



Human Rights Commission
Te Kāhui Tika Tangata

Submission of The Disability Rights Commissioner on the End of Life Choice Bill

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Submission of the Disability Rights Commissioner to the Justice Select Committee on the End of Life Choice Bill

Introduction and Summary of Position

1. The Human Rights Commission ('the Commission') is an independent Crown Entity. The primary statutory functions of the Commission include advocating and promoting respect for human rights and promoting and protecting the full and equal enjoyment of human rights by people with disabilities.
2. As Disability Rights Commissioner, I have a specific statutory responsibility to lead the work of the Commission in relation to the priority area of disability rights.
3. In January 2016 the Commission provided a submission to the Health Select Committee Inquiry into End of Life Matters (the "2016" submission). This explored the human rights principles, legislation and case law relevant to the issues being considered by the present committee. The 2016 submission concluded that a legal framework permitting assistance to be given to a competent terminally ill adult to end his or her life (if he or she freely and autonomously chose to do so) could potentially be implemented if:¹
 - a. It is developed in a manner consistent with core human rights principles; and
 - b. Is accompanied by adequate legal and procedural safeguards to protect vulnerable members of society; and
 - c. Appropriate palliative care services are available and remain accessible for all.
4. **Taking into account the Commission's position above, and my specific statutory responsibility to the disability community, my position is that:**
 - a. **this Bill undermines the position of disabled and vulnerable members of our community and poses significant risks to them, as individuals and as a group;**
 - b. **the proposed safeguards in the Bill are deficient, both procedurally and substantively, for both terminal and non-terminal conditions;**
 - c. **It is not possible to consider the issue of legalising assistance in dying in isolation from palliative care service provision and the current services and resources available to those who experience serious but non-terminal conditions.**

¹ Submission of the New Zealand Human Rights Commission to the Health Select Committee in relation to its investigation into End of Life Matters; 29 January 2016 at para 48.

5. These matters are discussed in more detail below. A copy of the 2016 submission, and a summary of my recommendations in relation to key aspects of the current Bill, are attached as appendices. These should be read in conjunction with this submission. For the avoidance of doubt, this submission builds on and does not replace, the 2016 agreed Commission position on end of life matters. It focusses on issues specifically affecting the disability community

Human Rights Principles and Scope of the Bill

6. In its 2016 submission the Commission examined human rights principles and jurisprudence relevant to the issues addressed in the current Bill. It concluded that it may be acceptable to permit a competent, adult facing imminent death to end their life but only if a safe and appropriate framework could be implemented and a number of other important prerequisites and safeguards met. It noted the importance of the broader societal context in which decisions are made, including palliative care service provision.
7. When considering the safety and appropriateness of any framework it is also necessary to consider risks to other members of the community, as well as those who are terminally ill and wish to utilise an assisted dying process. The feedback I have received from members of the disability community is that it may not be possible, from their perspective, to identify and implement safeguards that would sufficiently protect them from harm. In any case, the procedural safeguards provided in the Bill fall far short of the mark in terms of protecting the interests of even terminally ill individuals for the reasons outlined later in this submission.
8. In my view, when considering assistance in dying for non-terminal conditions, the balance must be weighted in favour of protecting the vulnerable, both as individuals and as a group. I do not consider that legalising assisted dying in circumstances other than imminent death is compatible with a human rights approach. Such a step poses a substantial risk to vulnerable members of the community such as disabled people, older people and disadvantaged/ marginalised groups.

Specific Concerns About the Inclusion of “non-terminal” conditions

9. The Bill currently provides that any individual who “suffers from a grievous or irremediable medical condition” would be able to access the assisted dying procedures if he or she is in an advanced state of irreversible decline in capability and is experiencing suffering that cannot be relieved in a manner

that is considered tolerable.

10. This eligibility criteria captures a broad range of illnesses and conditions. It is possible that relatively common chronic health conditions, such as diabetes, heart disease, neurological disorders, intellectual disabilities, autism and other neuro-disabilities and regional pain syndromes, if advanced and sufficiently degenerative, could fall within the Bill's scope. Furthermore, the criteria is not expressly limited to physical conditions. It is possible that a person experiencing a mental health or psychological disorder, such as depression, anorexia or a bi-polar disorder could, in certain circumstances, be interpreted as fitting the criteria.
11. In addition, the criteria of "unbearable suffering that cannot be relieved in a manner that is considered tolerable"² is inherently subjective and can only be assessed by ascertaining the personal experience and views of the individual concerned. It is notable that the criteria is not limited to the existence of physical pain. There is a real risk that psychological pain manifested in feelings of hopelessness, despair or worthlessness could fall within the criteria. This is a matter of considerable concern to the disability community, in particular the implicit message this aspect of the Bill sends vulnerable and isolated disabled about the value of their lives.
12. Disabled New Zealanders make up 24 percent of New Zealand's overall population.³ They are marginalised and discriminated against in almost all areas of life. They face practical and attitudinal barriers that hinder their ability to participate fully in society and therefore many experience poor life outcomes in a range of areas. They often experience bullying, have difficulty obtaining an education and finding a job and often do not have access to the supports and resources that would allow them to take part in activities and experiences on an equal basis with non-disabled people.
13. Statistics indicate that disabled people are currently unable to participate in society on an equal basis with non-disabled people⁴. For many disabled people, this means they do not have the same freedom

² Section 4(f)

³ Disability Survey 2013, Statistics NZ.

⁴ For example, recent data from Statistics NZ Household Labourforce Survey 2017 (June Quarter) shows that 42 percent of young disabled people are not in education, employment, or training compared to 10 percent of non-disabled young people (the unemployment rate of disabled people (11.4 percent) is more than double that of non-disabled people (4.5 percent) and only 25.2 percent of disabled people of working age participate in the labour force compared to 72.6 percent of non disabled people. Furthermore, data from Statistics NZ's 2016 General Social Survey indicates more disabled people feel they experience discrimination than non-disabled people (21.5 percent compared to 16.5 percent); and significantly more disabled people also feel lonely most or all of the time (12.7 percent compared to 5.7 percent).

of choice in their everyday lives. This extends from limitations as to where and with whom they live - due to a lack of appropriate housing, support services, and low income – through to every day decision-making about what they eat, wear and where they spend their time. People with intellectual disabilities are particularly vulnerable in this respect. They often have decisions made for them, or are coerced into decisions made in their “best interests”, rather than being supported to make decisions that reflect their own will and preferences.

