council on a particular issue and then follow through with consequential amendments in relation to that issue.

In the first debate and the first division in relation to the ages of 16 and 18, the Council expressed its view that it preferred the age of 18 years. If the Minister is suggesting that we now revisit this particular issue every time, then potentially every time a member in this Chamber loses a vote during this long and arduous debate, rather than taking it as a test case, that member may seek to prolong the debate at this Committee stage by revisiting the issue every time it is raised.

It is certainly my view, and that of my Party, that we do not unnecessarily prolong the Committee stage debate in this Chamber. I am not sure what the Minister's intention is. We would like to see the matter, as expeditiously and as reasonable as possible, progress through the Committee stages of the Chamber. I indicate that I do not think it will be productive if we have to revisit every issue once the Council has established its view on a particular issue of principle.

So, I support the amendment, which is consequential and, as I said, in accordance with long-established practice, we ought to expedite consideration of consequential amendments during the Committee stages.

The Hon. DIANA LAIDLAW: I agree with the Minister's assessment that this is the first substantive amendment in terms of this issue. The earlier amendment merely dealt with the objects of the Act.

Listening to the debates and recalling the contributions that both the Hon. Mr Burdett and I made to the Mental and Dental Procedures Act some years ago, I think that what we have done in terms of the objects of the Act is to deny many existing rights. I am not sure that that is necessarily the intention of the mover or of many of those who voted for that measure, because as a matter of principle so many times in this place we hear from lawyers and others that the denial of pre-existing rights is abhorrent.

I believe, recalling the debate and the many contributions to this Bill, that at issue is the power to make a medical power of attorney and the age at which a person can appoint such an agent. At the present time the Bill provides that that age is 16 years. I think that, given the last vote on the objects and listening to the debate, the majority of members would support that being amended to 18 years. It is possible that we could move and support an amendment to do that and concentrate on that concern—that is, in terms of the medical power of attorney—but not deny existing rights that people

have had at least since 1985, when we agreed to the age of 16 years.

The Hon. Mrs Schaefer's amendment would mean that we are denying rights that people have had for the past eight years. I do not think that would sit comfortably with any member in this place if they searched their conscience on this matter. I believe that we should keep the reference to the age of 16 in terms of a child, but that we could accommodate the concerns of the majority of members—not my concerns—by changing the age to 18 in relation to the medical power of attorney in clause 7. For those reasons I oppose this amendment.

The Hon. K.T. GRIFFIN: I want now to join the debate on this question of denying existing rights. With respect to my colleague the Hon. Diana Laidlaw, I think she misunderstands the previous debate on the question of denying pre-existing rights, because that argument has always been in relation to retrospective legislation. This legislation is not retrospective; it is not taking away a right that has accrued.

We have argued about retrospective legislation in the past. Let us consider Gawler Chambers. The court had decided that the Adelaide Development Company had an existing right to appeal. What the Government did was bring in a Bill that removed that right. The right was established; it had accrued. However, the Government sought to remove it. Action had been taken under that accrued right. But this measure is not doing anything other than changing prospectively the rights of persons who may be between 16 and 18 years of age. That is a different issue.

The Hon. M.J. Elliott interjecting:

The Hon. K.T. GRIFFIN: You do that with the Road Traffic Act. We passed legislation in this Council not so long ago to impose a penalty upon people who drove without being licensed. That was a penalty of imprisonment. One would never change the law if one used that argument because every day laws are passed that change the conditions under which people live or conduct business—

The Hon. M.J. Elliott: You change the law because it fails.

The Hon. K.T. GRIFFIN: That is nonsense; you don't change the law just because its fails. You sometimes change the law because you want to do other things. You know that; you have been party to supporting retrospective legislation to take away accrued rights. The fact of the matter is that laws come in here for a variety of reasons. Let us consider the Environment Protection Authority Bill and the Development Bill. They are changing existing rights that people presently have, but they are not changing rights upon which people have acted and which people are using.

With respect to things like Gawler Chambers, Adelaide Development Company had acted upon a right which it had. After the company had exercised the right the Government sought to try to take that right away from it.

My argument is that if we want to recommit the Bill later and consider distinguishing between consent to medical treatment and dental treatment to put it back to the present position under the consent to medical treatment legislation, and distinguish that from the appointment of a medical attorney, then let us reconsider that issue. However, that is not the point that we are discussing at the moment. We have made a decision on the principle that 18 years is the age at which people can make decisions about medical treatment and appointment of medical agents. In my view consistency requires that we support in this definition the increase to 18 years. If people have concern about that then we can recommit it when we have been through the Bill—if people want to distinguish between the two areas of the law that are to be affected.

The Hon. J.C. BURDETT: I support the amendment. My colleague the Hon. Diana Laidlaw has referred to my position in regard to the Consent to Medical and Dental Treatment Act in 1985, but I think the debate was in 1984. The previous Natural Death Act referred to the age of 18 years. Medical and dental treatment deals certainly not only with having a tooth pulled out but with very serious and life threatening procedures.

However, this present Bill deals specifically with making up one's mind as to whether one lives or dies. That seems to me to be in a distinctly different category. Therefore I believe that, in accordance with the amendment that has already been passed in regard to the objects of the Bill, we ought to retain the reference to the age of 18 years.

The Hon. M.J. ELLIOTT: When we debated previously the question of the age of 16 or 18 years a number of people spoke once but a number of people did not speak at all. I think it would be fair to say that the matter was not exhaustively treated. I believe that only after the numbers were counted perhaps some people decided to take the debate further.

I think the Hon. Miss Laidlaw may be correct in saying that one way of resolving the problem could be to differentiate between general issues of consent in relation to medical and dental matters and the living will or agents. I personally do not have any special need for a differentiation, but then I support the age of 16 in both cases. However, there may be some people who think that 16 is appropriate in relation to matters of medical and dental consent and that 18 may be appropriate elsewhere. I do not know whether an indication from other members of where they stand during this debate might facilitate the proceedings. It might be helpful if we knew how members voted and why they voted the way they did, because a number of members did not contribute.

The Hon. K.T. Griffin: They don't have to.

The Hon. M.J. ELLIOTT: No, they don't have to, but I was saying that if we want to have an informed debate among members here it is useful to know why people have voted the way they have. Some people have not indicated that at all, or in any depth. It is not a criticism but an observation. However, I was saying that if the Hon. Miss Laidlaw's suggestion is to be explored further it will be interesting to know whether or not other members share that opinion.

I have been in this Legislative Council for almost eight years and every day, as is the case with most other members, I get letters and phone calls on a multitude of issues. Not once in eight years have I had a person come to me and complain about the way that the old legislation in relation medical and dental consent was working—not once in eight years.

I receive many complaints about a lot of legislation and the ways in which laws are applied, but I have not received one complaint about that legislation. That tends to suggest to me that there is not a problem in this area. Some members might be able to imagine problems but, if people are not saying that they are having difficulty, what problem is the Committee trying to solve by changing the age back from 16 to 18? We could be reinstating the problems and the reasons for choosing the age of 16, which are covered in the debate of 1984. So, I do not think that, at least in relation to consent to medical and dental treatment, changing the age from 16 to 18 would solve anything; in fact, all it will do is create a set

of problems which the 1984 legislation set about solving. I do not know how members will vote on this Bill, but I think it would be useful to have some indication of whether or not an amendment to separate medical and dental consent from the appointment of an agent would be successful or worth pursuing.

The Hon. R.I. LUCAS: In my first contribution I think I indicated that this was an amalgam of two pieces of legislation, one of which provided for the age of 16 and the other for the age of 18. The dilemma that members face is that in pulling those two pieces of legislation together the Bill before us favours the age of 16. Trying to differentiate between 16 and 18 in accordance with these two pieces of legislation is an option that the Committee could consider, but I do not think that it can do this on the run or that if it tries to—

The Hon. M.J. Elliott interjecting:

The Hon. R.I. LUCAS: Exactly. I am just saying that I do not think it is productive. The Committee has established a principle regarding the age, which is 18. I believe that position ought to prevail as a consequence during the Committee stage. At the end of the Committee stage, which will not be today, the Bill will have to be recommitted in order to consider clauses that involve this issue. In the end, we can test whether or not it is possible to continue with the existing situation where under the Natural Death Act the age is 18 and under this consent legislation the age is 16. I suspect that we might be able to arrive at a majority position in this Chamber. However, we might need to consider any inconsistencies that might result in the legislation from having a majority decision regarding two separate ages. There may not be any inconsistencies. We may need to listen to advice from Parliamentary Counsel on this matter so that the Committee can sensibly reconsider it when the Bill is recommitted rather than trying to do it now.

Having established a principle, if we try to test it and amend it in accordance with other provisions, that will prolong the Committee stage. As I have said, the most sensible proposition is to have a general agreement to recommit this matter after Parliamentary Counsel and others have had the opportunity to look at the alternative option that has been flagged by a number of members to see whether or not it is sensible. It can then be tested by way of recommittal to see whether or not the majority of members is prepared to support the continuation of the existing provisions of 18 under the Natural Death Act and 16 under the consent legislation.

The Hon. G. WEATHERILL: I voted against the age of 16. The Hon. Mr Lucas's suggestion to recommit the Bill is a good idea if it is possible. I want to go over some of the comments that have been made. The Hon. Diana Laidlaw mentioned her 14-year-old niece whom she felt was competent to handle life and death matters while the Hon. Mr Elliott spoke of his 12-year-old daughter, whom he believes is guided by him. I think that, as parents, we try to guide our children into adult life. I have three sons whom I think are intelligent young men. I often wonder who people are talking about when they mention these 16-year-olds, because when my sons were that age and I asked them what career they would like to follow for the rest of their life they could not make a decision. I had to put them into different areas so they could make up their mind later. In my opinion, a 16-year-old is much too young to make these sorts of decisions.

The Hon. R.R. ROBERTS: I want to make the observation that, at the moment, there is no age in this legislation. All we have done is taken out the age of 16; we have not written anything into this part of the legislation to state that the age is 18. However, I think it is clear that we have established a principle that 18 is the age. I tend to agree with the comments of the Hon. Rob Lucas. I have concerns about expressed rights that people have had in the past. The previous clause does not refer only to the right to make a decision to have medical treatment but about the power of attorney, etc. These are life and death matters, and parents have rights and responsibilities until their children reach the age of 18.

In my view, one cannot take a chance on what will happen with some of the remaining clauses; for instance, clause 7, which involves the power of attorney. If we go through the legislation, we see that a person over the age of 18 years may by way of medical power of attorney appoint an agent. I am prepared to reconsider the definition of 'child', but at this moment I support my original proposition that at this stage of the proceedings the age ought to be 18. If the remainder of my concerns are satisfied I would be prepared for that matter to be recommitted. However, if we vote for the age of 16 now we may reach a different decision later, because this matter involves a conscience vote. I am not prepared to take a punt; I want to have my cake and eat it too. If I am satisfied on these other areas, I am prepared to support a recommittal to look at this issue. I am neither wet nor dry, I am damp, as are many other members of this Party.

The Hon. BARBARA WIESE: The issues have been clearly identified. The point that I tried to make in the first place by opposing this amendment has been stated much more clearly by the Hon. Ms Laidlaw and then taken up by the Hon. Mr Elliott. The Hon. Mr Weatherill and the Hon. Mr Ron Roberts have raised issues which are of fundamental concern to them and which they are prepared to deal with later by way of recommittal of appropriate clauses. I think that would be an acceptable way for us to proceed on this matter regarding the age of consent for various issues. I intend to follow the recommendations that have been made by those members so that at the appropriate time we can sift from the legislation the issues about which people feel strongly. In that way we may end up with a piece of legislation that more accurately reflects the views of this Committee than might be the case if we were to assume that a decision taken on the first clause relating to age reflected the views of all members on all matters relating to the age of consent.

Amendment carried.

The Hon. K.T. GRIFFIN: I move:

Page 2, line 11—Leave out 'temporarily or'.

I seek to make some amendments to the definition of 'extraordinary measures'. It is always difficult in any sort of legislation when one seeks to introduce definitions on matters such as extraordinary measures to define them accurately and be able to ensure that they are interpreted in the way that the Parliament may have intended. I suppose the fact that this Bill is largely a conscience issue might make it difficult for anyone to discern exactly what is the will of the Parliament other than from the written word, and then undoubtedly there will be those who may disagree with one interpretation who may want to have it examined by the courts. I have always said that, with issues such as bills of rights, the moment you start to crystallise those rights and seek to enshrine definitions in statute law is the moment you create more work for the legal profession, and that may well happen here.

The definition of 'extraordinary measures' is relevant, particularly to clause 13. Clause 13(2) provides:

> A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use, or to continue to use, extraordinary measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery.

That definition, as it presently is drafted, would mean that, if the operation of a vital bodily function is temporarily incapable of independent operation, then the medical practitioner's duty is removed in the context of subclause (2), although it is qualified by the subsequent part of that subclause: > . . . in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery.

The second application of 'extraordinary measures' is contained in subclause (3), which provides:

> For the purposes of the law of the State—
> (b) the non-application or discontinuance of extraordinary measures in accordance with subsection (2) does not constitute a cause of death.

There, I suggest, is a very fine line between proper medical care and a criminal offence. In relation to the definition 'extraordinary measures'—and they say there is the reference to the bodily functions that are temporarily incapable of independent operation—it seems to me that the reference to 'temporary incapacity' is a rather difficult one to relate to the issue of extraordinary measures. I suppose there are many instances one could relate where a vital bodily function might be temporarily incapable of independent operation. It seems to me that in those circumstances it would be very difficult to reach the conclusion that to take an extraordinary measure to treat the patient would be mere merely to prolong life in a moribund state without any real prospect of recovery if the incapacity is merely temporary. I want to remove the reference to 'temporary' because that removes some of the uncertainty.

The latter part of the definition provides an exclusion from extraordinary measures of treatment that forms part of the conventional treatment of an illness and is not significantly intrusive or burdensome. The Hon. Dr Ritson, when he was debating this matter, drew attention to what might be intrusive or not intrusive, what might be burdensome or not burdensome, and what might be significant or not significant. It seems to me that, by introducing the concept of 'not significantly intrusive or burdensome' involves a much more subjective judgment for the medical practitioner. Inserting a catheter is certainly intrusive, but is it significantly intrusive? In some circumstances it may be argued that it may be significant, in some circumstances not. Is it intrusive to use a nasal drip? That raises an important question of definition.

I do not see how one can really make an effective assessment of what is and is not burdensome, because that will essentially be a subjective and not an objective judgment. The definition will be improved, and the operation of clause 13 will be significantly improved if one removes this connotation of something which is temporary, and also removes the judgment which has to be made that something is or is not significantly intrusive or significantly burdensome. My amendments seek to clarify that and, if they are carried, that will mean an improvement to the operation of the Bill.

The Hon. BARBARA WIESE: I oppose this amendment. In relation to the Natural Death Act, the words 'temporarily or' have been part of the definition of 'extraordinary measures' in that Act since 1983. It is not something which suddenly or precipitately has been included in this Bill. It should also be noted that the transitional provisions in the Bill provide for a direction under the Natural Death Act to remain effective as a statement of that person's desire not to be subjected to extraordinary measures to prolong life if suffering from a terminal illness, despite the fact that the Natural Death Act will be repealed by this Bill. In other words, a direction which was made under that Act will continue to have force, but if the honourable member's amendment is accepted then my legal advice is that the direction would be narrowed in its application.

People who made directions in good faith under the Natural Death Act may suddenly find that they will not cover all the situations that they had envisaged. People could rightly feel somewhat disfranchised. As established by the Bill, if the amendment is accepted, the course for the future would be narrower than has applied since the 1983 legislation. So, the first point that I want to take up is that the honourable member would appear to be introducing an element of retrospectivity which he has just argued against with respect to other matters that we have debated on this legislation, and it would be wrong of us to narrow the focus of rights that people have had since the 1983 legislation was passed and to change the interpretation that would be placed upon forms signed in good faith in the years since that legislation passed.

The second issue that I want to take up is looking at the definition itself. We are talking about someone suffering from a terminal illness. It is also clear that medical treatment that forms part of a conventional treatment of an illness and is not significantly intrusive or burdensome is outside the definition. Read in the context in which it is used in clause 13, there are further limitations. To seek to limit the definition even more by removing the words, 'temporarily or' is considered restrictive and unacceptable, and that takes into account the views of the medical practitioners who work in the area and who gave expert evidence to the select committee.

The Hon. R.I. LUCAS: Looking at schedule 2, the transitional provisions provide:

> Despite the repeal of the Natural Death Act 1983 a direction made under that Act remains effective, subject to revocation or amendment by the person who made it. . .

My non-legal reading of that says that means that, despite the repeal of the Natural Death Act, if a person has made a directive under the Natural Death Act, it remains effective. How is the Minister or her advisers arguing that in doing that this amendment creates a narrowing of the interpretation to which she referred?

The Hon. BARBARA WIESE: The legal advice that has been provided indicates that if this matter were to be changed in the way that is recommended by the Hon. Mr Griffin, it would be viewed as a new expression of opinion on this matter on the part of the Parliament. Even though the conditions under which the previous application was signed were different, it is likely that it would be interpreted more narrowly because of the passage of this subsequent amendment. That is the advice that I have received and I can only assume that it is good advice.

The Hon. K.T. GRIFFIN: If that is the Minister's advice, the simple solution, if the amendment is carried, is to amend the transitional provisions. It is not to use the transitional provisions to argue against the substantive issue here. If the Minister is arguing that because the reference to 'extraordinary measures' in schedule 2 means that 'extraordinary

measures' refer to extraordinary measures under the Bill, I do not agree with her. If she were arguing that, she would also have to acknowledge that the definition of 'extraordinary measures' under this Bill is broader than what is in the Natural Death Act and therefore suggests that, because of her argument about the transitional provisions, what may have been an exercise of responsibility under the Natural Death Act, but may subsequently have been found to be invalid, might be validated by the transitional provisions. We have different definitions for 'extraordinary measures' and 'terminal illness'. We cannot have it both ways. If there is a doubt in the Minister's mind about the meaning of the transitional provisions, that is clarified. I am not arguing to remove or vary decisions which have been made by people under the Natural Death Act if they want them to continue as valid exercises of their responsibility.

The Hon. BERNICE PFITZNER: I oppose the amendment. Clause 13(2) provides:

> A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness. . .

