Introduced by Mr A H Greenwich, MP First print

New South Wales

Voluntary Assisted Dying Bill 2021

Explanatory note

This explanatory note relates to this Bill as introduced into Parliament.

This Bill is co-sponsored by Ms J K Aitchison, MP, Ms Abigail Boyd MLC, Mr T C Crakanthorp MP, the Hon Anthony D'Adam MLC, Mrs H J Dalton MP, Ms T L Doyle MP, Mr L J Evans MP, Ms Cate Faehrmann MLC, Mr J R Field MLC, the Hon John Graham MLC, Mr A H Greenwich MP, Ms J E Harrison MP, Ms J E Haylen MP, Ms S K Hornery MP, the Hon Emma Hurst MLC, The Hon T J Khan MLC, Ms Jenny Leong MP, Mr D R Mehan MP, Mr J T Parker MP, the Hon Mark Pearson MLC, Mr G M Piper MP, the Hon Adam Searle MLC, Mr David Shoebridge MLC, Ms T F Smith MP, Ms L D Tesch AM MP, Ms K R Washington MP, The Hon L G Williams MP, and Ms F L Wilson MP.

Overview of Bill

The objects of this Bill are to—

(a) enable eligible persons with a terminal illness to access voluntary assisted dying, and

(b) establish a procedure for, and regulate access to, voluntary assisted dying, and

(c) establish the Voluntary Assisted Dying Board and provide for the appointment of members and functions of the Board.

Outline of provisions

Part 1 Preliminary

Division 1 sets out the name, also called the short title, of the proposed Act and provides for the commencement of the proposed Act. The Division provides for the proposed Act to bind the

Crown in right of New South Wales and, in so far as the legislative power of the Parliament of New South Wales permits, the Crown in all its other capacities.

Division 2 sets out the principles to be applied in exercising a power or performing a function under the proposed Act.

Division 3 provides for the Dictionary in the proposed Act, Schedule 1 to define certain words and expressions used in the proposed Act. The Division sets out requirements that must be met for a patient to have decision-making capacity in relation to voluntary assisted dying for the purposes of the proposed Act. The Division specifies that a patient is presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision. A patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

The Division enables the Secretary of the Ministry of Health (the ***Health Secretary***) to approve a voluntary assisted dying substance and sets out when a request and assessment process for voluntary assisted dying in relation to a patient has been completed.

Division 4 provides that a registered health practitioner who has a conscientious objection to voluntary assisted dying has a right to refuse to participate in voluntary assisted dying. The Division provides that a health care worker who provides health services or professional care services to a person must not, while providing services to the person, initiate a discussion with the person about voluntary assisted dying or suggest voluntary assisted dying to the person unless certain circumstances are satisfied.

The Division clarifies that a contravention of the proposed Act by a registered health practitioner may constitute unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law (NSW)*, whether or not the contravention constitutes an offence under the proposed Act.

The Division specifies that a person who dies as a result of the administration of a prescribed substance in accordance with the proposed Act does not die by suicide. The Division also provides that certain actions taken in relation to voluntary assisted dying do not constitute an attempt by the person to cause serious physical harm to themselves for the purposes of the *Mental Health Act 2007*, section 22, or otherwise provide a ground for a police officer to take action under that section.

The proposed Act does not affect the inherent jurisdiction of the Supreme Court. If there is an inconsistency between a provision of the proposed Act and a provision of the *Poisons and Therapeutic Goods Act 1966* or the *Drug Misuse and Trafficking Act 1985*, the provision of the proposed Act prevails to the extent of the conflict or inconsistency.

Part 2 Requirements for access to voluntary assisted dying

Part 2 sets out the requirements that must be met for a person to be eligible for access to voluntary assisted dying.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 1 sets out the requirements that must be met for a medical practitioner to act as a coordinating practitioner or consulting practitioner in relation to a person's request for access to voluntary assisted dying.

Division 2 provides for a person to make a first request to a medical practitioner for access to voluntary assisted dying and for the practitioner's response to the request. A person who makes a first request may decide at any time not to continue with the request and assessment process. The Division imposes certain record-keeping requirements on the medical practitioner, including a requirement to notify the Voluntary Assisted Dying Board (the ***Board***) of the patient's first request and the practitioner's response. If the medical practitioner accepts the first request, the practitioner becomes the coordinating practitioner for the patient.

Division 3 sets out requirements that must be met by a coordinating practitioner when assessing a patient's eligibility for access to voluntary assisted dying, including requirements to—

(a) refer a patient to—

(i) if the coordinating practitioner is unable to decide whether the patient has a disease, illness or medical condition that satisfies certain criteria for eligibility for access to voluntary assisted dying—a medical practitioner with appropriate skills and training, or

(ii) if the coordinating practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying—a psychiatrist or another registered health practitioner with appropriate skills and training, or

(iii) if the coordinating practitioner is unable to decide whether the patient is acting voluntarily, or whether the patient is acting because of pressure or duress—a psychiatrist or another registered health practitioner or person with appropriate skills and training, and

(b) inform a patient who meets all of the eligibility criteria about certain matters, and

(c) assess a patient as—

(i) eligible for access to voluntary assisted dying if the coordinating practitioner is satisfied the patient meets all of the eligibility criteria and understands the matters about which the patient was informed, or

(ii) ineligible for access to voluntary assisted dying if the practitioner is not satisfied of these matters, and

(d) inform the patient of the outcome of the first assessment as soon as practicable after its completion, and

(e) give the patient and the Board a copy of an approved form completed by the coordinating practitioner, including information about the outcome of the first assessment, and

(f) refer a patient to another medical practitioner for a consulting assessment if the patient is assessed as eligible for access to voluntary assisted dying.

Division 4 sets out requirements that must be met by a medical practitioner who receives a referral for a consulting assessment, including the circumstances in which the practitioner may or must refuse the referral. The medical practitioner must record certain information in the patient's medical record, including the practitioner's decision to accept or refuse the referral. The medical practitioner is required to give the Board an approved form, including information about the practitioner's decision to accept or refuse the referral. If the medical practitioner accepts the referral, the practitioner becomes the consulting practitioner. The consulting practitioner must—

(a) assess whether the patient is eligible for access to voluntary assisted dying and, independently of the coordinating practitioner, form the practitioner's own opinion about the patient's eligibility, and

(b) refer a patient to—

(i) if the consulting practitioner is unable to decide whether the patient has a disease, illness or medical condition that satisfies certain criteria for eligibility for access to voluntary assisted dying—a medical practitioner with appropriate skills and training, or

(ii) if the consulting practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying—a psychiatrist or another registered health practitioner, or

(iii) if the consulting practitioner is unable to decide whether the patient is acting voluntarily, or whether the patient is acting because of pressure or duress—a person with appropriate skills and training, and

(c) inform a patient who meets all of the eligibility criteria about certain matters, and

(d) assess a patient as—

(i) eligible for access to voluntary assisted dying if the consulting practitioner is satisfied the patient meets all of the eligibility criteria and understands the matters about which the patient was informed, or

(ii) ineligible for access to voluntary assisted dying if the practitioner is not satisfied of these matters, and

(e) inform the patient and the patient's coordinating practitioner of the outcome of the consulting assessment as soon as practicable after its completion, and

(f) give the patient, the Board and the patient's coordinating practitioner a copy of an approved form completed by the consulting practitioner, including information about the outcome of the consulting assessment.

The coordinating practitioner may refer the patient to another medical practitioner if the consulting practitioner assesses the patient as ineligible for access to voluntary assisted dying.

Division 5 provides for a patient assessed as eligible for access to voluntary assisted dying by the patient's coordinating practitioner and consulting practitioner to make a written declaration requesting access. The Division specifies requirements that must be met in relation to the written declaration, including a requirement for the patient's coordinating practitioner to give a copy of the declaration to the Board.

Division 6 provides for a patient who has made a written declaration to make a final request to a coordinating practitioner for access to voluntary assisted dying. The coordinating practitioner for the patient must conduct a final review and complete an approved form before giving a copy of the form to the Board. In addition to other matters, the coordinating practitioner must include a statement in the form certifying whether or not the coordinating practitioner is satisfied that the patient has decision-making capacity, is acting voluntarily, is not acting because of pressure or duress and has made an enduring request to access voluntary assisted dying. A patient may decide not to take any further steps in relation to access to voluntary assisted dying despite the completion of the request and assessment process.

Part 4 Accessing voluntary assisted dying and death

Division 1 sets out the requirements that must be met for a person to be eligible to act as an administering practitioner for a patient.

Division 2 provides for the administration of a voluntary assisted dying substance to a patient if the request and assessment process has been completed and the patient's coordinating practitioner has certified certain requirements have been satisfied. A patient may, in consultation with, and on the advice of, the patient's coordinating practitioner, decide to self-administer a voluntary assisted dying substance or decide a substance is to be administered by a practitioner (an ***administering practitioner***). The Division specifies requirements that must be met in relation to the decision about the administration of a voluntary assisted dying substance, including a requirement for the patient's coordinating practitioner to record the administration decision in the patient's medical record and complete and give a copy of the approved form for the administration decision to the Board.

The patient may, at any time, revoke the patient's decision to self-administer, or proceed with the administration of, a voluntary assisted dying substance. The Division specifies requirements that must be met in relation to the revocation, including a requirement for the coordinating practitioner or administering practitioner informed of the patient's decision to record the revocation in the patient's medical record and complete and give a copy of the approved form to the Board.

If a patient has decided to self-administer a voluntary assisted dying substance and has not revoked the decision, the patient is authorised to receive, possess, prepare and self-administer a dose of a voluntary assisted dying substance that is sufficient to cause death. An agent of the patient is authorised to receive, possess, prepare and supply the substance to the patient. If a patient has decided to proceed with the administration of a voluntary assisted dying substance and has not revoked the decision, the administering practitioner is authorised to receive, possess, prepare and, in the presence of a witness, administer the voluntary assisted dying substance if satisfied of certain matters at the time of administration. In both cases, the coordinating practitioner for the

patient is authorised to prescribe a sufficient dose of a voluntary assisted dying substance (a ***prescribed substance***) and an authorised supplier is authorised to possess, prepare and supply the prescribed substance.

The patient's coordinating practitioner and administering practitioner, if relevant, must comply with certain reporting requirements. The Division specifies persons eligible to witness the administration of a prescribed substance.

The Division also provides for an administering practitioner to transfer the role of administering practitioner to another person eligible to act as an administering practitioner in certain circumstances. The Division specifies requirements that must be met if a person accepts the transfer of the role, including to inform the patient of the transfer, to record the transfer in the patient's medical record and to complete and give a copy of the approved form to the Board.

Division 3 requires a patient who has decided to self-administer a voluntary assisted dying substance to appoint a contact person. The patient, or another person acting on behalf of the patient, must include certain information about the contact person in the approved form. A copy of the form is to be given to the patient's coordinating practitioner and the Board. The patient's coordinating practitioner must not prescribe a voluntary assisted dying substance for the patient before the form is given to the practitioner.

The contact person is authorised to receive, possess, prepare and supply a prescribed substance to the patient for self-administration and give the substance, or any remaining substance, to a person authorised to dispose of the substance. The contact person must inform the patient's coordinating practitioner if the patient dies, regardless of whether or not the patient's death is the result of self-administering the prescribed substance. The contact person may refuse to continue the role at any time, at which point the patient must appoint another contact person.

Division 4 sets out requirements that must be met by a patient's coordinating practitioner in relation to an application to the Board for a prescribed substance authorisation for the patient. The Board must consider the application as soon as practicable after the application is received and decide to approve or, if the Board has not received certain documents or suspects the requirements of the proposed Act have not been met, refuse the application.

If the application is approved, the Board must, as soon as practicable after making the decision to approve the application, grant a voluntary assisted dying substance authority in relation to the patient. A voluntary assisted dying substance authority must be in the approved form and include certain information. If the application is refused, the Board must notify the patient's coordinating practitioner and specify the reasons for refusing the application.

Division 5 sets out requirements in relation to the prescription, supply, storage and disposal of voluntary assisted dying substances, including requirements to inform a patient or other person of certain matters.

Division 6 enables the Health Secretary to authorise a registered health practitioner, or persons in a class of registered health practitioners, to supply or dispose of prescribed substances. The Health Secretary may revoke an authorisation and must keep a register of practitioners authorised to supply or dispose of prescribed substances.

A coordinating practitioner must not direct a health professional to supply a prescribed substance to the practitioner's patient unless certain circumstances are met. A coordinating practitioner or administering practitioner must not direct a health professional to administer a prescribed substance to the patient.

The Division prohibits the issue of certain documents in relation to the administration or supply of medicine for the purpose of voluntary assisted dying.

The Division requires a patient's coordinating practitioner or administering practitioner to notify the Board, in the approved form, of the patient's death after becoming aware the patient has died, whether or not after self-administering or being administered a voluntary assisted dying substance in accordance with the proposed Act. A medical practitioner required to give a cause of death certificate for a person must also notify the Board if the practitioner knows or reasonably believes the person was a patient who self-administered, or was administered, a voluntary assisted dying substance in accordance with the proposed Act.

Part 5 Participation

Part 5 provides that residential facilities, private health facilities and public hospitals may decide they will not provide services relating to voluntary assisted dying at the facility or establishment. The decision not to provide services relating to voluntary assisted dying is subject to obligations imposed by the proposed Part on the following entities in relation to persons receiving care—

(a) entities providing certain services at residential facilities,

(b) entities that own or occupy residential facilities,

(c) entities that own or operate private health facilities or public hospitals.

The nature of the obligations differ according to whether or not the entity provides certain services at a residential facility, owns or occupies a residential facility or owns or operates a private health facility or public hospital. The obligations relate to access to the following—

(a) information about voluntary assisted dying,

(b) the request and assessment process for voluntary assisted dying,

(c) the administration of a voluntary assisted dying substance,

(d) information about the fact that the entity does not provide services relating to voluntary assisted dying at the residential facility, private health facility or public hospital.

Part 6 Review by Supreme Court

Part 6 enables a person to apply to the Supreme Court for administrative review of certain decisions. The Part provides for the consequences of an application for administrative review of decisions relating to the request and assessment process in relation to a patient. An application for administrative review made in relation to a patient is taken to be withdrawn if the patient dies.

The Part specifies the decisions the Court may make and the effect of certain decisions, including in relation to a patient's access to voluntary assisted dying.

The Court must conduct hearings in private. The Principal Registrar and the Board are required to give notice of certain matters in relation to an application for administrative review. A patient's coordinating practitioner or consulting practitioner must give certain information and documents to the Principal Registrar in response to a notice received from the Principal Registrar. The Part inserts requirements in relation to the giving of reasons for a decision and the disclosure of personal information and clarifies that the Court may make an interim order it considers just.

Part 7 Offences

Part 7 creates offences in relation to the unauthorised administration of a prescribed substance and inducing another person to self-administer a prescribed substance, or request or access voluntary assisted dying. The Part also makes it an offence to give false or misleading information or advertise certain poisons as voluntary assisted dying substances. The Part sets out obligations and offences in relation to the cancellation of a document presented as a prescription for a voluntary assisted dying substance and the return of unused or remaining prescribed substances to an authorised disposer.

The Part also creates offences in relation to the recording, use, disclosure and publication of certain information.

Part 8 Enforcement

Part 8 provides for the enforcement of offences under the proposed Act, including requirements in relation to the commencement of proceedings.

Part 9 Protection from liability

Part 9 excludes persons from liability in the following circumstances—

(a) exclusion from criminal liability—if the person, in good faith, assists another person to request access to, or access, voluntary assisted dying or is present when another person self-administers, or is administered, a prescribed substance,

(b) exclusion from civil or criminal liability, or liability under certain administrative processes—if the person, in good faith and with reasonable care and skill, does a thing, or does not do a thing, in accordance with the proposed Act or believing on reasonable grounds the thing is done, or not done, in accordance with the proposed Act,

(c) exclusion from punishment under law or sanction by a regulatory body—if a medical practitioner refers a person, seeks information, examines a person referred or gives information in response to a request,

(d) exclusion from civil or criminal liability, or liability under certain administrative processes—for certain persons who, in good faith, do not administer lifesaving treatment in circumstances in which the other person has not requested the administration of lifesaving treatment, or the first person believes on reasonable grounds the other person is dying after self-administering or being administered a prescribed substance in accordance with the proposed Act.

Part 10 Voluntary Assisted Dying Board

Division 1 establishes the Voluntary Assisted Dying Board as an agent of the Crown with the status, immunities and privileges of the Crown.

Division 2 sets out the functions and powers of the Board. The Board may delegate a function of the Board to certain persons.

Division 3 requires the Health Secretary to ensure the Board is provided with staff, services and facilities and other resources and support that are reasonably necessary to enable the Board to perform its functions. The Board may, with the Minister's approval, appoint a person with special knowledge or skills to assist the Board in a particular matter.

Division 4 enables the Minister to give directions to the Board about the performance of the Board's functions and to have access to certain information.

Division 5 provides for the membership of the Board, including the term of office and remuneration of members of the Board.

Division 6 contains provisions relating to the requirements and procedures for Board meetings.

Division 7 requires Board members to disclose material personal interests and provides for the consequences of a disclosure. The Division also provides for the powers and responsibilities of the Minister in relation to disclosures.

Division 8 provides for the Board to establish committees to assist the Board in the performance of its functions.

Division 9 provides for the obligations and powers of the Board in relation to certain information in connection with the functions of the Board, including a requirement to record and keep statistical information about matters relating to voluntary assisted dying.

Division 10 contains provisions relating to the receipt of forms, execution of documents and the preparation of annual reports by the Board.

Part 11 Access standard

Part 11 requires the Health Secretary to issue a standard setting out how the Ministry intends to facilitate access to voluntary assisted dying.

Part 12 General

Part 12 contains various provisions relating to the general operation of the proposed Act, including provisions relating to the following—

(a) the transfer of the role of coordinating practitioner,

(b) the use of audiovisual communication and electronic signatures,

(c) the publication of information about voluntary assisted dying,

(d) the approval of an entity to provide support, assistance and information in relation to voluntary assisted dying to certain persons,

(e) the Health Secretary's approval of training about matters relating to the operation of the proposed Act, including training for health practitioners in relation to practitioners' functions under the proposed Act, the assessment of a patient's eligibility for access to voluntary assisted dying and risk factors for pressure or duress,

(f) the approval of forms,

(g) requirements for interpreters,

(h) the relationship of the proposed Act with other Acts,

(i) the review of the operation and effectiveness of the proposed Act,

(j) the power to make regulations.