14. “Supported decision making” means ensuring that disabled people can make their own decisions. The concept is articulated in Article 12 of the United Nations Convention on the Rights of Persons with Disabilities. It enables people to have control and choice about their lives and what happens to them. Some disabled people need assistance so they can express their will and preferences and make their own decisions. New Zealand law and practice is not well aligned with Article 12 and there are many areas where disabled New Zealanders are not supported to make their own decisions.
15. The risk of coercion, particularly for people with intellectual disabilities, is of significant concern in the context of end of life decisions, particularly given the gravity – and irreversibility – of a decision to opt for assisted dying. This lack of choice, imposed or substituted (instead of supported) decision-making, and possibility for coercion must be taken into account when considering autonomy-based arguments for assisted dying. Many people with disabilities simply do not enjoy the right to personal autonomy on an equal basis to non-disabled people. We must therefore first work towards ensuring, to the greatest extent possible, that all people have the same freedom of choice in life before we consider legislating choice in death.
16. Furthermore, while proponents of assisted dying claim it is a solely individual choice and should be left up to each individual to make decisions about their own lives, it is misleading to suggest there is no impact on others when people exercise such choice. Indeed, there are many laws which limit individual choice to protect the wider community: the requirement to wear a seatbelt, adhere to speed limits, and obligations to pay tax. If we didn’t have such laws, there would be negative collective impacts on society. Similarly, someone choosing to end their life through assisted dying, while personal to that individual, could have far-reaching consequences for the people around them. For example, those with similar medical conditions/prognoses may feel pressured to do the same.
17. Anecdotal evidence (such as the portrayal of disability in the media, and peoples’ response to those stories) suggests that many people see disabilities, particularly in more severe forms, as tragic or

even 'a fate worse than death'. As with other marginalised groups in history, disabled people are often perceived as an 'other' (ie someone not like "you" or "me") to be pitied or avoided.

18. Unlike ethnicity or gender, disability can be seen as a medical issue that requires management rather than being an integral aspect of a person's identity. While overt hostility to disability exists in our society, the most pressing issue is societal apathy or indifference towards the value of disability within a population. This serves to reinforce negative perceptions about disabled people and the lives that they lead.
19. By providing a pathway for disabled people to end their lives prematurely through the enactment of the Bill, Parliament risks sending a message to all disabled people and to the wider community that the lives of disabled people are of less value than non-disabled people and therefore may not be worth living. This sort of paradigm contributes to the stigmatisation and exclusion of disabled members of our community.
20. A distinction can be made between providing choice and options to those who are in the final stages of a terminal illness and implementing a pathway for those who are not imminently facing death, but who believe that they do not wish to continue living. My position is that providing the latter group with an assisted dying option carries significant risks for disabled people and other vulnerable groups such as older members of our community. Because of the insidious nature of the risks, they cannot be adequately addressed through legislative safeguards.
21. In jurisdictions where euthanasia is available for people without a terminal illness, it is notable that cases of euthanasia for psychiatric conditions have increased. In Belgium, reported cases of the euthanasia of people with neuropsychiatric conditions increased from 0.8% to 3.9%.⁵ Similarly, euthanasia deaths based on psychiatric reasons have also increased in the Netherlands.⁶
22. Of further note, a recent study in Oregon found that the most commonly cited reasons for choosing assisted dying were losses of autonomy (91.6%) and loss of dignity (78.6%) rather than inadequate pain management which only contributed to the decision in 25.2% of cases.⁷ In other words, most people chose assisted dying not because they were in insufferable pain, but because they were afraid

⁵<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5088089/>

⁶ <https://www.ieb-eib.org/en/document/report-2016-euthanasia-in-netherlands-488.html>

⁷ <https://jamanetwork.com/journals/jamaoncology/article-abstract/2616352>

of losing their independence and dignity. This outcome is concerning from a disability perspective, as it is indicative of prevailing attitudes towards the experiences of disabled people. Many disabled people rely on others for basic daily living tasks, some of which such as showering and toileting, may be perceived to be undignified.

Current Health and Disability Supports and Resources

23. It is of considerable concern that extensive resources, time and money would be required to support the implementation of this Bill, yet there are many areas where adequate resources are not made available to ensure the full and equal enjoyment of human rights by disabled members of the community in core areas of life. More focus and energy must be directed towards ensuring that disabled people and those who experience chronic conditions receive the clinical care and treatment they require. Everyone should have access to high quality resources and support to enable them to reach their full potential.
24. There are well known and acknowledged limitations and constraints with clinical and support service provision in relation to many physical and mental illnesses in New Zealand. Medications available in other jurisdictions are not available to New Zealanders. Innovative and people-centred resources and support models are either not available at all or are provided only on a limited basis through small scale pilot projects.
25. These types of limitations could effectively result in a “Clayton’s choice” for disabled people, whereby an inability to access the services, medication or supports that would improve quality or length of life mean that an individual might feel that there is no option but to access assisted dying procedures. The lower cost and relative ease with which an assisted dying process could be accessed, as compared with the difficulties and obstacles (both practical and financial) of trying to obtain adequate social, medical and practical supports for chronic conditions, is a matter of considerable concern.
26. New Zealand has ratified the Convention on the Rights of People with Disabilities (the “CRPD”). This obliges the government to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

27. People with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
28. New Zealand has a long way to go in order to fully meet the obligations set out in the CRPD. Our focus should be on ensuring progress in this area and better meeting the needs of disabled New Zealanders and those with chronic health conditions.

Palliative care provisions

29. A core component of the Commission's 2016 submission was the need to consider the issue of end of life assistance for the terminally ill in the context of palliative care service provision. Ensuring that high quality palliative care services are (and always remain) available and accessible for all New Zealanders is a crucial aspect of ensuring dignity at the end of life.
30. It is essential for this core health care service to be funded and resourced appropriately to safeguard against assisted death becoming a "default option" because of an absence of humane alternatives for those who are terminally ill. Any consideration of legislative change in respect of assisted dying is premature in the absence of a thorough consideration of palliative care services and guarantees regarding continued access to, and provision of, these services throughout the country.