This definition of 'extraordinary measures' is to help the medical practitioner to provide palliative care to help the patient so that the patient does not suffer. If we omit the word 'temporarily', it will narrow the definition of 'extraordinary measures' and place a medical practitioner in a very difficult position, because at times one is not able to decide whether vital bodily functions are permanent or temporary. Therefore, the words 'extraordinary measures' would be narrowed and the practitioner would be unable to provide palliative care in the best interests of the patient.

I refer to the words 'not significantly intrusive or burdensome'. As all medical practitioners who look after the terminally ill and care for the dying know, putting in a catheter or a nasogastric tube is not classified as being significantly intrusive or burdensome. Things which are classified are when a person is riddled with cancer and one is wanting more chemotherapy and X-rays which result in more pain and nausea or things which call for surgery on certain parts of the body when the whole body is already terminally ill.

I do not accept that minor treatments, such as putting in catheters, are classified as being significantly intrusive or burdensome. I do not support the amendment because it defeats the purpose of this provision in the care of the dying, which is to provide good palliative care and treatment for the benefit of the patient.

The Hon. M.J. ELLIOTT: The words 'temporarily or' are already in the Natural Death Act 1983. Looking at the definition of 'extraordinary measures', nothing that the Hon. Mr Griffin has said has illustrated that there is any particular problem with the words 'temporarily or'. They have resided in the other Act for 10 years. In the past eight years in Parliament, nobody has said to me that the Natural Death Act is deficient because of those words. Nothing by way of argument or example has been raised to suggest that there is any need to change what is working. In fact, it starts to create some difficulties which have already been illustrated by earlier speakers. I shall not be supporting the amendment.

Amendment negatived.

The Hon. K.T. GRIFFIN: I move:

> Page 2, line 14—After 'means a person' insert 'acting or'.

I have already indicated my position. I point out that it is not in the current definition.

The Hon. BARBARA WIESE: I oppose the amendment for the reasons that I have already outlined.

The Hon. R.I. LUCAS: I have been busily scurrying through the debates in this and another place, because it is an important issue later. The Hon. Dr Pfitzner, to whose greater medical knowledge I bow, expressed a view in relation to what procedures were intrusive and burdensome and referred to nasogastric drips, for example, and things like that. The Minister acknowledged that, in his view and on his advice, it was a procedure that would be deemed to be intrusive. The Hon. Dr Ritson put a differing medical perspective, and I concede that with lawyers and medical practitioners there will be differing views as to what is and is not intrusive. As this is an important issue, what is the advice to this Minister professionally as to whether nasogastric drips are deemed to be intrusive? I note a number of amendments made by the Hon. Mr Atkinson in another place in relation to this particular issue. What is the Minister's advice as to whether that medical procedure is intrusive?

The Hon. BARBARA WIESE: My advice is that these matters would be considered intrusive treatments, but what is more relevant here is not what my advice is but what the patient or the patient's agent believes to be intrusive treatment. I want to quote from some correspondence that was received by the Minister of Health from a senior medical practitioner in the palliative care field.

The Hon. K.T. Griffin: Who is it?

The Hon. BARBARA WIESE: I would rather not say who it is because I have not requested his permission to provide this information. However, I indicate that he is a senior practitioner in the palliative care field and I would have thought that that is sufficient indication of the qualifications of the individual to be able to make comments relating to these matters. In outlining his views about the issues that have been addressed by the Hon. Mr Griffin and his opposition to the removal of the words 'temporarily or' in the previous amendment and this whole area of definitions, he states:

> It may be that the proposer of the amendment considers that all interventions which supplant or maintain the operation of vital bodily functions in relation to a person suffering from a terminal illness must, by definition, be permanently incapable of independent operation. This is not clinically the case, and it is quite conceivable to have potentially reversible components of a terminal illness. It may not be appropriate to obstruct the dying process by reversing the problem. The whole point of both the Natural Death Act and the Bill is not to supplant or maintain the operation of vital bodily functions that are failing as part of a natural dying process.

These are the words of someone who is dealing with this situation on a daily basis, and those words support very strongly the views that were expressed by the Hon. Dr Pfitzner with respect to what is or is not appropriate treatment in circumstances relating to terminal illness.

The Hon. BERNICE PFITZNER: In the initial treatment the examples that I have given are fully intrusive and burdensome. The other treatments, for example, catheterisation for letting out urine from the bladder and nasogastric tube for feeding the patient, are not intrusive and burdensome initially. However, if they have been in-dwelling for many months and if they cause pain through the nasal and bladder areas, those treatments become intrusive and burdensome. If there is a tumour in the areas where these surgical instruments have to be inserted, and that causes pain and discomfort it becomes intrusive and burdensome, but if those procedures, when initially accessed, do not cause pain but

cause relief, on the whole they are not considered intrusive and burdensome, but are considered a comfort to the patient.

The Hon. K.T. GRIFFIN: I draw attention to the fact that the words used are not significantly intrusive 'and' burdensome, but significantly intrusive 'or' burdensome. It must surely be a matter of subjective judgment as to whether something is significantly intrusive or not so. The fact is that, at least in legal terminology, I would expect that catheters and feeding tubes would be regarded as intrusive, though it may be a judgment as to whether or not it is significant. The point I make is that there is no need, in my view, for these areas of doubt to be introduced into the definition, remembering of course that the medical practitioner is to be protected from criminal liability where it is not significantly intrusive or burdensome, but not protected if it is significantly intrusive or burdensome. I do not believe that the question of immunity or liability ought to depend upon that sort of judgment.

Looking at it objectively, one must argue and recognise that the determination of what is significantly intrusive or significantly burdensome will be a particularly difficult task in all circumstances. It will not be easy for the medical practitioner to make a decision, and I do not think that we ought to introduce into the legislation that significant element of doubt—using the word 'significant' in that context—which divides the legal from the illegal.

The Hon. R.I. LUCAS: I tracked down the views of the Minister who has been guiding the legislation through the Parliament. In another place he said:

> Because of the death denying nature of society we assume that everyone wants sustenance and wants life up to the very moment when life expires. However, the fact is that, as death approaches, many people refuse food and water. To have it forced upon them through nasogastric feeding is an oppressive act that causes extreme distress and discomfort.

Then he goes on to say:

> However, neither is it reasonable to be forced upon a patient through an intrusive measure, namely nasogastric feeding.

I think that confirms that Minister Martin Evans' professional view, his own personal view and his judgment is that nasogastric feeding is certainly an intrusive measure from his understanding of the legislation and that will assist us in our discussion in Committee.

The Hon. Mr Elliott talked about the old definition of 'extraordinary measures' in the Natural Death Act not having any problems and the fact that he had not received any correspondence on the matter and therefore could not support the first amendment from the Hon. Mr Griffin which sought to change the existing definition of extraordinary measures under the Natural Death Act. The last sentence in the provision relating to 'extraordinary measures' is a change to the existing definition of 'extraordinary measures' under the Natural Death Act. I would be interested in a response from the Hon. Mr Elliott in relation to how he would now view this further change to 'extraordinary measures'. Can the Minister say what is the reason for amending the definition of 'extraordinary measures' from the Natural Death Act to add this last provision which basically deals with treatments which are significantly intrusive or burdensome?

The Hon. BARBARA WIESE: As I understand it, these new words and sentiments were introduced into this definition because the select committee received evidence from various parties that this was a matter of concern to many people, that it ought to form part of the definition and that the select committee's views on this matter should be—

The Hon. R.I. Lucas: What was the concern that was expressed to the committee?

The Hon. BARBARA WIESE: The issues that the honourable member referred to when quoting from the Minister's contribution in another place about intrusive and burdensome treatment were the sorts of issues that the select committee wanted to take account of in drafting this legislation. They were not matters that formed part of the definition in the previous legislation, but issues relating to those matters of treatment were raised with the select committee, and it felt it was appropriate to take account of that in the drafting of this legislation.

The Hon. CAROLYN PICKLES: I concur in the comments of the Hon. Dr Pfitzner in relation to when medical treatment becomes intrusive or burdensome. I have a personal family member—my father—who, in the initial phases of his illness, was given a tracheotomy in order to help him breathe and in order to feed him. Initially, of course, this was keeping him alive, for which we were all extremely grateful at the time, because we had no knowledge of the seriousness of the progressive and fatal disease that he had. However, after a very short time this medical procedure that initially was life saving became painful, intrusive and burdensome (they would be rather mild words to describe it) and, although my father was dying, his mental facilities were still there, but of course he could not speak and was able to write his desire to die very quickly.

So, I think it is necessary to have these words included, and I agree that on my reading of the select committee report it was quite clear that there needs to be an extra provision in the definition that describes these particular cases to which the Hon. Dr Pfitzner and I have referred.

The Hon. BERNICE PFITZNER: I thank my colleague the Hon. Mr Lucas for identifying the part that the Minister spoke about—that particular nasogastric tube or catheter. Those implements in themselves are not intrusive or burdensome; they only become so when the patient cannot tolerate these implements in their particular environment. So, as my colleague the Hon. Carolyn Pickles says, initially they do not cause a burden; they are not looked upon as being intrusive; but after a while they become so because those areas around where the surgical instruments are placed become painful. They cause soreness and become significantly intrusive and burdensome.

The Hon. M.J. ELLIOTT: I am not sure whether I am misreading clause 13, where the term 'extraordinary measures' is used, but I would have almost expected, if the words which are being added were not there, that the Hon. Mr Griffin would have moved that they be inserted, because subclause 13(2) states:

> A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a medical illness or a person participating in the treatment or care of a patient under the medical practitioner's supervision, is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use, or to continue to use, extraordinary measures. . .

It seems to me that those words actually add some further limitations, if anything, for the doctor, and that the doctor is required to continue to use measures as long as they are not significantly intrusive or burdensome. The absence of those words in fact surprises me. I would have thought Mr Griffin would argue the other way around: I find people on the opposite side of the argument to that, as I would have expected. This is really saying that, so long as a drip or whatever is not being significantly intrusive or burdensome,

it will continue to be used. Otherwise, in the absence of those words, it would have been defined to be an 'extraordinary measure' perhaps and would not have continued to be used.

The Committee divided on the amendment:

AYES (7)

Burdett, J. C.	Davis, L. H.
Dunn, H. P. K.	Griffin, K .T. (teller)
Irwin, J. C.	Schaefer, C. V.
Stefani, J. F.	

NOES (13)

Crothers, T.	Elliott, M. J.
Laidlaw, D. V.	Levy, J. A. W.
Lucas, R. I.	Pfitzner, B. S. L.
Pickles, C. A.	Roberts, R. R.
Roberts, T. G.	Stefani, J. F.
Sumner, C. J.	Weatherill, G.
Wiese, B. J.(teller)	

Majority of 6 for the Noes.

Amendment thus negatived.

The Hon. K.T. GRIFFIN: I move:

Page 2, line 14—After 'means a person' insert 'acting or'.

There are areas in the law where a guardian may be recognised without having formally been appointed under the Act. It seems to me that that ought to be recognised, and my amendment achieves that end.

The Hon. BARBARA WIESE: I support this amendment.

Amendment carried.

The Hon. BARBARA WIESE: I move:

Page 23, after line 14—Insert definition as follows:

'Guardianship Board' means the Guardianship Board established under the Guardianship and Administration Act 1993.

This definition is necessary because of a later amendment which inserts a new clause 7(b) giving the Guardianship Board a role in defined circumstances to review a medical agent's decision.

The Hon. K.T. GRIFFIN: At the moment I will not raise an objection to it. However, I do not want it to be taken as the point at which we argue the question of which body ought to have jurisdiction to review decisions. I think that probably when we get to the substantive amendments of the Guardianship Board involvement and the Supreme Court involvement I will be arguing that the two can act comfortably together. There are differing roles and responsibilities. Rather than getting into the detail of that, I indicate that I am prepared to support the definition being inserted with a view to debating the substantive issues at a later stage.

The Hon. R.I. LUCAS: I take a similar view. Can the Minister undertake to provide to the Committee after the dinner break the current membership of the Guardianship Board and its legislative structure—what requirements there are on the Chair, any others and so on. As one member who believes that at the very least there should be some form of appeal rights but has not formed a view as to what form those rights should take, I would be interested to know who comprises the Guardianship Board and whether it is a body or collection of persons in whom I should place great trust.

The Hon. BARBARA WIESE: I am sure I can obtain that information during the dinner break, but I can assure the honourable member in advance that the people appointed to the board are indeed fit and proper people in whom he can place enormous trust. I am also sure that the detail that I will obtain for him will convince the honourable member of the accuracy of my statements.

The Hon. M.J. ELLIOTT: I support this amendment. When the legislation was debated in the previous session, I made it plain that I saw a need for appeal rights, although the form of those, as others have commented, will need to be debated later on. I do see the Guardianship Board as playing a significant role and, in fact, that is why the Government is inserting this amendment at this time.

Amendment carried.

The Hon. CAROLINE SCHAEFER: I move:

Page 2, lines 27-29—Leave out the definition of 'terminal phase' and insert—

'terminal phase' of a terminal illness means the phase of the illness reached when—

(a) there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis); and

(b) death is imminent;.

This amendment refers to the definition of 'terminal phase' of a terminal illness. In the context of this Bill, 'terminal phase' refers to Division 2 of the Bill, which is entitled 'The care of the dying'. It would therefore seem logical to me that death be mentioned somewhere in the definition of a 'terminal phase.' I believe it is merely an anomaly in that definition.

Again, we are talking about the palliative care section of this Bill, which I believe is the important section of this Bill and possibly the only reason why at some stage I may support it. I believe that those who care for the dying deserve the support of the law. The definition as it stands does not go far enough. The law should be simple enough for people who need to act upon it to understand it. My addition of 'and death is imminent' I believe merely reinforces what 'terminal phase' means in this context.

The Hon. BARBARA WIESE: I oppose this amendment, largely because the definitions of 'terminal phase' and 'terminal illness' in the Bill are satisfactory and in accordance with the recommendations of the select committee, which looked at these matters in great detail.

The Hon. M.J. ELLIOTT: I would have to ask the question: does 'death is imminent' mean five minutes, five hours, five days, five weeks or five months?

The Hon. K.T. Griffin interjecting:

The Hon. M.J. ELLIOTT: Let us just take the question that 'death is imminent' to start off with. You can argue about the other word later on: I am arguing about this one. I am not sure how a court would ever cope with the word 'imminent'—it is totally unpredictable. There is no doubt about what is a 'terminal illness'; that is certainly understood.

The Hon. Peter Dunn: What is it?

The Hon. M.J. ELLIOTT: Of course, 'terminal illness' is defined in the previous clause, which in fact was not challenged. So don't ask that, Mr Dunn.

The Hon. Peter Dunn: Do you reckon that is correct?

The Hon. M.J. ELLIOTT: You didn't debate it. We have already passed that clause, Mr Dunn, so I presume that you are accepting it. I think the term 'death is imminent' adds nothing but confusion. In fact, doctors themselves in relation to terminal illnesses can often be accurate about the prognosis but not the timing. I do not think that it adds anything but confusion and I therefore oppose it.

The Hon. BERNICE PFITZNER: I oppose the amendment. I concur with my two colleagues who spoke immediately before me. Being a medical doctor I would have great trouble in saying that someone is probably going to die in three months or six months, and deciding whether I would

call that imminent. I am not sure, and I would have difficulty in defining what is meant by 'death is imminent'.

The Hon. R.I. LUCAS: This is a difficult issue; in fact, they are all difficult for me. I return to the arguments that the Hon. Mr Elliott used earlier, when he said that for eight years he had never received a piece of correspondence indicating complaint about the existing law and that we should not change it. The existing legislation that we have under the Natural Death Act refers to death being imminent. We seem to have moved from the term 'terminal illness' under the old law to 'terminal illness' and 'terminal phase'. As I understood the legislation—

The Hon. Carolyn Pickles interjecting:

The Hon. R.I. LUCAS: That is right: we have moved from one definition of 'terminal illness' under the existing law to two definitions of 'terminal illness' and 'terminal phase'. My recollection of the debates in another place is that the Minister tried to explain—because I am obviously not the only member having difficulty with this—that 'terminal phase' was the end process of 'terminal illness' in some way, that we needed the two definitions and that the term 'terminal phase' was trying to highlight that the end was nigh.

The Hon. I. Gilfillan interjecting:

The Hon. R.I. LUCAS: 'The last quarter', my colleague the Hon. Mr Gilfillan suggests.

The Hon. R.R. Roberts interjecting:

The Hon. R.I. LUCAS: The Hon. Mr Ron Roberts is getting closer in suggesting that it is 'time on'.

Members interjecting:

The Hon. R.I. LUCAS: We are getting very sporting here. Under the Natural Death Act, 'terminal illness' means:

> Any illness, injury or degeneration of mental or physical faculties—
>
> (a) such that death would, if extraordinary measures were not undertaken, be imminent.

This Act has existed for eight years, and there have not been too many complaints. However, there are many question marks over words we use in this Bill, and 'imminent' may well be one of them. What is a 'real prospect of recovery'; who will make that judgment? It would be a difficult decision for a medical practitioner or a lawyer. Whether 'death is imminent' would be a difficult decision as would whether treatment is 'significantly intrusive'. Just about every word or phrase that is inserted in this Bill will be difficult to define to the satisfaction of a court, a guardianship board, a family or any other interested person. As I indicated in my brief second reading contribution, I suspect that, as the years go by, this legislation will become increasingly controversial as case after case goes through the courts.

In relation to consistency, an argument that some members have used during this debate, the word 'imminent' is currently used. I have not discussed this amendment with my colleague the Hon. Caroline Schaefer, but I presume that her advice from Parliamentary Counsel picked up some aspects of the current definition of 'terminal illness'. I would be interested to know the attitude of members towards this definition and why we now find it necessary to add the definition of 'terminal phase' to the definition of 'terminal illness', which is provided under the Natural Death Act. At some stage, I would like the Minister's response as to why this term has been introduced.

The Hon. M.J. ELLIOTT: I was not responsible for creating the two terms 'terminal illness' and 'terminal phase', but we are now debating the definition of 'terminal phase'. I do not think that the definition of 'terminal phase' is very good. I am not sure how the one medical practitioner in our midst feels about this, but I do not think that the definition adequately describes what a terminal phase is. I certainly do not feel that the words 'death is imminent' resolve the issue either. I am still grappling with this problem in my mind. One can have a terminal illness with no suffering.

The Hon. Peter Dunn: I've got one; it's called old age.

The Hon. M.J. ELLIOTT: Yes, and you have it worse than I.