Schedule 1A Consequential amendment of other Acts

Schedule 1A.1 amends the *Births, Deaths and Marriages Registration Act 1995* to require the Registrar, if the Registrar receives a cause of death certificate specifying that the medical practitioner knew or reasonably believed the deceased person self-administered, or was administered, a voluntary assisted dying substance in accordance with the proposed Act, to register the death in the Births, Deaths and Marriages Register and record certain information. The information recorded in the entry in the Register is not to be included in a certificate issued by the Registrar under the *Births, Deaths and Marriages Registration Act 1995*, section 49.

Schedule 1A.2 amends the *Criminal Procedure Act 1986* to insert certain offences under the proposed Act in the Act, Schedule 1. An offence under proposed section 124 of the proposed Act is an indictable offence to be dealt with summarily unless the prosecutor or person charged elects otherwise. An offence under proposed section 127 of the proposed Act is an indictable offence to be dealt with summarily unless the prosecutor elects otherwise.

Schedule 1A.3 amends the *Ombudsman Act 1974* to provide that, despite the exclusion of conduct of certain public authorities comprised of members appointed by the Governor or a Minister, the conduct of the Board may be the subject of a complaint to the Ombudsman.

Schedule 1 Dictionary

Schedule 1 defines certain words and expressions used in the proposed Act.

Introduced by Mr A H Greenwich, MP First print

New South Wales

Voluntary Assisted Dying Bill 2021

Contents

b2020-039.d27

Page

Page

Page

Page

Page

Page

New South Wales

Voluntary Assisted Dying Bill 2021

No , 2021

A Bill for

An Act to provide for, and regulate access to, voluntary assisted dying for persons with a terminal illness; to establish the Voluntary Assisted Dying Board; and to make consequential amendments to other Acts.

Tabling copy

The Legislature of New South Wales enacts—

Part 1 Preliminary

Division 1 Preliminary

1 Name of Act

This Act is the *Voluntary Assisted Dying Act 2021*.

2 Commencement

This Act commences on the day that is 18 months after the date of assent to this Act.

3 Act to bind Crown

This Act binds the Crown in right of New South Wales and, in so far as the legislative power of the Parliament of New South Wales permits, the Crown in all its other capacities.

Division 2 Principles

4 Principles

(1) A person exercising a power or performing a function under this Act must have regard to the following principles—

(a) every human life has equal value,

(b) a person's autonomy, including autonomy in relation to end of life choices, should be respected,

(c) a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a way the person understands, information about medical treatment options, including comfort and palliative care and treatment,

(d) a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life,

(e) a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained,

(f) a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted,

(g) a person should be supported in conversations with the person's health practitioners, family, carers and community about care and treatment preferences,

(h) a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,

(i) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region,

(j) there is a need to protect persons who may be subject to pressure or duress,

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(k) all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

(2) In subsection (1), the reference to a person exercising a function under this Act includes the Supreme Court exercising its jurisdiction in relation to a decision made under this Act.

Division 3 Interpretation

5 Definitions

The Dictionary in Schedule 1 defines words and expressions used in this Act.

Note— The *Interpretation Act 1987* also contains definitions and other provisions that affect the interpretation and application of this Act.

6 Decision-making capacity

(1) For the purposes of this Act, a patient has ***decision-making capacity*** in relation to voluntary assisted dying if the patient has the capacity to—

(a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and

(b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and

(c) understand the matters involved in a voluntary assisted dying decision, and

(d) understand the effect of a voluntary assisted dying decision, and

(e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and

(f) communicate a voluntary assisted dying decision in some way.

(2) For the purposes of this Act, a patient is—

(a) presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and

(b) presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

(3) In this section—

voluntary assisted dying decision means—

(a) a request for access to voluntary assisted dying, or

(b) a decision to access voluntary assisted dying.

7 Voluntary assisted dying substance

(1) The Health Secretary may, in writing, approve a Schedule 4 poison or Schedule 8 poison for use under this Act for the purpose of causing a patient's death.

(2) A poison approved under subsection (1) is a ***voluntary assisted dying substance***.

(3) The Health Secretary must keep a list of voluntary assisted dying substances.

8 When request and assessment process completed

For the purposes of this Act, the request and assessment process has been ***completed*** in relation to a patient if the patient's coordinating practitioner—

(a) has completed the final review form in relation to the patient, and

(b) has certified in the final review form that the request and assessment process has been completed in accordance with this Act.

Division 4 Other provisions

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

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following—

(a) participate in the request and assessment process,

(b) prescribe, supply or administer a voluntary assisted dying substance,

(c) be present at the time of the administration of a voluntary assisted dying substance.

(2) Subsection (1) does not limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in the subsection.

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

(1) A health care worker who provides health services or professional care services to a person must not, while providing the services to the person—

(a) initiate a discussion with the person that is in substance about voluntary assisted dying, or

(b) in substance, suggest voluntary assisted dying to the person.

Note— A contravention of this Act is capable of constituting unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law*, whether or not the contravention constitutes an offence.

(2) Subsection (1) does not apply to a medical practitioner who initiates a discussion or makes a suggestion referred to in subsection (1)(a) or (b) if, at the time the discussion is initiated or the suggestion is made, the medical practitioner also informs the person about the following—

(a) the treatment options available to the person that would be considered standard care for the disease, illness or medical condition with which the person has been diagnosed,

(b) the likely outcomes of the treatment options available to the person,

(c) the palliative care and treatment options available to the person,

(d) the likely outcomes of the palliative care and treatment options.

(3) Also, subsection (1) does not apply to a health care worker, other than a medical practitioner, who initiates a discussion or makes a suggestion referred to in subsection (1)(a) or (b) if, at the time the discussion is initiated or the suggestion is made, the health care worker also informs the person that the person—

(a) has palliative care and treatment options available, and

(b) should discuss the palliative care and treatment options with the person's medical practitioner.

(4) To avoid doubt, subsection (1) does not apply to a health care worker who provides information about voluntary assisted dying to a person at the person's request.

(5) A contravention of subsection (1) by a disability care provider may be grounds for—

(a) if the disability care provider is a relevant worker—

(i) for a Public Service employee within the meaning of the *Government Sector Employment Act 2013*—disciplinary action under that Act, or

(ii) for another relevant worker—the disciplinary action the Secretary of the Department in which the *Disability Inclusion Act 2014* is administered considers appropriate, or

(b) otherwise—the suspension or termination of financial assistance under the *Disability Inclusion Act 2014* or National Disability Insurance Scheme.

(6) In this section—

disability care provider means—

(a) a relevant worker, or

(b) a person or other entity receiving financial assistance under the *Disability Inclusion Act 2014* or National Disability Insurance Scheme, or

(c) a person employed, or otherwise engaged, by a person or eligible entity referred to in paragraph (b).

health care worker means—

(a) a registered health practitioner, or

(b) another person who provides health services or professional care services.

relevant worker—

(a) means a person employed or otherwise engaged to provide support and services directly to persons in the target group in a way that involves face to face or physical contact with the persons, and

Example— a public service employee, a volunteer, a person undertaking training as part of an educational or vocational course or program, a self-employed person, contractor or subcontractor

(b) includes an NDIS worker within the meaning of the *National Disability Insurance Scheme (Worker Checks) Act 2018*.

11 Contravention of Act by registered health practitioner

(1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law*.

(2) Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

12 Voluntary assisted dying not suicide

(1) For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

(2) Voluntary assisted dying action does not—

(a) constitute an attempt by the person to cause serious physical harm to the person for the purposes of the *Mental Health Act 2007*, section 22, or

(b) otherwise provide a ground for a police officer to take action under that section.

(3) In this section—

voluntary assisted dying action means any of the following done in accordance with this Act—

(a) a request for access to voluntary assisted dying,

(b) a self-administration decision or a practitioner administration decision,

(c) self-administration by a person of a prescribed substance,

(d) asking an administering practitioner to administer a prescribed substance.

13 Inherent jurisdiction of Supreme Court not affected

Nothing in this Act affects the inherent jurisdiction of the Supreme Court.

14 Relationship with Poisons and Therapeutic Goods Act 1966 and Drug Misuse and Trafficking Act 1985

If there is an inconsistency between a provision of this Act and a provision of the *Poisons and Therapeutic Goods Act 1966* or the *Drug Misuse and Trafficking Act 1985*, the provision of this Act prevails to the extent of the conflict or inconsistency.

Part 2 Requirements for access to voluntary assisted dying

15 When person may access voluntary assisted dying

A person may access voluntary assisted dying if—

(a) the person has made a first request, and

(b) the person has been assessed as eligible for access to voluntary assisted dying by—

(i) the person's coordinating practitioner, and

(ii) the person's consulting practitioner, and

(c) the person has made a written declaration, and

(d) the person has made a final request to the person's coordinating practitioner, and

(e) the person's coordinating practitioner has certified in a final review form that—

(i) the request and assessment process has been completed in accordance with this Act, and

(ii) the practitioner is satisfied of each of the matters referred to in section 52(3)(f), and

(f) the person has made an administration decision, and

(g) if the person has made a self-administration decision—the person has appointed a contact person, and

(h) a voluntary assisted dying substance authority has been issued by the Board in relation to the person.

16 Eligibility criteria

(1) The following criteria must be met for a person to be eligible for access to voluntary assisted dying—

(a) the person is an adult,

(b) the person—

(i) is an Australian citizen, or

(ii) is a permanent resident of Australia, or

(iii) at the time of making a first request, has been resident in Australia for at least 3 continuous years,

(c) at the time of making a first request, the person has been ordinarily resident in New South Wales for a period of at least 12 months,

(d) the person is diagnosed with at least 1 disease, illness or medical condition that—

(i) is advanced, progressive and will cause death, and

(ii) will, on the balance of probabilities, cause death—

(A) for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or

(B) otherwise—within a period of 6 months, and

(iii) is causing suffering to the person that cannot be relieved in a way the person considers tolerable,

(e) the person has decision-making capacity in relation to voluntary assisted dying,

(f) the person is acting voluntarily,

(g) the person is not acting because of pressure or duress,

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(h) the person's request for access to voluntary assisted dying is enduring.

(2) A person is not eligible for access to voluntary assisted dying merely because the person has—

(a) a disability, or

(b) a mental health impairment within the meaning of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.

17 Residency exemptions

(1) A person may apply to the Board for an exemption from the requirement in section 16(1)(c).

(2) The Board must grant the exemption if satisfied—

(a) the person has a substantial connection to New South Wales, and

Examples—

1 a person who is a long-term resident of a place close to the New South Wales border and who works in New South Wales or receives medical treatment in New South Wales

2 a person who has family members who reside in New South Wales and who has moved to New South Wales to be closer to the family members for care and support as a result of the person's terminal illness

3 a person who resides outside New South Wales but who is a former resident of New South Wales and whose family resides in New South Wales

(b) there are compassionate grounds for granting the exemption.

Part 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 1 Eligibility requirements for medical practitioners

18 Eligibility to act as coordinating practitioner or consulting practitioner

A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if—

(a) the medical practitioner—

(i) holds specialist registration, or

(ii) holds general registration and has practised the medical profession for at least 10 years as the holder of general registration, or

(iii) is an overseas-trained specialist who holds limited registration or provisional registration, and

(b) the medical practitioner has completed the approved training, and

(c) the medical practitioner meets other requirements prescribed by the regulations for the purposes of this section, and

(d) the medical practitioner is not a family member of the patient, and

(e) the medical practitioner does not know or believe that the practitioner—

(i) is a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the patient.

Division 2 First request

19 Person may make first request to medical practitioner

(1) A person may make a request to a medical practitioner for access to voluntary assisted dying.

(2) The request must be—

(a) clear and unambiguous, and

(b) made during a medical consultation, and

(c) made in person or, if that is not practicable, in accordance with section 182(1)(a).

(3) The person may make the request—

(a) verbally, or

(b) in another way.

Example for paragraph (b)— by use of gestures

(4) The person may make the request with the assistance of an interpreter.

20 No obligation to continue after making first request

(1) A person who makes a first request may decide at any time not to continue the request and assessment process.

(2) The request and assessment process ends if the person decides not to continue the process.

(3) If the request and assessment process ends under subsection (2), the person may begin a new request and assessment process by making a new first request.

21 Medical practitioner to accept or refuse first request

(1) If a first request is made to a medical practitioner, the practitioner must decide to—

(a) accept the request, or

(b) refuse the request.

(2) The only reasons for which the medical practitioner may decide to refuse the first request are that—

(a) the practitioner has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a coordinating practitioner, or

(b) the practitioner is unable to perform the duties of a coordinating practitioner because of unavailability or another reason, or

(c) the practitioner is required to refuse the request under subsection (3).

(3) The medical practitioner must immediately decide to refuse the first request if the practitioner is not eligible to act as a coordinating practitioner at the time the first request is made.

(4) Unless subsection (5) applies, the medical practitioner must, within 2 business days after the first request is made—

(a) inform the patient that the practitioner has decided to accept or refuse the request, and

(b) give the patient the information approved by the Health Secretary, by Gazette notice, for the purposes of this section.

(5) If the medical practitioner decides to refuse the first request because the practitioner has a conscientious objection to voluntary assisted dying, the practitioner must, immediately after the first request is made—

(a) inform the patient that the practitioner has decided to refuse the request, and

(b) give the patient the information approved by the Health Secretary, by Gazette notice, for the purposes of this section.

22 Medical practitioner to record first request and acceptance or refusal

The medical practitioner must record the following in the patient's medical record—

(a) the first request,

(b) the practitioner's decision to accept or refuse the first request,

Note— See section 21(2), which provides the only reasons for which a medical practitioner may refuse a first request.

(c) if the practitioner's decision is to refuse the first request—the reason for the refusal,

(d) whether the practitioner has given the patient the information referred to in section 21(4)(b) and (5)(b).

23 Medical practitioner to notify Board of first request

(1) Within 5 business days after deciding to accept or refuse the first request, the medical practitioner must—

(a) complete the approved form (the ***first request form***), and

(b) give a copy of the first request form to the Board.

(2) The first request form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the medical practitioner's name and contact details,

(c) the date the first request was made,

(d) whether the first request was made in person or using audiovisual communication,

(e) whether the first request was made verbally or in another way,

(f) if the patient was assisted by an interpreter to make the first request—the interpreter's name, contact details and accreditation details,

(g) the medical practitioner's decision to accept or refuse the first request,

(h) if the medical practitioner's decision is to refuse the first request—the reason for the refusal,

(i) the date the medical practitioner informed the patient of the practitioner's decision and gave the patient the information referred to in section 21(4)(b) or (5)(b),

(j) the medical practitioner's signature and the date the form was signed.

24 Medical practitioner becomes coordinating practitioner if first request accepted

If the medical practitioner accepts the first request, the practitioner becomes the coordinating practitioner for the patient.

Division 3 First assessment

25 First assessment

(1) The coordinating practitioner for a patient must assess whether the patient is eligible for access to voluntary assisted dying.

(2) For the purposes of subsection (1), the coordinating practitioner must make a decision in relation to each of the eligibility criteria.

(3) Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

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

(1) This section applies if the coordinating practitioner is unable to decide whether the patient has a disease, illness or medical condition that meets the requirements of section 16(1)(d).

(2) The coordinating practitioner must refer the patient to a medical practitioner who has appropriate skills and training to make a decision about the matter.

(3) The medical practitioner must—

(a) decide whether the patient has a disease, illness or medical condition that—

(i) is advanced, progressive and will cause death, and

(ii) will, on the balance of probabilities, cause death—

(A) for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or

(B) otherwise—within a period of 6 months, and

(iii) is causing suffering to the person that cannot be relieved in a way the person considers tolerable, and

(b) provide a clinical report to the coordinating practitioner that sets out the medical practitioner's decision.

(4) If the coordinating practitioner makes a referral under this section, the coordinating practitioner may adopt the decision of the medical practitioner about the matter in relation to which the referral was made.

(5) A medical practitioner to whom the patient is referred under this section must not be—

(a) a family member of the patient, or

(b) a person who knows or believes that they—

(i) are a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

27 Referral for opinion—other matters

(1) This section applies if the coordinating practitioner is unable to decide whether—

(a) as required by section 16(1)(e), the patient has decision-making capacity in relation to voluntary assisted dying, or

Example— due to a past or current mental illness of the patient

(b) as required by section 16(1)(f), the patient is acting voluntarily, or

(c) as required by section 16(1)(g), the patient is not acting because of pressure or duress.

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(2) The coordinating practitioner must refer the patient to—

(a) if the coordinating practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying—a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter, or

(b) if the coordinating practitioner is unable to decide whether the patient is or is not acting voluntarily or whether the patient is or is not acting because of pressure or duress—a psychiatrist or another registered health practitioner or person who has appropriate skills and training to make a decision about the matter.

(3) If the coordinating practitioner makes a referral under this section, the coordinating practitioner may adopt the decision of the psychiatrist, other registered health practitioner or other person about the matter in relation to which the referral was made.

(4) A psychiatrist, registered health practitioner or other person to whom the patient is referred under this section must not be—

(a) a family member of the patient, or

(b) a person who knows or believes that they—

(i) are a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

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

(1) If the coordinating practitioner is satisfied the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters—

(a) the patient's diagnosis and prognosis,

(b) the treatment options available to the patient that would be considered standard care for the disease, illness or medical condition with which the patient has been diagnosed and the likely outcomes of treatment,

(c) the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(d) the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the patient's death,

(e) that the expected outcome of self-administering or being administered a substance referred to in paragraph (d) is death,

(f) the method by which a substance referred to in paragraph (d) is likely to be self-administered or administered,

(g) the request and assessment process, including the requirement for a written declaration signed by the patient, or a person on the patient's behalf, in the presence of 2 witnesses,

(h) that if the patient makes a self-administration decision, the patient must appoint a contact person,

(i) that the patient may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying,

(j) that if the patient is receiving ongoing health services from a medical practitioner (the ***treating practitioner***) other than the coordinating practitioner—

(i) the patient is encouraged to inform the treating practitioner about the patient's request for access to voluntary assisted dying, and

(ii) it is unlawful for the treating practitioner to withdraw other services the practitioner would usually provide to the patient or the patient's family and other close contacts because of the patient's request for access to voluntary assisted dying, and

(iii) if the treating practitioner withdraws services mentioned in subparagraph (ii)—the matter should be the subject of a complaint to the Health Care Complaints Commission under the *Health Care Complaints Act 1993*,

(k) that if the patient is a resident of a residential facility, whether permanently or not, the patient should inform the residential facility manager about the patient's request for access to voluntary assisted dying.

