Voluntary Assisted Dying Board
Western Australia

Annual Report
2024–25

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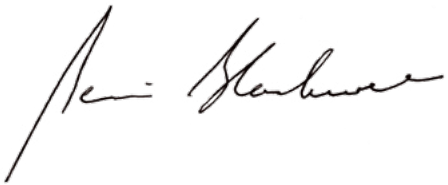
Statement of Compliance

The Hon Meredith Hammat MLA
Minister for Health; Mental Health

Dear Minister

Pursuant to section 155 of the *Voluntary Assisted Dying Act 2019*, I have pleasure in submitting to you, for presentation to each House of Parliament, the Annual Report of the Voluntary Assisted Dying Board for the year ended 30 June 2025.



Dr Scott Blackwell
Chairperson, Voluntary Assisted Dying Board

28 October 2025

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Overview

About this report

This annual report fulfils the requirement of section 155 of the *Voluntary Assisted Dying Act 2019* by reporting on the operations of the *Voluntary Assisted Dying Act 2019* for the 12 months to 30 June 2025.

Data in this report

The data in this report has been extracted from the Voluntary Assisted Dying Information Management System (VAD-IMS), unless specified otherwise. VAD-IMS is a bespoke, web-based application developed to manage voluntary assisted dying in Western Australia (WA). Health practitioners upload forms at each stage of the process and can use the platform to register for access to the Western Australian Voluntary Assisted Dying Approved Training. Forms submitted to the Voluntary Assisted Dying Board via VAD-IMS are monitored by the Voluntary Assisted Dying Board Secretariat Unit.

Data was extracted from VAD-IMS on 15 July 2025 to account for activity that occurred up to 30 June 2025. Footnotes are included throughout the report to assist with interpretation of the data. Figures have been rounded to one decimal place and, due to rounding, totals may not summate to 100 per cent. Patients may undertake the same process step in different time periods, so the sum of the number of patients undertaking an activity each year may exceed the all-time count. This report also contains minor revisions to the 2021–22, 2022–23 and 2023–24 data where new information was received or updated. Unless specified otherwise, data in the annual report reflects information collected from valid forms only. VAD-IMS also holds data on forms with other status types including void, revoked or invalid. Unless specified, data for region is based on the postcode of the patient's home address, with the Perth metropolitan region including the Peel region and patients with no fixed address.

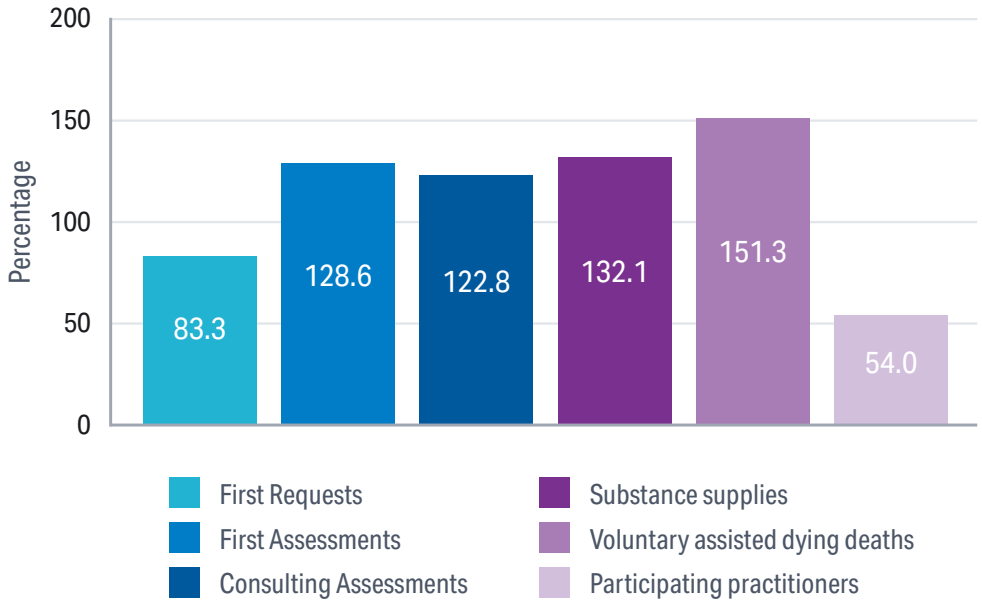
Foreword

On behalf of the Voluntary Assisted Dying Board (the Board) of Western Australia (WA), I am pleased to present the fourth annual report on the operations of the *Voluntary Assisted Dying Act 2019* (the Act).

This report will show that voluntary assisted dying activity in WA continues to increase year-on-year (Figure 1). In 2024–25, there were 480 voluntary assisted dying deaths, an increase of 63.8 per cent over the number of deaths in 2023–24 (n=293).

Noting these considerable and consistent increases over time, the Board expresses our concern about the vulnerability and sustainability of voluntary assisted dying services in this report.

Figure 1: Increase in voluntary assisted dying activity and participating practitioners in 2024–25 compared with 2021–22

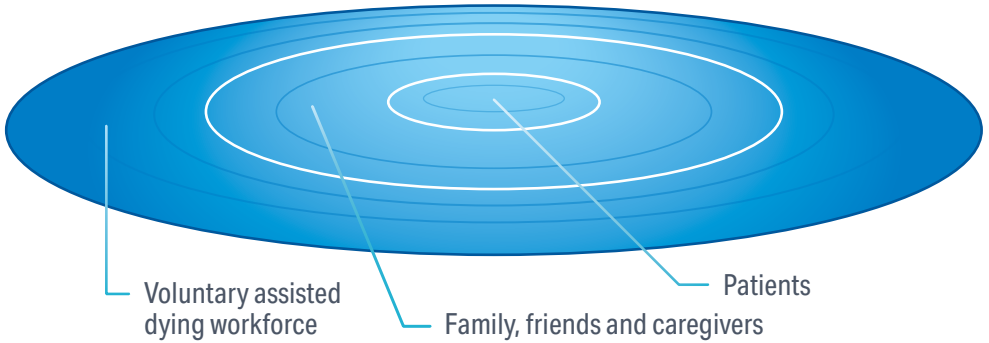


Condolences

On behalf of the Board, we pay our respects to all Western Australians who have made the choice of voluntary assisted dying in 2024–25.

When a pebble drops into a pond of still water there is an initial splash followed by a series of concentric waves that steadily flow to the edge of the pond. So it is, when an eligible person who will die soon, and is suffering in a manner unacceptable to themselves, makes the choice for voluntary assisted dying. The choice of the person at the centre is felt by their community and the dedicated people who work to support the voluntary assisted dying process (Figure 2).

Figure 2: Effect of patients who make a request for voluntary assisted dying



The ripple effect of a person's choice for voluntary assisted dying is first felt by their family, friends and caregivers. On behalf of the Board, I express our condolences to all family members, friends and caregivers of those who made the choice of voluntary assisted dying and have died in 2024–25.

The Board is thankful to those who have shared their stories and experiences of the voluntary assisted dying process during 2024–25. Sharing a personal reflection with the Board supports the recommendations that we make to improve the operation of voluntary assisted dying as we monitor the operations of the Act.