Members interjecting:

The CHAIRMAN: Order! The Hon. Mr Elliott has the call.

The Hon. M.J. ELLIOTT: I am thankful for the Hon. Mr Dunn's useful contribution to the debate; may he continue to do so. A person may be suffering from a terminal illness but not actually ill, just simply suffering from a condition. This definition attempts to say that a person has reached the point where the symptoms are extreme, but it does not actually say that. I do not think that the current definition of 'terminal phase' is adequate, but I do not think that the use of the words 'death is imminent' adds anything further.

Speaking off the cuff, I do not have a better definition, but clearly this definition attempts to say that a person clearly is in the last stages of an illness and is suffering with no prospect of recovery or remission from what are clearly serious symptoms. At this point, the definition simply says 'symptoms'. Symptoms can be mild to start off with, but I am sure that this is not what the definition means. So, while I flag opposition to the amendment I also indicate that I do not believe that this definition of 'terminal phase' is adequate. I think that in itself it might create some difficulties later.

The Hon. K.T. GRIFFIN: I indicate support for the amendment. It adds clarity; and it certainly does not add a greater level of uncertainty. The current definition of 'terminal phase' refers to 'a terminal illness'. 'Terminal illness' is defined as 'an illness or condition that is likely to result in death'. Many illnesses, such as cancer and multiple sclerosis, are likely to result in death but not immediately. The 'terminal phase' of a terminal illness 'means the phase of the illness reached when there is no real prospect of recovery or remission of symptoms. . . ' It may be possible two years earlier to say that there is no real prospect of recovery or remission of symptoms, but then the definition applies. In those circumstances, under clause 13, a medical practitioner:

> . . . incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress—
>
> it may be physical, mental or emotional distress—
>
> (a) with the consent of the patient or of a person empowered to consent to medical treatment. . . and
> (b) in good faith and without negligence; and
> (c) in accordance with proper professional standards of palliative care,
>
> even though an incidental effect of the treatment is to hasten the death of the patient.

We are moving into the realms of voluntary euthanasia, and I object to that. The introduction of the description 'the death is imminent' will be a significant safeguard against moving down that track. That is why I support the amendment.

The Hon. R.I. LUCAS: I have shown my legal ignorance and I will now show my medical ignorance, but I recall reading in the debate about a number of diseases or illnesses, one of which I think is dwarfism, where it is known at a very early stage of the child's development that the child will not live beyond the age of 12 to 15. Sometimes we hear a story

of a child lasting a year or two longer, but inevitably the child dies within that time span. There are a number of such conditions, but I cannot remember what they are—the Hon. Dr. Pfitzner may know. However, regarding the definitions of 'terminal illness' and terminal phase', if we as legislators looked at that condition, whatever it is, at an early stage we would say that it is a terminal illness because it is likely to result in death and it has reached the stage where there is no real prospect of recovery or remission of symptoms. I understand that there is never a prospect of recovery with these young people, that they remain on a plateau for a while but that there is a steady downhill decline until at the age of 12 to 15 they die.

It appears to me that what the Minister was arguing—and what this Minister and other supporters would argue in defence of this definition—is that right from the age of, say, two or three when this condition can be identified through tests is that that child has entered the terminal phase. Yet, we see these young children, although not leading the life they would like to lead, leading a happy, productive life for perhaps 10 or 15 years. I ask those who support this definition and who oppose the Hon. Caroline Schaefer's amendment whether it is their intention that young people in the circumstances that I have inadequately explained to the Committee—although I am sure most members understand what I am trying to say—

The Hon. Carolyn Pickles: What disease are you talking about?

The Hon. R.I. LUCAS: I do not know its name; I am not a medical practitioner, as the honourable member well knows.

The Hon. Carolyn Pickles interjecting:

The Hon. R.I. LUCAS: I do not know. I am saying that there are conditions which I have read about in the newspapers and seen on television—

An honourable member interjecting:

The Hon. R.I. LUCAS: I do not read *The Readers Digest*, but I am sure it probably does, and *Real Life* probably does stories on them also, but let us not be diverted; we are addressing an important issue.

We have all seen examples (and I do not know the names of the diseases or the conditions) where at a very early stage it is identified that a child has a terminal condition, that the child will die at 12, 15 or whatever years of age. There is no real prospect of recovery or remission of symptoms with regard to the terminal phase: it is basically a downhill slide from birth or from the identification of this disease or condition until the stage that child dies. Whatever definition you might want to put on 'imminent', at the age of two years, people would say that death was not imminent, because most legal and medical advisers say that death is more likely to be imminent the closer you get to 12, 14 or 15 years but closer to the ages of two, three or four years it would be not as imminent. We ought to take advantage of the dinner break to reflect on this issue.

The Hon. Barbara Wiese: What is the question you are asking? What do you want to solve with this question?

The Hon. R.I. LUCAS: What I am saying is that there seems to be some sense in what the Hon. Carolyn Schaefer moved. She said that the terminal phase is the stage when death is imminent. In relation to a child of the age I am talking about, death would more likely be imminent at some stage closer to 12, 13 or 15 years—whatever the age these young adults are likely to die on all the medical evidence. Something else happens at that stage where that occurs.

The Hon. Barbara Wiese: In the context of what? In the context of an individual being able to make a choice, or in the context of whether or not medical treatment should be provided, or who makes the judgment about medical treatment? What is the concern you have about the terminal phase?

The Hon. R.I. LUCAS: Given the child we are talking about, I would not be comfortable with the terminal phase coming in at age two, three, four or five years.

The Hon. Barbara Wiese: In what context is that?

The Hon. R.I. LUCAS: That does not appear to indicate that death is imminent. To me death is imminent at some later stage, rather than at what I would see as an early stage. I have a problem with this. Given the time, it would be sensible for the Committee to report progress so that we could discuss the matter over the dinner adjournment and discuss it further after the evening break.

The Hon. M.J. ELLIOTT: I had already made quite plain that the definition of 'terminal phase' is not a good description of terminal phase. But I do not also believe that inserting the words 'death is imminent' solves the problem. The Hon. Mr Griffin might be thankful that he lost his previous amendment, because we must realise that we are talking about a phase of terminal illness in relation to extraordinary measures. So, if we are talking about extraordinary measures, we are talking not about withdrawal of simple treatments, which one would have in the early stages of illness, or about taking the inhaler away from an asthmatic child or something like that, but about a measure which is not significantly intrusive or burdensome as well, and luckily those words survived Mr Griffin's amendment. As the Hon. Mr Lucas said, it is worth some consideration as to whether that definition of 'terminal phase' can be somewhat better defined.

The Hon. BARBARA WIESE: Obviously, we need further time to discuss a number of issues, and I know that other members have a contribution to make. For my part, I am not in a position to indicate at this stage why it is that the select committee chose this definition or why it arrived at this set of words as opposed to some other words. They are matters which I will investigate during the dinner break and perhaps make that contribution when we return from dinner, and we will then be in a stronger position to make a judgment about the amendment.

[Sitting suspended from 6.1 to 7.45 p.m.]

The Hon. BARBARA WIESE: Before we broke for dinner, we were debating the definitions of 'terminal illness' and 'terminal phase'. At one stage I was asked why the Minister or the select committee had determined to use these definitions rather than some of the terminology in the Natural Death Act which was passed by Parliament 10 years ago. I am advised that the terminology here came about as part of the evolutionary process of hearing evidence from relevant parties who have some interest in these matters. It came from information supplied by medical practitioners, heads of churches and people who were concerned about how to determine imminent death as opposed to the terminal phase of an illness.

There is no short answer as to why we have these definitions compared with others, except that the members of the select committee specifically did not want to use the term 'imminent death' because it is difficult to define and tends to imply a very short period prior to death. It could be defined

as a day or two or a few hours before death. That is not what the members of the select committee were trying to achieve. The aim of this legislation is to provide dignity and some sense of autonomy for people who are dying, and that means a longer period than a couple of hours before death.

The members of the select committee were trying to achieve a judgment about the final stages of life. I have to acknowledge that that is a matter for some interpretation, but largely for medical rather than legal interpretation. I would argue that we ought to be concentrating more upon the human aspects of this matter than some of the legalistic arguments that have perhaps formed the major part of the discussion on this issue thus far.

Judgments are being made every day of the week about appropriate treatment during the final phases of life. To try to focus on every possibility or the worst scenario of the way in which this definition could be interpreted by people who are going to be involved in that process is to some extent denying what is already happening within the community where, as I said, judgments are being made every day of the week about the final phase of life in a terminal illness. It is preposterous to suggest that it would be acceptable, taking the example given by the Hon. Mr Lucas, that a person who is suffering from a terminal illness with an average span of, say, 25 years should have life support treatment or treatment of any kind withdrawn in year two of that 25-year span when that individual is obviously in an acceptable stage of life. That would not happen. If it did and it led to the death of the individual, that would be murder, and there are legal mechanisms for handling such situations if something like that were to occur.

The period of the terminal phase of life in practice is pretty well identified when it comes down to what happens in hospices and other places of medical treatment every day of the week. These judgments are not as complicated as some members want us to believe. Such judgments are being made. The terminal phase is a matter for judgment, but, by and large, it is an identifiable period of life. Therefore, the decisions to be made during that period are not as difficult as some members suggest. As with so many other things, there is here a very strong element of good faith to be taken into consideration. These things can only work with good faith. For example, should somebody try to bump someone off, legal remedies and mechanisms will be available as they are now.

The Hon. BERNICE PFITZNER: I oppose the amendment. In medical practice we often use the terms 'terminal' and 'moribund', but when we use the word 'imminent' it has the connotation of a time span. Different people have different interpretations of how long the time span for imminent death might be: it might be three hours or it might be three days. I believe that medical practitioners will feel very uncomfortable with the term 'imminent death'. We use the term 'terminal illness' to describe the patient's condition. When we add the term 'terminal phase', it restricts that area further. The definition in the Bill is:

> 'terminal phase' of a terminal illness means the phase of the illness reached when there is no real prospect of recovery or remission. . .

The word 'remission' is important because it has the connotation that there will be an improvement in the condition. Therefore, in relation to the Hon. Mr Lucas' concern about young children, there are diseases that young children have from childhood which would be classified as terminal illnesses because they are likely to result in death. Such things would be childhood leukaemia, chromosome disorders causing micro-encephaly (small brain) or anencephaly (no brain) and therefore death would be the result, or fibrocystic disease where death could result at 15 or 20 years of age. They would be encompassed in the phrase 'terminal illness', but when you add the two words 'terminal phase' it would not apply to children who had these illnesses because, as with leukaemia, there would be periods of remissions and periods of recovery. Similarly, for other chromosomal disorders there will be periods where the child will be better, so that phrase 'terminal phase' would not apply to a young child but the words 'terminal illness' would.

When this Bill was initially drafted there was only mention of the phrase 'terminal illness', and that caused me some concern because it would then encompass quite a lot of illnesses including childhood illnesses. When we add the words 'terminal phase' it shows that there would be no remissions and no recoveries, and that the patient would be in a moribund state. However, if the words 'imminent death' were included it would be very difficult for a medical practitioner to interpret that, because in the minds of most medical practitioners that would have a time connotation to it, and many practitioners would have different time connotations to those words 'imminent death'. So, I would support the words 'terminal phase' of a terminal illness because I feel that medical practitioners will be comfortable using those two phrases together.

The Hon. M.J. ELLIOTT: The definition of 'terminal phase' is not expressed as well as it might be. However, it is worth noting that that term is used in clause 13(2), and we have layer upon layer of protection. We are talking about medical practitioners being responsible for the treatment or care of a patient who must be in the terminal phase of a terminal illness. The situation of a medical practitioner's making a decision would have to be in the absence of an express direction by the patient or the patient's representative to the contrary. There is another layer of protection. We then have the definition of 'extraordinary measures' which, as the definition stands, means that treatments which are not significantly intrusive or burdensome would continue, so that is another layer of protection. Finally, the person has to be in a moribund state without any real prospect of recovery. It seems to me there is layer upon layer of protection.

I cannot see how, realistically, there is the potential for abuse with that level of protection. When we talk about moribund state without any real prospect of recovery, I believe the term 'imminent' is unsuitable because a person could be in a moribund state for a significant length of time. In fact, when a person is in a moribund state a doctor may be in no position to say whether the person is going to die in a minute's time or in a year's time. There would be clearly times when there would be no way of telling.

The Hon. Barbara Wiese: Such as the Quinlan case.

The Hon. M.J. ELLIOTT: Yes, that is a classic example. The moribund state is only one of the protections provided. I would have liked to see 'terminal phase' a little better defined. I think doctors understand what it means without it being defined. The definition itself is not perfect but I do not think it creates difficulties in relation to the many other layers of protection which exist, and I would have thought that, if it ever found its way into the courts, the courts themselves would have to see that terminal phase meant something more than terminal illness because of the way clause 13(2) is structured. In that instance the implication of the real meaning

would become clear in any event. The concept of imminent death in fact muddies the waters rather than clarifies them.

The Hon. PETER DUNN: I support the definition. Unlike the previous speaker, I think it clarifies the matter distinctly. We are talking about time factors here and not how sick the person is or anything else. It is all to do with time factors. I have a terminal illness and it is called 'age', but if a person has a stroke, quite obviously becoming extremely ill, they are probably in the terminal phase of their life but they are not in imminent danger of dying. 'Imminent' means the last little bit of something and, despite what our medical friend says, I think that imminent is quite clear: it is imminent. Perhaps we should not be debating this here: perhaps we should let the doctors determine what is imminent; what is a medical phase; what is a terminal illness; and what is a terminal phase. The mere fact we are here arguing about the matter shows just how unsure we all are of these terms.

I have dealt with animals for a long time and I had a very unfortunate incident on Friday when I lost two of my dogs. I knew when death was imminent looking at them. You can tell when animals are suffering from old age or when they catch a disease of some kind. You know when they are terminally ill; you know when they are in the terminal phase. It is quite obvious when death is imminent. We are not the people to determine that; neither is a third person (as it says in clause 13(2)) able to determine that. If we confine it to when death is imminent, at that point the person who has power of attorney then may be able to make the decision whether that treatment is continued or withdrawn.

An honourable member: What if a cow broke its leg?

The Hon. PETER DUNN: Death is imminent. That is a terminal illness unless extraordinary conditions prevail, because ultimately they get pneumonia and die. We are talking about time, nothing more than time. If a person is born with *spina bifida* they are terminally ill from the day they are born, but that does not mean to say they are in a terminal phase. The terminal phase is later on in life, and right at the last it is imminent. So, those three definitions should be in the Bill because you can go in and out of death in the terminal phase. The Minister admitted that herself; there might be periods of recovery. If you are going to have terminal phase further out that will be even longer with more chances of recovery. If death is imminent there may be miraculously a recovery period but it is bound to be short if it is that far down the track.

I would have thought 'imminent' defined more clearly the last few hours or the last few minutes. The word 'immminent' defines it much better than 'terminal phase', which the Minister admits herself could be a year or two years. During that terminal phase somebody might say, as your definition rightly states, 'Withdraw treatment.' Surely, that is not what we are after.

The Hon. BARBARA WIESE: I do not want to prolong this, because we have much to deal with on this matter, but I want to correct a couple of things that the Hon. Mr Dunn has said in interpreting what I said. I did not indicate that a terminal phase could be a couple of years. I indicated that the terminal phase of an illness is usually something about which a decision is likely to be made by a medical practitioner. I did not put any time on that.

However, I refer the honourable member to the definition itself which indicates that '"terminal phase" of a terminal illness means the phase of the illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or a temporary basis).' So it is very close to the end of life if you read those last few words.

I remind the honourable member about the objectives of this legislation, which are to provide a period of some dignity for people who are dying, and that does not mean in the last couple of hours or the last couple of days of life. If the terminal phase of an illness, during which these sorts of conditions apply, where there is 'no real prospect of recovery or remission of symptoms (on either a permanent or a temporary basis)', is longer than a couple of hours or a couple of days, then people, I would argue—and many others here would argue—have a right to some choices and a right to say, 'Enough is enough,' and to have some involvement in what happens to them and what kind of treatment they receive during that time.

That is the objective of this legislation. We are not trying to deal with just the last couple of minutes of a person's life and make it easy or comfortable for them: it is a longer period than that which we are covering here. Nevertheless, the safeguards are there against people who might, for whatever appalling purpose, want to use their power inappropriately. The safeguards and protections are there, both within this legislation and in other aspects of the law, against people who may want to use their powers inappropriately.

The Hon. M.J. ELLIOTT: I think the analogy of Mr Dunn's sheep in his paddock is hardly fair. The fact is that you do not take sheep to hospital and put them on drips, put them in heart-lung machines and on various other things and then say that you can tell when death is imminent. Take the analogy of an animal that is crook in a paddock: the fact that it is unable to feed itself when it is ill means that death is almost always imminent in those circumstances, and will be pretty quick. I do not think too many of his sheep have spent a lot of time in hospital, with his wondering how long they will live and whether or not with various means of support death is imminent or not. I do not think the analogy is really a fair one at all.

The Hon. R.R. ROBERTS: I will not be supporting the amendment. I think we have got bogged down in the morality of situations and we are trying to apply what is essentially a definition to particular cases which we are all envisaging. We spend a lot of time in this Parliament trying to write legislation so that it is simple to interpret. One of the things that we often talk about is plain language, and I put it to this Committee that the terminal phase of the terminal illness means precisely that.

Because we have a terminal illness it means that the result is inevitable: someone will die. All we are really trying to say is: which is the last part of that when there is no turning back? I think this clause as it is written defines the situation for me in plain English. We are talking about providing legislation so that people can understand it clearly and, although I am not a lawyer or a doctor, I think this does the job. I think that we are getting bogged down on what is essentially a definition. As we go through the legislation, when we apply the definition to those particular examples, people ought to make their own judgments on that. I think that this is plain English terminology that defines the inevitable with which we are all grappling. I think we all know what it means. The normal layman, who will not be complicated by medical terminology or legalese, will understand clearly what that means, and I suggest that we ought to support it.

The Hon. K.T. GRIFFIN: One of the objects of the Bill is not only to provide, as the Minister suggested, a way by which people can die with dignity but also to protect medical

practitioners from criminal prosecution. Whilst there has been a lot of focus upon clause 13(2), let me bring members back to subclause (1), which provides:

> A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress, with the consent of the patient or of a person empowered to consent to medical treatment on the patient's behalf and in good faith and without negligence and in accordance with proper professional standards of palliative care even though an incidental effect of the treatment is to hasten the death of the patient.