Specific Drafting Concerns

Definition of "Competent"

31. For the purposes of this legislation a person is considered "competent" if he or she "has the ability to understand a) the nature of assisted dying; and b) the consequences for him or her of assisted dying" (clause 4(f)).
32. This is a simplistic definition that falls well short of common definitions of "competency" in both the legal and clinical sense. Furthermore, the definition significantly complicates, and potentially undermines, the additional specialist review process contained in clause 12. The specialist psychiatrist or psychologist providing an opinion is only required to decide if the person is "competent" as defined above. There is no requirement for the specialist, or the attending practitioner in the first instance, to determine whether the individual experiences a mental health condition or a physical health condition that may affect judgement, behaviour or decision-making.

An individual could experience severe depression or be affected by potentially transient factors such as fear, despair or loneliness and still easily be able to demonstrate that he or she understands the nature of assisted dying and the consequences and thus meet the legal threshold.

33. The safeguards around coercion and undue influence are also deficient. These factors are notoriously difficult to identify, particularly when subtle. The Bill merely requires the attending practitioner to *“do his or her best to ensure that the person expresses his or her wish free from pressure from any other person by- i) talking with other health practitioners who are in regular contact with the person and ii) talking with members of the person’s family approved by the person.”*
34. The requirement to “do his or her best” is wholly unsatisfactory and open to broad interpretation. Although requiring the attending practitioner to talk to other medical practitioners the scope of the obligation is not clear, nor is it evident whether the obligation extends to all practitioners involved in care or whether just one would be sufficient.
35. More concerning is the limiting of enquiries with family members to those “approved by the person”. Often concerns about coercion, influence or psychological control are raised by neighbours, social workers, district nurses, care providers or extended family. Those “approved by the individual” are the group most likely to be the protagonists in situation where influence or control is at play. The chance of detecting improper influence through the process outlined in the Bill seems minimal.
36. In addition, the limitations outlined above in terms of the nature and focus of the “specialist review” nullify any potential protection that this step could offer. A person could easily meet the “competence” requirement yet still be subject to influence or coercion (explicit or indirect). Coercion and influence can affect the exercise of personal autonomy. Disabled or ill people could be particularly vulnerable to manipulation of this nature.

Informed Consent, Information Regarding Options and Choice of Medication

37. Clause 15 does not require the attending medical practitioner to provide any information regarding the risks or side effects of a particular medication and/or choice of administration. Strangely, the clause appears to be focussed only on the method of administration, rather than the actual pharmacological options available and the risks or benefits of each, as applicable to the individual patients’ circumstances. The information that must be provided falls well short of the requirements for other medical procedures as contained in rights 6 and 7 of the Code of Health and Disability Services Consumers Rights.

38. In terms of the information regarding the options vis a vis the other choices available, palliative care and ongoing care of individuals with chronic illness are specialist medical fields. It is highly unlikely that general practitioners or other physicians with different skill sets would have the clinical knowledge or experience to adequately and properly inform the patient of the full range of treatment and pain relief options available, in his or her specific circumstances, and how these would compare with the relative risks and benefits of end of life assistance options. Neither do the provisions recognise the important, and relevant, information that might be available from other sources, such as support groups or those experiencing similar conditions.
39. The concept of informed consent is based on the principle of autonomy – unless an individual is in receipt of appropriate information he or she cannot make informed autonomous choices about medical procedures, including those that might be available at the end of life. The provisions of the current Bill do not support the provision of information to existing legal standards and do not support the exercise of autonomous choice by individuals who may wish to utilise the end of life process.
40. Other jurisdictions that have enacted choice in dying legislation, such as the US state of Oregon, have explicitly recognised the need for genuine informed consent based on full provision of relevant information about choices, options, risks and side effects. The absence of comprehensive safeguards in relation to these issues in the current Bill is highly concerning.

Requirement for Attending Practitioner to be Present

41. The attending medical practitioner is required to be in the same room or in close proximity to the person during the administration of medication and until death occurs (clause 16(5)-(6)). The practitioner is also required to immediately remove the medication from the room and return the medication to the dispensing pharmacist if the person indicates that he or she does not wish to receive it when asked by the practitioner (clause 16(3)).
42. Presumably these requirements are intended to safeguard the interests of the person seeking assistance in dying. Perversely, they may have the opposite effect. Knowing that the attending practitioner has come to the person's home and must remain there until death has occurred, or that the practitioner must remove the medicine immediately if the person indicates a change of heart, might compel an individual to proceed despite doubts. The sense of urgency to continue once the process is so far advanced, and the wish to avoid further inconvenience due to a prolonged home visit by a doctor or loss of face due to a last minute change in heart are very real.

“Cooling off” period /Practical Issues

43. The Bill does not appear to provide for a specific “cooling off period” to prevent hasty or transient requests being actioned. Although it can be assumed that the administrative processes set out in the Bill would take some time to complete, the only specific time requirement appears to be that contained in clause 15(4). This requires the attending medical practitioner to advise the registrar of the method and time chosen by the person seeking assistance in dying and to provide the registrar with the prescription at least 48 hours before the chosen time of death.

44. If the registrar is satisfied that the required processes have been complied with, he or she must co-sign the prescription and provide it to the attending medical practitioner. The absence of a specific period to allow reflective consideration of options and choices is concerning. This is relevant in the context of both terminal and non-terminal conditions – both of which are known to give rise to periods of grief, despair and depression of varying intensity and duration. Quick or reactive decisions could be made in times of low mood without a reasonable opportunity for proper consideration. This is particularly concerning in the context of non terminal illness, where a considered period of reflection and consideration would seem to be even more essential in order to determine whether a wish to die is enduring and based on clear grounds, or is transient and based on a lack of appropriate supports or resources.

45. There are also some obvious logistical issues arising from the process contemplated in the Bill. These include the transmitting of prescriptions for lethal substances in a secure manner, establishing a process for dispensing pharmacists to check the veracity of a signature by a registrar, and ensuring that legal requirements under the Medicines Act 1981, Medicines Regulations 1984 and the controlled drugs provisions of the Misuse of Drugs Act 1975 are complied with throughout all steps of the process.

46. Similarly, the processes for obtaining/dispensing/possessing the medication once a prescription is prepared in the required form, seem incomplete and in many respects incompatible with existing legal requirements around use and possession of controlled medications. Nor are issues of approval of medicines suitable for use in the contemplated manner and availability and supply via Pharmac addressed.