The ripple effect of a person making a choice for voluntary assisted dying is also felt by the clinical professionals who support that person through the legislated process:

- care navigators and voluntary assisted dying coordinators within the WA health system connect patients with trained practitioners and often walk with the patient and their support network throughout the voluntary assisted dying process
- voluntary assisted dying practitioners perform clinical assessments of eligibility, take responsibility for the voluntary assisted dying process, and, when requested, administer the voluntary assisted dying substance
- pharmacists who travel throughout the metropolitan area and across WA to support patients and practitioners, and provide safe access to the voluntary assisted dying substance.

These health professionals perform their respective roles to enable a person's choice for voluntary assisted dying to be realised.

It is here that my analogy falls down a little. The activity outlined in this report paints a picture more of a hailstorm on a pond rather than a single pebble. Multiple simultaneous waves of activity with an ever-increasing frequency are a challenge for these health professionals, and yet they have continued to provide a person-centred, compassionate service with kindness and respect, and in compliance with the principles and provisions of the Act.

As a Board we recognise there is still work to be done to deliver a sustainable system that is equipped to enable the person at the centre to make genuine choices about their care at end of life.

Recommendations under review

The Board's primary role is to monitor the operations of the Act, to manage voluntary assisted dying information it receives and to make recommendations for the improvement of voluntary assisted dying in WA. In drafting this report, the Board has looked back to previous reports and reflected on progress made towards previous recommendations.

Two issues that have been a growing concern throughout the past four years are:

- access to a sufficient pool of trained practitioners to perform functions under the Act
- the impact of increasing activity on pharmacists, care navigators and voluntary assisted dying coordinators within the WA health system (Figure 1).

The Board has made recommendations with a focus on workforce in each annual report and the matter is now more urgent with the considerable increase in activity in 2024–25.

The Board expresses its gratitude to those who have arranged and contributed to voluntary assisted dying training opportunities for practitioners and to those practitioners who became part of the available clinical workforce in 2024–25. Thank you, your efforts are vital to the sustainability of voluntary assisted dying in WA.

We recognise that the implementation of a state funding system for clinician services for voluntary assisted dying commenced in July 2024, and look forward to its full impact on workforce as awareness of it grows in the clinician community. We recognise those clinicians who provided voluntary assisted dying services without adequate remuneration in the early days of implementation and, despite the progress made in the previous year, understand that there are those who continue to do so.

With the increased activity, the workload on the Statewide Care Navigator and Pharmacy Services is also a concern for the Board. Their ability to provide a safe and reliable service depends not only on adequate staffing, but also on the safety and privacy issues impacted upon by the circumstances in which they are housed. Teamwork in end of life care is a long-held principle and measures to facilitate this into the future are supported by the Board.

Front (left to right): Ms Maria Osman, Ms Linda Savage. Back (left to right): Dr Scott Blackwell, Dr Gareth Wahl, Mr Colin Holt.

Compliance and monitoring

The Board has implemented a rigorous program to monitor compliance, with issues arising addressed through an educational program and by referral to relevant agencies or persons in line with the Board's function in the Act. We are pleased to report that compliance with the requirements of the Act remains high. However, we again express our disappointment and concern as we continue to hear of people who have been hindered or prevented from accessing voluntary assisted dying when they have made a legitimate request.

The Board's Monitoring Policy not only involves the review of data but also relies on personal feedback from all the people involved in the process of voluntary assisted dying. Through the receipt of personal reflections and our interaction with service providers and the community, including regional visits, we are better informed about how voluntary assisted dying is being received in WA and reflect this in the recommendations that we make to improve the service. In this report we share some of the reflections we have received, and they are presented under a series of themed headings to facilitate their meaning.

Research

The Board is required to conduct analysis of, and research in relation to, the information given to the Board under the Act. The Board's Research Advisory Group is now established, and the Board is moving forward with both local and interjurisdictional research with its research partners. Research is an essential and fundamental tool for the Board as it fulfils its role under the Act. We recognise the privilege in being the recipients of information, and the responsibility to use it wisely, and are committed to developing an evidence base to support the future understanding and improvement of voluntary assisted dying in WA.

Thank you

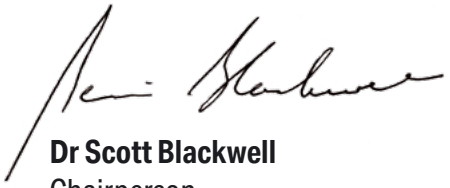
Firstly, to the doctors, nurse practitioners, care navigators, voluntary assisted dying coordinators and pharmacists, we know you work under pressure that is physical, psychological and spiritual, and yet you continue to operate with diligence, care and respect. We are extremely grateful as a Board for the work that you do and the way that you do it.

To our secretariat, who have also risen to the demand of increasing workload and have still given us the high-level support that the Board needs as it faces often complex and sensitive issues. We are very indebted to your professionalism and expertise.

Thank you to Dr Shirley Bowen, Director General of the WA Department of Health, for your ongoing support for the work of the Board. We are grateful also for the efforts of the members of the End of Life Care Program team in the WA Department of Health and look forward to continuing to work together on the many issues we face in supporting access to voluntary assisted dying for the people of WA.

In 2024–25, Dr Robert Edis relinquished his role after serving on the Board since its inception. During his tenure, the Board benefitted from Dr Edis' expertise as a consultant neurologist and extensive experience in working across the health sector to provide person-centred care for patients with motor neurone disease. The Board thanks Dr Edis for his contributions and wishes him well in his retirement. Dr Gareth Wahl joined the Board in 2025, bringing experience as a voluntary assisted dying practitioner, emergency physician and medical administrator.

The Board expresses its gratitude to the outgoing Minister for Health, Hon Amber-Jade Sanderson for her enduring support for access to voluntary assisted dying as an end of life choice. We look forward to establishing a productive relationship with the incoming Minister for Health, Hon Meredith Hammat in 2025–26.



Dr Scott Blackwell
Chairperson
Voluntary Assisted Dying Board

Year in review

Voluntary assisted dying in 2024–25 (including change from 2023–24)

First Requests	First Assessments	Consulting Assessments	Substance supplies	Voluntary assisted dying deaths
1,329 ▲ 37.3%	878 ▲ 48.3%	722 ▲ 45.6%	550 ▲ 60.8%	480 ▲ 63.8%

Patients found eligible to access voluntary assisted dying

Age	Male	Resided in metropolitan area	Cancer-related diagnosis
23 – 101	57.6%	73.8%	71.9%
Median age 76	Female 42.4%	Resided in regional area 26.2%	Receiving palliative care 83.9%

Voluntary assisted dying deaths

Self-administration	Practitioner administration				
29 (6.0%)	451 (94.0%)	44.3% of practitioner administrations occurred at the patient's home	33.5% of practitioner administrations occurred in a public hospital ward	89.4% of practitioner administrations via intravenous administration	2.6% of total deaths in Western Australia in 2024–25