(2) For the purposes of subsection (1)(d), if the access standard includes information about the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing the patient's death, the information must be given in accordance with the access standard.

Note— See section 180(3), which provides that the access standard may include information about the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act for the purposes of causing a patient's death.

(3) The withdrawal of services by a medical practitioner in circumstances mentioned in subsection (1)(j)(ii) may be unsatisfactory professional conduct for the purposes of the *Health Practitioner Regulation National Law*.

(4) In addition to informing the patient about the matters referred to in subsection (1), the coordinating practitioner must take all reasonable steps to fully explain to the patient and, if the patient consents, another person nominated by the patient—

(a) all relevant clinical guidelines, and

(b) a plan in relation to the administration of a voluntary assisted dying substance.

(5) Nothing in this section affects a duty a medical practitioner has—

(a) at common law, or

(b) under another Act or other law.

29 Outcome of first assessment

(1) The coordinating practitioner must assess the patient as eligible for access to voluntary assisted dying if the coordinating practitioner is satisfied—

(a) the patient meets all of the eligibility criteria, and

(b) the patient understands the information required to be provided under section 28(1).

(2) If the coordinating practitioner is not satisfied about a matter in subsection (1)—

(a) the coordinating practitioner must assess the patient as ineligible for access to voluntary assisted dying, and

(b) the request and assessment process ends.

Note— See sections 26 and 27, which provide that the coordinating practitioner may, in certain circumstances, refer a patient to another registered health practitioner or another person if the coordinating practitioner is unable to make a decision about eligibility for access to voluntary assisted dying.

30 Recording and notification of outcome of first assessment

(1) The coordinating practitioner must inform the patient of the outcome of the first assessment as soon as practicable after its completion.

(2) Within 5 business days after completing the first assessment, the coordinating practitioner must—

(a) complete the approved form (the ***first assessment report form***), and

(b) give a copy of the first assessment report form to the Board.

Maximum penalty—100 penalty units.

(3) As soon as practicable after completing the first assessment report form, the coordinating practitioner must give a copy of the form to the patient.

(4) The first assessment report form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the following information about the patient—

(i) gender,

(ii) nationality,

(iii) ethnicity,

(iv) whether the patient has a disability and, if so, details of the disability,

(v) whether the patient's first language is a language other than English,

(vi) whether the coordinating practitioner engaged an interpreter in accordance with section 182(2) to communicate the information in section 28(1) and (4) to the patient,

(c) the coordinating practitioner's name and contact details,

(d) a statement confirming the coordinating practitioner meets the requirements of section 18,

(e) the date the first request was made,

(f) the date the first assessment was completed,

(g) the outcome of the first assessment, including the coordinating practitioner's decision about each of the eligibility criteria,

(h) the date the patient was informed of the outcome of the first assessment,

(i) if the patient was referred under section 26(2) or 27(2)—the outcome of the referral, including a copy of a report given by the registered health practitioner or other person to whom the patient was referred,

(j) if the patient was assisted by an interpreter when having the first assessment—the interpreter's name, contact details and accreditation details,

(k) the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(l) a statement confirming the patient has been advised of the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(m) the coordinating practitioner's signature and the date the form was signed.

31 Referral for consulting assessment if patient assessed as eligible

If the coordinating practitioner assesses the patient as eligible for access to voluntary assisted dying, the practitioner must refer the patient to another medical practitioner for a consulting assessment.

Division 4 Consulting assessment

32 Medical practitioner to accept or refuse referral for consulting assessment

(1) If a patient is referred to a medical practitioner for a consulting assessment under section 31, 42 or 181(6)(a), the practitioner must decide to accept or refuse the referral.

(2) The reasons for which the medical practitioner may decide to refuse the referral are that—

(a) the practitioner has a conscientious objection to voluntary assisted dying or is otherwise unwilling to perform the duties of a consulting practitioner, or

(b) the practitioner is unable to perform the duties of a consulting practitioner because of unavailability or some other reason, or

(c) the practitioner is required to refuse the referral under subsection (3).

(3) The medical practitioner must decide to refuse the referral if the practitioner is not eligible to act as a consulting practitioner.

(4) Unless subsection (5) applies, the medical practitioner must, within 2 business days after receiving the referral, inform the patient and the patient's coordinating practitioner that the practitioner has decided to—

(a) accept the referral, or

(b) refuse the referral.

(5) If the medical practitioner decides to refuse the referral because the practitioner has a conscientious objection to voluntary assisted dying, the practitioner must, immediately after receiving the referral, inform the patient and the patient's coordinating practitioner that the practitioner has decided to refuse the referral.

33 Medical practitioner to record referral and acceptance or refusal

The medical practitioner must record the following in the patient's medical record—

(a) the referral,

(b) the practitioner's decision to accept or refuse the referral,

(c) if the practitioner's decision is to refuse the referral—the reason for the refusal.

34 Medical practitioner to notify Board of referral

(1) Within 5 business days after deciding to accept or refuse the referral, the medical practitioner must—

(a) complete the approved form (the ***consultation referral form***), and

(b) give a copy of the consultation referral form to the Board.

Maximum penalty—100 penalty units.

(2) The consultation referral form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the medical practitioner's name and contact details,

(c) the date the referral was received,

(d) the medical practitioner's decision to accept or refuse the referral,

(e) if the medical practitioner's decision is to refuse the referral—the reason for the refusal,

(f) the date the medical practitioner informed the patient and the patient's coordinating practitioner of the medical practitioner's decision,

(g) the medical practitioner's signature and the date the form was signed.

35 Medical practitioner becomes consulting practitioner if referral accepted

If the medical practitioner accepts the referral, the practitioner becomes the consulting practitioner for the patient.

36 Consulting assessment

(1) The consulting practitioner for a patient must assess whether the patient is eligible for access to voluntary assisted dying.

(2) For the purposes of subsection (1), the consulting practitioner must—

(a) make a decision about each of the eligibility criteria, and

(b) independently of the coordinating practitioner, form the practitioner's own opinions on the matters to be decided.

(3) Nothing in this section prevents the consulting practitioner having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

37 Referral to another medical practitioner for opinion—disease, illness or medical condition

(1) This section applies if the consulting practitioner is unable to decide whether the patient has a disease, illness or medical condition that meets the requirements of section 16(1)(d).

(2) The consulting practitioner must refer the patient to a medical practitioner who has appropriate skills and training to make a decision about the matter.

(3) The medical practitioner must—

(a) decide whether the patient has a disease, illness or medical condition that—

(i) is advanced, progressive and will cause death, and

(ii) will, on the balance of probabilities, cause death—

(A) for a disease, illness or medical condition that is neurodegenerative—within a period of 12 months, or

(B) otherwise—within a period of 6 months, and

(iii) is causing suffering to the person that cannot be relieved in a way the person considers tolerable, and

(b) provide a clinical report to the consulting practitioner that sets out the medical practitioner's decision.

(4) If the consulting practitioner makes a referral under this section, the consulting practitioner may adopt the decision of the medical practitioner about the matter in relation to which the referral was made.

(5) A medical practitioner to whom the patient is referred under this section must not be—

(a) a family member of the patient, or

(b) a person who knows or believes that they—

(i) are a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

38 Referral for opinion—other matters

(1) This section applies if the consulting practitioner is unable to decide whether—

(a) as required by section 16(1)(e), the patient has decision-making capacity in relation to voluntary assisted dying, or

Example— due to a past or current mental illness of the patient

(b) as required by section 16(1)(f), the patient is acting voluntarily, or

(c) as required by section 16(1)(g), the patient is not acting because of pressure or duress.

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(2) The consulting practitioner must refer the patient to—

(a) if the consulting practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying—a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter, or

(b) if the consulting practitioner is unable to decide whether the patient is or is not acting voluntarily or is or is not acting because of pressure or duress—a

psychiatrist or another registered health practitioner or person who has appropriate skills and training to make a decision about the matter.

(3) If the consulting practitioner makes a referral under this section, the consulting practitioner may adopt the decision of the psychiatrist, other registered health practitioner or other person about the matter in relation to which the referral was made.

(4) A psychiatrist, registered health practitioner or other person to whom the patient is referred under this section must not be—

(a) a family member of the patient, or

(b) a person who knows or believes that they—

(i) are a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services in connection with the referral.

39 Information to be provided if patient assessed as meeting eligibility criteria

(1) If the consulting practitioner is satisfied the patient meets all of the eligibility criteria, the consulting practitioner must give the patient information about the matters referred to in section 28(1).

(2) Nothing in this section affects a duty a medical practitioner—

(a) has at common law, or

(b) under another Act or law.

40 Outcome of consulting assessment

(1) The consulting practitioner must assess the patient as eligible for access to voluntary assisted dying if the consulting practitioner is satisfied—

(a) the patient meets all of the eligibility criteria, and

(b) the patient understands the information required to be given under section 39(1).

(2) If the consulting practitioner is not satisfied about a matter in subsection (1), the consulting practitioner must assess the patient as ineligible for access to voluntary assisted dying.

41 Recording and notification of outcome of consulting assessment

(1) The consulting practitioner must inform the patient and the patient's coordinating practitioner of the outcome of the consulting assessment as soon as practicable after its completion.

(2) Within 5 business days after completing the consulting assessment, the consulting practitioner must—

(a) complete the approved form (the ***consulting assessment report form***) in relation to the patient, and

(b) give a copy of the consulting assessment report form to the Board.

Maximum penalty—100 penalty units.

(3) As soon as practicable after completing the consulting assessment report form, the consulting practitioner must give a copy of the form to the patient.

(4) The consulting assessment report form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the consulting practitioner's name and contact details,

(c) a statement confirming the consulting practitioner meets the requirements of section 18,

(d) the date the referral for the consulting assessment was made,

(e) the date the referral for the consulting assessment was received,

(f) the date the consulting assessment was completed,

(g) the outcome of the consulting assessment, including the consulting practitioner's decision about each of the eligibility criteria,

(h) the date the patient was informed of the outcome of the consulting assessment,

(i) the date the patient's coordinating practitioner was informed of the outcome of the consulting assessment,

(j) if the patient was referred under section 37(2) or 38(2)—the outcome of the referral, including a copy of a report given by the registered health practitioner or other person to whom the patient was referred,

(k) if the patient was assisted by an interpreter when having the consulting assessment—the interpreter's name, contact details and accreditation details,

(l) the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(m) the consulting practitioner's signature and the date the form was signed.

(5) The consulting practitioner must give a copy of the consulting assessment report form to the patient's coordinating practitioner as soon as practicable after completing the consulting assessment.

42 Referral for further consulting assessment if patient assessed as ineligible

If the consulting practitioner assesses the patient as ineligible for access to voluntary assisted dying, the patient's coordinating practitioner may refer the patient to another medical practitioner for a further consulting assessment.

Division 5 Written declaration

43 Patient assessed as eligible may make written declaration

(1) A patient may make a written declaration requesting access to voluntary assisted dying if the patient has been assessed as eligible for access to voluntary assisted dying by—

(a) the patient's coordinating practitioner, and

(b) the patient's consulting practitioner.

(2) The written declaration must be—

(a) in the approved form, and

(b) given to the patient's coordinating practitioner.

(3) The written declaration must—

(a) state that the patient—

(i) makes the declaration voluntarily, and

(ii) does not make the declaration because of pressure or duress, and

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(iii) understands its nature and effect, and

(b) be signed by the patient, or a person referred to in subsection (4), in the presence of 2 witnesses, and

(c) include the following—

(i) the patient's name, date of birth and contact details,

(ii) if the patient was assisted by an interpreter—the interpreter's name, contact details and accreditation details,

(iii) the name and contact details of the patient's coordinating practitioner.

(4) A person may sign the written declaration on behalf of the patient if—

(a) the patient is unable to sign the declaration, and

(b) the patient directs the person to sign the declaration, and

(c) the person—

(i) is an adult, and

(ii) is not a witness to the signing of the declaration, and

(iii) is not the coordinating practitioner or consulting practitioner for the patient making the declaration.

(5) A person who signs the written declaration on behalf of the patient must do so in the patient's presence.

(6) If the patient makes the written declaration with the assistance of an interpreter, the interpreter must certify on the declaration that the interpreter provided a true and correct translation of any material translated.

44 Witness to signing of written declaration

(1) For the purposes of section 43(3)(b), a person is eligible to witness the signing of a written declaration if the person—

(a) is an adult, and

(b) is not an ineligible witness.

(2) For the purposes of subsection (1)(b), a person is an ineligible witness if the person—

(a) knows or believes the person—

(i) is a beneficiary under a will of the patient making the declaration, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient making the declaration, or

(b) is a family member of the patient making the declaration, or

(c) is the coordinating practitioner or consulting practitioner for the patient making the declaration, or

(d) is a family member or employee of the coordinating practitioner or consulting practitioner for the patient making the declaration.

45 Certification of witness to signing of written declaration

(1) A person who witnesses the signing of a written declaration by the patient making the declaration must—

(a) certify in writing in the declaration that, in the presence of the witness, the patient appeared to freely and voluntarily sign the declaration, and

(b) state that the witness is not knowingly an ineligible witness.

(2) A person who witnesses the signing of a written declaration by another person on behalf of the patient making the declaration must—

(a) certify in writing in the declaration that—

(i) in the presence of the witness, the patient appeared to freely and voluntarily direct the other person to sign the declaration, and

(ii) the other person signed the declaration in the presence of the patient and the witness, and

(b) state that the witness is not knowingly an ineligible witness.

(3) In this section—

ineligible witness means a person who is an ineligible witness under section 44(2).

46 Coordinating practitioner to record written declaration

If a patient gives a written declaration to the patient's coordinating practitioner, the coordinating practitioner must record the following in the patient's medical record—

(a) the date the written declaration was made,

(b) the date the written declaration was received by the coordinating practitioner.

47 Coordinating practitioner to notify Board of written declaration

Within 5 business days after receiving a written declaration made by a patient, the patient's coordinating practitioner must give a copy of the declaration to the Board.

Maximum penalty—100 penalty units.

Division 6 Final request and final review

48 Patient may make final request to coordinating practitioner

(1) A patient who has made a written declaration may make a final request to the patient's coordinating practitioner for access to voluntary assisted dying.

(2) The final request must be—

(a) clear and unambiguous, and

(b) made in person or, if that is not practicable, in accordance with section 182(1)(a).

(3) The patient may make the final request—

(a) verbally, or

(b) in another way.

Example for paragraph (b)— by use of gestures

49 When final request may be made

(1) The final request must not be made—

(a) before the end of the designated period, except as provided in subsection (2), and

(b) until after the day on which the consulting assessment that assessed the patient as eligible for access to voluntary assisted dying was completed.

(2) The final request may be made before the end of the designated period if—

(a) in the opinion of the patient's coordinating practitioner, the patient is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period, and

(b) the coordinating practitioner's opinion is consistent with the opinion of the patient's consulting practitioner.

50 Coordinating practitioner to record final request

The patient's coordinating practitioner must record in the patient's medical record—

(a) the date the final request was made, and

(b) if the final request was made before the end of the designated period—the reason for the final request being made before the end of the period.

51 Coordinating practitioner to notify Board of final request

(1) Within 5 business days after receiving a final request made by a patient, the patient's coordinating practitioner must—

(a) complete the approved form (the ***final request form***), and

(b) give a copy of the final request form to the Board.

Maximum penalty—100 penalty units.

(2) The final request form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the coordinating practitioner's name and contact details,

(c) the date the first request was made,

(d) the date the final request was made,

(e) whether the final request was made in person or using audiovisual communication,

(f) whether the final request was made verbally or in another way,

(g) if the patient was assisted by an interpreter when making the final request—the interpreter's name, contact details and accreditation details,

(h) if the final request was made before the end of the designated period—the reason for the final request being made before the end of the period,

(i) the coordinating practitioner's signature and the date the form was signed.

52 Final review by coordinating practitioner on receiving final request

(1) On receiving a final request made by a patient, the coordinating practitioner for the patient must—

(a) review all consulting assessment report forms in relation to the patient, and

(b) review the patient's written declaration, and

(c) complete the approved form (the ***final review form***) in relation to the patient.

(2) In conducting the final review, the coordinating practitioner must have regard to a decision made by the Supreme Court under Part 6 in relation to a decision made in the request and assessment process.

(3) The final review form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the coordinating practitioner's name and contact details,

(c) a statement that the coordinating practitioner has reviewed—

(i) all consulting assessment report forms in relation to the patient, and

(ii) the patient's written declaration,

(d) a statement certifying whether or not the request and assessment process has been completed in accordance with this Act,

(e) if the patient was assisted by an interpreter—the interpreter's name, contact details and accreditation details,

(f) a statement certifying whether or not the coordinating practitioner is satisfied that—

(i) the patient has decision-making capacity in relation to voluntary assisted dying, and

(ii) the patient, in requesting access to voluntary assisted dying, is acting voluntarily, and

(iii) the patient, in requesting access to voluntary assisted dying, is not acting because of pressure or duress, and

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(iv) the patient's request to access voluntary assisted dying is enduring,

(g) the coordinating practitioner's signature and the date the form was signed.

(4) Within 5 business days after completing the final review form, the coordinating practitioner must give a copy of the form to the Board.

Maximum penalty—100 penalty units.

53 Technical error not to invalidate request and assessment process

The validity of the request and assessment process is not affected by—

(a) a minor or technical error in a document under this Act, including, for example—

(i) a final review form, or

(ii) a consulting assessment report form, or

(iii) a patient's written declaration, or

(iv) a prescription, or

(b) the failure of a person to provide a form within the time required under this Act.

54 No obligation for patient to continue after completion of request and assessment process

A patient for whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

Part 4 Accessing voluntary assisted dying and death

Division 1 Eligibility requirements for administering practitioners

55 Eligibility to act as administering practitioner

A person is eligible to act as an administering practitioner for a patient if—

(a) the person is—

(i) a medical practitioner who holds specialist registration, or

(ii) a medical practitioner who holds general registration and has practised the medical profession for at least 5 years, or

(iii) a medical practitioner who is an overseas-trained specialist who holds limited registration or provisional registration, or

(iv) a nurse practitioner, or

(v) a registered nurse who has practised the nursing profession for at least 5 years, and

Note— Under the *Interpretation Act 1987*, section 21D, a reference to a registered nurse does not include an enrolled nurse.

(b) the person has completed approved training, and

(c) the person meets other requirements prescribed by the regulations for the purposes of this section, and

(d) the person is not a family member of the patient, and

(e) the person does not know or believe that the person—

(i) is a beneficiary under a will of the patient, or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the administering practitioner for the patient.