It is all very well, I would suggest, for the Hon. Mr Roberts to say, 'Look, in normal language everyone seems to know what "terminal phase of a terminal illness" might mean,' but I suggest that one has to look to what the courts may do with this, particularly if it is a medical practitioner being prosecuted for hastening the death of a patient.

As everyone has recognised, one may have a terminal illness and one may be in a terminal phase, because there is no real prospect of recovery or remission of symptoms, but it may be several years down the track that one finally faces death. It cannot be proper—

The Hon. Carolyn Pickles interjecting:

The Hon. K.T. GRIFFIN: That is right: who knows? But it cannot be proper to give medical practitioners immunity from the law where they administer medical treatment that has the incidental effect of hastening the death of a patient, where it is some, two, three or four years down the track that death might finally occur. The law cannot justify that. As I said right at the beginning of my contribution, we are tending towards voluntary euthanasia.

The Hon. Barbara Wiese interjecting:

The Hon. K.T. GRIFFIN: We are. You look at the clear language of the Bill. The Minister says that we are not and shakes her head. But the fact is that that is the effect of it, because there is nothing in the Bill or in the definitions that will relate 'terminal phase' to death. That is the problem. You look at the Bill; there is nothing to link 'terminal phase' with death when you apply it in the context of clause 13.

The Hon. Dr Pfitzner has made a reference to medical practitioners knowing what 'terminal illness' and 'terminal phase' might be. I think probably most experienced medical practitioners will have some appreciation of those conditions, and they may understand certain things. But the fact of the matter is that it does not matter what medical practitioners understand to be the meaning of 'terminal illness' and 'terminal phase'; the fact is that they will then be governed by the definitions in this Bill. They are not then governed by their medical judgment or medical understanding of what is a 'terminal illness' and what is a 'terminal phase'. They are governed by what the law says, in the context of this Bill and the immunity it provides for those doctors, 'terminal illness' and 'terminal phase' might mean.

If there were no definitions of 'terminal illness' and 'terminal phase' then we would be back in the area to which the Hon. Dr Pfitzner is referring, and I would have no difficulty then with that, except that others would then say, 'There is no definition; how can you be sure?' But, of course, that is the problem we are facing all along with this particular legislation.

It is my very strong view that the amendment that relates 'terminal phase' to death is an essential ingredient of this legislation, even if it is only in relation to clause 13(1), which provides the immunity for medical practitioners.

The other point that ought to be noted is that the Minister has an amendment later on which seeks to identify a procedure by which there can be an anticipatory grant or refusal of consent to medical treatment in circumstances where a person is in the terminal phase of a terminal illness or in a vegetative state that is likely to be permanent. It is in those circumstances where a person is incapable of making decisions that certain consequences are deemed to flow from it. So, that has to be taken into consideration even though the Council has not yet determined whether or not that new clause should be inserted. I return then to the point that it is essential, if one is to apply properly and interpret this legislation, that the amendment be carried.

The Hon. R.I. LUCAS: I want to return this definition of 'terminal phase', which as most members have indicated refers to no real prospect of recovery or remission of symptoms. I know that some members have indicated that it is not useful to try to refer to examples, but I must confess that that is the only way I can struggle to understand the effects of the legislation—that is, by looking at real world examples of what might occur in relation to certain conditions.

If one looks at the prospect of an adult with some terminal illness that is a degenerative condition, not something like a cancer that can go into remission, as the Hon. Dr Pfitzner talked about in relation to leukaemia, where one goes into remission and may well go into an active phase again. However, if one is talking about some sort of ongoing degenerative condition or terminal illness, which closes down the system and the persons dies as a result of that particular condition, it is a steady degenerative process in an adult which results in that particular person dying as the body closes down.

On any reading of 'terminal phase', I would suggest that that condition would have to be the terminal phase of a terminal illness. There is no real prospect of recovery. One knows what the condition is: it is a degenerative condition that has slowed and in the end, over a period of years (it may well be a couple of years, 10 years or whatever), there is no real prospect of recovery or remission of symptoms. It is a steady degenerative illness—

The Hon. R.R. Roberts interjecting:

The Hon. R.I. LUCAS: Yes, painful. I do not know where AIDS, for example, fits into this. Is that something which has remission of symptoms? I am not sure. There are examples where people know that over a period of time their condition will steadily degenerate and that they will die. There is no real prospect of recovery and the patient knows that; it is just a question of two years, five years or 10 years. There is no remission of symptoms, because it is not the sort of thing that goes up and down; one's system just gradually closes down and in the end the person dies. That condition is the terminal phase. As soon as one identifies that Rob Lucas has that particular disease he is in the terminal phase of a terminal illness, because he knows—

The Hon. Carolyn Pickles interjecting:

The Hon. R.I. LUCAS: It is my definition, but it is what I am suggesting to this Committee is a reasonable way of reading the Bill before us; that is, a doctor could diagnose that Rob Lucas had a particular degenerative condition and it would not be a question of two, five or 10 years, because it could be any of those, but at some time I will die in a steady degenerative way over a number of years.

With that condition, I think any reasonable reading of this says that that is the 'terminal phase' of a terminal illness. I do

not think that is necessarily (although I am not sure) what many members wished in relation to this provision. On the other hand, I concede that some might argue that 'imminent' might be defined by some to be a very short period, whereas others have argued that it could be weeks or months. I do not know in the end what are the precedents in law for the definition of 'imminent'.

I think that the current definition is far too wide. Therefore, I am inclined to support some tightening of it. If someone can come up on a recommittal—and this seemed to be in part the Hon. Mr Elliott's position earlier—with some sort of tightening of the current definition in the Bill, but perhaps not going as far as 'imminent', then certainly I would be prepared to consider it. However, at this stage, given the choice of the two, I must say that I am leaning toward the amendment moved by the Hon. Caroline Schaefer.

The Hon. Mr Elliott referred to clause 13(2) when he talked about all these layers of protections. He talked about prolonging life in a moribund state without any real prospect of recovery. In the context of that discussion the case of Kathleen Quinlan was raised by way of interjection and discussion. We know the results in relation to that case. We also know that there are a number of very well documented cases of young people being in comas for a very long period of time. One of the members in this Chamber gave an example where a member of the family was in a coma for over three weeks, where some medical experts made a judgment, although they may not have used the term 'moribund state'. However, our colleague indicated that they did not hold out much prospect at all for recovery, and that family had a difficult decision to take in relation to life support during that period. That story has an extraordinarily happy ending, in that the young man involved came out of that moribund state, which some might have seen as being without any real prospect of recovery, and is now a fully functioning member of our society at university.

I am told that there are other examples of people for up to two years being in comas and coming out of those comas and again being fully functioning members of society. So, my response to the Hon. Mr Elliott is that I do not believe that these layers upon layers of protection of which he talks are necessarily as black and white as it might first appear on the surface. When we refer to the Kathleen Quinlan case, some members have implied that the plug should have been pulled. I am not saying that, but some members have suggested that that view should have been taken. But, equally, there have been other examples of people in similar positions who have come out of those comas and then have become fully functioning and happy members of society.

Finally, I make the point that many members had useful discussions over the dinner break, and I had a long discussion with Martyn Evans and other members. I will try to summarise the two views at the moment. Certainly, the Hon. Mr Evans's view is that the amendment is too short; 'imminent' is a very short period and therefore the terminal phase of a terminal illness would be a very short period. The Minister argues that the definition in the Bill is much wider. How wide it is, who knows. However, he argues that it is much wider than the definition in the amendment that is being moved at the moment. He and, I presume, other members are arguing that we should not therefore restrict it.

Members ought to bear in mind the amendments that the Minister has on file in relation to appeal provisions, because I know this is an important matter for many members in this Chamber. As that has been explained to me, the appeal provisions that the Minister is moving to the Guardianship Board will not apply during the terminal phase of a terminal illness.

Clause 7B(2) provides that the Guardianship Board may not review a decision by a medical agent to discontinue treatment if the patient is in the terminal phase of a terminal illness. There is no secret: the intention of Mr Evans and others who support the Bill is, by way of this combination of amendments and the provisions of the Bill, to have a much wider period in which there is no appeal provision during the terminal phase of a terminal illness.

I respect the views put forward by the Hon. Mr Roberts with some courage during the Committee stage of this debate, but I do not think we are getting bogged down in a semantic argument about definitions, because it is the definitions and the amendments that the Minister will move later that will activate the key clauses in the legislation. The package that is before us provides for no appeal provision at all during the terminal phase of a terminal illness. Many members in this Chamber have had some degree of reservation about the Bill, but I suspect that the majority of Labor, Liberal and Democrat members is prepared to support the Bill with the insertion of these appeal provisions. I think that is a fair summary of the majority view of members.

Therefore, this issue of when the appeal provisions cut in and cut out is important because, if our interpretation of the terminal phase of a terminal illness is right and it is a very long period, there will be no appeal rights during that very long period for those people. I refer to the case of the adult with a degenerative condition over a long period of time who eventually dies. During the period of the terminal phase of that terminal illness there can be no appeal at all to the Guardianship Board in spite of the reasons advanced by members to include some appeal provisions for the purpose of protection. So, although I respect the views of the Hon. Mr Roberts and other members, it is important that we get the definitions right because, once we decide on these definitions, that will activate a series of different circumstances in the Bill and in the amendments which the Minister will move later, particularly regarding the appeal provisions.

The Hon. BARBARA WIESE: I want to place on the record a couple of points regarding the matters that have been discussed. First, I do not think that it is possible for the Committee to expect that any legislation that deals with matters such as the ones covered by this legislation will cover every single circumstance. It certainly will not cover those miraculous circumstances that we read about from time to time where a person who has been in a coma for X number of years suddenly comes to life and those sorts of very rare cases, that is probably true, but we are dealing here with circumstances that relate to the vast majority of people. We are trying to provide mechanisms by which the vast majority of people who find themselves in these circumstances can, if they choose, have some control over the last phase of their life.

I remind members that the word 'terminal' means 'last'; it means the last stage of a fatal disease. It does not mean a period of three or four years before a person dies from a terminal disease when they are still running around the street or pushing themselves around in a wheelchair; it refers to the last phase of life of a terminal disease. I remind the Hon. Mr Griffin and other members who have referred to matters regarding clause 13, that that clause forms part of division 2, which is entitled 'The care of the dying'. We are talking about a very specific part of the last phase of life. As I

understand it, clause 13(1) was incorporated in the legislation because the select committee received evidence from medical practitioners that there may be occasions during the last phase of life where the administration of a particular drug to provide relief from pain, such as morphine, may also have the side-effect of causing respiratory problems that could lead to death. However, in the last phase of life it is reasonable for such a judgment to be made in circumstances where the relief of pain because life is fading away and making the patient as comfortable as possible in that phase are the most important issues.

I do not think we ought to concentrate so much on the definition of the last phase of a terminal illness, because we have heard from the Hon. Dr Pfitzner, who is a medical practitioner, that that terminology is well understood by the medical profession. We have heard from the select committee that the evidence received from medical practitioners indicates that this terminology is understood in the medical field. At the end of the day, the medical practitioner will be the most influential person amongst those who make decisions about the sort of treatment a person will receive in the last phase of life. So, my view, as I said some time ago, is that I feel some members are making this issue more complicated than it is in practice in real life.

The Hon. BERNICE PFITZNER: I would like to respond to some of the arguments of my colleagues. First, regarding the Hon. Mr Griffin's argument, it is agreed that the final debate on which treatment is correct to use lies with the legal officer and not with the medical practitioner, although the medical practitioner is supposed to interpret this Bill. I put to the Committee that a legal officer would interpret this Bill more easily if the terms 'terminal phase of a terminal illness' together with 'a moribund state' are used rather than the term 'imminent death', because a medical practitioner will be a witness on the witness stand, and 'imminent death' will not mean much to a medical practitioner: 10 medical practitioners could have 10 interpretations of the time-frame of imminent death. We often write comments in case notes regarding a terminal illness and moribund conditions.

Another aspect to which I wish to respond regards a comment by the Hon. Mr Lucas. He cited an example of a disease or condition that could be prolonged if the term 'terminal phase of a terminal illness' were used.

I cannot think of any disease that always leads straight to death—even a neurological disease. There will be recoveries and remissions. I do not think there is any such disease—or if there is one, it is very rare. Even if it is a demyelinating, nervous or brain disease, or meningitis, there are periods where there will be recoveries and remissions. I do accept that the honourable member has argued in this fashion, but I just cannot think of any such example and, if I could, it would be very rare.

The Hon. K.T. GRIFFIN: First, although the Minister has referred to the headings in the Bill, I draw her attention to the fact that in interpreting the Bill no regard is to be had for the headings or marginal notes. So, how it is headed up is irrelevant to the issue of statutory interpretation. Secondly, the other point we need to be brought back to is that, in the current Natural Death Act, terminal illness already refers to death being imminent. It provides:

> 'Terminal illness' means any illness, injury or degeneration of mental or physical faculties—
>
> (a) such that death would, if extraordinary measures were not taken, be imminent;
>
> and
>
> (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.

We already have the word 'imminent' there. Everyone is arguing against its being included in this definition, but the fact of a matter is, as was used against me in another instance about the definition of 'extraordinary measures', that no-one seems to have felt that that definition using the word 'imminent' has created any problem since 1983, so why should it create any problems now?

The Hon. Barbara Wiese interjecting:

The Hon. K.T. GRIFFIN: Everyone else is saying it is raising problems.

The Committee divided on the amendment:

AYES (8)

Burdett, J. C.	Davis, L. H.
Dunn, H. P. K.	Griffin, K .T.
Irwin, J. C.	Lucas, R. I.
Schaefer, C. V.(teller)	Stefani, J. F.

NOES (13)

Crothers, T.	Elliott, M. J.
Feleppa, M. S.	Gilfillan, I.
Laidlaw, D. V.	Levy, J. A. W.
Pfitzner, B. S. L.	Pickles, C. A.
Roberts, R. R.	Roberts, T. G.
Sumner, C. J.	Weatherill, G.
Wiese, B. J.(teller)	

Majority of 5 for the Noes.

Amendment thus negatived.

The Hon. BARBARA WIESE: I move:

> Page 2, after line 29—Insert new subclause as follows:
>
> (2) A medical agent or other person will not be regarded as available to make a decision about the medical treatment of another unless that person is mentally competent to do so.

This amendment seeks to insert a new subclause (2). It seeks to incorporate an added protection for a patient in the perhaps unlikely but nevertheless possible event that a medical agent may have become mentally incompetent. It is arguable that a decision in those circumstances would not be valid, anyway; however, the amendment is designed to put the matter beyond doubt. I understand that, since the Bill was drafted, representations have been made to the Minister of Health about this matter and, in order to put the matter beyond doubt, he has suggested to me that I move this amendment to satisfy the concerns that have been raised with him.

The Hon. J.C. IRWIN: Who judges whether the person is mentally competent?

The Hon. BARBARA WIESE: I am advised that the judgment would be made by the medical practitioner who would receive requests from the agent on behalf of the person concerned. If that medical practitioner believed that the requests being made of him or her were unreasonable and demonstrated that the individual concerned showed signs of mental incompetency, then he or she would simply choose to ignore the instructions given by that person.

The Hon. J.C. IRWIN: It may be a desirable state to reach when an agent and a doctor are conferring at the last minute of a person's life. On the Minister's explanation, the doctor may say to the agent, 'I do not think you are mentally competent; you are not making the decision that I would have made as a doctor,' or the other way around. That person, as the agent, can then be dismissed as being medically incompe-

tent. It is not good enough in the circumstances for the Committee to accept that amendment as it is because there are no safeguards. Many of these decisions are made at the end. It is not as though there is time for somebody to go to a psychiatrist or a psychologist to verify that the agent is not competent; it is all done in the heat of the moment. It is not good enough for me and I will not support it, even though the intention may be correct. I think we need a better form of words or sequence of events for that to come into play.

The Hon. M.J. ELLIOTT: It seems to me that the Hon. Mr Irwin has misunderstood how the clause would work. It is actually an additional protection. A doctor cannot make a decision which is stronger than the agent is asking for. The Hon. Mr Irwin's fear seems to be that the doctor may say, 'I want to do something that will hurry death along and the agent, who is mentally incompetent, is mucking things up.' In fact, it is the other way around. The mentally incompetent person could be asking the doctor to do something that would lead to the acceleration of death and the doctor may say, 'I do not think this person is mentally competent and I am not going to follow that demand.' It is actually an extra protection; it is not the other way around.

The Hon. J.C. IRWIN: My question was: who decides who is mentally competent, what is the test and how is it done quickly? I want assurances on those matters, whether the doctor is being accused of mental incompetence or the doctor is accusing the agent of being mentally incompetent.

The Hon. CAROLINE SCHAEFER: I may live to regret this, but I do not have a problem with this amendment, because I understand that the Minister has a further amendment to provide for the right of appeal to the Guardianship Board. I assume that would be the normal procedure under this legislation. If mental incompetency were suspected by either the agent or the medical practitioner, they would then set in motion the right of appeal to the Guardianship Board. Although I wonder about the necessity for this amendment, if my understanding of a further amendment providing for the right of appeal to the Guardianship Board is correct, I see no danger to the patient.

The Hon. R.I. LUCAS: I suppose this is a procedural question. Is this the position in the Bill where the Minister intends to insert this subclause? Clause 4 does not have any subclauses; it has a list of definitions. The proposal is that we should now insert subclause (2) in the list of definitions. It may be that this is the trend with Parliamentary Counsel and I have not picked it up, but it seems a strange place to be slotting it in. Even if we were slotting it in, why do we have subclause (2)? Will the list of definitions make up subclause (1)?

The Hon. BARBARA WIESE: As a matter of clerical procedure, once this new subclause is added, all that precedes it will be subclause (1). That will be taken care of in a bookkeeping sense in the usual way.

I should like to clarify one concern raised by the Hon. Mr Irwin. This amendment relates only to the mental incompetency of the medical agent, not the medical practitioner. It is there to be super cautious. As I indicated when moving the amendment, circumstances of this kind are likely to be very rare, but in the rare circumstances that an agent has become mentally incompetent and incapable of providing sensible instructions on behalf of the person for whom he has been appointed agent, the medical practitioner, who is trained in these matters, would have a right to indicate that that person was not competent and he would ignore the instructions. I suggest that these circumstances would arise when the instructions being given by an agent were so far off the planet that almost anybody would recognise that that person was no longer mentally competent.