Practitioners

Trained practitioners	Training completed in 2024–25		Location of practice		Participated in 2024–25		Participated since 1 July 2021	
152	35 Medical practitioners	3 Nurse practitioners	68.4% Perth metro	31.6% Regional	73 ▲ +7 Medical practitioners	4 ▲ +1 Nurse practitioners	96 Medical practitioners	5 Nurse practitioners

Personal reflections

The Voluntary Assisted Dying Board (the Board) receives feedback via personal reflections from those involved in the voluntary assisted dying process, including the patient, their family or practitioners who are part of their care. The Board is very appreciative for the contribution of personal reflections in 2024–25, which assisted the Board's understanding of voluntary assisted dying in WA. The Board has been pleased that most of the feedback received has been positive, with 75 per cent (n=27) of reflections including positive remarks regarding the patient and family experience in accessing voluntary assisted dying. However, in 2024–25 the Board continued to receive reflections detailing barriers for patients accessing voluntary assisted dying as an end of life choice. Fifty six per cent (n=20) of reflections received by the Board outlined issues regarding access to voluntary assisted dying[1]. The consideration of personal reflections throughout the year enabled the Board to share a number of recommendations with the Minister for Health, Director General of the WA Department of Health, and with statewide services to improve the safety and quality of voluntary assisted dying.

Key themes expressed in personal reflections include:

- gratitude for the option to choose voluntary assisted dying and experience a peaceful death
- care navigators, practitioners, pharmacists and voluntary assisted dying coordinators within health service providers (HSP Coordinators) are highly valued for guiding patients and families through the voluntary assisted dying process with the utmost care and compassion
- poor communication and lack of understanding of the voluntary assisted dying process in the community and amongst practitioners causes delays to accessing voluntary assisted dying as an end of life choice
- patients and family members seek amendments of eligibility criteria and processes for accessing voluntary assisted dying
- the low number of trained voluntary assisted dying practitioners has put pressure on and exposed vulnerabilities in the system
- patients who are eligible to access voluntary assisted dying expressed alleviation of their distress and suicidal ideation
- individual and institutional obstructions to accessing voluntary assisted dying has caused distress and delays to patients in private facilities which has impacted their ability to exercise their lawful end of life choice and human right to have their health choices respected.

To protect the privacy of individuals, personal reflections have been deidentified[2]. We acknowledge the following personal reflections may be difficult for some readers.

1 Personal reflections may include both positive remarks and issues regarding access to voluntary assisted dying.

2 Minor typographical errors have been corrected in some personal reflections to clarify meaning.

Gratitude for the option to choose voluntary assisted dying and experience a peaceful death

'...Having watched and cared for my husband for so many years in and out of hospital and so many operations and close calls, to see him at peace with his decision was a beautiful experience. ... The procedure was so very respectful and a very moving experience. The doctors were lovely and explained it all to us before and during. [My husband] had the most beautiful smile on his face just before he passed which left us all feeling so sad but happy for him.'

Family member

'...Thank you. What a wonderful gift VAD is, making it possible for us all to be by my dad's side laughing, talking and singing with him till his last moment. ... VAD is a gift, an important part of patient care and a valuable option for anyone facing end of life.'

Family member

'...Although the death of a loved one is always immensely tragic, even when expected, to be able to go in such a caring and gentle way – at home in this situation, is something that simply cannot be underestimated by the manner and extent of the dignity involved.

I am immensely grateful that the VAD process has been put in place and am a very strong advocate for it perhaps extending to other circumstances.

I thank everyone who assisted in [my wife]'s process and the work of the VAD Board for implementing such a worthy and necessary service.'

Family member

'On the morning of the [administration], [my friend] was up early. He was quite settled and ready for his final journey. He was so relaxed that he enjoyed a meal of scrambled eggs and 12 oysters. He was certainly more relaxed than the rest of us.

Those last few moments of his life were so peaceful and dignified and I am sure this will make the grieving process for [my friend's family] much easier....'

Friend

'...Dad was especially grateful and it gave him the gift of going out "on a high".. the change in dad in the last 24 hours is something we never expected and for glimpses he was just our dad.. not our sick and dying dad.. I will never forget being able to spend those last few hours with him at home, in his shed and drinking one last glass of [champagne] around the kitchen bench with him. While I wish he didn't have to leave us, the way he did leave was the best possible way that could ever be imagined...'

Family member

'...My father died by VAD last February, following excellent palliative care. It was a wonderful experience. It should be available to all who meet the conditions.

Thank you to WA Health for a marvellous death experience using VAD at [public hospital]....'

Family member

'[My brother] and I found the process to be very efficient and dignified, considering the circumstances.

Once we contacted VAD, [Care Navigator] took control and arranged everything for us. This was fantastic as we had no stress during the whole process. We thought it was going to be a harrowing experience, but this was not the case. VAD and [Care Navigator] made our lives so much easier and it took no time at all and the process was very seamless.

We are very grateful that VAD is now available for those in need, as the alternative would not have been very nice, my brother suffering until the end and us watching it happen.'

Family member

'It is my great privilege that Western Australia supported and legalised VAD process and that it had provided state funded protocol mechanisms for its citizens, who were deemed eligible, to undertake VAD.

For me I am so pleased that I can undertake a legalised voluntary assisted dying process which will allow me a dignified and respectful way to die without the fear of enduring the extended pain and humiliation of dying slowly under the expansion of my cancer and it overwhelming my body. My daughters have respected and endorsed my VAD journey.

I thank everyone associated with my VAD journey for their support and dedication.

I AM A HAPPY CHAPPY.'

Patient

'...Upon hearing the procedure would be done that day, my husband truly had one of his happiest days, with family all being here for his farewell...'

Family member

'...One important qualitative measure of a country's level of development and education is how it treats the suffering....bravo to WA for showing the way, bravo to the VAD program. ... WA's VAD program helps people curtail the unnecessary long periods of pure pain and suffering. I was elated to read that the whole of Australia [is] adopting such VAD laws ... We hope that Australia's move might encourage many more countries to do the same...'

Family member

'...The final process was dignified and simple, with [my wife] in total control of proceedings.

As difficult as it was to watch my wife die, I know that she was more than ready. We were able to hug, kiss, lay in each other's arms one last time. Hold hands and look into each other's eyes with one final statement to each other. It was moving and surreal, I doubt I could have handled her going on as she was....'

Family member

'...He was privileged with a trip by ambulance and a paramedic to his favourite beach the day before his death and enjoyed the fish and chips for lunch. Palliative care supported me on the day and his end was so peaceful....'

Family member

Care navigators, practitioners, pharmacists and HSP Coordinators are highly valued for guiding patients and families through the voluntary assisted dying process with the utmost care and compassion

'...The work that you do is so vital – I cannot even let myself imagine what dad's last days would have been like if not for VAD. I remember how quickly everyone worked together to get the expedited process in place. Without this dad would have suffered so much and instead of looking back at his last 2 days as special, happy memories filled with love, I am quite sure the alternative would have been traumatic for everyone and that would have been our last memory...'

Family member

'...The [practitioner] and nurse in attendance were professional, considerate, kind and caring...'