Division 2 Administration of voluntary assisted dying substance

56 Application of Division

This Division applies if—

(a) the request and assessment process has been completed in relation to a patient, and

(b) the final review form for the patient certifies that the coordinating practitioner for the patient is satisfied—

(i) the patient has decision-making capacity in relation to voluntary assisted dying, and

(ii) the patient, in requesting access to voluntary assisted dying, is acting voluntarily, and

(iii) the patient, in requesting access to voluntary assisted dying, is not acting because of pressure or duress, and

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(iv) the patient's request to access voluntary assisted dying is enduring.

57 Administration decision

(1) The patient may, in consultation with and on the advice of the patient's coordinating practitioner—

(a) decide to self-administer a voluntary assisted dying substance (a ***self-administration decision***), or

(b) decide a voluntary assisted dying substance is to be administered to the patient by the administering practitioner for the patient (a ***practitioner administration decision***).

(2) An administration decision must be—

(a) clear and unambiguous, and

(b) made in person before the patient's coordinating practitioner or, if that is not practicable, in accordance with section 182(1)(a).

(3) The patient may make an administration decision—

(a) verbally, or

(b) in another way.

Example for paragraph (b)— by use of gestures

(4) The patient may make the administration decision with the assistance of an interpreter.

(5) If the patient makes an administration decision, the patient's coordinating practitioner must record the decision in the patient's medical record.

(6) The patient's coordinating practitioner must also, within 5 business days after the patient makes an administration decision—

(a) complete the approved form for the administration decision (the ***administration decision form***) as required by subsection (7), and

(b) give the Board a copy of the administration decision form.

Maximum penalty—100 penalty units.

(7) The administration decision form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the coordinating practitioner's name and contact details,

(c) the administration decision made by the patient,

(d) the date the administration decision was made,

(e) if the patient was assisted by an interpreter when making the administration decision—the interpreter's name, contact details and accreditation details,

(f) the coordinating practitioner's name and the date the form was signed.

58 Revocation of administration decision

(1) The patient may at any time—

(a) revoke a self-administration decision by informing the patient's coordinating practitioner the patient has decided not to self-administer a voluntary assisted dying substance, or

(b) revoke a practitioner administration decision by informing the patient's administering practitioner the patient has decided not to proceed with the administration of a voluntary assisted dying substance.

(2) A decision to revoke an administration decision must be clear and unambiguous.

(3) For the purposes of subsection (1), the patient may inform the coordinating practitioner or administering practitioner of the patient's decision—

(a) in writing, or

(b) verbally, or

(c) in another way.

Example for paragraph (c)— by use of gestures

(4) The patient may inform the coordinating practitioner or administering practitioner of the patient's decision with the assistance of an interpreter.

(5) If the patient revokes an administration decision under subsection (1), the coordinating practitioner or administering practitioner who is informed of the patient's decision must—

(a) record the revocation in the patient's medical record, and

(b) if the practitioner is not the patient's coordinating practitioner—inform the coordinating practitioner of the revocation, and

(c) within 5 business days after the revocation—

(i) complete the approved form (the ***revocation form***), and

(ii) give a copy of the revocation form to the Board.

Maximum penalty—100 penalty units.

(6) The revocation form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the name and contact details of the person completing the form,

(c) if the person completing the form is not the patient's coordinating practitioner—the coordinating practitioner's name and contact details,

(d) the date the administration decision was revoked,

(e) any reason given by the patient for the revocation of the administration decision,

(f) if the patient was assisted by an interpreter when revoking the administration decision—the interpreter's name, contact details and accreditation details,

(g) the signature of the person completing the form and the date the form was signed.

(7) The revocation of an administration decision does not prevent the patient from making another administration decision under section 57(1).

59 Self-administration

(1) This section applies if the patient—

(a) has made a self-administration decision, and

(b) has not revoked the decision.

(2) The coordinating practitioner for the patient is authorised to prescribe a voluntary assisted dying substance for the patient that is of a sufficient dose to cause death.

(3) To avoid doubt, subsection (2) is subject to—

(a) the contact person appointment form having been given to the coordinating practitioner as required by section 67(5), and

(b) the Board having granted a voluntary assisted dying substance authority under section 71 in relation to the patient.

(4) The authorised supplier who is given the prescription for the patient is authorised to—

(a) possess the prescribed substance for the purpose of preparing and supplying the substance to a person referred to in paragraph (c), and

(b) prepare the prescribed substance, and

(c) supply the prescribed substance to the patient, the contact person for the patient or an agent of the patient.

(5) The patient is authorised to—

(a) receive the prescribed substance from an authorised supplier, the contact person for the patient or an agent of the patient, and

(b) possess the prescribed substance for the purpose of preparing and self-administering it, and

(c) prepare the prescribed substance, and

(d) self-administer the prescribed substance.

(6) The contact person for the patient is authorised as set out in section 68(1).

(7) An agent of the patient is authorised to—

(a) receive the prescribed substance from an authorised supplier, and

(b) possess the prescribed substance for the purpose of supplying the substance to the patient, and

(c) prepare the prescribed substance for self-administration by the patient, and

(d) supply the prescribed substance to the patient.

60 Practitioner administration

(1) This section applies if the patient—

(a) has made a practitioner administration decision, and

(b) has not revoked the decision.

(2) The coordinating practitioner for the patient is authorised to prescribe a voluntary assisted dying substance for the patient that is of a sufficient dose to cause death.

(3) To avoid doubt, subsection (2) is subject to the Board having granted a voluntary assisted dying substance authority under section 71 in relation to the patient.

(4) The authorised supplier who is given the prescription for the patient is authorised to—

(a) possess the prescribed substance for the purpose of preparing and supplying the substance to the administering practitioner for the patient, and

(b) prepare the prescribed substance, and

(c) supply the prescribed substance to the administering practitioner for the patient.

(5) The administering practitioner for the patient is authorised to—

(a) receive the prescribed substance from an authorised supplier, and

(b) possess the prescribed substance for the purpose of preparing and administering the substance to the patient, and

(c) prepare the prescribed substance.

(6) The administering practitioner for the patient is authorised, in the presence of a witness, to administer the prescribed substance to the patient if the administering practitioner is satisfied at the time of administration that—

(a) the patient has decision-making capacity in relation to voluntary assisted dying, and

(b) the patient is acting voluntarily, and

(c) the patient is not acting because of pressure or duress, and

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(d) the patient's request for access to voluntary assisted dying is enduring.

61 Coordinating practitioner to notify Board about prescription of substance

(1) Within 5 business days after prescribing a voluntary assisted dying substance for the patient, the patient's coordinating practitioner must—

(a) complete the approved form for the prescription of the voluntary assisted dying substance (the ***prescription form***) including the information required by subsection (2), and

(b) give the Board a copy of the prescription form.

Maximum penalty—100 penalty units.

(2) The prescription form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the coordinating practitioner's name and contact details,

(c) a statement confirming the coordinating practitioner has complied with section 73(2) or (3),

(d) the date the prescription for the voluntary assisted dying substance was issued,

(e) the coordinating practitioner's name and the date the form was signed.

62 Certification by administering practitioner following administration of prescribed substance

(1) This section applies if the patient's administering practitioner administers the prescribed substance to the patient.

(2) The administering practitioner must certify in writing that—

(a) the patient made a practitioner administration decision and did not revoke the decision, and

(b) the administering practitioner was satisfied when administering the prescribed substance to the patient that—

(i) the patient had decision-making capacity in relation to voluntary assisted dying, and

(ii) the patient was acting voluntarily, and

(iii) the patient was not acting because of pressure or duress, and

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(iv) the patient's request for access to voluntary assisted dying was enduring.

(3) The certification must be in the approved form (the ***practitioner administration form***) and must include the following—

(a) the patient's name and date of birth,

(b) the administering practitioner's name and contact details,

(c) the name, date of birth and contact details of the witness to the administration of the prescribed substance,

(d) the date and time the prescribed substance was administered,

(e) the location at which the prescribed substance was administered,

(f) the date and time of the patient's death,

(g) the period of time that elapsed between the administration of the prescribed substance and the patient's death,

(h) details of any complications relating to the administration of the prescribed substance,

(i) the witness' certification required under section 63(3),

(j) the administering practitioner's signature and the date the form was signed,

(k) the witness's signature and the date the form was signed.

(4) Within 5 business days after administering the prescribed substance, the administering practitioner must give a copy of the practitioner administration form to the Board.

Maximum penalty—100 penalty units.

63 Witness to administration of prescribed substance

(1) For the purposes of section 60(6), a person is eligible to witness the administration of a prescribed substance to a patient if the person—

(a) is an adult, and

(b) is not an ineligible witness.

(2) For the purposes of subsection (1)(b), a person is an ineligible witness if the person—

(a) is a family member of the patient's administering practitioner, or

(b) is employed, or engaged under a contract for services, by the patient's administering practitioner.

(3) The witness to the administration of a prescribed substance to a patient must certify in the practitioner administration form for the patient that—

(a) the patient's request for access to voluntary assisted dying appeared to be free, voluntary and enduring, and

(b) the patient's administering practitioner administered the prescribed substance to the patient in the presence of the witness.

64 Transfer of administering practitioner's role

(1) This section applies if—

(a) a patient has made a practitioner administration decision, and

(b) the coordinating practitioner for the patient has prescribed a voluntary assisted dying substance for the patient, and

(c) the patient's administering practitioner (the ***original practitioner***) is unable or unwilling for any reason to administer the prescribed substance to the patient, whether the original practitioner is—

(i) the coordinating practitioner for the patient, or

(ii) a person to whom the role of administering practitioner has been transferred under subsection (2).

(2) The original practitioner must transfer the role of administering practitioner to another person who—

(a) is eligible to act as an administering practitioner for the patient, and

(b) accepts the transfer of the role.

(3) If a person (the ***new practitioner***) accepts the transfer of the role, the original practitioner must—

(a) inform the patient—

(i) that the role of administering practitioner has been transferred to the new practitioner, and

(ii) of the new practitioner's name and contact details, and

(b) record the transfer in the patient's medical record, and

(c) within 5 business days after the transfer is accepted, complete the approved form (the ***administering practitioner transfer form***) and give a copy of the form to the Board.

Maximum penalty—100 penalty units.

(4) The administering practitioner transfer form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the original practitioner's name and contact details,

(c) the new practitioner's name and contact details,

(d) the date the new practitioner accepted the transfer,

(e) the date the patient was informed of the transfer,

(f) the original practitioner's signature and the date the form was signed.

(5) If the original practitioner has possession of the prescribed substance when the role is transferred—

(a) the original practitioner is authorised to supply the prescribed substance to the new practitioner, and

(b) the new practitioner is authorised to receive the prescribed substance from the original practitioner.

(6) The coordinating practitioner for the patient remains the coordinating practitioner despite any transfer of the role of administering practitioner under subsection (2), but subject to section 181.

Division 3 Contact person

65 Application of Division

This Division applies if a patient has made a self-administration decision.

66 Patient to appoint contact person

(1) The patient must appoint a person as the patient's contact person.

(2) A person is eligible for appointment if the person is an adult.

(3) Without limiting who may be appointed as the contact person, the patient may appoint—

(a) the patient's coordinating practitioner, or

(b) the patient's consulting practitioner, or

(c) another registered health practitioner.

(4) A person must not be appointed as the contact person unless the person consents to the appointment.

(5) The patient may revoke the appointment of the contact person.

(6) If the patient revokes the appointment of the contact person—

(a) the patient must inform the person of the revocation, and

(b) the person ceases to be the contact person for the patient on being informed under paragraph (a), and

(c) the patient must make another appointment under subsection (1).

67 Contact person appointment form

(1) The appointment of a contact person by the patient must be made in the approved form (the ***contact person appointment form***) and include the following—

(a) the patient's name, date of birth and contact details,

(b) the name and contact details of the coordinating practitioner for the patient,

(c) the contact person's name, date of birth and contact details,

(d) a statement that the contact person consents to the appointment,

(e) a statement that the contact person understands the person's role under this Act, including the requirements and penalties for offences under section 129,

(f) if the patient was assisted by an interpreter when making the appointment, the interpreter's name, contact details and accreditation details,

(g) the contact person's signature and the date the form was signed,

(h) the patient's signature, or the signature of the other person who completes the form on behalf of the patient, and the date the form was signed.

(2) Another person may complete the form on behalf of the patient if—

(a) the patient is unable to complete the contact person appointment form, and

(b) the patient directs the person to complete the contact person appointment form, and

(c) the person is an adult.

(3) The patient or the patient's contact person must give the contact person appointment form to the patient's coordinating practitioner.

(4) Within 5 business days after receiving the contact person appointment form, the patient's coordinating practitioner must give a copy of the form to the Board.

Maximum penalty—100 penalty units.

(5) The patient's coordinating practitioner must not prescribe a voluntary assisted dying substance for the patient before the contact person appointment form is given to the coordinating practitioner.

68 Role of contact person

(1) The contact person for the patient is authorised to—

(a) receive the prescribed substance from an authorised supplier, and

(b) possess the prescribed substance for the purposes of paragraphs (c)–(e), and

(c) prepare the prescribed substance for self-administration by the patient, and

(d) supply the prescribed substance to the patient, and

(e) give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer as required by section 129.

(2) The patient's contact person must inform the patient's coordinating practitioner if the patient dies, whether as a result of self-administering the prescribed substance or from some other cause.

69 Contact person may refuse to continue in role

(1) The contact person for a patient may refuse to continue to perform the role of contact person.

(2) If the contact person for a patient refuses to continue to perform the role—

(a) the person must inform the patient of the refusal, and

(b) the person ceases to be the contact person for the patient on informing the patient under paragraph (a), and

(c) the patient must make another appointment under section 66(1).

Division 4 Authorisations in relation to voluntary assisted dying substances

70 Coordinating practitioner may ask Board to issue voluntary assisted dying substance authorisation

(1) If a patient has made an administration decision, the patient's coordinating practitioner may apply to the Board for a voluntary assisted dying substance authorisation for the patient.

(2) The application must be—

(a) in the approved form, and

(b) accompanied by the documents relating to the request and assessment process required by the Board.

71 Board must decide application

(1) As soon as practicable after receiving an application for a voluntary assisted dying substance authorisation from the patient's coordinating practitioner, the Board must—

(a) consider the application, and

(b) decide to—

(i) approve the application, or

(ii) if section 72 applies—refuse the application.

(2) If the Board decides to approve the application, the Board must, as soon as practicable after making the decision, grant a voluntary assisted dying substance authority, in the approved form, in relation to the patient.

(3) A voluntary assisted dying substance authority must include the following information—

(a) the patient's name and address,

(b) the name of the patient's coordinating practitioner,

(c) the period during which the patient's coordinating practitioner may prescribe a prescribed substance under the authority,

(d) other information required by the Health Secretary.

(4) A voluntary assisted dying substance authority may relate to a voluntary assisted dying substance that may be self-administered or administered to a person.

72 Refusal of application for voluntary assisted dying substance authority

(1) The Board must refuse to issue to a patient's coordinating practitioner a voluntary assisted dying substance authority in relation to the patient if—

(a) the Board has not received all the documents relating to the request and assessment process required under section 70(2)(b), or

(b) the Board suspects the requirements of this Act have not been met in relation to the patient.

(2) If the Board refuses an application for a voluntary assisted dying substance authority, the Board must, within 2 business days, give the patient's coordinating practitioner written notice that states—

(a) the application has been refused, and

(b) the reasons for the refusal.

Division 5 Prescribing, supplying and disposing of voluntary assisted dying substance

73 Information to be given before prescribing substance

(1) This section applies if—

(a) a patient has made an administration decision, and

(b) the Board has issued a voluntary assisted dying substance authority in relation to the patient.

(2) The patient's coordinating practitioner must, if the patient has made a self-administration decision, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following—

(a) the Schedule 4 poison or Schedule 8 poison, or combination of poisons, constituting the substance,

(b) that the patient is not under an obligation to obtain the substance,

(c) that the patient is not under an obligation to self-administer the substance,

(d) how to dispense the substance,

(e) that the substance must be stored—

(i) in a locked box that complies with the requirements stated in section 79, and

(ii) otherwise in accordance with the information provided by the authorised supplier who supplies the substance,

(f) how to prepare and self-administer the substance,

(g) the method by which the substance will be self-administered,

(h) the expected effects of self-administration of the substance,

(i) the period within which the patient is likely to die after self-administration of the substance,

(j) the potential risks of self-administration of the substance,

(k) that, if the patient decides not to self administer the substance, the patient's contact person must give the substance to an authorised disposer for disposal,

(l) that, if the patient dies, the patient's contact person must give any unused or remaining substance to an authorised disposer for disposal.

(3) The coordinating practitioner for a patient who has made a practitioner administration decision must, before prescribing a voluntary assisted dying substance for the patient, inform the patient, in writing, of the following—

(a) the Schedule 4 poison or Schedule 8 poison, or combination of poisons, constituting the substance,

(b) that the patient is not under an obligation to have the substance administered,

(c) how the substance will be dispensed,

(d) the method by which the substance will be administered,

(e) the expected effects of administration of the substance,

(f) the period within which the patient is likely to die after administration of the substance,

(g) the potential risks of administration of the substance,

(h) that, if the practitioner administration decision is made after the revocation of a self-administration decision, the patient's contact person must give any prescribed substance received by the patient, the contact person or an agent of the patient, to an authorised disposer for disposal.

74 Prescription for substance

(1) This section applies if a patient's coordinating practitioner prescribes a voluntary assisted dying substance for the patient.

Note—

1 The requirements in this section in relation to prescriptions for a voluntary assisted dying substance are in addition to the requirements applicable to prescriptions under—

(a) the *Poisons and Therapeutic Goods Act 1966*, or

(b) another law of New South Wales or the Commonwealth.

2 See also section 14 which provides that if there is an inconsistency between this Act and the *Poisons and Therapeutic Goods Act 1966*, this Act prevails to the extent of the inconsistency.

(2) The prescription issued by the coordinating practitioner must include—

(a) a statement that clearly indicates the prescription is for a voluntary assisted dying substance, and

(b) a statement—

(i) certifying that the request and assessment process has been completed in relation to the patient in accordance with this Act, and

(ii) certifying that the patient has made an administration decision and stating whether the decision is a self-administration decision or a practitioner administration decision, and

(c) the patient's telephone number.

(3) The prescription must not be in the form of a medication chart.

(4) The prescription must not provide for the prescribed substance to be supplied on more than 1 occasion.

(5) The coordinating practitioner must give the prescription directly to an authorised supplier.