SCENZ Group and Other Oversight Safeguards

47. The SCENZ group would be made up of medical practitioners appointed by the Director-General of Health. Functions of the SCENZ group include advising (in relation to the administration of medication under clause 16) on required medical and legal procedures cl 19(2)(g(ii)) and providing practical assistance, if requested (cl19(2)(g)(iii)).
48. It is difficult to envisage a group of medical practitioners who would be willing to provide advice on “legal procedures” and it is unclear what sort of practical assistance is contemplated, or could be given, by the group. These provisions are problematic and open to broad interpretation.
49. The composition of the group, being medical practitioners only, is also surprising. There is no provision for an ethicist, pharmacist or other non-medical professional. The inclusion of an ethicist in the Review Committee (which considers cases “after the fact”) but not in the real-time accountability structure provided by the SCENZ Group is highly questionable. Given that the framework is intended to extend to non-terminal illness the absence of a person with lived experience of disability and/or long term chronic illness is also notable.
50. This focus on a medical model is evident throughout the Bill. This is particularly concerning given the significant impact this legislation would have on the disability community and the very real dichotomy between the medical model of disability (with disability viewed as something to be “cured” or “fixed”) and the social model of disability, which considers how society responds or reacts to disabled people. This is played out in a number of very real ways for disabled people. There are longstanding bio-ethical issues that continue to breach peoples’ rights (for example, sterilisation, access to full information regarding outcomes of pre-natal screening). There are also issues of access to healthcare services leading to poorer outcomes for disabled people. For example, it is well understood that people with intellectual disability have significantly poorer health outcomes than the general population⁸, for a range of access needs.
51. It is also unclear whether this SCENZ group is to act collectively or as individuals. It is unacceptable to have such a degree of uncertainty about core functions and composition for a structure that is intended to fulfil a key oversight role under the proposed legislation.

⁸ Making citizenship and rights real in the lives of people with intellectual disabilities, IHC, 2017

52. In relation to non-terminal illness, given the potentially broad and imprecise nature of the conditions that could fall within the definition, my view is that nothing short of careful judicial consideration of the specific facts and circumstances should be sufficient to enable access to any assisted dying process. This should entail a full court hearing, with the applicant present, independent counsel appointed to assist the Court and expert evidence provided on key points. This level of oversight and judicial participation would be necessary to try and minimise the risk of inappropriate access to the process, identify potential conflicts and coercion that could influence the decision and ensure that any further potential supports and resources are identified. It may also help protect, to some degree, against some aspects of the “slippery slope” that is particularly pernicious for disabled people.
53. However, I would like to emphasise that my position as Disability Rights Commissioner is that non-terminal illness should not, under any circumstances, be a ground for accessing an assisted dying process. The above recommendations in relation to a judicial process for accessing end of life assistance for non-terminal conditions are included for the consideration of the Committee only for the sake of completeness in the event that a decision is made to include non-terminal conditions.

Summary

54. As outlined above, in my role as Disability Commissioner I cannot support this Bill. There are numerous deficiencies in relation to the general safeguards and processes proposed for both terminal and non-terminal conditions. This Bill proposes a law that poses real and significant risk to disabled people. It undermines our place in society and our value as human beings. In relation to non-terminal illness, in particular, it approaches the “problem” from a medical paradigm and does not take account of the views and experiences of disabled members of our community.
55. Of particular concern is that this Bill is being considered in isolation from any discussion about availability and access to palliative care service provision (in the context of terminal illness) and does not consider or take into account the current deficiencies in support and resources for disabled people. No discussion about end of life processes can, or should, take place in such a vacuum. I oppose this Bill being passed into law.

Appendix A: SUMMARY OF THE DISABILITY RIGHTS COMMISSIONER'S RECOMMENDATIONS

1

This Bill should not be passed into law.

2

The process contemplated in the Bill, and the safeguards that are included, are inadequate in a number of important respects. In particular:

- a) the Bill does not protect the interests of disabled and vulnerable members of the community**
- b) It contains insufficient provisions and protections in relation to matters such as provision of appropriate information before decisions are made; obtaining informed consent; assessing capacity; determining if undue influence or coercion exist; “cooling off” periods and oversight/approval mechanisms.**

3

Legislative change in relation to end of life choice cannot be considered in isolation from palliative care service provision and the current services and resources available to those who experience serious but non-terminal conditions. Disabled New Zealanders are discriminated against and marginalised in many areas of life. They do not always have access to the supports they need to participate in the community on the same basis as others. It is premature to discuss law change in this area without considering the adequacy of existing resources and services.

4

If the Bill is to be passed in some form (which I oppose) then the concerns outlined above must first be appropriately and comprehensively addressed, in consultation with the disability community. Further, any access to end of life assistance should only take place upon the issuing of an order from the Court and after a full examination of the facts and circumstances of each application.

Appendix B: Human Rights Commission 2016 Submission



Human Rights
Commission
Te Kāhui Tika Tangata

Submission to the Health Select Committee in Relation to its Investigation into End of Life Matters

29 January 2016

NEW ZEALAND HUMAN RIGHTS COMMISSION SUBMISSION TO THE HEALTH SELECT COMMITTEE IN RELATION TO ITS INVESTIGATION INTO END OF LIFE MATTERS

Introduction

1. The Human Rights Commission ('the Commission') welcomes the opportunity to provide a submission to the Health Committee ('the Committee') in relation to its investigation into end of life matters, following its receipt of the Petition of Hon. Maryan Street and 8,974 others ('the Petition').
2. The Petition itself follows the landmark High Court case brought by Lecretia Seales⁹ which sought to challenge the current legal prohibition against physician-assisted voluntary euthanasia. The Commission appeared as an intervener in those proceedings, pursuant to its functions under the Human Rights Act 1993.¹⁰ Ms Seales' case generated considerable public interest in this issue and has reignited the policy debate in New Zealand.
3. The Committee has identified four areas that it will consider during its investigation. The Commission has focused its submission on the human rights aspects of areas 3 and 4, these being the current legal situation and international experiences.

Summary of the Commission's position

4. This submission represents the agreed collective views of the Commission on matters where consensus has been reached. The Commission's position can be summarised as follows:
 - a. The Commission acknowledges the complexity of the issues being considered by the Committee and the need to balance competing principles such as the right to life, respect for human dignity, personal autonomy and the protection of vulnerable members of society.
 - b. The Commission is strongly of the view that any legal change that might be contemplated by Parliament in this area must incorporate sufficient safeguards in order to eliminate risk to vulnerable citizens. Minimum safeguards that should be included are set out later in this submission.