The Hon. K.T. GRIFFIN: I am relatively relaxed about the amendment because it ties in with later amendments that I have that seek to ensure that the medical agent acts honestly and in the best interests of the patient. I do not suggest that the Minister will support my later amendments, but they follow in the same vein. The sort of thing that I think has to be established under the legislation is that the medical agent has the necessary capacity to make the decision. It is a bit like the power of attorney. The attorney under an ordinary power of attorney at law does not have the power to act if he is mentally incapable of doing so and lacks the necessary capacity, just as a person who makes a will without the necessary testamentary capacity does not thereby make a valid will even if what purports to be a will has been signed.

I think it is appropriate to have this subclause inserted. It would be taken as the norm for that sort of provision to apply, but I agree that it should be specified. If a medical practitioner does not recognise that a person who gives instructions as a medical agent is mentally incompetent, where does that leave the doctor? However, that is for another day. I support the amendment.

There is the question, which the Hon. Mr Irwin raised by way of interjection: to whom do the words 'or other peron' apply? They do not apply to the person who grants the power or appoints the medical agent. I am not sure to whom that applies, and the Minister might be able to clarify that before we vote on the amendment.

The Hon. BARBARA WIESE: 'Any other person' referred to in this amendment relates to a parent, a guardian or any other person who has the power or responsibility to act in this matter.

Amendment carried; clause as amended passed.

Clause 5 passed.

Clause 6—'Legal competence to consent to medical treatment.'

The Hon. BERNICE PFITZNER: I move:

Page 3, line 5—Leave out 'may consent to medical treatment' and insert 'may make decisions about his or her own medical treatment'.

The Hon. BERNICE PFITZNER: I initially intended to move the amendment to this clause so it would read 'a person over 16 years of age may consent or refuse to consent', and I did this for consistency reasons because clause 7 (6)(a) contains the phrase 'consent or refuse to consent'. However, I note that the Minister's amendment will change that clause to include the provision that the person is to make decisions on his or her own behalf, and therefore I have amended my initial amendment. That is consistent with the Government's proposed amendment on clause 7, page 3, line 10 which reads 'to make decisions on his or her own behalf about medical treatment'. I move this amendment for the sake of uniformity and consistency with the rest of the legislation.

The Hon. BARBARA WIESE: This amendment provides for consistency in the legislation and I indicate support for it.

The Hon. K.T. GRIFFIN: I remain to be convinced. It may be that it is the same as consenting to medical treatment, but my preference is to leave the provision as it is so that it relates to consent where the law about informed consent is very well developed. Making decisions about his or her own medical treatment introduces what could be regarded as a new concept where the decisions of the court in relation to

consent may not necessarily be translated through to making decisions. So, if the clause is to remain in the Bill my preference is to leave the reference to consent as it is.

The Hon. I. GILFILLAN: I had trouble with the wording in the Bill for a slightly different reason, that is, in relation to its understanding and its reading rather than relating to any body of law relating to consent to medical treatment. It could be subject to a reading which indicates that a person over 16 years of age is equivalent to an adult. Therefore, I was confused by its text in the Bill because 'a person over 16 years of age may consent to medical treatment as validly and as effectively as an adult' could be read as indicating some equivalence between a person of 16 and an adult. However, it purely relates to the validity of the decision, and therefore I think the wording of the amendment is preferable. So, although it may only appear a minor point it is on that basis that I will be supporting the amendment. The end result is the same, but I find it a more satisfactory drafting.

The Hon. R.I. LUCAS: I raise with the Minister a procedural question at this stage. We had the early debate about 16 or 18 being the age of majority. Then, as a result of that there was a further amendment where, in the end, my understanding was that we agreed that procedurally we would leave the Bill to run through Committee with the provision of 18 years of age and we would recommit the Bill to discuss this option, on which there has been further debate during the dinner break, of splitting it into alternative streams: potentially 16 years of age for the consent-type arrangements that used to exist under the consent legislation previously and 18 years of age for the provisions that relate more closely to the old Natural Death Act and those sorts of medical agent decisions. That was the option that was potentially going to be floated on a recommittal.

There is a series of amendments coming up which talk about 16 years of age and 18 years of age. My understanding of our last provision was that we finally agreed to treat it consequentially and move to 18, even though there were differing views about it. Would it not be sensible to run through this Bill at this stage providing for 18 and, when we recommit everything, we move back with this option of 18 and 16.

Members interjecting:

The Hon. R.I. LUCAS: We have already started going this other way. We agreed in the last consequential amendment in the definition of a child to opt for this other provision; that is, to go down the path of 18. We had the debate and there was no division on the definition of a child. We decided at that stage to sort this matter out at a recommittal. So, we have already half progressed down this particular path. What are you intending to do now? As we have procedurally gone down that path already, would it not be more sensible to take the first run-through on that particular basis with the understanding that we all have that the thing is going to be recommitted to look at this option of splitting the provision at 18 and 16, depending on the originating sources of the legislation?

The Hon. M.J. ELLIOTT: I am surprised by the amendment moved by the Hon. Dr Pfitzner in the light of the position she has taken on earlier amendments. I am also surprised that the Minister said that she would agree to it. It appears to me that to make a decision does not necessarily imply consent, but consenting does imply that you have made a decision.

The Hon. K.T. Griffin interjecting:

The Hon. M.J. ELLIOTT: That is right. I understand that both the Hon. Dr Pfitzner and the Minister, among others, have argued that they were quite satisfied with 16 year olds consenting. This amendment actually produces something which is weaker, and the very fact that they make a decision is neither here nor there.

The Hon. K.T. Griffin: It may not be a valid decision.

The Hon. M.J. ELLIOTT: That is right. They make a decision but, no matter what their decision, it does not mean that they are actually in a position to consent. I would ask both the movers, if they wish to remain consistent with positions they appear to have stated in earlier debate, to reconsider both moving the amendment and supporting it.

The ACTING CHAIRMAN (The Hon. G. Weatherill): I have another indication from the Hon. Mrs Schaefer that she will oppose this clause.

The Hon. R.I. LUCAS: That is the issue that I am raising with the Minister at this stage in relation to procedure.

The Hon. CAROLYN PICKLES: I for one would be reluctant to go along the path suggested by the Hon. Mr Lucas. I will suggest another alternative: that we actually vote on this, if he wishes to vote on it, and leave the 16 in, and the honourable member can test it later when he has some recommittals, because, quite frankly, I would be very reluctant to support any legislation that changed the age of consent. If we go down the path to get towards the end of this legislation and find that in every clause we have changed the age of consent to medical treatment, I am not sure whether I would actually trust the Council to reverse it.

The Hon. M.J. ELLIOTT: I note one other thing, too, noting some comments other members have made. This particular clause is only about consent to medical treatment and is not about powers of attorney. I had the impression that some people might treat those two separately, so I do not think it is out of order that people might wish still to see this remain at 16, even though they wished 18 to be inserted in other parts of the Bill.

The Hon. R.R. ROBERTS: I am attracted to keep going the way that I indicated earlier, but I think that we should stick with the 18 year old and do the whole Bill. I have already given a commitment that I am prepared to review the definition of 'adult' at 16, provided that persons over 18 years of age may, by medical power of attorney, appoint an agent. That is the area about which I am concerned, and here we are virtually doing the same thing but shifting it from the agent to what I think is essentially a child.

Clause 6 provides that a person over 16 years of age may consent to medical treatment as validly and effectively as an adult. When we recommit these clauses, if we agree to put 16 years in, all rights that are available to 16 year olds seeking medical attention or access to medical procedures now would be in place, but if we go back to 18 years I still have some concerns. If a person has to be 18 years old before he can appoint an agent to make these decisions, I think it is consistent that we should say that it is inconsistent for him as a 16 year old to make the decisions himself and deny his parents and/or guardians the opportunity to intervene.

So I would support the 18 year old at this stage and, when the recommittal takes place, we can do that, but as far as 16 year olds in the amendment are concerned, I have said before that if 'Division 2—medical powers of attorney' remains at 18 I am prepared to leave in place those rights that are guaranteed to 16 year olds now. By the recommittal I will be supporting 16 in the definitions.

The Hon. CAROLINE SCHAEFER: I am thoroughly confused now. We began by debating, I thought, the Hon. Dr Pfitzner's amendment, and we now appear to be debating my amendment. Either people need to vote for the retention of this clause, that 'a person over 16 years of age may make consent to medical treatment as validly and effectively as an adult' or, as I have suggested in my amendment, oppose that clause, because it simply makes no sense to say that a person over 18 years of age may consent to medical treatment as validly and effectively as an adult because they are an adult under all terms of the law.

So, we seem to have strayed considerably from what we should be debating at this stage. Having moved previously that the definition of a 'child' be under 18 years of age in the definitions, I think that we should oppose this clause. I agree that there needs to be further discussion at a later time as to whether 16 years is applicable in the general consent area, but I do not see that we can debate whether someone over 18 years is able to make an adult decision, because they are an adult.

The Hon. BERNICE PFITZNER: I am addressing the amendment I first moved, which is about consent rather than the age of 16 or 18 years. I do not see the subtle difference that the Hon. Mr Elliott has made. I would prefer the word 'decisions' to be used, but if we believe that 'decisions' should not be used then the words 'consent or refuse to consent' should be included, because further down in clause 7(1) the same phrase 'consent or refuse to consent' is used regarding medical treatment, and further down in clause 7(6)(a) we have again 'consent or refuse to consent'. I do not see the difference about 'decisions' or using the phrase 'consent or refuse to consent'.

The Hon. BARBARA WIESE: I must say that I am persuaded by the arguments that were put by the Hon. Mr Elliott about the question of consent as opposed to empowerment to make decisions. The suggestion which is now being made by the Hon. Dr Pfitzner to distinguish between 'consenting' or 'not consenting' is, in my view, a preferable way to amend this if it is considered appropriate to amend it. So, I indicate support for the path that is now being suggested by the Hon. Dr Pfitzner.

The Hon. BERNICE PFITZNER: If the word 'decision' is not accepted, I would ask that the term 'consent or refuse to consent' be inserted in clause 6.

The Hon. BARBARA WIESE: You do not need that. If you do not consent you are refusing.

The Hon. BERNICE PFITZNER: But if we do not use that, why are we using the term 'consent or refuse to consent' in clause 7(1), and why are we using it again in clause 7(6)(a)? If you do not have 'consent or refuse to consent' there, why do you have it in clause 7(1) and clause 7(6)(a)?

The Hon. M.J. ELLIOTT: I refer to the question of decisions. If one refers to clause 7, one sees that it may be true that one will have an agent who may not only want to consent or refuse consent in relation to medical treatment but who may also be making other decisions as well. Some of the decisions are not in the narrow sense 'medical treatment', such as which hospital a person goes to and things like that. It may be worth giving some consideration to the fact that both the words 'consent' and 'decisions' may be applicable in clause 7.

However, in looking at clause 6, it seems to me that the power to consent to something is automatically the power not to consent to something; that is the implication. Even as a non-lawyer, my understanding of the law is that that is automatically a consideration and the words are not necessary. Why they were ever used in clause 7 is probably one of those great mysteries of life.

The Hon. R.I. LUCAS: I again raise a procedural question. If we do not at this stage endorse the Hon. Mrs Schaefer's proposition—that the Bill is in effect inconsistent as we see it—there will some provisions in the definitional clause and some provisions in the body of the Bill that are inconsistent and will not make sense as one follows it through. We will then get ourselves into a mess in relation to trying to sort out the recommittal stage.

This amendment seems to me to be commonsense at this stage. It resolves two things: it at least maintains the position that we undertook in the last amendment, which is consequential—that is, that a child is a person under 18 years of age. We accept that there are differing views in the Committee at this stage about that and that there is an acceptance from virtually all members about that and we will recommit to try to resolve issue. That measure went through as a consequential amendment without a division on the basis that we would recommit to sort it out. It seems to me to be commonsense that we have this amendment from the Hon. Caroline Schaefer. For it to be consistent with her position that originally prevailed, we should have that provision prevail during this run through of the Committee stage and then, when we recommit, sort out the mess in relation to what should refer to 16 years and what should refer to 18 years. Not only will that course of action resolve that particular question, but it will also potentially resolve the question of the Hon. Dr Pfitzner's amendments—as to whether or not it should be 'decisions' or whether or not it should be 'consent' or 'refuse to consent'—and it will give the Hon. Dr Pfitzner, parliamentary counsel, the Minister and others time to consider the Minister's position.

I understood the Minister's position originally to be to support the Hon. Dr Pfitzner in relation to 'decisions' and then I thought the Minister was indicating that she would look at some other amendment in relation to 'consent' and then I thought the position in the end was to go back and say, 'Well, "consent" means in effect "not to consent", so why do you have to put it in?' Then we had this quite sensible question from the Hon. Dr Pfitzner, saying, 'Well, if that is the case then why do we have these provisions elsewhere?' Surely all those things can be sorted out while we puddle through the other issues and then, when we recommit, greater minds than ours at greater leisure can sort out those issues and a package of amendments can come back to the recommittal to solve the issue of the age of 16 years or 18 years and to resolve whether or not the Hon. Dr Pfitzner wants 'decisions', 'consent' or 'refusing consent' or, in fact, to leave it as it is, rather than our, in effect, delaying unnecessarily in my judgment the proceedings of the Committee on this first run through when we know we have to recommit it anyway.

The Hon. BARBARA WIESE: There are still two issues here. I have to indicate that, on the question of 'consent' and having had the opportunity to take even further advice, I am now of the view that for the purposes of clause 6 the Bill as it stands is the most appropriate wording on the question of consent and decision making, and that clause 7(1) as its stands is also the most appropriate wording. The distinction between these two issues comes in the fact that, with respect to the individual consenting to medical treatment, the issue is the matter of consent—whether a person of 16 years or 18 years should be able to consent on matters relating to medical treatment.

In relation to the second matter—which is the appointment of an agent to consent to medical treatment on behalf of an individual—the distinction that is being made here is that this individual not only has the power to consent on behalf of the person, but has the power not to consent should a form of treatment be recommended by a medical practitioner—the agent has the power not to consent to that treatment. So, the legislation is making it very clear that not only does this person have the right to say 'Yes' but they also have the right to say 'No' on behalf of the patient. It is worth maintaining that distinction in the Bill and it is not desirable, because we are dealing with different things and a different concept, to try to standardise the wording for those two clauses.

As to procedural matters, on balance I agree with the Hon. Mr Lucas that we must take people at their word, so we will deal with those matters when various clauses are recommitted, although I find it rather peculiar that some members intend to vote to include the words '18 years of age' in clause 6 when this is the very issue that those individuals have indicated they wish to preserve, because it is currently covered in existing legislation. If members have indicated that they want to preserve the right of a 16-year old to consent to medical treatment, as they are able under the law now, why is it not possible to agree to the legislation as it stands now rather than changing it and then recommitting it and changing it back? People ought to be able to read the legislation and make decisions as they go along acknowledging that a decision was taken earlier in the debate that they wish to reconsider. It does not mean that everything must be reconsidered. We could make these judgments as we go along, and the distinction could be made. That would be my preference: that where we are able to make a final decision on a matter we should do so as we go along. However, if it is the wish of the majority that we go through a very long and, I would suggest, unnecessary debate, we will have to do that.

The Hon. BERNICE PFITZNER: I am still confused about the logic of consent. First, does the Minister mean that a 16-year old does not have the right to refuse to consent but that the medical agent does have that right? Secondly, in her later amendment of that clause 7(1) she omits that consent or refusal to consent and inserts 'to make decisions on his or her behalf'.

The Hon. M.J. ELLIOTT: Clause 6 does not have any relationship to decisions made by agents; it simply concerns individuals who consent to treatment for themselves. It is about an individual consenting or, by implication, not consenting; although those words are not included, the implication in a legal sense exists.

The Hon. K.T. GRIFFIN: I agree with what the Hon. Mr Elliott suggests regarding consent. We are talking about two different things. If the Minister's subsequent amendments regarding the appointment of an agent are carried, particularly in the context of anticipatory granting or refusal to consent to medical treatment, we may need to talk more about decisions rather than consent. I do not see any difficulty with those changes, because they cover more than merely consent to medical treatment. Consent to medical treatment in relation to a person whether under the age of 16 or 18 does not offer an option, because a positive decision will be made to allow treatment to occur. It is not a question of refusing treatment, which is one of the issues regarding a medical agent. I have no difficulty with the distinction between consent in the context of this clause and decisions in relation to clause 7.

However, in relation to the other matter to which the Hon. Robert Lucas has referred, having amended the definition of 'child' and removed the definition of 'adult', and clauses 9 and 10 relating to the administration of medical treatment to a child, the issue of consent does not arise. One could say that clauses 9 and 10 could ultimately be omitted. However, I agree with the course that the honourable member proposes, and I think those issues will be dealt with on their merits. No attempt is being made to introduce a device that is designed to give one group in this Chamber an advantage over another. I think we have all explored the possibilities; some have not committed themselves, others have. If we deal with all the issues relating to children when the Bill is recommitted, as we will deal with clauses 16 and 18, that is the appropriate course to follow.

The Hon. BARBARA WIESE: The summary by the Hon. Mr Griffin is acceptable. The amendment that I have on file to clause 7, which refers to making decisions, is appropriate regarding the powers of an attorney, because a distinction needs to be drawn between the question of consent and the range of issues upon which an attorney is likely to be consulted on behalf of an individual. It is likely that this agent will be asked not only to consent or not to consent to treatment but to make decisions about which hospital a person might be taken to for the purpose of treatment or a whole range of other matters relating to the care of an individual. So, the power to make a decision as opposed to just giving consent or otherwise is relevant, but the question of consent is the threshold argument in the case of the legal competence of a person over the age of 16, or 18 as the case may eventually be.

The Hon. BERNICE PFITZNER: I find it difficult to understand the Minister's explanation. One amendment refers to a person who consents to medical treatment and the other amendments to clauses 7(1) and 7(6)(a) refer to an agent. A decision about a hospital does not involve medical treatment and is not encompassed in this clause, but because of the lateness of the hour I will not pursue that matter.

The Hon. CAROLYN PICKLES: In relation to clause 6, whether or not we propose to put in 18 years and then go back to it, I fail to understand why those members who have indicated on a previous clause that they generally accept that the existing age of consent to medical treatment should remain at 16 years but in relation to the new clauses contained in this legislation they wish to see it at 18 years. I do not agree with the age of 18 years in either case, but I can see the differential.