(6) To avoid doubt, the requirement under subsection (5) to give the prescription directly to an authorised supplier does not require the prescription to be given to the authorised supplier in person but may be given by post or electronic means, including email.

(7) In this section—

medication chart means a chart, however described, that records medicines used, or to be used, for the treatment of a patient.

75 Authorised supplier to authenticate prescription

An authorised supplier who is given a prescription for a voluntary assisted dying substance must not supply the substance in accordance with the prescription unless the authorised supplier has confirmed—

(a) the authenticity of the prescription, and

(b) the identity of the person who issued the prescription, and

(c) the identity of the person to whom the substance is to be supplied.

76 Information to be given when supplying prescribed substance

(1) This section applies if an authorised supplier supplies a prescribed substance to a patient, a patient's contact person or an agent of a patient (the ***recipient***).

(2) The authorised supplier must, when supplying the prescribed substance, inform the recipient, in writing, of the following—

(a) that the patient is not under an obligation to self-administer the substance,

(b) that the substance must be stored—

(i) in a locked box that complies with the requirements stated in section 79, and

(ii) otherwise in accordance with other requirements provided by the authorised supplier,

(c) how to prepare and self-administer the substance,

(d) that, if the patient decides not to self-administer the substance, the patient's contact person must give the substance to an authorised disposer for disposal,

(e) that, if the patient dies, the patient's contact person must give any unused or remaining substance to an authorised disposer for disposal not later than 14 days after the day on which the patient dies,

(f) details of the place where any unused or remaining substance may be given to an authorised disposer for disposal.

(3) If the recipient is not the patient, the authorised supplier must, when supplying the prescribed substance, advise the recipient to give the information given under subsection (2) to the patient.

77 Labelling requirements for prescribed substance

(1) In addition to labelling requirements under the *Poisons and Therapeutic Goods Act 1966*, an authorised supplier who supplies a prescribed substance must attach a statement in writing to the relevant package or container that—

(a) warns of the purpose of the dose of the substance, and

(b) states the dangers of administration of the substance, and

(c) states that, if the substance is supplied for self-administration—

(i) the substance must be stored—

(A) in a locked box that complies with the requirements stated in section 79, and

(B) otherwise in accordance with other requirements provided by the authorised supplier, and

(ii) any unused or remaining substance must be given to an authorised disposer by the contact person for the patient to whom the substance is supplied.

(2) The statement must be in the approved form.

78 Authorised supplier to record and notify of supply

(1) An authorised supplier who supplies a prescribed substance must immediately complete the approved form (the ***authorised supply form***).

(2) The authorised supply form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the authorised supplier's name and contact details,

(c) a statement certifying that the prescribed substance was supplied,

(d) the name and contact details of the person to whom the prescribed substance was supplied,

(e) the date the prescribed substance was supplied,

(f) a statement certifying that the requirements under sections 75, 76 and 77 were complied with,

(g) the authorised supplier's signature and the date the form was signed.

(3) Within 5 business days after supplying the prescribed substance, the authorised supplier must give a copy of the completed authorised supply form to the Board.

Maximum penalty—100 penalty units.

79 Storage of voluntary assisted dying substance

(1) A person who receives a voluntary assisted dying substance must store the substance in a locked box.

(2) The locked box must be—

(a) made of steel, and

(b) not easily penetrable, and

(c) locked using a lock of sturdy construction.

80 Disposal of prescribed substance by authorised disposer

(1) This section applies if a prescribed substance, or any unused or remaining prescribed substance, is given to an authorised disposer by the patient's contact person.

(2) The authorised disposer is authorised to—

(a) possess the prescribed substance for the purpose of disposing of it, and

(b) dispose of the prescribed substance.

(3) The authorised disposer must dispose of the prescribed substance as soon as practicable after receiving it.

(4) In disposing of the prescribed substance, the authorised disposer must comply with requirements of the *Poisons and Therapeutic Goods Act 1966* that apply to the disposal.

81 Authorised disposer to record and notify of disposal

(1) An authorised disposer who disposes of a prescribed substance must immediately complete the approved form (the ***authorised disposal form***).

(2) The authorised disposal form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the authorised disposer's name and contact details,

(c) the name and contact details of the person who gave the prescribed substance to the authorised disposer,

(d) the date the prescribed substance was given to the authorised disposer,

(e) the date the prescribed substance was disposed of by the authorised disposer,

(f) the authorised disposer's signature and the date the form was signed.

(3) Within 5 business days after disposing of the prescribed substance, the authorised disposer must give a copy of the completed authorised disposal form to the Board.

Maximum penalty—100 penalty units.

82 Disposal of prescribed substance by administering practitioner

(1) Subsections (2) and (3) apply if—

(a) a patient who has made a practitioner administration decision revokes the decision, and

(b) the administering practitioner for the patient has possession of the prescribed substance when the decision is revoked.

(2) The administering practitioner is authorised to—

(a) possess the prescribed substance for the purpose of disposing of it, and

(b) dispose of the prescribed substance.

(3) The prescribed substance must be disposed of by the administering practitioner as soon as practicable after the practitioner administration decision is revoked.

(4) Subsections (5) and (6) apply if—

(a) a patient who has made a practitioner administration decision dies, whether or not after being administered the prescribed substance, and

(b) the patient's administering practitioner has possession of any prescribed substance that is unused or remaining after the patient's death (the ***unused or remaining substance***).

(5) The administering practitioner is authorised to—

(a) possess the unused or remaining substance for the purpose of disposing of it, and

(b) dispose of the unused or remaining substance.

(6) The unused or remaining substance must be disposed of by the administering practitioner as soon as practicable after the patient's death.

(7) In disposing of the prescribed substance or the unused or remaining substance, as the case requires, the administering practitioner must comply with requirements of the *Poisons and Therapeutic Goods Act 1966* that apply to the disposal.

83 Administering practitioner to record and notify of disposal

(1) A patient's administering practitioner who disposes of a prescribed substance must immediately complete the approved form (the ***practitioner disposal form***).

(2) The practitioner disposal form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the administering practitioner's name and contact details,

(c) the date the prescribed substance was supplied to the administering practitioner,

(d) the date the patient revoked the practitioner administration decision or died,

(e) the date the prescribed substance was disposed of by the administering practitioner,

(f) the administering practitioner's signature and the date the form was signed.

(3) Within 5 business days after disposing of the prescribed substance, the administering practitioner must give a copy of the completed practitioner disposal form to the Board.

Maximum penalty—100 penalty units.

Division 6 Other matters

84 Authorised suppliers and authorised disposers

(1) The Health Secretary may, by Gazette notice, authorise a registered health practitioner, or persons in a class of registered health practitioners, to supply prescribed substances for the purposes of this Part.

(2) A person who is authorised under subsection (1) is an ***authorised supplier***.

(3) The Health Secretary may, by Gazette notice, authorise a registered health practitioner, or persons in a class of registered health practitioners, to dispose of prescribed substances for the purposes of this Part.

(4) A person who is authorised under subsection (3) is also an ***authorised disposer***.

(5) The Health Secretary may, by Gazette notice, revoke an authorisation given under subsection (1) or (3).

(6) The Health Secretary must keep a register that includes details of—

(a) authorised suppliers, and

(b) authorised disposers.

(7) The register kept under subsection (6) may only be made available for inspection by a person who is—

(a) a patient, or

(b) a contact person or an agent of a patient, or

(c) a coordinating practitioner, or

(d) a consulting practitioner, or

(e) an administering practitioner, or

(f) a person performing functions under this Act, for the purposes of performing the functions.

85 Certain directions as to supply or administration prohibited

(1) A patient's coordinating practitioner must not direct a health professional to supply a prescribed substance to the patient, the contact person for the patient or an agent of the patient, unless—

(a) the health professional is an authorised supplier, and

(b) the direction is in the form of a prescription for the prescribed substance given directly to the authorised supplier.

(2) A patient's coordinating practitioner or administering practitioner must not direct a health professional to administer a prescribed substance to the patient.

86 Structured administration and supply arrangement not to be issued for substance

(1) A person must not issue a structured administration and supply arrangement in relation to the administration or supply of a medicine for the purpose of voluntary assisted dying.

(2) In this section—

structured administration and supply arrangement means a document that sets out the circumstances in which a health professional stated, or of a class stated, in the document may administer or supply a medicine stated in the document.

87 Notification of death

(1) A patient's coordinating practitioner or administering practitioner must, within 5 business days after becoming aware the patient has died, notify the Board, in the approved form, of the patient's death.

Maximum penalty—100 penalty units.

(2) Subsection (1) applies whether or not the patient dies after self-administering, or being administered, a voluntary assisted dying substance in accordance with this Act.

(3) Subsection (1) does not apply if the administering practitioner for a patient gives the Board a copy of a practitioner administration form in relation to the patient under section 62(4).

(4) Subsections (5) and (6) apply if a medical practitioner who is required to give a cause of death certificate for a person knows or reasonably believes the person was a patient who self-administered, or was administered, a voluntary assisted dying substance in accordance with this Act.

(5) The medical practitioner must, within 5 business days after becoming aware the person has died, notify the Board, in the approved form, of the person's death unless the medical practitioner is the person's coordinating practitioner or administering practitioner.

(6) The medical practitioner must identify the following in the cause of death certificate for the person—

(a) that the medical practitioner knows or reasonably believes the patient self-administered, or was administered, a voluntary assisted dying substance in accordance with this Act,

(b) the disease, illness or medical condition with which the person had been diagnosed that made the person eligible to access voluntary assisted dying.

Maximum penalty—100 penalty units.

(7) In this section—

cause of death certificate, for a person, means a notice of the death of the person and of the cause of the person's death under the *Births, Deaths and Marriages Registration Act 1995*, section 39(1).

Part 5 Participation

Division 1 Preliminary

88 Definitions

In this Part—

deciding practitioner, for a decision about a person, means—

(a) the person's coordinating practitioner, or

(b) if the person's coordinating practitioner is not available—another medical practitioner nominated by the person.

health care means medical, surgical or nursing care.

health care establishment means—

(a) a private health facility within the meaning of the *Private Health Facilities Act 2007*, or

(b) a public hospital within the meaning of the *Health Services Act 1997*.

health entity means an entity that owns or operates a health care establishment.

relevant entity means an entity, other than an individual, that provides a relevant service.

relevant service means—

(a) a personal care service, or

(b) a residential aged care service.

residential aged care means nursing care or personal care provided to a person in a residential facility in which the person is also provided with accommodation that includes—

(a) staffing to meet the nursing care and personal care needs of the person, and

(b) meals and cleaning services, and

(c) furnishings, furniture and equipment for the provision of the person's nursing care or personal care and accommodation.

89 Participation in providing voluntary assisted dying services

(1) A residential facility or health care establishment may decide that it will not provide services relating to voluntary assisted dying at the facility or establishment.

(2) For the purposes of subsection (1), the residential facility or health care establishment may refuse to do any of the following or refuse to have persons employed by or at the facility or establishment do any of the following at the facility or establishment—

(a) participate in the request and assessment process,

(b) participate in an administration decision,

(c) prescribe, supply or administer a voluntary assisted dying substance,

(d) store a voluntary assisted dying substance,

(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

(3) Subsections (1) and (2) are subject to the requirements of Divisions 2 and 3.

Division 2 Residential facilities

Subdivision 1 Information about voluntary assisted dying

90 Access to information about voluntary assisted dying

(1) This section applies if—

(a) a person is receiving relevant services from a relevant entity at a residential facility, and

(b) the person asks the relevant entity for information about voluntary assisted dying, and

(c) the relevant entity does not provide at the residential facility, to persons to whom relevant services are provided, the information that has been requested.

(2) The relevant entity and any other entity that owns or occupies the residential facility—

(a) must not hinder the person's access at the residential facility to information about voluntary assisted dying, and

(b) must, if asked, allow reasonable access to the person at the residential facility by—

(i) a registered health practitioner or another person to enable the practitioner or other person to personally provide the requested information about voluntary assisted dying to the person, or

(ii) a member of an official voluntary assisted dying care navigator service to provide support, assistance and information to persons relating to voluntary assisted dying.

Subdivision 2 Access to voluntary assisted dying

91 Application of Subdivision

This Subdivision applies if a person is receiving relevant services from a relevant entity at a residential facility.

92 First and final requests

(1) This section applies if—

(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a ***relevant request***), and

(b) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the request and assessment process at the facility.

(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the residential facility by a medical practitioner—

(a) whose presence is requested by the person, and

(b) who—

(i) for a first request—is eligible to act as a coordinating practitioner, or

(ii) for a final request—is the coordinating practitioner for the person.

(3) If the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made to—

(a) the requested medical practitioner, or

(b) another medical practitioner who is eligible and willing to act as a coordinating practitioner.

93 First assessments

(1) This section applies if—

(a) the person has made a first request, and

(b) the person, or the person's agent, advises the relevant entity that the person wishes to undergo a first assessment, and

(c) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by a relevant practitioner for the practitioner to assess the person, and

(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—

(i) the relevant practitioner, or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person, or

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner, for a person, means—

(a) the person's coordinating practitioner, or

(b) a medical practitioner to whom the person's coordinating practitioner has referred a matter under section 26.

94 Consulting assessments

(1) This section applies if—

(a) the person has undergone a first assessment, and

(b) the person, or the person's agent, advises the relevant entity that the person wishes to undergo a consulting assessment, and

(c) the entity does not provide, to persons to whom the relevant services are provided at the residential facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by a relevant practitioner for the practitioner to assess the person, and

(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—

(i) the relevant practitioner, or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person, or

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner, for a person, means—

(a) the person's consulting practitioner, or

(b) a medical practitioner to whom the person's consulting practitioner has referred a matter under section 37.

95 Written declarations

(1) This section applies if—

(a) the person has been assessed as eligible for access to voluntary assisted dying, and

(b) the person or the person's agent advises the relevant entity that the person wishes to make a written declaration, and

(c) the entity does not provide, to persons to whom relevant services are provided at the residential premises, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by—

(i) the person's coordinating practitioner, and

(ii) another person lawfully participating in the person's request for access to voluntary assisted dying to enable the person to make a written declaration, and

(b) if the coordinating practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from the place where the person may make a written declaration.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person may make a written declaration, or

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by—

(i) the person's coordinating practitioner, and

(ii) any other person lawfully participating in the person's request for access to voluntary assisted dying.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

96 Application for administration decision

(1) This section applies if—

(a) the person has made a final request, and

(b) the person or the person's agent advises the relevant entity that the person wishes to make an application for an administration decision, and

(c) the entity does not provide, to persons to whom relevant services are provided at the residential facility, access to a person's coordinating practitioner to enable the application to be made.

(2) If the person is a permanent resident at the residential facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the person's coordinating practitioner for the practitioner to consult with and assess the person in relation to the application, and

(b) if the coordinating practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where consultation and assessment of the person can occur in relation to the application in consultation with, and on the advice of—

(i) the coordinating practitioner, or

(ii) another medical practitioner who is eligible and willing to act as the person's coordinating practitioner.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from the place where the person's coordinating practitioner can consult with and assess the person in relation to the application, or

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the residential facility must allow reasonable access to the person at the facility by the person's coordinating practitioner to consult with and assess the person in relation to the application.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

Subdivision 3 Administration of voluntary assisted dying substance

97 Administration of voluntary assisted dying substance

(1) This section applies if—

(a) the person has made an administration decision, and

(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have the person's administering practitioner administer a voluntary assisted dying substance to the person, and

(c) the relevant entity does not provide, to persons to whom relevant services are provided at the residential facility, access to the administration of a voluntary assisted dying substance at the facility.

(2) If the person is a permanent resident at the residential facility, the relevant entity and any other entity that owns or occupies the facility must—

(a) if the person has made a practitioner administration decision—allow reasonable access to the person at the facility by the following persons—

(i) the person's administering practitioner, for the practitioner to administer a voluntary assisted dying substance to the person,

(ii) any other person lawfully participating in the person's request for access to voluntary assisted dying, including an eligible witness to the administration of the voluntary assisted dying substance by the person's administering practitioner, or

(b) if the person has made a self-administration decision—

(i) allow reasonable access to the person at the facility by a person lawfully delivering a voluntary assisted dying substance to the person, and

(ii) allow reasonable access to the person at the facility by another person lawfully participating in the person's request for voluntary assisted dying, and

(iii) not otherwise hinder access by the person to a voluntary assisted dying substance.

(3) If the person is not a permanent resident at the residential facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance, or

(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—subsection (2) applies in relation to the person as if the person were a permanent resident at the residential facility.

(4) In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

Subdivision 4 Information about non-availability of voluntary assisted dying

98 Relevant entities to inform public about non-availability of voluntary assisted dying

(1) This section applies to a relevant entity that does not provide, at a residential facility at which the entity provides relevant services, services associated with voluntary assisted dying, including access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

(2) The relevant entity must publish information about the fact the entity does not provide any services, or services of a specified type, associated with voluntary assisted dying at the residential facility.

(3) The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the residential facility become aware of the information.

Division 3 Health care establishments

Subdivision 1 Information about voluntary assisted dying

99 Access to information about voluntary assisted dying

(1) This section applies if—

(a) a person is receiving health care from a health entity at a health establishment, and

(b) the person asks the health entity for information about voluntary assisted dying, and

(c) the health entity does not provide at the health establishment, to persons to whom health care is provided, the information that has been requested.

(2) The health entity—

(a) must not hinder the person's access at the health establishment to information about voluntary assisted dying, and

(b) must, if asked, allow reasonable access to the person at the health establishment by a member of an official voluntary assisted dying care navigator service to provide support, assistance and information to persons relating to voluntary assisted dying.

Subdivision 2 Access to voluntary assisted dying

100 Application of Subdivision

This Subdivision applies if a person is receiving health care from a health entity at a health establishment.

101 First and final requests

(1) This section applies if—

(a) the person or the person's agent advises the health entity that the person wishes to make a first request or final request (each a ***relevant request***), and

(b) the health entity does not provide, to persons to whom health care is provided at the health care establishment, access to the request and assessment process at the establishment.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made to—

(a) a medical practitioner requested by the person who—

(i) for a first request—is eligible to act as a coordinating practitioner, or

(ii) for a final request—is the person's coordinating practitioner, or

(b) if the requested medical practitioner is not available—another medical practitioner who is eligible and willing to act as a coordinating practitioner for the person.

102 First assessments

(1) This section applies if—

(a) the person has made a first request, and

(b) the person, or the person's agent, advises the health entity that the person wishes to undergo a first assessment, and

(c) the health entity does not provide, to persons to whom health care is provided at the health establishment, access to the request and assessment process at the facility.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person.