⁹ *Seales v Attorney-General* [2015] NZHC 828

¹⁰ Human Rights Act 1993 s 5(2)(a) and 5(2)(j).

- c. The Commission considers that a legal framework permitting assistance to be given to a competent terminally ill adult to end his or her life (if he or she freely and autonomously chooses to do so), would likely be acceptable if accompanied by adequate legal and procedural safeguards and in the context of appropriate palliative care services being available and accessible.
 - d. The Commission notes that the New Zealand Bill of Rights Act 1990 (NZBORA) does not specifically include the core human rights principles of dignity, personal autonomy or the liberty and security of the person as free-standing rights. This stands in contrast with some overseas jurisdictions. This position is particularly relevant to consideration of end of life matters but also has broader application. The Commission recommends that the Committee consider whether the current form of the NZBORA adequately engages the human rights issues that arise from end of life matters.
5. The Commission's position is set out in more detail below. The Commission would appreciate the opportunity to speak to its submission.

The Current Legal Position in New Zealand

6. The current legal position is well established and is noted only briefly in this submission to establish the basis for the discussion that follows. *Seales v Attorney General* confirmed that any action taken by a physician to assist a terminally ill person to take his or her own life upon their request constitutes a serious criminal offence under the Crimes Act 1961¹¹.
7. The primary basis for the decision in *Seales* can be found in section 63 of the Crimes Act, which provides that no person has the right to consent to the infliction of death upon themselves, and that the existence of such consent does not affect the criminal responsibility of any person who is party to such an act. In line with the text and purpose of section 63, and with reference to similar UK law, Justice Collins concluded that Ms Seales' consent would not provide her doctor with a lawful excuse to administer "aid-in-dying" to Ms Seales.¹²
8. Lecretia Seales had sought to test the current position by seeking a declaration that her doctor would not be liable for culpable homicide under the Crimes Act if she "administered aid in dying" to her; nor aiding and abetting suicide if she "facilitated

¹¹ Culpable homicide (s160) and Aiding and Abetting Suicide (s179(b))

¹² *Seales v Attorney-General* [2015] NZHC 828, paragraphs [89]-[99]

aid in dying". Alternatively, Ms Seales sought a declaration that the provisions of the Crimes Act that prohibited her doctor from administering or facilitating aid to end her life were inconsistent with her rights under the NZBORA.

9. In declining to grant the orders sought, Justice Collins held that the implications of such a change to the law could not appropriately be effected through the Court, concluding that "*the complex legal, philosophical, moral and clinical issues raised by Ms Seales' case could only be addressed by Parliament passing legislation to amend the effect of the Crimes Act*"¹³.

Core Human Rights Principles

10. In his judgment, Justice Collins identified four core principles engaged by Ms Seales' case¹⁴. They are:

- a. The sanctity of life
- b. Respect for human dignity
- c. Respect for human autonomy;
- d. Protection of the vulnerable.

11. Each of these core principles invokes corresponding human rights principles. The manner in which these core principles apply in the context of end of life decisions is a vexed issue and there is an absence of international consensus.

The sanctity of life

12. In *Seales v Attorney General*, Justice Collins described the sanctity of life as "*one of society's most fundamental values*"¹⁵. It conceptually underpins the human right to life, itself the most basic human right¹⁶. It is also included in various forms across a wide range of international human rights instruments, constitutional charters and bills of rights. Article 6.1 of the International Covenant on Civil and Political Rights ["ICCPR"], to which New Zealand is a signatory, states:

¹³ *Seales v Attorney-General* [2015] NZHC 828, paragraph [211]

¹⁴ *ibid* at [62]

¹⁵ *Ibid* at [163]

¹⁶ Butler & Butler, para 9.2

"Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life"

13. A truncated version of the right is incorporated into New Zealand statutory law by section 8 of the New Zealand Bill of Rights Act 1990, which states:

"No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice."

14. Justice Collins found that the right to life under s 8 of NZBORA was directly engaged by Ms Seales' case. In doing so, he noted that it is well established that the right to life is not absolute, stating that *"...the sanctity of life.... underpins s 8. Section 8 does not, however, require all human life be preserved in all circumstances."*¹⁷¹⁸

15. In the medico-legal context, this qualification permits physicians to withdraw life support for patients in extreme vegetative states without fear of criminal prosecution for culpable homicide, as confirmed in the landmark 1993 case of *Auckland Area Health Board v Attorney-General*¹⁹. In that case Justice Thomas observed that the sanctity of life was "not an absolute value" for the purposes of section 8 and noted that it could be offset by values of human dignity and privacy, values "central to our concept of life." This qualification also permits the provision of appropriate levels of pain relief in accordance with good medical practice even if such doses may hasten death, as long as the primary intention is to relieve pain and not to end life.

16. Overseas jurisdictions have taken various approaches when interpreting and applying the right to life in assisted suicide cases. In the case of *Pretty v United Kingdom*, both the UK House of Lords²⁰ and the European Court of Human Rights²¹ concluded that the right to life under Article 2 of the European Convention on Human Rights primarily reflected values pertaining to the sanctity of life. Lord Bingham held that the right to life cannot be interpreted as conferring a right to die or enabling a person to enlist the aid of another person in bringing about their

¹⁷ [2015] NZHC 828 at [163]

¹⁸ Butler and Butler have also noted that the Attorney General's report on the 2003 Death with Dignity Bill suggested that one meaning of "deprive" is to "take without permission" the right not to be deprived of life under s 8 or NZBORA something is discretionary and can be waived by individuals who, for example, consent to suicide

¹⁹ *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 253

²⁰ *R v Director of Public Prosecutions ex parte Diane Pretty & Ors* [2001] UKHL 61

²¹ *Pretty v United Kingdom* [2002] ECHR 2346/02 29 April 2002

death²². The European Court of Human Rights agreed, finding that the right to life “cannot be interpreted as involving a negative aspect”.²³

17. However, in its more recent decision in *Haas v Switzerland*²⁴, the European Court of Human Rights shifted its interpretative approach and focus towards an emphasis on personal dignity, and in particular, personal autonomy. In *Haas*, the European Court interpreted Article 8 of the European Convention on Human Rights, which provides for the right to self-determination and a private life, as a basis for a right to exercise personal autonomy in end of life decisions. In doing so, the Court reframed its interpretation of the right to life under Article 2 to provide a basis for procedural safeguards that “establish a procedure capable of ensuring that a decision to end one’s life does indeed correspond to the free wish of the individual concerned.”²⁵

18. The Supreme Court of Canada took a very different approach to the right to life in its March 2015 decision in *Carter v Canada*²⁶, finding that the right to life does not require an “absolute prohibition in assistance in dying”²⁷. The Supreme Court also considered that²⁸:

“The right to life is engaged when the law of the state imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition [against physician assisted dying] deprives some individuals of life, as it has the effect of forcing some individuals to take their own life prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.”