Family member

'...It's 90 hours before I pass. I feel at peace with the world in large part due to the caring, sensitive help my wife and family have (and friends) been shown by [practitioner], [Care Navigator], others we have spoken to.

I know what is ahead and only wish for the courage and strength shown by those we know from VAD. They are so committed in bringing peace to those in real need – like me.

Vocation is not a word used much these days and before my need for their care, I reserved it for 'angels' who rendered humanity to others in need...'

Patient

'I wish to congratulate the VAD Board and wonderful, loving and supportive staff who made my dear wife feel so relaxed....'

Family member

'...[Care Navigator] is perfect for her role. From outlining the whole procedure, steps, time frame etc to her nurturing, professional demeanour. She was amazing with everyone but especially my beautiful wife. [She] definitely deserves a pay rise. Eternally grateful for everything she did to make my wife's transition as smooth, loving and dignified...'

Family member

'...Could not have asked for better care and professionalism and thoughtfulness from everyone involved especially [practitioner]. Her care for [my husband] was above and beyond.

Thank you so much for making [my husband]'s last moments comfortable and painless, also the compassion shown to [my husband] and myself....'

Family member

'...The coordinator ... was the most lovely, professional, caring and so compassionate to my aunty as well as us family members going through this with her. [Coordinator] explained every detail to all of us.....'

Family member

'It is a complicated process, but I understand why it has to be. You really have to persevere to get to the end. The Care Navigators are an excellent resource.... I do feel like lots of people who could benefit from this likely won't due to the complexity of access.'

Patient

Poor communication and lack of understanding of the voluntary assisted dying process in the community and amongst practitioners causes delays to accessing voluntary assisted dying as an end of life choice

'…Despite my dad's request repeated to his [practitioner] to "wind things up", [my dad] did not receive any written information about the VAD process. …. My dad's GPs also seemed unaware they have a requirement to provide VAD approved information once their patient makes an enquiry about VAD…

At a deeply distressing period for my dad with loneliness, extreme nausea and frightening episodes of breathlessness, even a few days would have made a real difference to my dad's sense of comfort about progressing towards his goal.

… so much suffering and uncertainty could be alleviated if this information is easily and readily available as soon as they raise this query with their health practitioner. I hope in the near future, VAD information is made freely available to those facing end of life…'

Family member

'[My wife] first made it obvious to her doctor, on [date] that she did not want her life prolonged and hoped to be allowed to peacefully pass away. [My wife] was told [by a practitioner who had not completed the VAD training] she would not fit the criteria and would not be given access to VAD.

I do not believe proper protocol has been followed to ensure the appropriate documents such as the First Request have been promulgated and followed. [The] First Request form was handed to [my wife's doctor] which he took reluctantly, and I do not know if it was… properly recorded….'

Family member

'…I sincerely hope that when I am approaching end of life, access to information and support for the gentle, sane option of VAD is more readily available and widely supported. I hope medical practitioners who currently seem unaware of their legal obligations to their patients around VAD information and support are much more alive and responsive to this important aspect of their responsibilities.

It seemed to me that [my dad's] request for VAD support from his medical practitioners was not met…It seems the medical community have a woeful lack of insight into their legal obligations around VAD.

… Many weeks of unnecessary stress, anxiety and suffering could have been reduced or avoided altogether for [him] if his practitioners had been curious, attentive to his end of life questions, sought clarification about his interest in end of life options and simply provided him with the contact information they are required to…

If his medical practitioners had been alive and responsive to their legal obligations to supply VAD Navigator Service contact details, my father may well have been able to expedite his VAD approval and enjoyed a more peaceful last few weeks, knowing he could action this at any time. That would have been good medicine…'

Family member

'…[I understand that] the medical team … sometimes give a "cooling off/ thinking" time with the patient before putting in the First Request paperwork – it would be good to do more education, so they realise that is already built into the VAD process and that the sooner we get involved the better….'

Health practitioner

Patients and family members seek amendments of eligibility criteria and processes for accessing voluntary assisted dying

'...The requirement for a prognosis of death within 12 months is a nonsense given the nature of degenerative neurological conditions. Surely having a terminal illness and poor quality of life should be a sufficient threshold to meet? ... Waiting to die of natural causes is mentally exhausting and distressing not only for [my wife], but her family too.

The current legislation should be amended to remove the required prognosis of death within the currently stated 12 months for degenerative neurological conditions. A person suffering a terminal illness should be allowed to die with dignity at a time of their choosing, not in accordance with an arbitrary timeframe.

We would be rightly criticised for denying our pets a compassionate death, yet the current VAD legislation denies our loved ones the same kindness...'

Family member

'[My father] was a 97 year old man with full mental cognition and extremely articulate, however he was physically declining.... he requested and applied to be assessed by the VAD system, however he was rejected. [He] did not suffer any terminal illness nor dementia at the time of VAD assessment... [My father] wanted to express his valuable opinion in having the right to be granted VAD. [He] wished to see changes and advancement towards a more compassionate governing VAD criteria and policy ...'

Family member

'...My Dad was diagnosed with un-treatable B Cell Lymphoma while in the hospital. He was not able to access VAD because he did not have enough time from diagnosis to death...

Dad had always been an advocate of voluntary dying and he made it no secret to his family that he wanted to be in control of his own death when there was nothing else that could be done... We began the VAD process but did not manage to make it through as from diagnosis to death was only 3 weeks. Being with him in his last 3 weeks was traumatic and painful and we wished he had access to VAD as we believe it would have been much more humane than what he went through.

...I feel that the process needs to be quicker or that you can begin the process prior to receiving notice that you are dying. Why can the first steps not be undertaken whilst a person is well and then the substance be given as soon as diagnosis has been received. Much like we write an advanced health directive, or choose to donate our organs and have this witnessed and signed well in advance of a life and death event. ...Please don't stop trying to make it more accessible to those who want it....'

Family member

'....The pressure about having to be capable of administering and being of sound mind was stressful for [my husband].

He was terrified he would have another seizure and not be able to administer the drug to himself. That pressure made him decide earlier than he needed.

It would be nice if someone [could] sign a Stat Dec or similar allowing the VAD doctor/nurse to administer the drug if he was unable so he didn't have to go into palliative care and be a burden on his family...'

Family member

The low number of trained voluntary assisted dying practitioners has put pressure on and exposed vulnerabilities in the system

'...We have unrelenting demand. We have generous doctors who go above and beyond but cannot ever seem to get on top of the workload and requests.

... chronic under-resourcing and inability to access doctors is causing widespread problems and patient distress. ...we need to grow a more sustainable system, or we will be facing critical levels of concern very soon. ...Staff are exhausted and can no longer just push harder...

For most of us involved in this work, the alleviation of suffering is core to what motivates us. I feel that much of my work these last months is supporting patients to manage the emotional distress that the system and delays are causing.'

Health practitioner

'.....delays prior to admission at [health facility] add a lot of stress to the process, add time pressure and [patients] often pass away soon after admission. These situations also add immense pressure to our very small workforce of doctors and our limited resources to support them well..'