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(4) In this section—

relevant practitioner, for a person, means—

(a) the person's coordinating practitioner, or

(b) a medical practitioner to whom the person's coordinating practitioner has referred a matter under section 26.

103 Consulting assessments

(1) This section applies if—

(a) the person has undergone a first assessment, and

(b) the person, or the person's agent, advises the health entity that the person wishes to undergo a consulting assessment, and

(c) the entity does not provide, to persons to whom health care is provided at the health establishment, access to the request and assessment process at the establishment.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person.

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

(4) In this section—

relevant practitioner, for a person, means—

(a) the person's consulting practitioner, or

(b) a medical practitioner to whom the person's consulting practitioner has referred a matter under section 37.

104 Written declarations

(1) This section applies if—

(a) the person has been assessed as eligible for access to voluntary assisted dying, and

(b) the person or the person's agent advises the health entity that the person wishes to make a written declaration, and

(c) the entity does not provide, to persons to whom health care is provided at the residential premises, access to the request and assessment process at the facility.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person may make a written declaration.

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

105 Application for administration decision

(1) This section applies if—

(a) the person has made a final request, and

(b) the person or the person's agent advises the health entity that the person wishes to make an application for an administration decision, and

(c) the entity does not provide, to persons to whom relevant services are provided at the health establishment, access to a person's coordinating practitioner to enable the application to be made.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to and from the place where the person's coordinating practitioner can consult with and assess the person in relation to the application.

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

Subdivision 3 Administration of voluntary assisted dying substance

106 Administration of voluntary assisted dying substance

(1) This section applies if—

(a) the person has made an administration decision, and

(b) the person or the person's agent advises the health entity that the person wishes to self-administer a voluntary assisted dying substance or have the person's administering practitioner administer a voluntary assisted dying substance to the person, and

(c) the health entity does not provide, to persons to whom health care is provided at the health establishment, access to the administration of a voluntary assisted dying substance at the establishment.

(2) The health entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered, or may self-administer, a voluntary assisted dying substance.

(3) In making a decision under subsection (2) about the reasonable steps that may be taken to facilitate the transfer of the person, the health entity must have regard to the following—

(a) whether the transfer would be likely to cause serious harm to the person,

(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,

(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,

(d) whether the place to which the person is proposed to be transferred is available to receive the person,

(e) whether the person would incur financial loss or costs because of the transfer.

Subdivision 4 Information about non-availability of voluntary assisted dying

107 Relevant entities to inform public about non-availability of voluntary assisted dying

(1) This section applies to a health entity that does not provide, at a health establishment at which the entity provides health care, services associated with voluntary assisted dying, including access to the request and assessment process or access to the administration of a voluntary assisted dying substance.

(2) The health entity must publish information about the fact the entity does not provide any services, or services of a specified type, associated with voluntary assisted dying at the health establishment.

(3) The health entity must publish the information in a way in which it is likely that persons who receive health care at the health establishment will become aware of the information.

Part 6 Review by Supreme Court

108 Definitions

In this Part—

eligible applicant means—

(a) a patient who is the subject of a decision referred to in section 109(1)(a)–(d), or

(b) a person who has been appointed by a patient mentioned in paragraph (a) as the patient's agent—

(i) in writing, or

(ii) by other means the Supreme Court considers satisfactory in the circumstances, or

(c) another person who has a sufficient and genuine interest in the rights and interests of a patient referred to in paragraph (a) in relation to voluntary assisted dying.

party to the proceeding, in relation to a review application, means a party to the proceeding before the Supreme Court relating to the application.

review application, in relation to a patient, means an application under section 109(1) for a review of a decision made in relation to the patient.

reviewed decision, in relation to a review application, means the decision the subject of the application.

109 Application for review of certain decisions by Supreme Court

(1) An eligible applicant may apply to the Supreme Court for a review of any of the following decisions—

(a) a decision of a patient's coordinating practitioner in a first assessment that the patient—

(i) at the time of making the first request, has or has not been ordinarily resident in New South Wales for a period of at least 12 months, or

(ii) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(iii) is or is not acting voluntarily, or

(iv) is or is not acting because of pressure or duress,

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(b) a decision of a patient's consulting practitioner in a consulting assessment that the patient—

(i) at the time of making the first request, has or has not been ordinarily resident in New South Wales for a period of at least 12 months, or

(ii) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(iii) is or is not acting voluntarily, or

(iv) is or is not acting because of pressure or duress,

(c) a decision of a patient's coordinating practitioner to make a statement in a final review form certifying that the coordinating practitioner is satisfied the patient—

(i) has or does not have decision-making capacity in relation to voluntary assisted dying, or

(ii) in requesting access to voluntary assisted dying—

(A) is or is not acting voluntarily, or

(B) is or is not acting because of pressure or duress, and

(d) a decision of the Board to refuse an application for a voluntary assisted dying substance authority in relation to a patient.

(2) A review of a reviewed decision—

(a) is to be dealt with as a new hearing, and

(b) evidence or information may be given in addition to, or in substitution for, the information given in relation to the reviewed decision.

110 Patient party to proceedings

If a review application is made in relation to a patient, the patient is a party to the proceeding whether or not the patient is the applicant for the review.

111 Consequences of review application

(1) This section applies if a review application is made in relation to a patient.

(2) If the request and assessment process in relation to the patient has not been completed—

(a) the request and assessment process is suspended, and

(b) no further step in the process is to be taken until the review application is decided or otherwise disposed of.

(3) If the request and assessment process in relation to the patient has been completed—

(a) the process for accessing voluntary assisted dying under Part 4 is suspended, and

(b) no step under that Part, including the prescription, supply or administration of a voluntary assisted dying substance, is to be taken in relation to the patient until the review application is decided or otherwise disposed of.

112 Review application taken to be withdrawn if patient dies

A review application made in relation to a patient is taken to be withdrawn if the patient dies.

113 Decision of Supreme Court

In deciding a review application made in relation to a patient, the Supreme Court may decide that—

(a) at the time of making the first request, the patient had been ordinarily resident in New South Wales for a period of at least 12 months, or

(b) at the time of making the first request, the patient had not been ordinarily resident in New South Wales for a period of at least 12 months, or

(c) the patient has decision-making capacity in relation to voluntary assisted dying, or

(d) the patient does not have decision-making capacity in relation to voluntary assisted dying, or

(e) the patient is acting voluntarily, or

(f) the patient is not acting because of pressure or duress, or

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(g) the patient is not acting voluntarily, or

(h) the patient is acting because of pressure or duress, or

(i) a ground to refuse to issue a voluntary assisted dying substance authority exists, or

(j) a ground to refuse to issue a voluntary assisted dying substance authority does not exist.

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

(1) If the Supreme Court makes a decision referred to in section 113(a), (c), (e), (f) or (j) on a review application made in relation to a patient—

(a) section 111 ceases to apply, and

(b) if the request and assessment process in relation to the patient had not been completed when the review application was made—the request and assessment process can be resumed, and

(c) if the request and assessment process in relation to the patient had been completed when the review application was made—the process under Part 4 can be resumed, and any step that is authorised under that Part can be taken, in relation to the patient, and

(d) if the Court sets aside the reviewed decision—subsection (2), (3) or (4) applies.

(2) If the reviewed decision set aside by the Supreme Court is a decision of a coordinating practitioner in a first assessment—

(a) the Court's decision is substituted for the reviewed decision, and

(b) if the outcome of the first assessment would, but for the reviewed decision, have been that the patient was assessed as ineligible for access to voluntary assisted dying—the coordinating practitioner is taken to have made a first assessment assessing the patient as eligible for access to voluntary assisted dying.

(3) If the reviewed decision set aside by the Supreme Court is a decision of a consulting practitioner in a consulting assessment—

(a) the Court's decision is substituted for the reviewed decision, and

(b) if the outcome of the consulting assessment would, but for the reviewed decision, have been that the patient was assessed as ineligible for access to voluntary assisted dying—the consulting practitioner is taken to have made a consulting assessment assessing the patient as eligible for access to voluntary assisted dying.

(4) If the reviewed decision set aside by the Supreme Court is a decision of a coordinating practitioner in a final review—

(a) the Court's decision is substituted for the reviewed decision, and

(b) the final review form is taken to include—

(i) if the reviewed decision is a decision referred to in section 109(1)(c)(i)—a statement certifying that the coordinating practitioner is satisfied that the patient has decision-making capacity in relation to voluntary assisted dying, or

(ii) if the reviewed decision is a decision referred to in section 109(1)(c)(ii)(A)—a statement certifying that the coordinating practitioner is satisfied the patient is acting voluntarily in requesting access to voluntary assisted dying, or

(iii) if the reviewed decision is a decision referred to in section 109(1)(c)(ii)(B)—a statement certifying that the coordinating

practitioner is satisfied the patient is not acting because of pressure or duress in requesting access to voluntary assisted dying.

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

115 Effect of decision under s 113(b), (d), (g), (h) or (i)

If the Supreme Court makes a decision referred to in section 113(b), (d), (g), (h) or (i) on a review application made in relation to a patient—

(a) the patient is taken to be ineligible for access to voluntary assisted dying for the purposes of the request and assessment process in relation to the patient, and

(b) if the request and assessment process in relation to the patient had not been completed when the review application was made—the request and assessment process ends, and

(c) if the request and assessment process in relation to the patient had been completed when the review application was made—

(i) the process for accessing voluntary assisted dying under Part 4 ends, and

(ii) no step under that Part, including the prescription, supply or administration of a voluntary assisted dying substance, is to be taken in relation to the patient.

116 Coordinating practitioner may refuse to continue in role

(1) If, under section 114(2)(a) or (4)(a), a decision of the Supreme Court is substituted for a decision of a patient's coordinating practitioner, the coordinating practitioner may refuse to continue to perform the role of coordinating practitioner.

(2) A coordinating practitioner who refuses under subsection (1) to continue to perform the role of coordinating practitioner must transfer the role of coordinating practitioner in accordance with section 181.

117 Hearings of Supreme Court to be held in private

(1) Hearings of the Supreme Court in relation to a review application must be held in private.

(2) The Supreme Court may give directions about persons who may be present at a hearing in relation to a review application.

118 Notice requirements

(1) If a review application is made in relation to a patient, the Principal Registrar of the Supreme Court must give notice of the application and any decision or order, however described, of the Court in relation to the application to the following—

(a) if the coordinating practitioner is not a party to the proceeding—the patient's coordinating practitioner,

(b) if the consulting practitioner is not a party to the proceeding—the patient's consulting practitioner,

(c) if the role of administering practitioner for the patient has been transferred under section 64(2)—the patient's administering practitioner,

(d) the Health Secretary,

(e) the Board.

(2) The Board must, as soon as practicable after receiving notice of a review application under subsection (1), give notice of the effect of section 111(2) and (3) to—

(a) each party to the proceeding, and

(b) if the coordinating practitioner is not a party to the proceeding—the patient's coordinating practitioner, and

(c) if the role of administering practitioner for the patient has been transferred under section 64(2)—the patient's administering practitioner.

119 Coordinating and consulting practitioners to give Supreme Court relevant material

(1) After receiving a notice of a review application under section 118(1), a patient's coordinating practitioner or consulting practitioner must give the Principal Registrar of the Supreme Court—

(a) if the coordinating practitioner or consulting practitioner made the decision the subject of the review—

(i) a statement of the reasons for the reviewed decision, and

(ii) other documents and material in the practitioner's possession or under the practitioner's control and relevant to the Court's review of the reviewed decision, or

(b) if the coordinating practitioner or consulting practitioner did not make the decision the subject of the review—documents and material—

(i) in the practitioner's possession or under the practitioner's control, and

(ii) relevant to the Court's review of the reviewed decision.

(2) The coordinating practitioner or consulting practitioner must give the Principal Registrar of the Supreme Court the documents and material, including any statement of reasons—

(a) within 7 business days after receiving the notice of the review application, or

(b) within the shorter period ordered by the Court.

120 Supreme Court to give written reasons for decision

(1) The Supreme Court must give written reasons for a decision made in relation to a review application.

(2) The Principal Registrar of the Supreme Court must give a copy of the written reasons to the following—

(a) each party to the proceeding,

(b) if the coordinating practitioner is not a party to the proceeding—the coordinating practitioner for the patient,

(c) if the consulting practitioner is not a party to the proceeding—the consulting practitioner for the patient,

(d) if the role of administering practitioner for the patient has been transferred under section 64(2)—the administering practitioner for the patient,

(e) the Health Secretary,

(f) the Board.

(3) A written transcript of the part of the proceeding in which the Supreme Court's reasons for the decision are given orally is sufficient to constitute written reasons for the purposes of this section.

121 Published decisions or reasons to exclude personal information

(1) If the Supreme Court publishes a decision, or its reasons for a decision, made in relation to a review application, the Court must ensure the decision or reasons are

published in a form that does not disclose personal information about any of the following—

(a) a party to the proceeding,

(b) a person who has appeared before the Court in the proceeding,

(c) if the coordinating practitioner is not a party to the proceeding—the coordinating practitioner for the patient,

(d) if the consulting practitioner is not a party to the proceeding—the consulting practitioner for the patient,

(e) if the person is not a party to the proceeding—a former coordinating practitioner or consulting practitioner for the patient,

(f) if the role of administering practitioner for the patient has been transferred under section 64(2)—a person to whom the role has been transferred.

(2) Subsection (1) does not prevent the Supreme Court from disclosing personal information about a person referred to in the subsection—

(a) in written reasons given under section 120(1), or

(b) in a copy of written reasons given under section 120(2).

(3) In this section—

personal information includes any information that would disclose the identity of a person.

122 Interim orders

On a review application, the Supreme Court may make an interim order the Court considers just.

Part 7 Offences

123 Unauthorised administration of prescribed substance

A person commits a crime if—

(a) the person (the ***first person***) administers a prescribed substance to another person, and

(b) the first person is not authorised by section 60(6) to administer the prescribed substance to the other person.

Maximum penalty—imprisonment for life.

124 Inducing another person to request or access voluntary assisted dying

(1) A person commits a crime if the person, by dishonesty or pressure or duress induces another person—

(a) to make a request for access to voluntary assisted dying, or

(b) to access voluntary assisted dying.

Maximum penalty—imprisonment for 7 years.

Summary conviction penalty—330 penalty units or imprisonment for 3 years, or both.

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(2) In this section—

request for access to voluntary assisted dying means—

(a) a first request, or

(b) a written declaration, or

(c) a final request, or

(d) an administration decision.

125 Inducing self-administration of prescribed substance

A person commits a crime if the person, by dishonesty or pressure or duress, induces another person to self-administer a prescribed substance.

Maximum penalty—imprisonment for life.

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

126 False or misleading information

It is an offence under the *Crimes Act 1900*, Part 5A for a person, for any purpose or requirement under this Act, to—

(a) make a statement or give information the person knows is false or misleading, or

(b) omit anything without which the statement or information is, to the person's knowledge, misleading.

127 Advertising Schedule 4 or 8 poison as voluntary assisted dying substance

A person commits a crime if the person advertises a Schedule 4 poison or Schedule 8 poison as a voluntary assisted dying substance.

Maximum penalty—330 penalty units or imprisonment for 3 years, or both.

128 Cancellation of document presented as prescription

(1) This section applies if—

(a) an authorised supplier is given a document that is presented as a prescription for a voluntary assisted dying substance, and

(b) the authorised supplier is satisfied the document—

(i) does not comply with section 74, or

(ii) is not issued by the coordinating practitioner for the patient to whom the document relates, or

(iii) is false in a material particular.

(2) The authorised supplier must—

(a) cancel the document by marking the word "cancelled" across it, and

(b) give the Health Secretary written notice—

(i) that the document has been cancelled, and

(ii) the reasons for cancelling the document.

Maximum penalty—imprisonment for 12 months.

129 Contact person to give unused or remaining substance to authorised disposer

(1) If a patient revokes a self-administration decision after an authorised supplier has supplied a prescribed substance for the patient, the contact person for the patient must, as soon as practicable and not later than 14 days after the day on which the decision is revoked, give the prescribed substance to an authorised disposer.

Maximum penalty—imprisonment for 12 months.

(2) If a patient who has made a self-administration decision dies and the patient's death occurs after an authorised supplier has supplied a prescribed substance for the patient, the contact person for the patient must, as soon as practicable and not later than 14 days after the day on which the patient dies, give any unused or remaining substance to an authorised disposer.

Maximum penalty—imprisonment for 12 months.

(3) In subsection (2), the reference to any unused or remaining substance is a reference to any prescribed substance the contact person knows is unused or remaining after the patient's death.

130 Recording, use or disclosure of information

(1) A person must not, directly or indirectly, record, use or disclose information obtained by the person because of a function the person has or had under this Act.

Maximum penalty—imprisonment for 12 months.

(2) Subsection (1) does not apply to the recording, use or disclosure of information—

(a) for the purpose of performing a function under this Act, or

(b) as required or allowed under this Act or another Act, or

(c) under an order of a court or other person or body acting judicially, or

(d) for the purpose of a proceeding under Part 6 or another proceeding before a court or other person or body acting judicially, or

(e) for the purpose of the investigation of a suspected offence or the conduct of proceedings against a person for an offence, or

(f) with the written consent of—

(i) the person to whom the information relates, or

(ii) an executor or administrator of the estate of the person to whom the information relates.

(3) Subsection (1) does not apply to the recording, use or disclosure of statistical or other information that is not personal information.

131 Publication of personal information concerning proceeding before Supreme Court

(1) A person must not publish information about a proceeding under Part 6 that discloses personal information about the following—

(a) a party to the proceeding,

(b) a person who has appeared before the Supreme Court in the proceeding,

(c) if the coordinating practitioner is not a party to the proceeding—the patient's coordinating practitioner,

(d) if the consulting practitioner is not a party to the proceeding—the patient's consulting practitioner,

(e) if the person is not a party to the proceeding—a former coordinating practitioner or consulting practitioner for the patient,

(f) if the role of administering practitioner for the patient has been transferred under section 64(2)—a person to whom the role has been transferred.

Maximum penalty—imprisonment for 12 months.

(2) In this section—

information about a proceeding means information about—

(a) a proceeding before the Supreme Court under Part 6, or

(b) a decision or order, however described, of the Supreme Court in a proceeding under Part 6.

party to the proceeding—see section 108.

publish means to disseminate to the public or a section of the public by any means, including the following—

(a) in a newspaper or periodical publication,

(b) by radio broadcast, television, a website, an online facility or other electronic means.