19. However, it is important to emphasise that there is a crucial distinction between the framing of the right to life under the Canadian Charter of Rights and the NZBORA. Section 7 of the Canadian Charter includes the rights to liberty and security of the person, alongside the right to life. These concepts are missing from s 8 of the NZBORA. Protection of the individual’s right to liberty and personal security were decisive factors in the Court’s judgment in *Carter*.

20. Interpretive guidance about aspects of human rights treaties can also be issued by United Nations treaty bodies in the form of “general comments”. These comments

²² *R v Director of Public Prosecutions ex parte Diane Pretty & Ors* [2001] UKHL 61 at [5]

²³ *Pretty v United Kingdom* [2002] ECHR 2346/02 29 April 2002 at [39]

²⁴ *Haas v Switzerland* [2011] Ap. 31322/07

²⁵ *Ibid* at [54]

²⁶ *Carter v Canada (Attorney General)* [2015] SCC 5

²⁷ *Ibid* at [63]

²⁸ *Ibid* at [57]

provide guidance on the interpretation and application of various treaty provisions. However, to date, the UN Treaty bodies are yet to develop any definitive position on the human rights implications of assisted suicide.

21. The United Nations Human Rights Committee (UNHRC) issued a general comment on the right to life as expressed in Article 6 of the ICCPR in April 1982. This comment does not contain specific mention of matters pertaining to end of life matters, such as physician assisted suicide, although it notes that the right to life should be interpreted broadly. The UNHRC is currently preparing an updated General Comment on the right to life following its day of discussion on the right to life at its 114th session in July 2015²⁹. Once available, this updated comment may be relevant to the deliberations of the Health Committee on this matter.
22. However, after reviewing the Netherlands' compliance with the ICCPR in 2009, the UNHRC expressed concern at the "extent of assisted suicide and euthanasia" in that country, noting in particular the lack of independent judicial oversight to guard against the existence of undue influence or misapprehension³⁰. The UNHRC recommended that the statute that legally authorises physician-assisted suicide in the Netherlands³¹ be reviewed in light of Article 6 of the ICCPR.
23. In the Commission's view, the right not to be arbitrarily deprived of life does not directly translate into an absolute prohibition on parliament implementing a legislative framework that would permit terminally ill people to obtain assistance to end their lives. This position is subject to the provisos and safeguards identified later in this submission.

The Right to Dignity

24. Human dignity is a core human rights concept. Human rights themselves have been described as "*fundamental rights which empower human beings to shape their lives in accordance with liberty, equality and respect for human dignity*"³² and as a "*manifestation of human dignity*" that provides the conceptual nucleus from which all existential human rights derive³³.

²⁹ <http://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx>

³⁰ UN Human Rights Committee, Concluding Observations" Netherlands, CCPR/C/NDL/CO/4, paragraph 7, 25 August 2009

³¹ The Termination of Life Upon Request and Assisted Suicide Act

³² Nowak (2003), *Introduction to the Human Rights Regime*, Martinus Nijhoff Publishers, Leiden p 1

³³ *ibid*

25. The first recital of the Universal Declaration of Human Rights states that the “*recognition of inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*”. The same statement is included in the preamble of the ICCPR and the preambles of both the ICCPR and International Covenant of Economic Social and Cultural Rights (“ICESCR”) recognise that the rights contained therein “*derive from the inherent dignity of the human being*”. Article 3(a) of the Convention on the Rights of Persons with Disabilities (“CRPD”) provides that the principles of the Convention “*shall be respect for inherent dignity, individual autonomy including the freedom to make ones’ own choices, and independence...*”

26. In New Zealand, a free-standing right to dignity is not expressly provided for in the Bill of Rights and other human rights legislation. This contrasts with jurisdictions such as South Africa, where the right to dignity is included in the South African Bill of Rights, which states at section 10 that “Everyone has inherent dignity and the right to have their dignity protected and respected.”

27. The absence of a justiciable right to dignity in New Zealand law was highlighted by Justice Collins in *Seales v Attorney General*, stating³⁴:

“I fully acknowledge the consequences of the law against assisting suicide as it currently stands are extremely distressing for Ms Seales and that she is suffering because that law does not accommodate her right to dignity and personal autonomy”

28. Despite the absence of the right to dignity in New Zealand human rights legislation, the New Zealand courts have affirmed the centrality of the concept of dignity in human rights law. In *Auckland Area Health Board v Attorney General* Justice Thomas found that loss and degradation of bodily functions invoked the values of human dignity and personal privacy³⁵. His Honour also emphasised that “*dignity and worth of the human person is a key value underlying the rights affirmed in the Bill of Rights*” in the 2007 case of *Brooker v Police*³⁶.

29. The right to dignity has been a central factor across the body of international case law on assisted suicide. In *Carter v Canada*, the Supreme Court of Canada held that the rights to liberty and security of the person are underpinned by “*a concern for the protection of personal autonomy and dignity*”³⁷. The Supreme Court of Canada

³⁴ [2015] NZHC 828 at [192]

³⁵ [1993] 1 NZLR 253 at p 245

³⁶ *Brooker v Police* [2007] NZSC 30, 3 NZLR 91 at [177]-[192]

³⁷ *Carter v Canada* [2015] SCC 5 at [64]

also drew a connection between an individual's respective senses of bodily integrity and dignity, observing that an individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.³⁸

30. In the 2015 South African assisted case of *Stransham-Ford v Ministry of Justice*³⁹, Justice Fabricius referenced South African legal authorities that establish the concept of dignity as a justiciable and enforceable right intertwined with the right to life⁴⁰. In that case, the judge found that a number of conditions suffered by the applicant, who was in Stage 4 of terminal cancer, compromised his dignity⁴¹.