Health practitioner

Patients who are eligible to access voluntary assisted dying expressed alleviation of their distress and suicidal ideation

'[My father considered] suicide .... One shudders to think of the accidental consequences which may arise by ... suicidal misadventure. The horrors of illegal procedures are best avoided by facilitating slick information, process and access....

Thank goodness VAD is now available in WA. My father passed away very peacefully, surrounded by his loving family....'

Family member

'It is a great relief to me to have VAD in place. Up to this point I [was] thinking I would have to take matters into my own hands, despite the impact on my family. I came very close on at least 2 occasions. The only thing that stopped me was concern for the unlucky person who would have to discover my body. I spent too much time on my back, in pain ruminating on this. Thank you for relieving me of that burden. ...'

Patient

'...During that early stage [following diagnosis], [my friend] was more convinced than ever that [suicide] was the way to go. Much of my discussion with [my friend] was trying to convince him that the VAD process available to him would be a far better outcome for the family. It was interesting to see the changes in his thinking as he progressed through the different visits from and phone calls with the VAD team... Initially he was sceptical, then moved to wanting to self-administer and finally, after his final meeting, he accepted that having [Care Navigator] and [practitioner] take on this final task was the correct way to go.....'

Friend

Individual and institutional obstructions to accessing voluntary assisted dying has caused distress and delays to patients in private facilities which has impacted their ability to exercise their lawful end of life choice and human right to have their health choices respected

'I have been distressed today by witnessing the effects of the unnecessary obstacles [private] Hospice impose on their patients who want to pursue a legitimate end of life option. The patient was admitted to [private] Hospice last week. [His son] was going to wheel him over to the [public] outpatient clinic in a wheelchair [for his final assessment, as the private hospital would not permit this on their premises], but when today came, [the patient was] very weak, has an NG tube and continuous oxygen, and spends almost all his time in bed. And it is raining.

Getting to the outpatient department was too far, so [we] compromised by seeing him in the shelter of a cafe that was closer to the hospice. It actually wasn't that sheltered, and certainly not private. What part of this is OK?...'

Health practitioner

'...Another barrier [to accessing VAD] is the provision of hospice and public hospital care by the Catholic sector. If my father had received palliative care [at our local faith-based hospice] he would have been blocked from preparatory consults for VAD. There are other Catholic conflicts of course. In this case – patients should be warned and accept a disclaimer that VAD isn't available....'

Family member

'....We felt [we] were being judged [by staff at a faith-based private hospital] because ... Mum had expressed her wish to access VAD....

It was made clear that VAD could only be given away from the [private] hospital and we were also warned to try to keep this a secret from many of the staff members....'

Family member

'The family suggested they were told to keep it a secret at [private hospital] and were required to only discuss the matter with specifically named individuals. In her daughter's words – "the hospital's response was all about the institution, not about us or what was best for Mum."

...the hospital's response to the patient's request for VAD [was] deeply impacting and distressing on both [the patient] and her family.

Conscientious objection and the [private hospital's] approach seems to be causing distress to patients and family, both ... during the admission and also continuing after their discharge, particularly when transferred elsewhere for end of life care. It is also causing delays that, for many patients, mean they will not be able to access VAD. ...'

Health practitioner

Health practitioners

Health practitioner participation in voluntary assisted dying

Medical and nurse practitioners participating in the voluntary assisted dying process must meet eligibility criteria as defined in the *Voluntary Assisted Dying Act 2019*, including registration type, practice duration and completion of the Western Australian Voluntary Assisted Dying Approved Training (WA VAD Approved Training). Once training is completed, medical practitioners may complete patient assessments as a Coordinating or Consulting Practitioner. Trained medical and nurse practitioners may administer the voluntary assisted dying substance as an Administering Practitioner.

A total of 152 medical and nurse practitioners have completed the WA VAD Approved Training (138 medical practitioners, 14 nurse practitioners), with 35 medical practitioners and 3 nurse practitioners completing the training in 2024–25.

Since 1 July 2021, 96 medical practitioners (63.2% of trained practitioners) acted as a Coordinating, Consulting or Administering Practitioner[3], with 17 medical practitioners acting in a role for the first time in 2024–25. Eleven medical practitioners who acted as a Coordinating, Consulting or Administering Practitioner in 2023–24 did not act in a role in 2024–25. In 2024–25, 77 practitioners acted as a Coordinating, Consulting or Administering Practitioner, including 4 nurse practitioners acting as an Administering Practitioner. Medical practitioners and nurse practitioners participating in the voluntary assisted dying process are required to have completed the WA VAD Approved Training within the last 3 years. In 2024–25, 14 practitioners did not renew their WA VAD Approved Training and no longer meet the eligibility requirement to act as a Coordinating, Consulting or Administering Practitioner.

3 A practitioner is considered to have acted in the role of a Coordinating, Consulting or Administering Practitioner through the submission of a First Assessment, Consulting Assessment or Practitioner Administration Form.

Practitioner participation

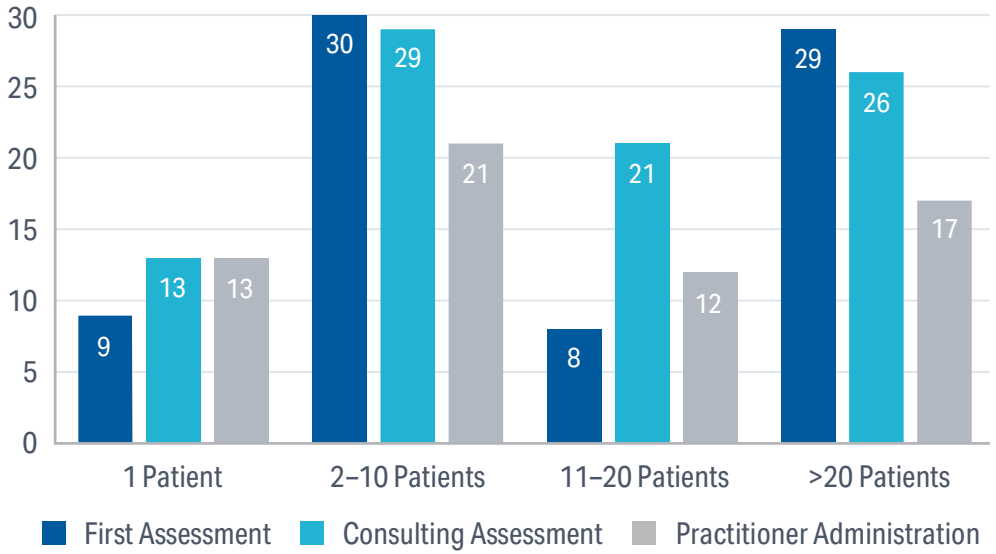
Since 1 July 2021, participating practitioners are most likely to have acted as a Coordinating, Consulting or Administering Practitioner for between 2 to 10 patients (Figure 3).

More than half of participating medical practitioners have completed at least one First Assessment as a Coordinating Practitioner (n=76, 55.1%). Of these, 88.2 per cent (n=67) completed more than one First Assessment and 48.7 per cent (n=37) completed First Assessments for 11 or more patients. Nearly all patients who underwent a First Assessment did not have a previous relationship with their Coordinating Practitioner (n=2,115; 90.8%).