Part 8 Enforcement

132 Application of Poisons and Therapeutic Goods Act 1996

(1) The provisions of the *Poisons and Therapeutic Goods Act 1966*, Part 5, Divisions 2–4 (the ***applied provisions***) apply, for the purposes of the enforcement of this Act, with—

(a) the modifications prescribed by the regulations, and

(b) other necessary modifications.

(2) A definition in the *Poisons and Therapeutic Goods Act 1966* of a term used in the applied provisions also applies for the purposes of the application of the provisions under subsection (1).

133 Court to notify Health Secretary of conviction of offence under Act

If a court convicts a person of an offence under this Act, the registrar of the court must give the Health Secretary and the Board notice of—

(a) the conviction, and

(b) the penalty imposed.

134 Who may commence proceedings for simple offence

A prosecution for an offence under this Act may only be commenced by—

(a) the Health Secretary, or

(b) a person authorised, in writing, by the Health Secretary.

135 Time limit for prosecution of offence

(1) A prosecution for an offence under this Act must be commenced within 2 years after the day on which the offence is alleged to have been committed.

(2) However, if a prosecution notice alleging an offence specifies the day on which evidence of the alleged offence first came to the attention of a person authorised under section 134 to commence the prosecution—

(a) the prosecution may be commenced within 2 years after that day, and

(b) the prosecution notice need not contain particulars of the day on which the offence is alleged to have been committed.

(3) The day on which evidence first came to the attention of a person authorised under section 134 to commence a prosecution is, in the absence of evidence to the contrary, the day specified in the prosecution notice.

Part 9 Protection from liability

136 Protection for persons assisting access to voluntary assisted dying or present when substance administered

A person does not incur criminal liability if the person—

(a) in good faith, assists another person to request access to, or access, voluntary assisted dying in accordance with this Act, or

(b) is present when another person self-administers, or is administered, a prescribed substance in accordance with this Act.

137 Protection for persons acting in accordance with Act

(1) This section applies if a person, in good faith and with reasonable care and skill, does a thing—

(a) in accordance with this Act, or

(b) believing on reasonable grounds the thing is done in accordance with this Act.

(2) The person does not incur—

(a) civil liability for doing the thing, or

(b) criminal liability under this Act for doing the thing.

(3) The doing of the thing is not to be regarded as—

(a) a contravention of professional ethics or standards or principles of conduct applicable to the person's employment, or

(b) unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law*.

(4) In this section, a reference to the doing of a thing includes a reference to an omission to do a thing.

138 Protection for medical practitioner who refers person or seeks information

(1) A medical practitioner—

(a) may, despite any other law—

(i) refer a person (a ***patient***) to another person under this Act, and

(ii) make a request for a copy of the patient's medical records, or other information about the patient, to another person under this Act, and

(b) is not liable to any punishment under law because of the referral or request, and

(c) may not be sanctioned, censured or otherwise penalised by an entity whose function is to regulate the professional conduct of the medical practitioner, only because of having made the referral or request.

(2) A person to whom a referral or request mentioned in subsection (1)(a) is made—

(a) may, despite any other law—

(i) examine the patient to whom the referral relates, or

(ii) give to the medical practitioner who made the request a copy of the medical records or the information requested, and

(b) is not liable to any punishment under law because of having carried out the examination or having given a copy of the medical records or other information requested, and

(c) may not be sanctioned, censured or otherwise penalised by an entity whose function is to regulate the professional conduct of the medical practitioner only

because of having carried out the examination or having given the copy of the medical records or other information requested.

139 Protection for certain persons who do not administer lifesaving treatment

(1) This section applies if a protected person, in good faith, does not administer lifesaving treatment to another person in circumstances in which—

(a) the other person has not requested the administration of lifesaving treatment, and

(b) the protected person believes on reasonable grounds the other person is dying after self-administering or being administered a prescribed substance in accordance with this Act.

(2) The protected person is not liable, civilly, criminally or under an administrative process, for not administering the lifesaving treatment.

(3) Without limiting subsection (2), the failure to administer the lifesaving treatment does not constitute—

(a) professional negligence or another contravention of a duty of care that would incur professional liability, or

(b) a contravention of professional ethics or standards or a departure from accepted standards of professional conduct, or

(c) unsatisfactory professional conduct or professional misconduct for the purposes of the *Health Practitioner Regulation National Law*, or

(d) a contravention of principles of conduct applicable to the protected person's employment.

(4) In this section—

ambulance officer means a person employed or engaged, including on a voluntary basis, by the provider of an ambulance service to provide medical or other assistance to persons in an emergency.

lifesaving treatment means—

(a) lifesaving medical treatment, or

(b) life-preserving medical treatment.

protected person means—

(a) a registered health practitioner, or

(b) an ambulance officer, or

(c) a person, other than a person referred to in paragraph (a) or (b), who has a duty to administer lifesaving treatment to another person.

Part 10 Voluntary Assisted Dying Board

Division 1 Establishment

140 Board established

The Voluntary Assisted Dying Board is established.

141 Status

The Board—

(a) is an agent of the Crown, and

(b) has the status, immunities and privileges of the Crown.

Division 2 Functions and powers

142 Functions of Board

(1) The Board has the following functions—

(a) to monitor the operation of this Act,

(b) to keep a list of registered health practitioners who are willing to assist with voluntary assisted dying, including by—

(i) participating in the request and assessment process, and

(ii) prescribing, supplying or administering a voluntary assisted dying substance, and

(iii) being present at the time of the administration of a voluntary assisted dying substance,

(c) to make decisions about applications made to the Board under section 17(1),

(d) to make decisions about voluntary assisted dying substance authorities,

(e) to provide to the Minister or the Health Secretary, on its own initiative or on request, advice, information and reports on matters relating to the operation of this Act, including recommendations for the improvement of voluntary assisted dying,

(f) to refer to any of the following persons or bodies any matter identified by the Board in relation to voluntary assisted dying that is relevant to the functions of the person or body—

(i) the Commissioner of Police under the *Police Act 1990*,

(ii) the Registrar of Births, Deaths and Marriages under the *Births, Deaths and Marriages Registration Act 1995*,

(iii) the State Coroner appointed under the *Coroners Act 2009*, section 7,

(iv) the Health Secretary,

(v) the Secretary of the Department in which the *Coroners Act 2009* is administered,

(vi) the Australian Health Practitioner Regulation Agency established by the *Health Practitioner Regulation National Law*, section 23,

(vii) the Commissioner appointed under the *Health Care Complaints Act 1993*, section 76,

(g) to conduct analysis of, and research in relation to, information given to the Board under this Act,

(h) to collect, use and disclose information given to the Board under this Act for the purposes of performing its functions,

(i) any other function given to the Board by or under this Act or another Act.

(2) The Board, or a member of the Board, must not give the list of registered health practitioners kept under subsection (1)(b), or information on the list, to another entity unless the other entity is—

(a) an official voluntary assisted dying care navigator service, or

(b) a person employed or otherwise engaged by or acting for an official voluntary assisted dying care navigator service, or

(c) another person exercising functions under this Act who needs access to the list or information on the list to exercise the functions.

Example for paragraph (c)— a coordinating practitioner, a consulting practitioner, an administering practitioner

143 Powers of Board

The Board has all the powers the Board needs to exercise its functions.

144 Delegation by Board

(1) The Board may delegate a function of the Board, other than this power of delegation, to—

(a) a member of the Board, or

(b) to a committee established under section 169.

(2) The delegation must be in writing.

(3) A person or committee to whom or which a function is delegated under this section must not delegate the function.

(4) A person or committee exercising a function that has been delegated to the person or committee under this section is taken to do so in accordance with the terms of the delegation unless the contrary is shown.

(5) Nothing in this section limits the ability of the Board to perform a function through—

(a) a member of staff provided to the Board under section 145, or

(b) an agent of the Board.

Division 3 Staff and assistance

145 Staff and services

The Health Secretary must ensure the Board is provided with the staff, services and facilities, and other resources and support, that are reasonably necessary to enable the Board to perform its functions.

146 Assistance

(1) The Board, with the Minister's approval, may appoint a person with special knowledge or skills to assist the Board in a particular matter.

(2) A person who has been appointed to assist the Board may attend meetings of the Board and participate in its deliberations but must not vote at a meeting of the Board.

Division 4 Accountability

147 Minister may give directions

(1) The Minister may give written directions to the Board about the performance of its functions.

(2) The Board must comply with a direction given by the Minister under subsection (1).

(3) However, a direction under subsection (1) must not be about the performance of a function in relation to a particular person or matter.

148 Minister to have access to information

(1) The Minister is entitled—

(a) to have information in the Board's possession, and

(b) if the information is in or on a document—to have, and make and keep copies of, the document.

(2) However, the Minister is not entitled to have personal information about a person unless the person has consented to the disclosure of the information.

(3) For the purposes of subsection (1), the Minister may—

(a) ask the Board to give information to the Minister, and

(b) ask the Board to give the Minister access to information, and

(c) for the purposes of paragraph (b), make use of staff provided to the Board under section 145 and the Board's facilities to obtain and give the information to the Minister.

(4) The Board must—

(a) comply with a request under subsection (3), and

(b) make staff and facilities available to the Minister as required under subsection (3)(c).

(5) In this section—

document includes any tape, disk or other device or medium on which information is recorded or stored.

information means information specified, or of a description specified, by the Minister that relates to the functions of the Board.

Division 5 Membership

149 Membership of Board

(1) The Board consists of 5 members jointly appointed by the Minister and the Attorney General by Gazette notice.

(2) A person may be appointed as a member of the Board if the Minister and Attorney General are satisfied the person has knowledge, skills or experience relevant to the Board's functions.

(3) A person may not be appointed as a member of the Board if the person—

(a) is an insolvent under administration under the *Corporations Act 2001* of the Commonwealth, section 9, or

(b) has a conviction, other than a spent conviction, for an indictable offence, or

(c) is a member of either House of Parliament.

(4) In this section—

spent conviction means a spent conviction under the *Criminal Records Act 1991*.

150 Chairperson and deputy chairperson

(1) The Minister and the Attorney General must appoint—

(a) one member of the Board to be the chairperson of the Board, and

(b) another member of the Board to be the deputy chairperson of the Board.

(2) A member of the Board is not eligible to be appointed as the chairperson or deputy chairperson unless the person is—

(a) an Australian legal practitioner with at least 7 years' legal practice experience, and

(b) either—

(i) a Judge or other judicial officer, or a former Judge or other judicial officer, of a superior court of record of the State or of another State or Territory or of Australia, or

(ii) qualified to be appointed as a Judge or other judicial officer of a court referred to in subparagraph (i).

(3) If the chairperson is unable to act because of illness, absence or other cause or if there is no chairperson, the deputy chairperson acts in the chairperson's place.

(4) An act or omission of the deputy chairperson acting in the chairperson's place must not be questioned on the ground that the occasion to act in the chairperson's place had not arisen or had ceased.

151 Term of office

(1) A member of the Board holds office for the term, not more than 3 years, specified in the member's instrument of appointment.

(2) A member of the Board is eligible for reappointment.

152 Casual vacancies

(1) The office of a member of the Board becomes vacant if the member—

(a) dies, resigns or is removed from office under this section, or

(b) becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with the member's creditors or makes an assignment of the member's remuneration for the benefit of the member's creditors, or

(c) is convicted of an offence punishable by imprisonment for more than 12 months, or

(d) is convicted of an offence under section 164.

(2) A member of the Board may at any time resign from office by written notice given to the Minister or the Attorney General.

(3) The Minister and the Attorney General acting jointly may remove a member of the Board from office on the grounds of—

(a) neglect of duty, or

(b) misconduct or incompetence, or

(c) mental or physical incapacity, other than temporary illness, impairing the performance of the member's duties, or

(d) absence, without leave, from 3 consecutive meetings of the Board of which the member has had notice.

(4) In this section—

misconduct includes conduct that renders the member unfit to hold office as a member of the Board even though the conduct does not relate to a duty of the office.

153 Extension of term of office during vacancy

(1) If the office of a member of the Board becomes vacant because the member's term of office expires, the member continues to be a member during the vacancy until the day on which the vacancy is filled, whether by reappointment of the member or appointment of a successor to the member.

(2) Subsection (1) ceases to apply if the member resigns or is removed from office under section 152.

(3) The maximum period for which a member of the Board continues to be a member under this section after the member's term of office expires is 3 months.

154 Alternate members

(1) If a member of the Board other than the chairperson is unable to act because of illness, absence or other cause, the Minister may appoint another person as an alternate member to act temporarily in the member's place.

(2) If the deputy chairperson is acting in the chairperson's place, the Minister may appoint another person as an alternate member of the Board to act temporarily in the deputy chairperson's place.

(3) While acting in accordance with the person's appointment, an alternate member of the Board is taken to be, and to have any entitlement of, a member of the Board.

(4) An act or omission of an alternate member of the Board must not be questioned on the ground the occasion for the appointment or acting had not arisen or had ceased.

155 Remuneration of members

A member of the Board is entitled to be paid the remuneration and allowances the Minister may from time to time decide.

Division 6 Board meetings

156 Holding meetings

(1) The first meeting of the Board must be convened by the chairperson, and subsequent meetings must be held at times and places decided by the Board.

(2) A special meeting of the Board may at any time be convened by the chairperson.

157 Quorum

A quorum for a meeting of the Board is 3 members of the Board.

158 Presiding member

(1) The chairperson, if present, must preside at a meeting of the Board.

(2) If neither the chairperson, nor the deputy chairperson acting in the chairperson's place, is presiding under subsection (1), the members of the Board present at the meeting must elect one of the members to preside.

159 Procedure at meetings

The Board must decide its own meeting procedures to the extent the procedures are not fixed by this Act.

160 Voting

(1) At a meeting of the Board, each member of the Board present has a deliberative vote unless section 165 prevents the member from voting.

(2) In the case of an equality of votes, the member of the Board presiding has a casting vote in addition to a deliberative vote.

(3) A question is resolved by a majority of the votes cast.

161 Holding meetings remotely

The presence of a person at a meeting of the Board need not be by attendance in person but may be by that person and each other person at the meeting being simultaneously in contact by telephone or other means of instantaneous communication.

162 Resolution without meeting

A resolution in writing signed or otherwise assented to in writing by each member of the Board has the same effect as if the resolution had been passed at a meeting of the Board.

163 Minutes

The Board must ensure accurate minutes are kept of the proceedings at each of the Board's meetings.

Division 7 Disclosure of interests

164 Disclosure of material personal interest

(1) A member of the Board who has a material personal interest in a matter being considered or about to be considered by the Board must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest at a meeting of the Board.

Maximum penalty—100 penalty units.

(2) A disclosure under subsection (1) must be recorded in the minutes of the meeting.

165 Voting by interested member

(1) A member of the Board who has a material personal interest in a matter being considered by the Board—

(a) must not vote, whether at a meeting or otherwise, on the matter, and

(b) must not be present while the matter is being considered at a meeting.

(2) A reference in subsection (1) to a matter includes a reference to a proposed resolution under section 166 in relation to the matter, whether relating to the member or a different member.

166 Section 165 may be declared inapplicable

Section 165 does not apply if—

(a) a member of the Board has disclosed under section 164 an interest in a matter, and

(b) the Board has at any time passed a resolution that—

(i) specifies the member, the interest and the matter, and

(ii) states that the members of the Board voting for the resolution are satisfied the interest is so trivial or insignificant as to be unlikely to influence the disclosing member's conduct and should not disqualify the member from considering or voting on the matter.

167 Quorum where s 165 applies

(1) Despite section 157, if a member of the Board is disqualified under section 165 in relation to a matter, a quorum is present during the consideration of the matter if 2 members of the Board who are entitled to vote on any motion that may be moved at the meeting in relation to the matter are present.

(2) The Minister may deal with a matter to the extent the Board must not deal with the matter because of subsection (1).

168 Minister may declare ss 165 and 166 inapplicable

(1) The Minister may, by written notice, declare that section 165 or 166 does not apply in relation to a specified matter either—

(a) generally, or

(b) in voting on particular resolutions.

(2) The Minister must present a copy of a declaration made under subsection (1) to be laid before each House of Parliament within 14 sitting days of the House after the declaration is made.

Division 8 Committees

169 Establishment of committees

(1) The Board may establish committees to assist the Board in the performance of its functions.

(2) The Board may discharge, alter or reconstitute a committee.

(3) The Board may—

(a) decide the functions, membership and constitution of a committee, and

(b) appoint members of the Board or other persons as members of a committee.

170 Directions to committee

(1) The Board may give directions to a committee about its functions and procedures.

(2) A committee must comply with a direction given to the committee by the Board.

171 Committee to decide own procedures

Subject to any directions of the Board and the terms of a delegation under section 144, a committee may decide its own procedures.

172 Remuneration of committee members

A member of a committee is entitled to be paid the remuneration and allowances the Minister from time to time decides.

Division 9 Information

173 Board to send information to contact person for patient

The Board must, within 5 business days after receiving a copy of a contact person appointment form for a patient under section 67(4), send information to the patient's contact person that—

(a) explains the requirements under section 129 to give the prescribed substance, or any unused or remaining prescribed substance, to an authorised disposer, and

(b) outlines the support services available to help the contact person to comply with the requirements.

174 Request for information

(1) The Board may ask any person, including a patient's contact person, to give information to the Board to assist the Board in performing any of its functions.

(2) A person may comply with a request under subsection (1) despite any Act that prohibits or restricts the disclosure of the information.

175 Disclosure of information

The Board may, if asked, disclose information, other than personal information, obtained in the performance of its functions to—

(a) a public authority, or

(b) a person or body for the purposes of education or research.

176 Board to record and keep statistical information

(1) The Board must record and keep statistical information about the following matters relating to voluntary assisted dying—

(a) the disease, illness or medical condition of a patient that met the requirements of section 16(1)(d), whether or not the patient made a final request,

(b) if a patient has died after self-administering or being administered a voluntary assisted dying substance in accordance with this Act—the age of the patient on the day the patient died,

(c) participation in the request and assessment process, and access to voluntary assisted dying, by patients who are regional residents,

(d) a matter specified in a direction under subsection (2).

(2) The Minister may give a written direction to the Board requiring the Board—

(a) to record and keep statistical information about a matter relating to voluntary assisted dying specified in the direction, and

(b) to include the statistical information in its annual report.

(3) The Board must give effect to a direction under subsection (2).

Division 10 Miscellaneous

177 Board to notify receipt of forms

(1) The Board must, as soon as practicable after receiving a form or a copy of a form from a person under this Act, notify the person that the form has been received.