I understand there is some confusion in relation to the Hon. Mr Feleppa's next amendment. His amendment is about an anticipatory declaration of consent or refusal of consent to medical treatment and really is unrelated to the general provisions relating to consent to medical treatment. So, I would have thought that clause 6, with or without the Hon. Dr Pfitzner's amendments, is a clause on which members could change their mind and vote on now, and we could recommit the previous clause, and that would certainly allay my fears. I must say that I cannot see that there is any problem with it. This is the one clause—

The Hon. R.I. Lucas: It would make the whole thing inconsistent.

The Hon. CAROLYN PICKLES: It might make the whole thing inconsistent, but—

The Hon. R.I. Lucas interjecting:

The Hon. CAROLYN PICKLES: No, I wasn't in the Chamber at the time. This clause is the test. This is the one where those of us who wish to change our mind may now do so.

The Hon. R.I. Lucas interjecting:

The Hon. CAROLYN PICKLES: No; I'm just saying that I fail to understand why we can't do it here and now, and why we have to recommit this clause.

The Hon. R.I. Lucas interjecting:

The Hon. CAROLYN PICKLES: No, I don't.

The CHAIRMAN: Order!

The Hon. CAROLYN PICKLES: I don't support 18 years anywhere: I support 16 years. I make that perfectly clear. As this is the test case, we should put it in now and it would save the time of recommittal.

Amendment negatived.

The Committee divided on the clause:

AYES (10)

Crothers, T.	Elliott, M. J.
Gilfillan, I.	Laidlaw, D. V.
Levy, J. A. W.	Pfitzner, B. S. L.
Pickles, C. A.	Roberts, T. G.
Sumner, C. J.	Wiese, B. J. (teller)

NOES (11)

Burdett, J. C.	Davis, L. H.
Dunn, H. P. K.	Feleppa, M. S.
Griffin, K .T. (teller)	Irwin, J. C.
Lucas, R. I.	Roberts, R. R.
Schaefer, C. V.	Stefani, J. F.
Weatherill, G.	

Majority of 1 for the Noes.

Clause thus negatived.

New clause 6A—'Anticipatory grant or refusal of consent to medical treatment.'

The Hon. BARBARA WIESE: I move:

After clause 6—Insert new clause as follows:

6A. (1) A person over 16 years of age may, while of sound mind, give a direction under this section about the medical treatment that the person wants, or does not want, if he or she is—

(a) in the terminal phase of a terminal illness, or in a vegetative state that is likely to be permanent; and

(b) incapable of making decisions about medical treatment when the question of administering the treatment arises.

(2) A direction under this section—

(a) must be in the form prescribed by Schedule 1A or in a form prescribed by regulation; and

(b) must be witnessed by an authorised witness who completes a certificate in the form prescribed by Schedule 1A or in a form prescribed by regulation.

(3) If—

(a) a person by whom a direction has been given under this section—

(i) is in the terminal phase of a terminal illness or in a vegetative state that is likely to be permanent; and

(ii) is incapable of making decisions about his or her medical treatment; and

(b) there is no reason to suppose that the person has revoked, or intended to revoke, the direction,

the person is to be taken to have consented to medical treatment that is in accordance with the wishes of the person as expressed in the direction and to have refused medical treatment that is contrary to those expressed wishes.

This amendment seeks to insert a new clause to allow a person to make an advance directive in relation to medical treatment. The select committee in another place had rejected that notion initially, as it felt that such a directive would not necessarily keep pace with technological advances, and also a person's wishes may have changed over time but they may have neglected to change their directive. For these reasons, it was felt that the appointment of a medical agent was a better safeguard for a person, since it enabled decisions to be made in a contemporary context.

However, the Minister of Health and some other former select committee members have continued to consult and take account of submissions and now believe that the inclusion of a new clause 6A will enhance the Bill. It is accepted that there will be some people who will not have anyone whom they wish to appoint as a medical agent or, indeed, some people who will not wanted to appoint a medical agent.

Currently, people can make an advance directive in the terms of the Natural Death Act. New clause 6A will enable people to make an advance directive under this legislation. The form prescribed by schedule 1A contains the essential features of such a directive. However, the Minister of Health, Family and Community Services acknowledges that there may be better ways of presenting the form and intends that there be further consultation and refinement following the passage of the Bill. Power is therefore included to prescribe a subsequent form by regulation.

The Hon. M.S. FELEPPA: I move:

Page 3, after line 6—Insert new clause as follows:

6A. (1) A person who is of sound mind and over 18 years of age may make a declaration of intention under this section indicating any one or more of the following, namely—

(a) that the person refuses medical treatment if the effect of the treatment is likely to be to prolong life in a vegetative state or in a state of such dependence that assistance is permanently required to meet the exigencies of ordinary daily life;

(b) that the person refuses medical treatment, in the terminal phase of a terminal illness, if the effect of the treatment is likely to be to prolong life in a moribund state without any real prospect of recovery;

(c) that the person consents to palliative care of a proper professional standard even though an incidental effect of the treatment is to hasten death.

(2) A declaration under this section—

(a) must be in the form prescribed by Schedule 1A or in a form to similar effect; and

(b) must be witnessed by an authorised witness who completes a certificate in the form or to the effect of the certificate in Schedule 1A.

(3) If—

(a) a person by whom a declaration under this section is signed becomes incapable of making decisions about his or her medical treatment; and

(b) there is no reason to suppose that the person had revoked, or intended to revoke, the direction,

the person is to be taken to have consented or refused to consent to medical treatment in accordance with the terms of the declaration.

I tend to agree with what the Minister said, because my amendment and her amendment have some similarity, with the exception of the question of 18 years of age. That is the only point that I still would not be prepared to give up. When the clause has been recommitted, what consideration will the Minister give to my suggestion of 18 years of age?

The Hon. BARBARA WIESE: Having given the Committee the ability to vote on age in the previous clause relating to consent to medical treatment, I can see no point in having that debate again. I now accept the point that was made earlier and we will proceed to insert 18 years of age where 16 appears and put that in the parcel of matters to be further debated when various matters are recommitted. That is one of the issues that should be changed at this point with a view to further discussion taking place at the conclusion of debate on the Bill. As the honourable member has indicated, many of his general wishes for such a schedule to be available to individuals to allow for an advance directive are picked up in this amendment that I have moved on behalf of the Minister of Health, Family and Community Services. With the exception of the age issue, the Hon. Mr Feleppa and I are pretty much at one on these matters. The question of age

will be left for debate at a later time.

The CHAIRMAN: Is the Minister proposing to move the amendment in an amended form?

The Hon. BARBARA WIESE: Yes. I move to strike out '16' and to insert '18'.

The Hon. M.S. FELEPPA: If that is the case, I trust that the point that I made in this amendment will be considered later. I accept the Minister's amendment and withdraw my own.

Amendment withdrawn.

The Hon. M.J. ELLIOTT: I support the Minister's amendment. When we were debating this Bill in the last session of Parliament I raised the issue and requested that a living will be incorporated in the legislation. In fact, I tabled an example of a living will from Canada. It was far more complex than the document that is proposed in schedule 1A, which the Minister has circulated, but I note that the Minister in this amendment foresees the possibility of further alteration to that schedule by regulation.

I have supported the concept of a medical agent all along for those who wish to have an agent, but, as far as possible, I personally would like to give clear instructions about my medical treatment as far as this legislation prescribes it. This legislation puts boundaries on what I can request, but within those bounds, rather than have someone else act on my behalf, as far as practicable I should like to give those clear directions, and many other people to whom I have spoken have formed a similar view. It is a mighty burden for a person to have to make decisions for somebody else in this area, and it is a burden that I and others would not want to place on another loved one.

The Hon. K.T. GRIFFIN: I was inclined to give the Hon. Mr Feleppa some support, because he has greater safeguards in his amendment than appear in the Minister's amendment. The only difficulty I had with the Hon. Mr Feleppa's amendment was in subclause (1)(a) where there is a reference to 'a state of such dependence that assistance is permanently required to meet the exigencies of ordinary daily life'. I was uncomfortable about that, but the rest of the subclause I was more comfortable about because it embodies the concepts to which we referred earlier. For example, the declaration of intention may indicate:

> (a) that the person refuses medical treatment if the effect of the treatment is likely to be to prolong life in a vegetative state or. . .
> (b) that the person refuses medical treatment, in the terminal phase of a terminal illness, if the effect of the treatment is likely to be to prolong life in a moribund state without any real prospect of recovery;
> (c) that the person consents to palliative care of a proper professional standard even though an incidental effect of the treatment is to hasten death.

I think that had a greater measure of safeguards than appears in the Minister's amendment. Here we get back to the debate about the terminal phase of a terminal illness. It is not specifically related to a vegetative state that is likely to be permanent, but those are alternatives.

Then we deal with the incapacity to make decisions. I have some amendments in relation to incapacity under clause 7, which relates to the appointment of an agent to consent to medical treatment. Similar amendments may need to be incorporated here to put beyond doubt the extent to which the decisions are binding when a person ceases to be incapable of making decisions, but that issue can be addressed later.

If the majority view is to support the Minister's proposed clause 6A, on a recommittal it is possible that I shall want to move some additional subclauses with a view to including safeguards. One of the difficulties was not knowing which of the new clauses was going to get up and what amendments ought to be prepared in relation to both. As the Bill is to be recommitted, I think that will be a more convenient time to address that issue. I support the general concept, but I have some concerns about the breadth of the provisions.

The Hon. BERNICE PFITZNER: I have difficulty with the Minister's amendment. Initially, I thought that the medical agent was there to provide the necessary flexibility to make complicated decisions. We now have what we call an advance directive in which we have not only what is in the Natural Death Act, which is a refusal of extraordinary measures, but also a complicated procedure in which the advance directive will be required to fill in certain criteria. I foreshadow, in the failure of this amendment, my amendment to insert a new clause 8A, which is simply anticipatory refusal of extraordinary measures. I feel that in the case of a person who is giving an advance directive, the simple measure of refusing extraordinary measures is sufficient.

The Minister, in her amendment, proposes for the advance directive not only refusal of extraordinary measures, but, perhaps by regulation, writing in such things as a personal health care directive or advance directive. I have two such personal health care directives, one from Canada and the other from South Australia. The Canadian advance directive has in it very difficult decisions that the patient makes perhaps for five years down the track.

It shows life-threatening illness, things regarding feeding and things regarding cardiac arrest, and under that he or she will have to decide whether they want their care to be palliative, limited, surgical or intensive. Then there are definitions of these terms used in the directive. For example, reversible conditions are conditions that may be cured without any remaining disability. Does that mean that a condition resulting in a minor slurring of speech or a paralysis of one side of the face would not be a reversible condition because it is with minor remaining disability? The definition of irreversible condition is a condition that will leave lasting disabilities, for example in the case of a severe head injury. How bad must the lasting disability be?

Further there are definitions of palliative care, limited care, surgical care and intensive care. They are all very complicated issues about which the patient makes a decision in advance that has to be interpreted by the medical officer in relation to when to use limited care, because limited care includes palliative care, surgical care includes limited care and intensive care includes surgical care. So, if such a personal health directive were instituted I would be very reluctant to support the amendment.

Another advance directive put out by a South Australian group also has very complicated terms regarding irreversible mental or physical conditions, and definitions of persistent vegetative state, dementia, cardiopulmonary resuscitation and artificial feeding or hydration. All these are medical terms and I am not quite sure whether the patient will apply the definition in this advance directive which he or she will be putting in place and whether his or her understanding of these medical conditions would be the same as the understanding of the medical practitioner. I do not support the amendment of the Minister of anticipatory grant or refusal of consent to medical treatment because schedule 1A provides:

> The person by whom the direction is given must include here a statement of his or her wishes. The statement should clearly set out the kinds of medical treatment that the person wants or the kinds of

medical treatment that the person does not want or both. If the consent or refusal to consent is to operate only in certain circumstances or on certain conditions the statement should define those circumstances or conditions.

I think that schedule 1A is very complicated and very difficult for a general practitioner to interpret, especially as it is an advance directive which might be signed and written up five or 10 years before it is in place. Therefore, I do not support the amendment.

The Hon. BARBARA WIESE: I understand some of the honourable member's concerns with respect to what kinds of issues might have to be identified in the schedule or the form that is being suggested. I would like to remind her of my remarks when I moved this amendment. I indicated at that time that, although this schedule was being included as part of the amendment for incorporation with the legislation, the Minister of Health, in providing this schedule, indicated that there may very well be better ways of presenting the form and that it is his intention to further consult with relevant people in order that this form can be refined and made available for people in the most appropriate way.

So, I suggest that, if the honourable member generally agrees with the concept that this advance directive should be provided for in this legislation, perhaps she should not concentrate too much on the detail that is contained in the form as it stands because it is highly unlikely that this form will end up being the working document. I suggest that honourable members, such as the Hon. Doctor Pfitzner who has medical expertise, may very well want to make submissions to the Minister of Health about the appropriate issues that might be included in this form ultimately when it goes out for public use. I am sure there will be other organisations that will want to have an input in relation to that as well. I suggest that we do not concentrate too much on the detail of the form at this point, but that we ought to be broadly making a decision about whether or not we want this directive provision in the legislation.

The Hon. BERNICE PFITZNER: I hear what the Minister is saying but I still have concerns because schedule 1A provides for 'the kinds of medical treatment that the person wants or the kinds of medical treatment that the person does not want' and I think these two requests are too complicated to be written into an advance directive. An advance directive should be very limited because there can be so many interpretations and the person is not there, or if the person is there the person is unable to explain what he or she wants. That is why we have the medical agent. Therefore, that is why I foreshadow my amendment, which is that the advance directive should only give anticipatory refusal of what we defined as 'extraordinary measures'. I feel very nervous about an advance directive being given in such a complicated way and a lay person having to fill in such a very complicated medical form.

The Hon. K.T. GRIFFIN: I understand what the Hon. Dr Pfitzner is suggesting, and to some extent that reflects what I was talking about earlier when I indicated I had a preference for the Hon. Mr Feleppa's amendment over the Minister's because he talks about the refusal of medical treatment if the effect of the treatment is likely to prolong life in a vegetative state and that the person refuses medical treatment in the terminal phase of a terminal illness if the effect of the treatment is likely to prolong life in a moribund state without any real prospect of recovery. If one looks at the form which he has in his amendments that is essentially what he is doing. It states:

If the likely effect of medical treatment is to prolong my life in a vegetative state or a state of such dependence that assistance is permanently required to meet the exigencies of ordinary daily life, I do not desire such treatment and I exercise my statutory right to refuse it in advance.

I have signalled that I had some concern about the second part, namely, about such dependence that assistance is permanently required to meet the exigencies of ordinary daily life. However, I was attracted to the general concept of referring to the refusal of treatment in general terms which link in with the definition provisions of the Act. Earlier debates on this today have focused upon the issue of certainty or uncertainty and have focused recently on the issue of what is imminent and what is not.

The issue is brought even more into focus by what the Hon. Dr Pfitzner has said in relation to the sorts of treatment that might be part of the form which a citizen might complete, because it is suggested that there will be some description of the medical treatment required and that that will be linked not necessarily only to the definitions and other provisions of the Bill but to medical treatment in certain circumstances for certain types of illness. In those circumstances I certainly acknowledge that what the Hon. Dr Pfitzner says provides much more certainty, as did what the Hon. Mr Feleppa was proposing to move by way of amendment, than the Minister's amendment.

So, I think that issue of certainty is an important issue, as well as the issue of comprehension of what the person giving the direction may or may not understand by it. Certainly, the potential for misunderstanding and misinterpretation is greater where the citizen is required to develop the issue of treatment or not being treated in certain circumstances for particular illnesses than if one went along with something along the lines that the Hon. Dr Pfitzner is proposing.

The only other matter that needs to be referred to is that one of the problems with these anticipatory declarations is that they may well not be subject to review for many years. The difficulty with that, of course, is that whilst it may have been the intention of the person making the declaration at the time, circumstances may have so changed that one could assess that it would not have been the intention of the person to make such a declaration 20 years later. So there is a problem with that. I was contemplating some provision for regular review, but I do not intend to pursue that at this stage. However, it certainly does create a difficulty, and more so than in relation to medical powers of attorney.

The Hon. R.I. LUCAS: I just want to raise an issue in relation to the two options: the one raised by the Hon. Dr Pfitzner and the one raised now by the Minister. If one looks at the proposition from the Hon. Dr Pfitzner, which basically says that one will not be subjected to extraordinary measures, it takes us back to the earlier debate we have had in this Committee as to what the extraordinary measures might be.

It may well be that a person is not quite happy but actually wants something like a nasogastric drip to be used in those circumstances if they should find themselves in the terminal phase of a terminal illness. A person may well have the view that that is not an extraordinary measure.

It may well be that the result of our Committee debate, following the result of that previous discussion, is that something like a nasogastric drip will be seen to be an intrusive measure and come within the provision where someone other than this person—the doctor, for example—takes the view that this is an extraordinary measure, and

therefore he or she will not apply the nasogastric drip and the person then passes away.

Under the alternative that the Hon. Dr Pfitzner is raising, I take it that the person could not indicate that they wanted certain treatments, such as a nasogastric drip, not to be treated as an extraordinary measure, that they did not believe in that particular option or description and that 'extraordinary measure' was something other than just the provision of nutrition, whereas, as I understand it from the Minister, her provision would allow for a person to say, 'I would like that sort of treatment; the provision of nutrition through a nasogastric drip is something that I am comfortable about; that is not extraordinary; and, if I am in this particular circumstance, I would like that form of treatment.'

As I understand it, the Minister's provision would allow someone to say that, and I am seeking clarification from the Hon. Dr Pfitzner as to whether she agrees that her provision that she is moving would not allow someone to make that decision.

The only other general comment I would make is that, as I understand the Minister's proposition, a person does not have to stipulate what medical treatments they want in certain conditions: it just allows them that option. I presume there are some people out there (medical practitioners, for example) who would be quite capable, eloquently and articulately, to write down exactly what form of medical treatment they wanted and in what circumstances, which would make sense to a lot of medical practitioners. Someone like me obviously would not, and a whole range of other people obviously could not, and in those circumstances I would not seek to try, although obviously the Hon. Dr Pfitzner has an example of someone in Canada who did seek to try in a way that did not make too much sense.