Participating medical practitioners were most likely to have completed a Consulting Assessment with 64.5 per cent (n=89) completing at least one Consulting Assessment since 1 July 2021.

Approximately 4 out of every 10 participating medical and nurse practitioners have acted as an Administering Practitioner since 1 July 2021 (n=63, 41.4%).

Figure 3: Number of practitioners who completed a First Assessment, Consulting Assessment and Practitioner Administration 2021 to 2025



In 2024–25, 71 practitioners accepted a First Request:

- this includes 12 practitioners who were not trained at the time of accepting the request and did not go onto complete the WA VAD Approved Training during the period
- 7 practitioners were responsible for 54.7 per cent of all accepted First Requests.

In 2024–25, 55 medical practitioners completed a First Assessment:

- this represents one more practitioner completing a First Assessment compared with 2023–24 (n=54)
- 6 practitioners completed 50.9 per cent of all First Assessments.

In 2024–25, 66 medical practitioners completed a Consulting Assessment:

- this represents 9 more practitioners completing a Consulting Assessment compared with 2023–24 (n=57)
- 10 practitioners completed 51.2 per cent of all Consulting Assessments.

In 2024–25, 41 practitioners acted as an Administering Practitioner[4]:

- this represents one more practitioner acting as an Administering Practitioner compared with 2023–24 (n=40)
- 7 practitioners acted as the Administering Practitioner for 51.7 per cent of all practitioner administrations.

Location of practice

Trained practitioners have nominated a practice address[5] across all regions. In 2024–2025, almost two thirds of practitioners who acted as a Coordinating, Consulting or Administering practitioner were based in the Perth metropolitan region (n=50, 64.9%, Table 1).

4 Figures are based on valid Practitioner Administration Forms.

5 Medical practitioners nominate their work address when registering to use the Voluntary Assisted Dying Information Management System (VAD-IMS).

Table 1: Number of participating practitioners by health region

	2021 to 2025 number of trained practitioners		2024–25 number acted as a Coordinating, Consulting or Administering practitioner
Region of practice	Total	% of total	Total
Perth metropolitan	104	68.4	50
Goldfields	1	0.7	1
Great Southern	13	8.6	6
Kimberley	8	5.3	4
Midwest	3	2.0	3
Pilbara	3	2.0	0
South West	19	12.5	12
Wheatbelt	1	0.7	1
Total	**152**	**100.0**	**77**

Practitioner specialty

Medical practitioners hold registration with a range of specialties[6]. In WA, participating medical practitioners are not required to have specialty expertise in the disease, illness or medical condition expected to cause the patient's death. General practice was the specialty of 46.1 per cent (n=70) of trained practitioners (Table 2).

Table 2: Number of trained practitioners by specialty type 2021 to 2025

Practitioner specialty	Total	% of total[7]
General practice	70	46.1
Nurse practitioner	14	9.2
Anaesthesia	12	7.9
Haematology	10	6.6
Emergency medicine	9	5.9
Psychiatry	9	5.9
General medicine	6	3.9
General registration only	5	3.3
Geriatrics	4	2.6
Intensive care medicine	4	2.6
Medical oncology	4	2.6
Neurology	4	2.6
Obstetrics and gynaecology	2	1.3
Paediatrics	2	1.3
Palliative medicine	2	1.3
Clinical pharmacology	1	0.7
General surgery	1	0.7
Nephrology	1	0.7
Pain medicine	1	0.7
Physician	1	0.7
Rheumatology	1	0.7

6 Specialty is sourced from the practitioner's registration with the Australian Health Practitioner Regulation Agency and is recorded in VAD-IMS. The number of specialties exceeds the total number of practitioners as some practitioners hold more than one registration type.

7 Percentages are calculated based on the number of practitioners (n=152).

Voluntary assisted dying process

Access to voluntary assisted dying

The voluntary assisted dying process involves several steps from First Request to death notification. Each step is recorded, and a person can choose to stop the process at any point. If a person withdraws, or if they are not assessed as eligible, they may recommence the request and assessment process by making a new First Request (Figure 4).

Figure 4: Voluntary assisted dying process in WA

First Request

A person starts the voluntary assisted dying process by making a clear and unambiguous request for voluntary assisted dying to a medical practitioner during a medical consultation, known as a First Request. Medical practitioners must notify the Voluntary Assisted Dying Board (the Board) when they receive a First Request and advise if the First Request is accepted or refused.

Acceptance or refusal of a First Request relates to whether the practitioner is willing, able and eligible to take on the role of Coordinating Practitioner in the voluntary assisted dying process. Once a medical practitioner accepts a First Request, they become the person's Coordinating Practitioner.

Once the First Request has been accepted or refused, the medical practitioner must provide the person making a First Request a copy of the Approved Information for a person making a First Request for voluntary assisted dying booklet (Approved Information) and notify the Board by submission of the First Request Form. The Approved Information contains the contact details of the Statewide Care Navigator Service who can provide information, support and assistance to the person throughout the voluntary assisted dying process. This includes assistance with finding another participating medical practitioner when a First Request has been refused.

Since the commencement of the *Voluntary Assisted Dying Act 2019* on 1 July 2021 2,816 people have made a First Request to access voluntary assisted dying[8].
In 2024–25:

- 1,032 people made a First Request to access voluntary assisted dying, an increase of 38.0 per cent over the number of people who made a First Request in 2023–24 (n=748). Of these:
  - 718 people (69.6%) made only one First Request, of which 557 (77.6%) were accepted and 161 (22.4%) were refused
  - 314 people (30.4%) made more than one First Request.
- 1,329 First Requests were made as some people made more than one First Request (Table 3). Of these:
  - 68.2 per cent of First Requests were accepted (n=907), an increase from 65.0 per cent in 2023–24 (n=629)
  - 31.8 per cent of First Requests were refused (n=422), a decrease from 35.0 per cent in 2023–24 (n=339).

Since 1 July 2021, the number of First Requests has increased year-on-year, with the number of First Requests in 2024–25 being an increase of 83.3 per cent over the number of First Requests in 2021–22 (Figure 1, Table 3).

8 Information is provided based on a First Request being made and a First Request Form being submitted to the Board.

A practitioner being ineligible to participate in the voluntary assisted dying process was the most common reason a First Request was refused in 2024–25 (n=186, 44.1%). Conscientious objection to voluntary assisted dying was recorded as the reason in 8.3 per cent (n=35) of First Requests that were refused, which is a decrease from 13.6 per cent (n=46) in 2023–24.

In 2024–25, First Requests were made by persons residing in each region of WA, with 72.3 per cent (n=961) of First Requests made by persons in the Perth metropolitan region. The number of reported First Requests from persons residing in regional areas increased by 52.7 per cent from the previous year, with increased requests from the Great Southern, Midwest, South West and Wheatbelt health regions (Table 3).