(2) The Board must, as soon as practicable after receiving a copy of an authorised disposal form or practitioner disposal form, give a copy of the form to the Health Secretary.

178 Execution of documents by Board

(1) A document is executed by the Board if the document is signed on behalf of the Board by 2 members of the Board authorised under subsection (2).

(2) The Board may authorise any of its members to sign documents on behalf of the Board, either—

(a) generally, or

(b) subject to the conditions specified in the authorisation.

(3) A document purporting to be executed in accordance with this section is to be presumed to be executed until the contrary is shown.

179 Annual report

(1) The Board must, within 6 months after the end of each financial year, prepare and give to the Minister a report on the operation of this Act during the financial year.

(2) The report must include—

(a) any recommendations the Board considers appropriate in relation to voluntary assisted dying, and

(b) any information the Board considers relevant to the performance of its functions, and

(c) the number of referrals made by the Board under section 142(1)(f), and

(d) the text of any direction given to the Board under section 147(1) or 176(2), and

(e) details of any disclosure under section 164(1) that relates to a matter dealt with in the report and of any resolution under section 166 about the disclosure, and

(f) statistical information the Board is directed under section 176(2) to include in the report, and

(g) information about the extent to which regional residents had access to voluntary assisted dying, including statistical information recorded and kept under section 176(1)(c), and having regard to the access standard under section 180.

(3) The report must not include—

(a) personal information about a patient, medical practitioner or other person who has participated in the request and assessment process or the process for accessing voluntary assisted dying under Part 4, or

(b) information that would prejudice—

(i) a criminal investigation or criminal proceeding, or

(ii) a civil proceeding, or

(iii) a proceeding in the Coroner's Court of New South Wales.

(4) The Minister must ensure a copy of the report is laid before each House of Parliament within 6 sitting days of the House after the day on which the Minister receives the report.

Part 11 Access standard

180 Standard about access to voluntary assisted dying

(1) The Health Secretary must issue a standard (the ***access standard***) setting out how the Ministry of Health intends to facilitate access to voluntary assisted dying for persons ordinarily resident in New South Wales, including how the Ministry intends to facilitate access to—

(a) the services of medical practitioners and other persons who carry out functions under this Act, and

(b) prescribed substances, and

(c) information about accessing voluntary assisted dying.

(2) The access standard must specifically set out how the Ministry intends to facilitate access to voluntary assisted dying for regional residents.

(3) The access standard may also include information about the potential risks of self-administering or being administered a voluntary assisted dying substance likely to be prescribed under this Act.

(4) The Health Secretary may modify or replace the access standard.

(5) The Health Secretary must publish the access standard on the Ministry of Health's website.

Part 12 General

181 Transfer of coordinating practitioner's role

(1) The coordinating practitioner for a patient (the ***original practitioner***) may transfer the role of coordinating practitioner to another medical practitioner for the patient if—

(a) the consulting practitioner has assessed the patient as eligible for access to voluntary assisted dying, and

(b) the other medical practitioner accepts the transfer of the role.

(2) The transfer of the role may be—

(a) at the patient's request, or

(b) on the original practitioner's own initiative.

(3) Within 5 business days after being asked by the original practitioner to accept a transfer under subsection (1), the other medical practitioner must inform the original practitioner whether the medical practitioner accepts or refuses the transfer of the role.

(4) If the other medical practitioner accepts the transfer of the role, the original practitioner must—

(a) inform the patient of the transfer, and

(b) record the transfer in the patient's medical record, and

(c) within 5 business days after accepting the transfer—

(i) complete the approved form (the ***coordinating practitioner transfer form***), and

(ii) give a copy of the coordinating practitioner transfer form to the Board.

Maximum penalty—100 penalty units.

(5) The coordinating practitioner transfer form must include the following—

(a) the patient's name, date of birth and contact details,

(b) the original practitioner's name and contact details,

(c) the other medical practitioner's name and contact details,

(d) the date the other medical practitioner accepted the transfer,

(e) the date the patient was informed of the transfer,

(f) the original practitioner's signature and the date the form was signed.

(6) If the other medical practitioner refuses the transfer of the role, the original practitioner may—

(a) refer the patient to another medical practitioner for a further consulting assessment, and

(b) transfer the role of coordinating practitioner to that medical practitioner if the practitioner—

(i) accepts the referral for a further consulting assessment, and

(ii) assesses the patient as eligible for access to voluntary assisted dying, and

(iii) accepts the transfer of the role.

(7) On accepting the referral for a further consulting assessment, the consulting assessment that previously assessed the patient as eligible for access to voluntary assisted dying becomes void.

182 Communication between patient and practitioner

(1) If it is not practicable for a patient to make a first request, final request or administration decision in person—

(a) the patient may make the request or decision using audiovisual communication, and

(b) the medical practitioner who receives the request or is being informed of the decision may give the patient advice or information in relation to the request or decision using audiovisual communication.

(2) Subject to subsection (1)(b), a medical practitioner or other registered health practitioner may give advice or information to, or otherwise communicate with, a person for the purposes of this Act using any method of communication, including electronic communication or the use of an interpreter, the practitioner considers appropriate.

(3) However, subsections (1) and (2) do not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.

(4) In this section—

audiovisual communication means a method of electronic communication designed to allow people to see and hear each other simultaneously.

183 Electronic signature

(1) This section applies to a requirement under this Act for an approved form or other document to be signed.

(2) To avoid doubt, the document may be signed by electronic means.

Example— a digitised signature may be used

184 Information about voluntary assisted dying

(1) An authorised official may make information about voluntary assisted dying publicly available.

(2) Information may be made available under this section using any method of communication, including electronic communication, that the authorised official considers appropriate.

(3) However, subsection (2) does not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the Commonwealth.

(4) The Health Secretary may, by Gazette notice, designate persons, or persons in a class, as authorised officials for the purposes of this section.

(5) In this section—

authorised official means—

(a) the Health Secretary, or

(b) a public service officer employed in the Ministry of Health, or

(c) a person designated as an authorised official under subsection (4).

185 Official voluntary assisted dying care navigator service

(1) The Health Secretary may, by Gazette notice, approve an entity to be an official voluntary assisted dying care navigator service for this Act.

(2) The purpose of an official voluntary assisted dying care navigator service is to provide support, assistance and information in relation to voluntary assisted dying to entities, including—

(a) patients, and

(b) patients' carers, family and friends, and

(c) doctors and other members of patients' health care teams, and

(d) residential facility managers, and other persons employed or otherwise engaged by or providing services at, residential facilities.

(3) If an official voluntary assisted dying care navigator service is given a list of registered health practitioners kept under section 142(1)(b), a relevant person must not intentionally—

(a) give a copy of the list to another entity that is not also a relevant person, or

(b) disclose information on the list to another person unless the other person—

(i) has requested access to voluntary assisted dying, or

(ii) is assisting another person who has requested access.

Maximum penalty—100 penalty units.

(4) In this section—

relevant person means a person employed by, or otherwise engaged or acting for, an official voluntary assisted dying care navigator service.

186 Health Secretary may approve training

The Health Secretary may approve training about the following matters—

(a) the operation of this Act in relation to medical practitioners, registered nurses and other health practitioners, including the functions of coordinating practitioners, consulting practitioners and administering practitioners,

Note— Under the *Interpretation Act 1987*, section 21D, a reference to a registered nurse does not include an enrolled nurse.

(b) assessing whether or not a patient meets the eligibility criteria,

(c) identifying and assessing risk factors for pressure or duress,

Note— See the definition of ***pressure or duress*** in the Dictionary in Schedule 1.

(d) other matters relating to the operation of this Act.

187 Health Secretary may approve forms

The Health Secretary may approve forms for use under this Act.

188 Interpreters

(1) An interpreter for a patient—

(a) must be accredited by a body approved by the Health Secretary, and

(b) must not—

(i) be a family member of the patient, or

(ii) know or believe that they are a beneficiary under a will of the patient or that they may otherwise benefit financially or in any other material way from the death of the patient, or

(iii) be an owner of, or be responsible for the day-to-day management and operation of, a health facility at which the patient is being treated or resides, or

(iv) be a person who is directly involved in providing health services or professional care services to the patient.

(2) In this section—

health facility means the following—

(a) a hospital within the meaning of the *Health Services Act 1997*,

(b) premises where residential care, as defined in the *Aged Care Act 1997* of the Commonwealth, section 41-3, is provided,

(c) premises, other than a private residence, where accommodation and personal care or nursing care, or both, are provided to a person with a disability.

interpreter, for a patient, means an interpreter who assists a patient in relation to—

(a) the request and assessment process, or

(b) the process for accessing voluntary assisted dying under Part 4, or

(c) a proceeding under Part 6.

189 Relationship with Guardianship Act 1987 and Powers of Attorney Act 2003

To avoid doubt, voluntary assisted dying is not a matter to which the following Acts apply or for which provision may be made under an instrument made under either of the following Acts—

(a) the *Guardianship Act 1987*,

(b) the *Powers of Attorney Act 2003*.

190 Review of Act

(1) The Minister must review the operation and effectiveness of this Act, and prepare a report based on the review—

(a) as soon as practicable after the second anniversary of the day on which this section comes into operation, and

(b) after that, at intervals of not more than 5 years.

(2) Without limiting subsection (1), a review of the operation and effectiveness of this Act must include consideration of the principles set out in section 4 including, in particular, the following principles—

(a) a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,

(b) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region.

(3) The Minister must cause the report to be laid before each House of Parliament as soon as practicable after the report is prepared, but not later than—

(a) for the first review—12 months after the second anniversary, or

(b) for a subsequent review—12 months after the expiry of the period of 5 years.

191 Regulations

The Governor may make regulations about a matter that is—

(a) required or permitted to be prescribed by this Act, or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

Schedule 1A Consequential amendment of other Acts

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

[1] Section 42 Registration

Insert after section 42(2)—

(3) If the Registrar receives a cause of death certificate referred to in the *Voluntary Assisted Dying Act 2021*, section 87(6), the Registrar must register the death in the Register by making an entry about the death that records—

(a) the cause of death as the disease, illness or medical condition with which the person had been diagnosed that made the person eligible to access voluntary assisted dying, and

(b) the person was the subject of a voluntary assisted dying authority under the *Voluntary Assisted Dying Act 2021* and voluntary assisted dying was the manner of death.

[2] Section 49 Issue of certificate

Insert after section 49(3)—

(3A) If an entry in the register records information referred to in section 42(1A)(b), that information is not to be included in a certificate issued by the Registrar.

1A.2 Criminal Procedure Act 1986 No 209

[1] Schedule 1 Indictable offences triable summarily

Insert in Table 1, Part 4, after clause 24—

24AA Voluntary Assisted Dying Act 2021

An offence under the *Voluntary Assisted Dying Act 2021*, section 124.

[2] Schedule 1, Part 13, clause 25A

Insert after clause 25—

25A Voluntary Assisted Dying Act 2021

An offence under the *Voluntary Assisted Dying Act 2021*, section 127.

1A.3 Ombudsman Act 1974 No 68

[1] Schedule 1 Excluded conduct of public authorities

Insert "(1)" before "Conduct" in item 3.

[2] Schedule 1, item 3

Insert at the end of the item—

(2) However, sub-item (1) does not apply to the conduct of the Voluntary Assisted Dying Board established under the *Voluntary Assisted Dying Act 2021*.

Schedule 1 Dictionary

section 5

access standard—see section 180(1).

administering practitioner, for a person, means—

(a) the coordinating practitioner for the person, or

(b) a person to whom the role of administering practitioner is transferred under section 64(2).

administration, in relation to a voluntary assisted dying substance, includes self-administration.

administration decision means—

(a) a self-administration decision, or

(b) a practitioner administration decision.

adult means a person who is 18 years of age or more.

agent, of a patient, means a person who acts on behalf of the patient.

annual report, for the Board, means a report under section 179.

approved form means a form approved by the Health Secretary under section 187.

approved training means training approved by the Health Secretary under section 186.

authorised disposal form—see section 81(1).

authorised disposer—see section 84(4).

authorised supplier—see section 84(2).

Board means the Voluntary Assisted Dying Board established by section 140.

completed, in relation to the request and assessment process—see section 8.

consulting assessment means an assessment of a patient conducted under section 36(1).

consulting assessment report form—see section 41(2)(a).

consulting practitioner, for a person, means a medical practitioner who accepts a referral to conduct a consulting assessment of the person.

contact details, in relation to a person, includes the address, telephone number and email address of the person.

contact person, for a patient, means the person appointed by the patient under section 66(1).

contact person appointment form—see section 67(1).

coordinating practitioner, for a person, means—

(a) a medical practitioner who accepts the person's first request, or

(b) a medical practitioner who accepts a transfer of the role of coordinating practitioner for the person under section 181.

decision-making capacity, in relation to voluntary assisted dying, see section 6(1).

designated period, in relation to a patient's final request, means the period—

(a) starting on the day on which the patient made the first request, and

(b) ending on the day that is 5 days after that day.

disability has the same meaning as in the *Disability Inclusion Act 2014*, section 7(1).

eligibility criteria means the criteria set out in section 16(1).

entity includes—

(a) a person, and

(b) an unincorporated body.

family member, of a person, means any of the following—

(a) the person's spouse or de facto partner,

(b) the person's parent or step parent, or a sibling of the person's parent or step parent,

(c) the person's grandparent or step grandparent,

(d) the person's sibling or step sibling, or a child of the person's sibling or step sibling,

(e) the person's child or step child,

(f) the person's grandchild or step grandchild.

final request means a final request for access to voluntary assisted dying made under section 48(1).

final review means a review conducted under section 52(1)(a) and (b) by the coordinating practitioner for a patient.

final review form—see section 52(1)(c).

first assessment means an assessment of a patient conducted under section 25(1).

first request means a request for access to voluntary assisted dying made under section 19(1).

Gazette notice means a notice published in the Gazette.

general registration means general registration under the *Health Practitioner Regulation National Law* in the medical profession.

Greater Sydney Region has the same meaning as in the *Greater Sydney Commission Act 2015*.

Health Practitioner Regulation National Law means the *Health Practitioner Regulation National Law*—

(a) as in force from time to time, set out in the Schedule of the *Health Practitioner Regulation National Law Act 2009* of Queensland, and

(b) as it applies as a law of New South Wales or another State, with or without modification.

Health Secretary means the Secretary of the Ministry of Health.

health service has the same meaning as in the *Health Services Act 1997*.

limited registration means limited registration under the *Health Practitioner Regulation National Law* in the medical profession.

local government authority means any of the following under the *Local Government Act 1993*—

(a) a council,

(b) a county council,

(c) a joint organisation.

medicine means regulated goods within the meaning of the *Poisons and Therapeutic Goods Act 1966*.

official voluntary assisted dying care navigator service means a voluntary assisted dying care navigator service approved by the Health Secretary under section 185.

palliative care and treatment means care and treatment that—

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting, and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering to improve their comfort and quality of life.

patient means a person who makes a request for access to voluntary assisted dying under this Act.

personal information has the same meaning as in the *Government Information (Public Access) Act 2009*, Schedule 4, clause 4.

practitioner administration decision—see section 57(1)(b).

practitioner administration form—see section 62(3).

practitioner disposal form—see section 83(1).

prepare, in relation to a prescribed substance—

(a) means to do anything necessary to ensure the substance is in a form suitable for administration, and

(b) includes to decant, dilute, dissolve, mix, reconstitute, colour or flavour the substance.

prescribe, in relation to a voluntary assisted dying substance, means to issue a prescription for the substance.

prescribed substance means—

(a) a voluntary assisted dying substance prescribed for a patient by the coordinating practitioner for the patient, and

(b) in relation to a specific patient, the voluntary assisted dying substance prescribed for the patient by the patient's coordinating practitioner.

prescription, in relation to a voluntary assisted dying substance, has the same meaning as the prescription of a Schedule 4 poison or Schedule 8 poison in the *Poisons and Therapeutic Goods Act 1966*.

pressure or duress includes abuse, coercion, intimidation, threats and undue influence.

professional care services means any of the following provided to another person under a contract of employment or a contract for services—

(a) assistance or support, including the following—

(i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or meals,

(ii) assistance for persons with mobility problems,

(iii) assistance for persons who are mobile but require some form of assistance or supervision,

(iv) assistance or supervision in administering medicine,

(v) the provision of substantial emotional support,

(b) providing support or services to persons with a disability.

provisional registration means provisional registration under the *Health Practitioner Regulation National Law* in the medical profession.

public authority means—

(a) a government sector agency within the meaning of the *Government Sector Employment Act 2013*, or

(b) a local government authority, or

(c) a statutory body representing the Crown, or

(d) a body, whether incorporated or unincorporated, established for a public purpose under the provisions of an Act or other statutory instrument, or

(e) an entity prescribed by the regulations to be a public authority for this definition.

regional resident means a person who ordinarily resides in an area of New South Wales that is outside the Greater Sydney Region.

registered health practitioner means a person registered under the *Health Practitioner Regulation National Law* to practise a health profession, other than as a student.

request and assessment process means the process that consists of the following steps—

(a) a first request,

(b) a first assessment,

(c) a consulting assessment,

(d) a written declaration,

(e) a final request,

(f) a final review.

residential aged care facility means a facility at which residential aged care is provided, whether or not the care is provided by an approved provider under the *Aged Care Quality and Safety Commission Act 2018* of the Commonwealth.

residential facility means—

(a) a nursing home, hostel or other facility at which accommodation, nursing or personal care is provided to persons on a residential basis who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care, or

(b) a residential aged care facility.

residential facility manager means the person employed at the residential facility who is responsible for the management of that facility.

Schedule 4 poison has the same meaning as a Schedule 4 substance in the *Poisons and Therapeutic Goods Act 1966*, section 8.

Schedule 8 poison has the same meaning as a Schedule 8 substance in the *Poisons and Therapeutic Goods Act 1966*, section 8.

self-administration decision—see section 57(1)(a).

specialist registration means specialist registration under the *Health Practitioner Regulation National Law* in the medical profession in a recognised specialty.

supply, in relation to a voluntary assistance dying substance, has the same meaning as supply of a poison in the *Poisons and Therapeutic Goods Act 1966*, section 4.

unused or remaining substance—see section 82(4)(b).

voluntary assisted dying means the administration of a voluntary assisted dying substance and includes steps reasonably related to the administration.

voluntary assisted dying substance—see section 7(2).

voluntary assisted dying substance authority means an authority granted under section 71(2).

written declaration means a written declaration requesting access to voluntary assisted dying made under section 43(1).