As I understand it, it does not require anyone to do so; it just gives an option, and it may be the sort of option that someone who is medically trained and understands these sorts of procedures would like to be able to stipulate quite clearly to his or her doctor. They could say, 'In these circumstances I will take a nasogastric drip; I will take this or that, but under no circumstances will I take this or that.' So, I seek some response from the movers of both amendments.

The Hon. BARBARA WIESE: In the case of the amendment that I have moved, the honourable member's summary is correct. This type of schedule allows for an individual to stipulate certain treatments if they choose but, if they choose not to and they want to make a more general statement about their wishes, they may do that equally. The schedule, as it has been presented by the Minister, responds to very specific submissions that have been made by individuals in the community about what they are looking for in the protections that legislation of this sort will provide for them.

The fact is that a lot of people have very strong views about particular forms of treatment that they either want or, more particularly, do not want to occur should they be in circumstances such as this, and very often the very strong views of individuals about such forms of treatment are based on experiences that they may have had with members of their family who have died in particular circumstances and prior to death have suffered in a way that they consider to be unreasonable and unnecessary. They therefore do not want to be in that sort of situation themselves.

So, the provision is there in a form as suggested by the Minister for people to identify those areas if they specifically want to, or there can be a more general instruction if that is what is preferred.

However, what we are trying to do is to meet the wishes of people about what they want rather than trying to prescribe for people what doctors might think is good for them or what members of Parliament might think is appropriate for people to elect to do in these circumstances. So, I think that describes what the Minister is trying to achieve. I certainly support his endeavours here, but I indicate again that the wording in this schedule is not necessarily set in concrete; the Minister is prepared to take submissions if this sort of form can be improved in some way or another. I expect that the form will be changed before it is actually put into effect, and it will be put into effect by way of regulation.

The Hon. M.J. ELLIOTT: I refer to the schedule, which, of course, is alluded to within this amendment. As it now stands, it is a very simple document, with an area set aside where a person makes specific directions. I presume that it would, in fact, be reasonably possible for a person to take one of the directives illustrated by the Hon. Dr Pfitzner and use that in lieu of the blank space in the form, where one can give quite complex directives if one chooses to do so, or one could give a relatively simple directive.

The concern I had about schedule 1A is that it was almost too simple, although there might be one or two particular concerns that a person had that they wanted to make quite clear by way of a medical directive but in all other matters might be quite happy for an agent to make other decisions. Clearly, the directions of the individual are taken into account first and the decisions of an agent might simply fill the gaps where the patient has not given a clear indication. The only problem I had with the schedule was its simplicity; I thought it was overly simplistic. However, it is possible, as I said, perhaps to use existing forms such as the Canadian model, which I tabled earlier and which has been alluded to by the Hon. Dr Pfitzner. I think the living will is a significant improvement to this Bill; it is something which we have already under existing legislation and which I do not think we should lose.

The Hon. BERNICE PFITZNER: Regarding the Minister's amendment to schedule 1(a), there are two alternatives, as she mentioned. One is to put a very detailed kind of medical treatment that he or she wants or does not want. As I have already indicated, there is a Canadian form, which has been mulled over by many health providers, and there is the South Australian form. Both of these forms are very complex. For example, in the Canadian form, under 'limited care' it says that antibiotics should be used sparingly and that the patient may or may not be transferred to hospital. All these are very vague suggestions that the patient would have put down perhaps five years ago, and at present he or she would be incapable of making clear his or her intention. That is why I have great difficulty.

The problem also is that we are not to know under what circumstance the patient will need this health service. Is there a hospital nearby or 200 miles away? What degree of limited care and of palliative care is involved? What is the age of the patient, and so on? There are so many unknown factors that might be put into play when the patient needs his or her personal health care directive implemented that he or she might not have foreseen when he or she, five years ago, had signed this very detailed medical treatment directive that he or she wanted.

Further, to put in a very vague or general statement would be just as bad, because the medical officer then has to decide

what the general statement means. It may say, 'If I am in a vegetative state, please do not resuscitate,' or something like that. Refusal is much easier to implement. A consent to put in a medical treatment is very much more difficult, because the circumstance of the illness or injury that the patient may find himself or herself to be in cannot be known until that very time.

In relation to my foreshadowed amendment regarding 'extraordinary measures' that the Hon. Mr Lucas queried, I would abide by the definition of 'extraordinary measures' that is defined in clause 4. I felt that we had debated that in detail and that we had spoken of 'temporary and permanent incapacity', 'significantly intrusive' and 'significantly burdensome'. In the case of a nasogastric tube or a catheter, it is not the actual surgical implement but it is whether that implement causes intrusion or provides a burdensome factor to the patient.

So, I feel that this definition of 'extraordinary measures' that we have already discussed would be the definition used in my amendment of anticipatory refusal of extraordinary measures. I just feel that if a person is going to put in an advance directive it must be very simple, very limited and very clear. I have great concerns about implementing any of the examples here, and further examples will be very similar, because these two examples are the leading examples; they have been put together by many senior specialists, and I cannot see that it will change very much in further legislation.

The Hon. M.J. ELLIOTT: Has the Minister given any consideration that, if we are to have these directives, there be some sort of register of directives, even if it is a voluntary one whereby a person may choose for a nominal fee to register their directive so that hospitals can check on their existence? Perhaps also, if it were a fee for service type of arrangement, people could be contacted on a regular basis to be asked whether or not they wished to amend the directive. That might address one problem that people have raised.

The Hon. BARBARA WIESE: As I understand it, the Minister is currently considering a proposal that would allow for individuals to have some sort of plasticised card in their wallet so that it could be carried on their person at any time should it be needed. I do not think a lot of thought has been given to a registry at this stage, although that is something that could be considered for the future. I will certainly take that up with the Minister of Health, Family and Community Services so that he can consider the matter.

The Hon. K.T. Griffin interjecting:

The Hon. BARBARA WIESE: The Hon. Mr Griffin suggests that there may be some privacy considerations to be taken into account. That may be true, and obviously that would be one of the issues that would have to be examined before a decision is made, but I will undertake to draw that matter to the attention of the Minister of Health, Family and Community Services for his consideration.

The Hon. R.I. LUCAS: I support the Hon. Dr Pfitzner's proposition and therefore oppose the Minister's amendment with the expectation that the Hon. Dr Pfitzner's amendment is carried. If both the Minister's and the Hon. Dr Pfitzner's amendments are defeated, we should have another look at this issue during the recommittal, because I suspect that there is a variety of views about which proposal is the most appropriate. I am not sure where the numbers lie on this issue, but I would not like to see both fail.

The Hon. CAROLYN PICKLES: I briefly indicate my support for the Minister's amendment. As has been indicated, we will recommit this matter because I, of course, will continue to support the age of 16. However, I also want to take up the Hon. Mr Elliott's suggestion regarding a register. I am pleased that the Minister has indicated that she will discuss this issue with the Minister in another place, because I believe that one of the problems with the Natural Death Act is that no record of the wishes of people has been kept. On one occasion, I raised this matter regarding a patient at the Royal Adelaide Hospital and found that most people were unaware that such an Act existed, so it is a matter of concern. I think it would be worthwhile if some kind of a register were kept, taking into account in some way privacy issues so that everyone is aware of whether or not the patient has undertaken to become part of this legislation should it pass.

The Hon. CAROLINE SCHAEFER: At this stage, I support the Hon. Dr Pfitzner's amendment and therefore oppose the amendment that is before us. In doing so, I point out that when I came into this place I was lobbied extensively by a number of groups, most of whom explained to me that the reason for introducing a medical power of attorney was because the living will concept had not been successful. It was pointed out to me that one of the reasons for its lack of success was that the wish of a person who signed an advance directive many years previously may have changed in the meantime. I therefore request that when this Bill is recommitted some thought be given to making an advance directive redundant after a certain amount of time so that there will be a constant review and so that we can be reasonably confidently assured that the advance directive is the will of the person who signed it.

The Committee divided on the new clause:

AYES (12)

Crothers, T.	Elliott, M. J.
Feleppa, M. S.	Gilfillan, I.
Laidlaw, D. V.	Levy, J. A. W.
Pickles, C. A.	Roberts, R. R.
Roberts, T. G.	Sumner, C. J.
Weatherill, G.	Wiese, B. J. (teller)

NOES (9)

Burdett, J. C.	Davis, L. H.
Dunn, H. P. K.	Griffin, K .T. (teller)
Irwin, J. C.	Lucas, R. I.
Pfitzner, B. S. L.	Schaefer, C. V.
Stefani, J. F.	

Majority of 3 for the Ayes.

New clause thus inserted.

[Sitting suspended from 10.34 to 10.58 p.m.]

Clause 7—'Appointment of agent to consent to medical treatment'.

The Hon. CAROLINE SCHAEFER: I move:

Page 3, line 9—Leave out '16', insert '18'.

This amendment is consequential to my first amendment, and I do not feel that it requires debate.

Amendment carried.

The Hon. BARBARA WIESE: I move:

Page 3, line 10—Leave out 'to consent or to refuse to consent on his or her behalf to medical treatment' and insert 'to make decisions on his or her behalf about medical treatment'.

We really have already discussed this matter on a previous clause. However, essentially the argument that I am putting to the Committee is that there is a distinction to be made here between the simple act of saying 'yes' or 'no' to medical treatment and the much broader issue of having the power to

discuss medical treatment or issues relating to medical treatment, which is essentially what my amendment is doing. It is providing the ability to make decisions on his or her behalf about medical treatment. So, that can include a range of issues which relate to medical treatment but which are not specific to whether or not one consents or otherwise to a particular form of medical treatment. Therefore, since this provision is dealing with the powers of an attorney who is acting on behalf of an individual, then it seems appropriate that the broader power should be provided to that agent acting on behalf of the individual.

The Hon. BERNICE PFITZNER: I am trying very hard to understand the difference between clause 6, which involves legal competence to consent to medical treatment, and clause 7, which involves the agent to consent to medical treatment. I cannot understand how the Minister can incorporate a more comprehensive and detailed reading into the consent of medical treatment in clause 7, when to me it seems exactly the same, except that one involves the person consenting to medical treatment and the other one involves appointing an agent to consent to medical treatment. I feel that the Minister is arguing in circles to try to justify the Minister of Health, Family and Community Service's attitude to this very subtle difference.

The Hon. CAROLINE SCHAEFER: Can the Minister give some examples of decisions not directly of a medical nature that would need to be made by a medical power of attorney?

The Hon. BARBARA WIESE: The only example I can think of at the moment is one that I have already used, that is, a decision that may relate, for example, to which hospital a person might receive treatment from, whether the individual should go to a hospital, a hospice or whatever. That decision relates to medical treatment but it is not a simple decision about whether to say 'yes' or 'no' to the form of medical treatment.

Amendment carried.

The Hon. K.T. GRIFFIN:

Page 3, line 19—Leave out 'care or'.

This is essentially a drafting matter. I am seeking to remove the reference to 'medical care' so that the reference in subclause (4) is to medical treatment of the person. So, a person involved in the medical treatment may not be appointed an agent under a medical power of attorney. Medical treatment is defined 'medical care'. This is really the first place it appears. I raise it only as a matter of drafting.

The Hon. BARBARA WIESE: I oppose this amendment. It is considered that the restrictions in the clause as it stands are desirable. As it stands, all members of the health care team, including nurses and even the administrator of a health care facility, are ineligible to be appointed as medical agents. To broaden that provision is to increase the opportunity for abuse and to decrease the protection for the patient.

Amendment negatived.

The Hon. BARBARA WIESE: I move:

Page 3, lines 22 to 25—Leave out subclause (5) and insert:

(5) If a medical power of attorney appoints two or more agents, it must indicate the order of appointment and, in that case, if the person designated first in order of appointment is unavailable, the power is to be exercised by the person designated second in order of appointment, if the first and second are not available, by the person designated third in order of appointment, and so on, but a medical power of attorney may not provide for the joint exercise of the power.

This amendment is designed to ensure that where more than one medical agent is appointed, the appointing person indicates the order in which any further agent may exercise power in the event of the earlier agent or agents being unavailable. It is designed to avoid the unfortunate situation of bedside arguments during times of great stress.

The Hon. K.T. GRIFFIN: I do not think that is particularly in the interests of the person who is appointing the medical agents. Why should not the person who is appointing a medical agent be entitled to appoint two or three people to act together to make decisions on his or her behalf?

The Hon. M.J. Elliott: What is a quorum?

The Hon. K.T. GRIFFIN: There is no quorum; it is two. If there are three, they can either be joint or joint and several. It is a matter for the person who is making the power of attorney whether to have one, two or more. It is not a question of making it easier for the medical team. Whilst they are under stress, life should not be made too difficult for them. After all, we are talking about the person who is the subject of the treatment. If that person feels more comfortable about giving two people the right to make the decision—if they do not agree, the decision is not made—I think he should be entitled to do that. Who are we to say that anyone should be prevented from appointing two persons to act as attorneys? He may feel more comfortable about that. If it causes difficulties for the medical team, so what! I do not see that being a significant or relevant consideration. We are talking about the right of the patient to make the appointment. If that person wants to appoint two, he ought to be able to do so. He should not be prevented from doing so by an Act of Parliament which is designed not in his interests but in the interests of the people who are providing assistance. We should remember whose interests are to be paramount. Under the Minister's proposal, it is not the interests of the person who is appointing the agent. I oppose the amendment and shall be moving my own.

The Hon. M.J. ELLIOTT: I support the amendment. This is a question once again as to whether or not there may be a register of agents of some sort. When someone is taken ill, how is it to be known whether or not that person has agents? As there might be a register of living wills, could there not also be an available register for people who are appointing agents?

The issue of ordering agents was raised by the Hon. Dr Pfitzner during an earlier debate. My problem is that if someone appoints a couple of people at one time they might number them. But what happens if they are appointed at different times? Someone might appoint one person today and say, 'This is my number one appointment,' and, three years later, appoint someone else and say, 'This is now my number one appointment.'

The Hon. K.T. Griffin interjecting:

The Hon. M.J. ELLIOTT: Does a new number one replace an old number one? If there is some form of register, such confusions could be overcome. I support the concept of ordering agents. Someone may say, 'This is the person I want to make the decision, but if that person is unavailable, is no longer competent, or whatever, I want the second person to make the decision.'

In response to the concern raised by the Hon. Mr Griffin, if I were appointing an agent and other members of the family were interested, I would not appoint somebody who, although they had the responsibility of having the final say, would not consult other family members. That is not an unreasonable expectation. If the Hon. Mr Griffin feels that he is going to

appoint someone who will hold it all to himself, he should appoint somebody else.

The Hon. BARBARA WIESE: The reason for this amendment is the result of strong representations made by people involved with the delivery of palliative care to individuals who have no problem with joint consultation or members of the family being consulted before decisions are taken, but who say that at the end of the day there must be a clear instruction or person authorised to make a decision. Although this amendment indicates that there will be no joint exercise of power under this arrangement, it does not preclude the designated first choice agent from consulting other agents who have been listed as second and perhaps third choice or, indeed, another member of the family or anyone else whom the individual may have wanted to be involved in the decision making process. It is saying that at the end of the day one person must be responsible for making the decision. The instructions or wishes of the person concerned must be clear as to which individual the medical team should listen to.

The Hon. Mr Elliott raised the question of someone designating an agent this year and having a change of mind and designating someone else a year or two years later. In those circumstances, I would expect the individual to have completed a new form representing that person's most recent wishes. In any case, circumstances like these are likely to be rare. Indeed, it is not a decision that will be taken lightly, whenever it is made.

When someone is making this decision or deciding to change the decision about who will be their agent they would make it their business to leave instructions that are very clear for whoever it is who will have to act upon those instructions. So, I think that the case that the honourable member outlines where there may be confusion would be a very rare instance.

The Hon. K.T. GRIFFIN: No-one must do anything. There are circumstances of course where there will be no medical agent appointed and there will be even greater uncertainty about who will make the decision. I come back to the point that it is all very well to say that someone must take responsibility. The fact of the matter is that if the person who is appointing the agent prefers to have two people making the decision rather than one taking the responsibility they ought to be entitled to do it. It is as simple as that. It is a matter of giving the individual who is making the appointment an opportunity to say they want one person or two people making the decision, and that they are more relaxed about two doing it than just one.

It is all very well for the Hon. Mr Elliott to say, 'Appoint someone else if you cannot trust one.' The fact is that everybody has different ideas about what is the appropriate way of dealing with this legislation. I am saying that this legislation is facilitating and if it is facilitating it ought not to be restrictive, and accordingly I move:

Page 3, lines 24 and 25—Leave out 'but it may not provide for the joint exercise of the power' and insert 'and may provide for the joint exercise of the power by two or more persons'.

The Hon. R.I. LUCAS: The Hon. Mr Elliott raises some interesting questions. I do not think that it is fanciful to suggest that there may well be people with the passage of time who forget that they have appointed someone many moons ago to be their medical power of attorney and who forget to revoke it if there is to be power to revoke. I understand that is possibly the subject of further amendments. One or two people might turn up with medical powers of attorney suggesting that they do or do not have the power to pull the plug. In relation to people who are very wealthy we have had instances where one or two wills turn up and the question arises as to who will get the money. There have been a number of significant court cases throughout the world in relation to that particular issue.

I am sure this legislation will involve quite a number of controversial legal actions in the years to come. I do not think the scenario the Hon. Mr Elliott raised is fanciful in any way. I suspect that we will see some examples of that. The concept of a register was supported by the Hon. Carolyn Pickles in relation to another matter. If it is not to be a register or something like that perhaps one of the suggestions of the Hon. Caroline Schaefer, that some sort of natural sunset provision of, for example, five years, could be implemented, so at least people are required to consider updating it or reviewing it as some sort of ongoing requirement in the legislation.

The Hon. M.J. Elliott: A person with dementia cannot review it.

The Hon. R.I. LUCAS: The Hon. Mr Elliott raises a difficulty with that. The person with dementia can continue to issue medical powers of attorney if he or she wishes. There is nothing to prevent them continuing to issue them. I take it that the Minister is saying that, if there are a number of medical powers of attorney that have been issued, it is the Minister's view and her advice that the most recent one is the one under law that would take precedence.

The Hon. BARBARA WIESE: I would not go so far as to say I have legal advice about this matter but it would be my assumption that, if a person filled out a second form more recently than the last one, if there were some question about it it would be most likely that the second form would be the one upon which people would act or believe they should act, if that was not otherwise stipulated. I understand that the question of whether or not there should be some sort of sunset clause has not been canvassed thus far and there may well be some difficulties with such a provision being enacted because individuals would have to keep themselves up to date and remember how long ago it was that they made their last form.