Table 3: Number of First Requests made by health region in 2021–22, 2022–23, 2023–24 and 2024–25

Health region	2021–22	2022–23	2023–24	2024–25	Total	% of total
Perth metropolitan	554	562	727	961	**2,804**	74.2
Goldfields	14	14	14	15	**57**	1.5
Great Southern	63	55	56	87	**261**	6.9
Kimberley	7	10	9	5	**31**	0.8
Midwest	16	20	33	55	**124**	3.3
Pilbara	6	7	4	4	**21**	0.6
South West	47	63	102	171	**383**	10.1
Wheatbelt	18	26	23	31	**98**	2.6
Total	**725**	**757**	**968**	**1,329**	**3,779**	**100.0**

First Assessment

Once a medical practitioner accepts the First Request, they become the Coordinating Practitioner for the patient. The Coordinating Practitioner assesses the patient's eligibility to proceed with voluntary assisted dying through the First Assessment process.

Since 1 July 2021, 2,254 patients have completed a First Assessment to assess eligibility for voluntary assisted dying, with 851 patients assessed in 2024–25. This represents an increase of 47.0 per cent over the number of patients who completed a First Assessment in 2023–24 (n=579).

In 2024–25, 878 First Assessments were completed as some patients had more than one First Assessment[9]. This represents an increase of 48.3 per cent over the number of First Assessments in 2023–24 (n=592). Since 1 July 2021, the number of First Assessments has increased year-on-year, with the number of First Assessments in 2024–25 being an increase of 128.6 per cent over the number of First Assessments in 2021–22 (n=384, Figure 1). Of the First Assessments completed in 2024–25:

- 87.9 per cent of assessments (n=772) had an eligible outcome, a decrease from 88.7 per cent (n=525) in 2023–24
- 12.1 per cent of assessments (n=106) had an ineligible outcome, an increase from 11.3 per cent (n=67) in 2023–24.

Eligibility

The *Voluntary Assisted Dying Act 2019* requires that a patient must meet all the following criteria to be eligible for voluntary assisted dying:

- The person has reached 18 years of age.
- The person is an Australian citizen or permanent resident.
- At the time of making a First Request (for voluntary assisted dying), the person has been ordinarily resident in WA for a period of at least 12 months.
- The person is diagnosed with at least one disease, illness or medical condition that:
  - is advanced, progressive and will cause death
  - will, on the balance of probabilities, cause death within a period of 6 months or, in the case of a disease, illness or medical condition that is neurodegenerative, within a period of 12 months
  - is causing suffering to the person that cannot be relieved in a manner the person considers tolerable.
- The person has decision-making capacity in relation to voluntary assisted dying.
- The person is acting voluntarily and without coercion.
- The person's request for access to voluntary assisted dying is enduring.

If a patient does not meet the eligibility criteria, they are assessed as ineligible, and the voluntary assisted dying process stops.

9 A patient may have completed more than one First Assessment. Scenarios include:
- if a patient was assessed as not eligible on an initial assessment and then at a subsequent date made a new First Request and was assessed again
- if a patient withdrew from the request and assessment process and then at a subsequent date made a new First Request and was assessed again.

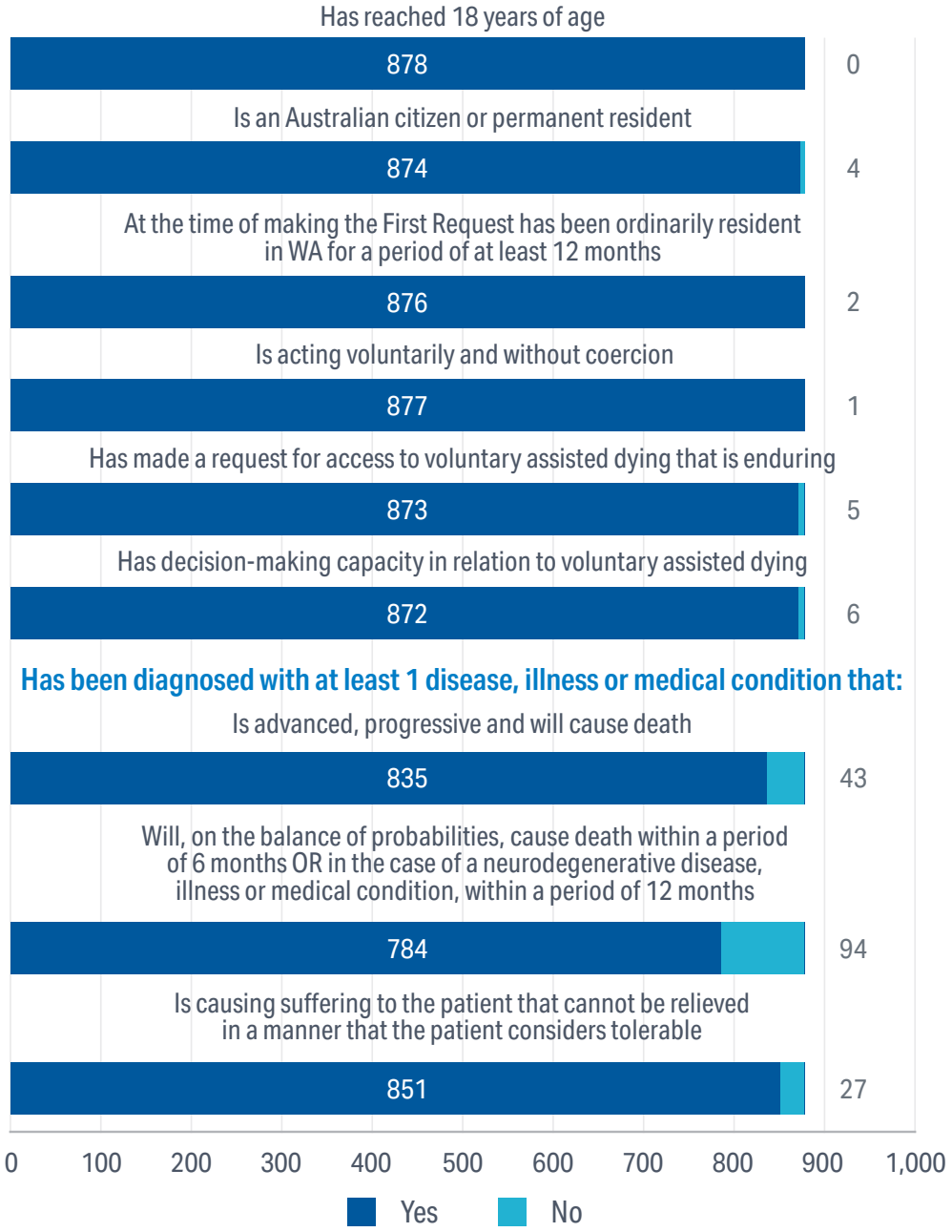
In 2024–25, the most common reason patients were found to be ineligible was because they had not been diagnosed with at least one disease, illness or medical condition that would, on the balance of probabilities, cause death within a period of 6 months or, in the case of a neurodegenerative disease, illness or medical condition, within a period of 12 months (n=94, Figure 5).