31. The observations of the Canadian and South African courts reflect the close connection between the general concept of personal dignity and the ability to maintain control over one's body and circumstances so as to prevent events or insult that the individual might find subjectively offensive. In this respect, it is a corollary of the right to be treated humanely and with respect.

The right to personal autonomy

32. Like the right to dignity, human rights concepts derived from the concept of personal autonomy have been influential in court decisions concerning the lawfulness of physician assisted suicide.

33. In *Carter v Canada*, the Canadian Supreme Court described the right to liberty under section 7 of the Canadian Charter of Rights as protecting " *the right to make fundamental choices free from state interference*" and the right to security of the person under that same section as " *encompassing a notion of personal autonomy involving control over ones bodily integrity free from state interference*", noting that " *it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes harm or suffering*".⁴²

34. In the European jurisdiction, the European Court of Human Rights in *Haas v Switzerland* interpreted the right of the individual to self-determination under Article 8 of the European Convention as creating an inalienable right to exercise personal autonomy on end of life decisions.

³⁸ Ibid at [66]

³⁹ *Stransham-Ford v Minister of Justice & Ors* [2015] 27401/15

⁴⁰ Ibid at p 14, 16

⁴¹ Ibid at p 18

⁴² *Carter v Canada* [2015] SCC 5 at [64]

35. In *Seales v Attorney General*, Justice Collins noted that the concept of personal autonomy was “multi-faceted and subject to much debate” amongst ethicists. His Honour referred to the concept as encompassing:⁴³

“self-rule that is free from both controlling influence by others and limitations that prevent [the individual from making] meaningful choice[s] [about his or her body.]”

36. Justice Collins noted that the concept of person autonomy was reflected in s 11 of the NZBORA, which establishes the right of an individual to refuse to undergo medical treatment. However, as set out above, he found that New Zealand law does not accommodate the right of the individual with a terminal illness to exercise their right of personal autonomy to end their life with the assistance of a physician.⁴⁴

Protection of the Vulnerable

37. The most fundamental public policy impact of any potential change to the law regarding assisted dying, whether judge-led or through legislation, is that it could be regarded as qualifying the State’s protection of the sanctity of life. Related to this is a fundamental human rights concern about protecting the vulnerable from harm and exploitation⁴⁵.

38. In the present context vulnerable groups may include children, older adults, those whose decision-making ability may be affected in some manner, those who may be susceptible to influence or who are unable to access optimal social or clinical care.

39. This is an area of particular interest to disabled members of the community for several reasons. There is concern that external influence (covert or overt) and/or internal belief systems shaped by inaccurate perception could lead to inappropriate access to, or disproportionate rates of, utilisation of any end of life assistance if this were legally available.

⁴³ [2015] NZHC 828 at [71], quoting Beauchamp and Childress, *Principles of Biomedical Ethics*, 7TH Ed, Oxford University Press, New York, 2013, at p 101

⁴⁴ At [192]

⁴⁵ For example, in respect of persons with disabilities, Article 12.4 of the CRPD provides: *“States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse...such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preference of the person, are free of conflict of interest, are proportional and tailored to the person’s circumstances...the safeguards shall be proportional to the degree to which such measures affect the persons rights and interests.”*

40. There is social and historical context associated with how society values and treats disabled people. Community attitudes to people with a disability and concepts such as “quality of life” affect the way that disability is perceived and the way in which disabled people value themselves and form their own identity. Fear of becoming disabled, or of becoming a “burden”, on family members and others can have an impact on the decisions that disabled people might make around end of life choices.
41. Such views may not be based on lived experience or personal knowledge of a particular disability but on information or attitudes shaped by the broader community. These can also be influenced by actual or perceived difficulty accessing appropriate services and support that would allow disabled people to participate equally in the community on the same basis as others. It is likely that these societal influences and attitudes, at least in part, may shape the views of some members of the broader community as to decisions they might make in future if they were incapacitated or became ill. Irrespective of any potential change to end of life options, it is essential that the community strive to eradicate stigma and incorrect information about living with a disability or serious long term illness. Ensuring appropriate access to services and assistance so that disabled people are able to participate fully in society on the same basis as others will also assist in this regard.
42. The situation is of particular concern in the context of non-terminal but serious and irreversible illness. The difference between taking active steps to shorten life in the face of a terminal illness/ imminent death compared with intervening to foreshorten life in a situation where an individual finds their situation unbearable but is not otherwise facing a shortened lifespan is complex.

International Policy Positions and Approaches

43. A number of countries have explored both the human rights and broader policy implications associated with legalisation of physician assisted dying. In Australia, the Australian Human Rights and Equal Opportunity Commission’s 1996 paper *Human Rights and Euthanasia* considered these human rights policy implications in detail in its analysis of the Northern Territory Rights of the Terminally Ill Act, which (ultimately unsuccessfully) sought to legalise physician assisted dying in that jurisdiction. The report concluded⁴⁶:

⁴⁶ Human Rights and Equal Opportunity Commission, *Human Rights and Euthanasia*, December 1996, p 18, https://www.humanrights.gov.au/sites/default/files/content/pdf/human_rights/euthanasia.pdf

- a. The right to life is a fundamental human right but is not absolute.
 - b. In certain prescribed circumstances, there would appear not to be a violation of the right to life if the law seeking to diminish the absolute effect of the right does not involve an arbitrary deprivation of life and legal protections are in place to ensure this.
 - c. A legal waiver may be able to operate in certain restricted circumstances if it is reliable, authentic and subject to appropriate safeguards.
44. In reaching these conclusions, the Australian Commission ultimately concluded that political and moral judgments about euthanasia are not ultimately capable of resolution through the application of international human rights standards. The Commission found that any final political or moral judgment must be made by the legislature.
45. It is notable that a number of jurisdictions have legalised or decriminalised some form of assisted dying. For example, Belgium, the Netherlands and the U.S. state of Oregon have passed legislation authorising physician assisted dying, albeit with contrasting approaches and thresholds. In the cases of Belgium and the Netherlands, this includes permitting the prescription and administration of lethal medication by a physician to both terminal patients and those patients experiencing intolerable suffering as a result of a serious incurable illness. In Oregon, authorisation is limited to the prescription of lethal medication for self-administration by a terminally ill adult patient.
46. In Switzerland, the provisions of its 1937 Criminal Code⁴⁷ do not prohibit assisted suicide if there is no "selfish motive". Accordingly, while there is no specific legislation authorising physician assisted dying, this feature of the Swiss criminal law has led to the establishment of non-profit agencies such as Dignitas and Exit that provide assisted suicide services in Switzerland. Legislative change can probably be anticipated in jurisdictions such as Canada and South Africa, where the Courts have held that criminal provisions prohibiting assistance in dying are inconsistent with relevant constitutional rights.
47. The UK has also considered the implications of legalising physician assisted suicide. In 1994, the Parliamentary Select Committee on Medical Ethics examined issues