So, if you had some sort of sunset clause which meant that after five years the previous expressions of their wishes ceased to be effective they would be replaced with nothing if they had not remembered that they had to update their information. So, I do not think that is a very satisfactory option, either. I understand that the proposed plasticised card to be carried in a person's wallet is likely to include information relating to the person's choice of agent or choices of agent so that information will be available and people will be able to carry it with them. That will also remind people that, if they have fallen out with Uncle Fred who they had previously nominated as their preferred agent and now wish to nominate someone else, they have the right to do that. The best way of achieving that and having their wishes fulfilled would be to complete a new form.

The Hon. M.J. ELLIOTT: In relation to the points raised by me and by Mr Lucas it appears that the solution to those problems may be in fact in the wording of schedule 1. Schedule 1 does not even have a place to put a date, and I thought that would have been something that would have gone on there. As currently designed the form indicates only one person being given power of attorney and does not really show in any way how the order of precedence is allocated. While recognising the proposal in the Minister's amendment, which I would be supporting, I believe that schedule 1 needs

some amendment to take account of the amendments we are currently considering.

The Hon. R.I. LUCAS: I think the Hon. Mr Elliott is probably right. In relation to the matter that was raised earlier on the sunset provision I accept that, from what the Hon. Mr Elliott and the Hon. Barbara Wiese have said, that is probably not a practical option. In relation to the particular matter of schedule 1, on reading the amendment it would seem to indicate that there may be consequential amendments as a result of this particular amendment which have not been followed through in relation to amendments to the schedule. I agree that there ought to be provision in the schedule for a date to be affixed to that.

The other question I have for the Minister is that, if someone arrives at the hospital and says, 'I am the husband or wife of so and so and I have the medical power of attorney but for the life of me I cannot find it—it was filled out three or four years ago, it got eaten by the dog or we have just had a fire and it has been burnt,' what are the provisions of the legislation that cover those circumstances? What are the provisions covering the circumstance where someone says, 'I have lived with them for 40 years; I do want to pull the plug, but I cannot find the bit of paper,' if there is no central registry and there is no sign of this plasticised card?

The Hon. BARBARA WIESE: Before I answer that question, I want to go back to the previous issue, because the Hon. Mr Lucas indicated that he thought there had not been a follow-through on the matter in relation to which I have just moved an amendment. There is actually an amendment to the schedule which I will be moving later, so that matter is covered. That is on page 4 of the tabled amendments that I will be moving.

As to the issue of whether or not an individual can be identified as the approved agent, the first point I make is that later the Hon. Mr Griffin will move an amendment which requires an agent to produce some evidence that they are the approved agent. It is desirable that that measure be incorporated in the legislation. If in the circumstances that the Hon. Mr Lucas has outlined the individual has had a house fire or something and is unable to produce that evidence, then I suppose the only other available information that we can fall back on at that time will be the plasticised card that the individuals themselves hopefully will be carrying, or a copy of the form that they may have.

I cannot be much more specific than that, but certainly these issues that are being raised now lend some merit to the suggestion that was made by the Hon. Mr Elliott that some sort of register may be appropriate at some stage in the future. I guess the Minister of Health, Family and Community Services will be taking all of these matters into consideration when he makes judgments about that matter.

The Hon. J.C. IRWIN: I support the notion that there should be a register of some sort. I recall that after my father died I found out that he had signed the Natural Death Act. I did not know that: none of my family knew that. I found it in his file after he died; he did not mention it to me, although he was quite capable of doing so. However, the discussion has highlighted the fact that we need to have one, and philosophically I can support what my colleague the Hon. Trevor Griffin has argued.

I think what has been said about the appointor's wishes, and whether that person wants one, two or three agents, is correct. Frankly, I think if you get past two it gets out of hand. I can perhaps accept two, but again it highlights the difficulties with this sort of legislation in trying to codify and quantify the details.

At this stage I am leaning towards supporting the Minister's amendment, but I have difficulties with what effort is required by the medical practitioner to find an agent first up. If three agents have been appointed and the medical practitioner finds that the first one is not there, I do not know what effort is required to find that first one, or who makes the effort to find the first agent. If more than one has been appointed and the first one is not available, who makes the effort to find the second one and for how long does that effort go on? Is it one day, one hour, half and hour or immediate and, if a decision is made by the second agent, is any course open to the first agent to say, 'I was not consulted; no-one asked me. I was home by the telephone, no-one rang me, and now a decision has been made that I do not agree with by No. 2 on the list.'?

That is why I have trouble. I am not supporting the legislation at all, but I am happy to try to make it better in some of the amendments that are before us. I have already participated in voting in that direction, and I have indicated previously that I will do that. I think it is my responsibility to do so because, if it does pass, it has to be in the best form. However, there are so many problems in trying to quantify and qualify these areas and write them into legislation, and that has been exposed by what we are discussing at great length here. I therefore have much trouble in supporting any sensible amendment. However, I am inclined to support the Minister's amendment if she can explain how this process will take place.

The Hon. BARBARA WIESE: I do not think that there are easy answers to the questions that are being raised here tonight about these matters. However, any individual who feels strongly enough about these matters that they would go to the trouble of filling out a form under this legislation in order to provide instructions for people who may be treating them at some time in the future should also ensure that they have lodged copies of this form with any relevant parties that they think may be at the appropriate time involved in making decisions about their health care.

I expect that someone who has filled in one of these forms would leave copies with children, siblings, parents, their medical practitioner or whomever they feel may be in a position to make a judgment about the issue down the track and who may have to make a decision about that matter.

As to who will be responsible for finding the chosen agent and how long it should be left before they move from choice 1 to choice 2 in order to make judgments, I do not think there again that the answers are simple. However, if the person has taken the precaution of ensuring that a range of people who may be involved in the decision making process about their health care has notified those people, then they—presumably close relatives—will be amongst the individuals who will be looking for the assistance of the designated agent. I would have expected that how quickly one moved from choice 1 to choice 2 in order to achieve some decisions would depend very much on the state of the health of the individual at the time and how urgent the decision making process was with respect to medical treatment that was required for that person.

That is about as specific as I can be at this point about those things. I do not think it will be possible to be more specific or to provide a tighter system, because this is very much a voluntary arrangement which is not required to be undertaken. Under this legislation individuals who feel strongly about these matters will have the power to take

action on their own behalf, but they must also take responsibility for ensuring that a reasonable range of people know about their wishes and will be in a position to act upon them.

The Hon. J.C. IRWIN: I guess I can understand some of the thinking process that is behind the Minister's amendment, where there is a progression from one to two to three, rather than the scenario of three, which raises the interjection of the Hon. Mr Elliott's about a quorum. If you are going to have a committee making a decision, it either has to be unanimous or there is no decision, and that should be codified. The amendment is not about that, so that has eliminated the problem of having a whole set of rules about what the decision is: whether it is a majority, unanimous or none, and therefore you go to the one, two or three scenario which I am accepting. However, I still think there should be some indemnity there for the second one making a decision when the first person is not about.

It is all so open. The Minister is saying that it is complicated, and everyone agrees with that. It may happen only every now and again, but it will happen at some stage when there will be a complete stuff up, or it will be swept under the carpet, with No. 3 making a decision when two others should have been asked. There could then be some legal action where there is a total difference of opinion between what No. 1 would have chosen to do and what No. 3 might have chosen to do, such as pulling the plug. That needs to be codified somewhere, or some indemnity should be given to No. 1 or No. 2 if someone else has made a decision.

The Hon. BARBARA WIESE: The only comment I can make about that is that anyone who feels strongly about these matters and what kinds of treatment they either want or do not want presumably will also have made quite clear to the people whom they have chosen as their respective agents what their views are on these matters. So, we should not get a situation where the actions or decisions taken by agent No. 1 would be so markedly different from those that might be taken by No. 2 or No. 3, should they be in the position of making decisions. But that really is a matter for the individual making the choices about who will be their agents. They really should do as much as they can to inform all those agents about their wishes and choose people whom they believe will follow through on their stated wishes or who will understand the framework within which they would want decisions to be made if they have not been specific about their particular wishes.

The Hon. K.T. GRIFFIN: The concern that the Hon. Mr Irwin has raised applies equally to existing subclause (5) in terms of the issue of availability or unavailability. It is all very well for the Minister to suggest that someone who is serious enough to appoint medical agents in order of priority would or should take the trouble to explain to those people and others what their wishes are. That may be all well and good for those who are exercising the authority, but that will not help the medical practitioner, who ultimately attracts the legal responsibility.

I think that there will be problems under either subclause as to what identifies a person as not being available; it is very wide open. I think it will create problems in future if there is not some codification as to how that is to be determined, and the problem will be faced by the medical practitioner legally and not by the person purporting to exercise the authority. That is one issue, but that issue is there whether my amendment or the Minister's amendment is accepted.

I come back to the point that I made: I think that it is important to allow the person making the appointment to decide for himself or herself whether that person wants one, two or more people to exercise the responsibility. It will be quite clear that, in the absence of some other direction by the person making the appointment, if it is two people then it will be unanimous and if it is three it will be unanimous, although there may be some provision that the person making the appointment provides in the medical power of attorney.

The Hon. R.R. ROBERTS: Something has been exercising my mind since the earlier part of the debate when we were talking about the 'terminal phase' of a terminal illness. I listened to the contribution made by the Hon. Rob Lucas, and I have thought about it for some time. I do not wish to reiterate that, but it triggers a question in my mind that we could be talking about a period where nominee No. 2, for instance, had made a decision and a week later nominee No. 1 came along. Does No. 1 have power of attorney at that stage or, if it is three months down the track and some technical medical procedure has been adopted, can he then override the first decision by saying (to use the crude term that is being bandied around), 'Pull the plug' or 'Put the plug back in again'? Does he still have power of attorney or has the action of No. 2 overridden his power of attorney? Has No. 1 lost his power of attorney by not being available in the first place?

The Hon. BARBARA WIESE: I do not really know how to answer to this question, and I am not sure that it has been canvassed by the select committee. I return to the point I made a few moments ago that one would expect a person appointing three people in order of preference to have selected those people carefully and to have been very careful about explaining as well as can be explained in advance what their wishes would be in certain circumstances. So, hopefully one would have all three of those agents—if there were three—acting in a very similar way should they be called upon to act.

So, I would hope that in practice the sort of situation to which the honourable member refers, where one might have agent No. 1 who has been overseas and returns a week later coming in and wanting to overturn decisions, would not occur because the agents would be of like mind in terms of what was the appropriate decision to be taken in these circumstances.

I would like to make a couple of comments about the amendment which has been moved by the Hon. Mr Griffin and which, of course, I will be opposing in favour of the amendment that I have moved. First, I want to indicate that if an individual wishes members of his or her family to be consulted jointly about his or her treatment then there is nothing under my amendment that would allow for that to occur. In fact, an individual could record that on their form: that they want all children to be involved in the decision making process, but at the end of the day nominating one of those people to be the final arbiter in the case where there may be disagreement amongst those people. The select committee was also quite clear that it did not see a role for the courts in arbitration amongst these parties.

The Hon. Mr Griffin's amendment, when read in conjunction with a later amendment which he has on file, sets up a situation whereby, in the increasingly unlikely event that joint appointees are unable to reach a decision acceptable to all, the Supreme Court will play a prominent role in making a decision about treatment. That goes to the very heart of the matters considered by the select committee and is not acceptable. I want to make that point at this stage of the debate, as we are considering the question of whether there

should be a single exercise of power or some other arrangement as has been suggested by the Hon. Mr Griffin.

The Hon. R.I. LUCAS: I thought that the Attorney's suggestion of referring it back to the select committee to sort out the mess was a good one, and I think I could suggest that in relation to a number of other clauses as well. One of the questions that I heard by way of interjection is: why are we appointing three agents? It may well be that there is a view that whilst you are still capable you should appoint three people, in case one or two of them die. I wonder whether we could look at another arrangement which does not involve the first agent being unavailable, because that could mean that that person could not be contacted by telephone at Victor Harbour. That raises this awful spectre that the Hon. Ron Roberts has suggested where 24 hours later the first agent arrives home and says, 'My decision is different to that of the second agent.'

I think priority should be organised on the basis of a more restrictive definition, but it should at least cover the circumstance of the first agent's dying, going mad or not being competent to undertake the task of being a medical power of attorney. There should be a more restrictive definition of the order of precedence, otherwise we will have this problem that I think the Hon. Ron Roberts has portrayed accurately. If that alternative is not acceptable, it may be worthwhile thinking about that option overnight or deciding whether it ought to be recommitted, as the majority of members might want to come back to the proposition of appointing one person, which would raise a problem if that person dies.

The Hon. Carolyn Pickles: Or if they are not available; they could have gone overseas.

The Hon. R.I. LUCAS: 'Unavailable' could mean a whole variety of things. It could mean that that person is at Victor Harbor and returns 24 hours later. I suggest that the Committee reflect on this matter overnight, decide to recommit it or examine the matter again with the Minister or anyone else who is interested to see whether we can make more sense of this unavailability question and take into consideration the Hon. Ron Roberts' very sensible questions. Perhaps my suggestion is too restrictive, there may be an alternative, but I suggest that we tackle it again tomorrow.

The Hon. BARBARA WIESE: I have no problem with members considering this matter further as we are doing that with most of the clauses. It seems to me that we will probably spend twice the time on reconsideration than we have on the preliminary consideration. However, I suggest that we vote on the amendment as it stands in the knowledge that if anyone comes up with a bright idea overnight we will consider anything that is recommitted later.

The Hon. R.I. LUCAS: Personally, I am happy with that, but there are obviously many different views. However, I seek an undertaking from the Minister that she or her adviser take up the issue with the Minister of Health, Family and Community Services so that he and his advisers can apply their mind to this question. Many members on both sides of the Chamber have raised this issue. It is a question of whether there is a more sensible alternative than the ones we are considering.

The Hon. BARBARA WIESE: I am happy to take up this matter with the Minister. With the experience that he and members of the select committee have had and the range of information that has been presented to them, they may well have an offering to make which none of us has been able to think of tonight.

The Hon. M.J. ELLIOTT: With respect to some other concerns that were raised a little earlier during this debate on this clause, I indicate that I am having amendments drafted regarding a register. They will simply require that the Minister have a register of medical powers of attorney and advance medical directives. It would be compulsory that the Minister keep the register but not that people must register on it. One of the problems involves knowing whether a medical power of attorney has been granted or whether there is an advance directive. If there is a register, which people choose to use, it will be much easier to find out if they exist as well as the priority of medical attorneys.

The Hon. BERNICE PFITZNER: My amendment is similar to the Minister's, so I support her amendment. It is important that if two or more agents are appointed they be prioritised. I often hear about the difficulties that occur if two agents disagree. Therefore, I do not think they should have a joint exercise of power. I can think of nothing worse than two or three people, especially if they are siblings, arguing over what to do. I think a register has some merit, so I support the amendment.

The Committee divided on the amendment:

AYES (4)

Dunn, H. P. K.	Griffin, K .T. (teller)
Schaefer, C. V.	Stefani, J. F.

NOES (17)

Burdett, J. C.	Crothers, T.
Davis, L. H.	Elliott, M. J.
Feleppa, M. S.	Gilfillan, I.
Irwin, J. C.	Laidlaw, D. V.
Levy, J. A. W.	Lucas, R. I.
Pfitzner, B. S. L.	Pickles, C. A.
Roberts, R. R.	Roberts, T. G.
Sumner, C. J.	Weatherill, G.
Wiese, B. J. (teller)	

Majority of 13 for the Noes.

The Hon. K.T. Griffin's amendment thus negatived; new subclause inserted.

Progress reported; Committee to sit again.

ENVIRONMENT PROTECTION BILL

The House of Assembly intimated that it had agreed to amendments Nos 1 to 12, 14 to 17 and 19 to 37, had disagreed to amendments Nos 13 and 18, and had agreed to amendment No. 38 with the amendments indicated by the annexed schedule.

LAND TAX (RATES) AMENDMENT BILL

Received from the House of Assembly and read a first time.

The Hon. BARBARA WIESE (Minister of Transport Development): I move:

That this Bill be now read a second time.

In view of the lateness of the hour, I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

In the 1991-92 Budget, the Government announced that it would limit growth in aggregate land tax receipts to zero in 1991-92 and to no more than estimated CPI growth in each of 1992-93 and 1993-94. In practice, land tax receipts have fallen in absolute terms in each of the last two years from $76.0 million in 1990-91 to $75.8 million in 1991-92 and $75.4 million in 1992-93.

This policy of limiting growth in land tax receipts to no more

than estimated inflation was introduced in response to representations over successive years from industry and small business groups for the Government to smooth annual fluctuations in land tax. The Government has decided to extend this policy for a further three years beyond 1993-94.

Consistent with the policy, the land tax scale will require adjustment in 1993-94. For land ownerships where the site value is in excess of $1 million, the marginal rate on the excess above $1 million will increase from 2.8 per cent to 3.7 per cent. Two per cent of land taxpayers will be affected by this change.

Tax rates will not alter on site values up to $1 million, where South Australia currently has the lowest level of land tax of all the States apart from Victoria. This relative position will be maintained.

The adjusted tax scale is estimated to result in land tax receipts increasing in 1993-94 by less than estimated inflation before taking into account the inclusion in the tax base, for the first time in 1993-94, of the Commonwealth Bank and the Commonwealth Bank Officers Superannuation Corporation. Following the repeal of section 119(1) of the Commonwealth Banks Act, 1959 which had previously provided an exemption from State and Local Government taxes those bodies will now be liable for land tax. In total, land tax receipts are estimated to yield $78.3 million in 1993-94 compared to $75.4 million in 1992-93.

Explanation of Clauses

The provisions of the Bill are as follows:

Clause 1: Short title

This clause is formal.

Clause 2: Commencement

This clause provides that the measure will be taken to have come into operation at midnight on 30 June 1993, being the time at which land tax for the 1993-1994 financial year is calculated (see section 10(3) of the Act).

Clause 3: Amendment of s. 12—Scale of land tax

This clause alters the top marginal rate of tax (relating to land with a taxable value exceeding $1 000 000) from 2.8 per cent to 3.7 per cent.

The Hon. K.T. GRIFFIN secured the adjournment of the debate.

ADJOURNMENT

At 11.59 p.m. the Council adjourned until Wednesday 13 October at 2.15 p.m.