⁴⁷ Article 115, Swiss Penal Code

surrounding withholding life-prolonging treatment, including euthanasia. The Select Committee recommended that euthanasia remain illegal in the UK, although strongly endorsed the right of a competent patient to refuse medical treatment, positions endorsed by the UK Government⁴⁸. More recently, in 2015, the Assisted Dying Bill, a private members bill which sought to introduce physician assisted dying for terminal patients and included judicial oversight mechanisms for individual cases, was defeated in the House of Commons⁴⁹.

Conclusions and recommendations

48. The Commission is of the view that a legal framework permitting assistance to be given to a competent terminally ill adult to end his or her life (if he or she freely and autonomously chose to do so), could potentially be implemented if:

- a. It is developed in a manner consistent with core human rights principles; and
- b. Is accompanied by adequate legal and procedural safeguards to protect vulnerable members of society; and
- c. Appropriate palliative care services are available and remain accessible for all.

49. The following are matters that the Commission believes require careful consideration and which would be essential minimum components of any legal framework that might be considered. These matters clearly require detailed examination and further investigation if any legal change is to be contemplated. These are not exhaustive and are noted by way of example only.

- a. Need for high thresholds.** Clear and sensible thresholds are necessary. A minimum age of 18 and likely death within 12 months would be essential.
- b. Decisions must be free from any indication of coercion or influence and must be competently made.** Systems would be required to ensure that decisions are competently and freely made. A framework that permits, or requires, self-administration of lethal medication may be preferable to one that provides for administration by a third party medical practitioner.

⁴⁸ Government Response to the Report of the Select Committee on Medical Ethics, Presented to Parliament by Command of Her Majesty, May 1994, Cm 2553

⁴⁹ <http://services.parliament.uk/bills/2015-16/assisteddyingno2.html>

c. Need for supporting medical review/and perhaps psychiatric screen.

Appropriate medical evidence must be available to confirm prognosis and to ensure absence of a treatable/remediable physical or mental health condition that may impact on any decision-making ability.

d. Cooling off period. A “cooling off period” would be essential to prevent hasty and reactive decisions, particularly in the face of recent diagnosis and to ensure an enduring and consistent wish to proceed.

e. Need for ongoing monitoring and independent review of the system.

Independent oversight of any system would be essential to prevent abuse or misuse, to ensure public transparency about what is occurring and to assist early identification of any potential problems.

f. Judicial /expert oversight. Judicial level consideration as to whether relevant prerequisites and thresholds have been met in each particular case would be desirable and could assist in the identification of irregularities or concerns not obvious to those directly involved. This input could be provided through direct review/inquiry and confirmation that requirements have been met similar to Protection of Personal and Property Rights proceedings in the Family Court. Alternatively, it could be achieved via a less intrusive “paper based” review system. Input from independent ethicists and others with specialist knowledge or skills in relevant areas (such as those with lived experience of disability) would also be highly desirable.

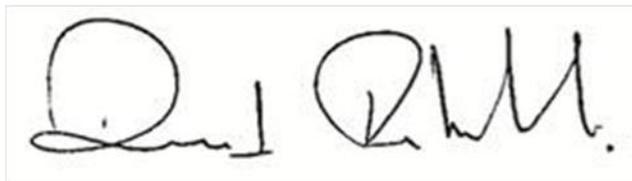
g. Participation by medical professionals and others in the process must be voluntary – ie an “opt out” conscience clause. There will be medical practitioners and pharmacists who would not want to participate in any manner in the deliberate bringing about of death even if this were permitted by the law. Such views ought to be respected and any proposed legal change should contain “conscientious objection” provisions similar to the current abortion legislation. Participation by health professionals should be on a voluntary basis only and not compelled.

h. Cultural considerations. Cultural considerations need to be taken into account and reflected in any framework and process that might be developed. This includes appropriate account being taken of the cultural diversity of the New Zealand population, including those for whom English is a second language.

- i. Need to ensure access to and standard of palliative care is not compromised and remains a viable and “first choice” option.** It is essential that high quality palliative care is provided, and remains, accessible to all. Palliative care is an essential component of the health system and diligent and dedicated palliative care providers throughout the country play a key role in assisting New Zealanders to die peacefully and with dignity in the vast majority of cases. Assisted death should not become a “default option” or a choice that is made because of an absence of alternatives.
- j. Importance of advanced care planning.** It is important not to lose sight of advance directives and other components of advance care planning that can also help give effect to autonomous decisions at the end of life, irrespective of any direct clinical intervention that might be available.

50. This submission does not purport to be an exhaustive or definitive overview of the human rights components of the matters that the Committee is inquiring into. The Commission is cognisant of the complexity of the matters under consideration and the likely volume of submissions that the Committee will receive. This document is only intended to highlight some key points of importance to the Commission and the Commission’s agreed overall approach to the issue of assisted dying. The Commission seeks an opportunity to meet with Committee to discuss these matters further.

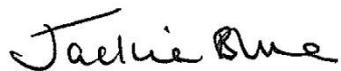
51. In closing, the Commission would like to note the importance of these issues to all New Zealanders and the desirability of the matters being debated in an open, robust and non-partisan manner.

A handwritten signature in black ink, appearing to read 'D. Rutherford', is enclosed in a thin black rectangular border.

David Rutherford – Chief Commissioner



Dame Susan Devoy – Race Relations Commissioner



Dr Jackie Blue – Equal Employment Opportunities Commissioner



Paul Gibson – Disability Rights Commissioner



Karen Johansen – Human Rights Commissioner



Richard Tankersley – Human Rights Commissioner