During the First Assessment, a Coordinating Practitioner may make a referral to another medical practitioner for determination that the patient:

- meets eligibility criteria related to disease, illness or medical condition
- has decision-making capacity in relation to voluntary assisted dying
- is acting voluntarily and without coercion.

A referral for determination was completed as part of 6 First Assessments in 2024–25, with one referral made for each of these patients. This represents 0.7 per cent of all First Assessments, a decrease from 2.0 per cent in 2023–24 (n=12). All referrals in 2024–25 (n=6) were made regarding the patient's disease, illness or medical condition.

Figure 5: Eligibility of patients undertaking a First Assessment in 2024–25

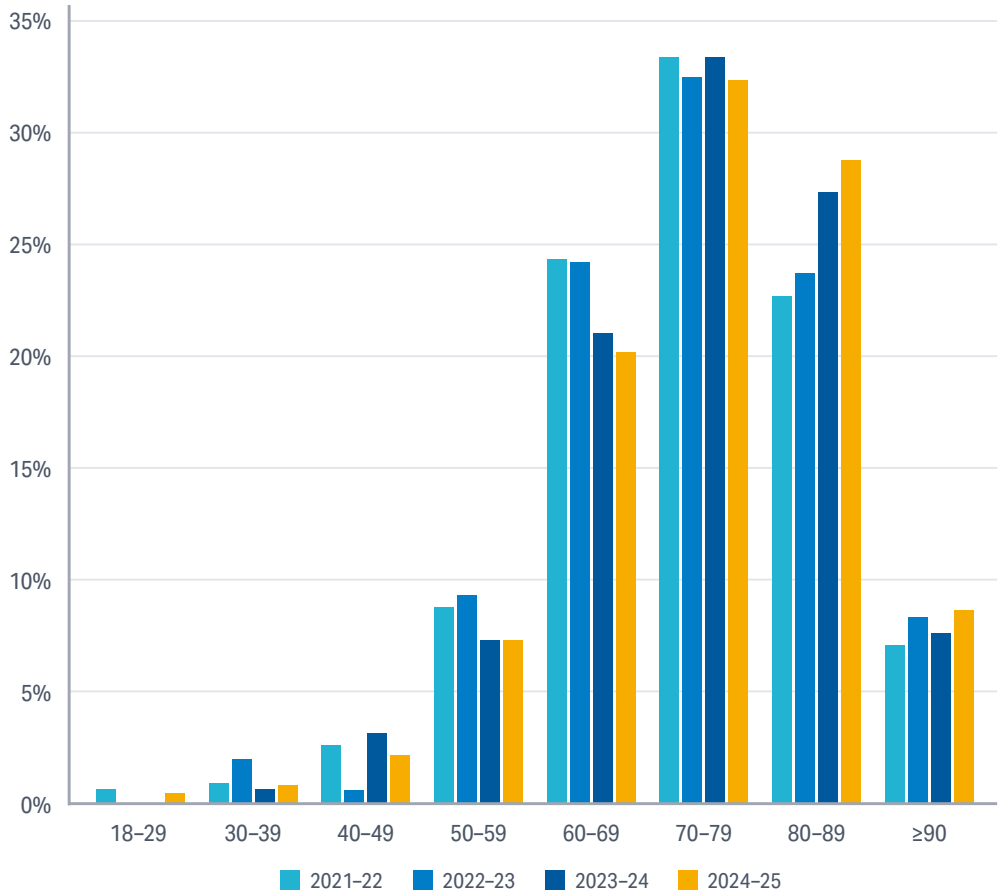


Profile of eligible patients requesting access to voluntary assisted dying

There were 772 patients assessed as eligible to access voluntary assisted dying after the completion of a First Assessment in 2024–25, bringing the total number of eligible patients to 2,074 since 1 July 2021.

In 2024–25, eligible patients were aged 23 to 101 years, with a median age of 76 (Figure 6).

Figure 6: Distribution of patient age at First Assessment in 2021–22, 2022–23, 2023–24 and 2024–25



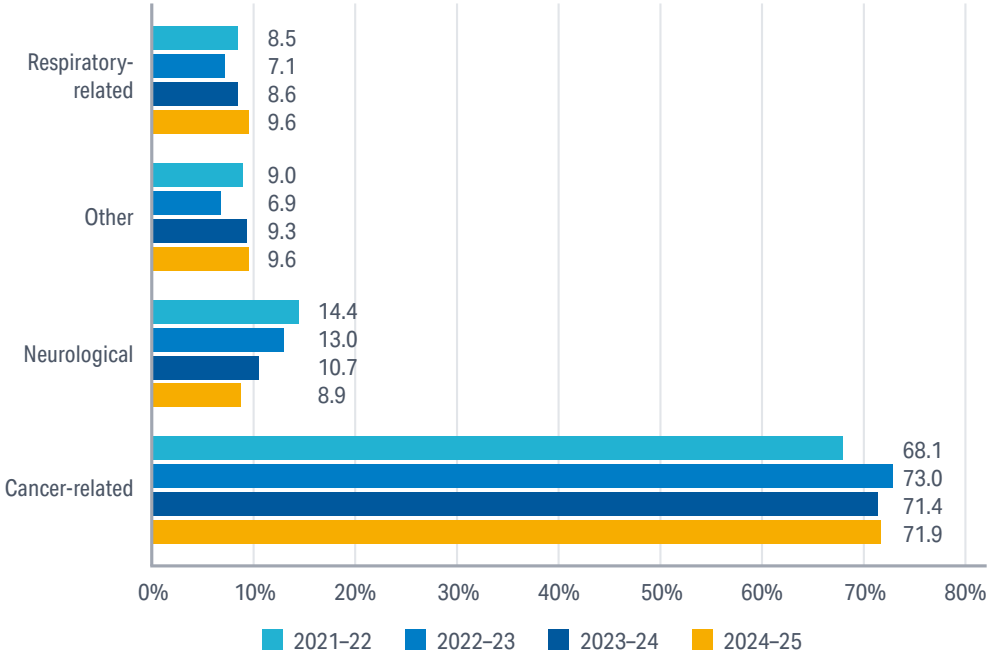
In 2024–25:

- a greater proportion of eligible patients were male (n=445, 57.6%) than female (n=327, 42.4%, Table 5)
- approximately three quarters of patients assessed as eligible resided in the Perth metropolitan region (n=570, 73.8%), a decrease from 74.7 per cent in 2023–24 (n=392)
- 1.4 per cent of patients assessed as eligible were of Aboriginal origin (n=11), an increase from 0.8 per cent in 2023–24 (n=4)
- approximately 1 out of every 3 patients assessed as eligible were born overseas (n=284, 36.8%), a decrease from 40.2 per cent in 2023–24 (n=211)
- 4.9 per cent of eligible patients did not identify English to be their first language (n=38), a decrease from 7.4 per cent in 2023–24 (n=39)
- patients assessed as eligible were most likely to report being in a married or de-facto relationship at the time of First Assessment (n=399, 51.7%)
- two thirds of patients assessed as eligible reported living with family or others at the time of First Assessment (n=514, 66.6%)
- patients assessed as eligible most commonly reported high school as their highest level of education (n=335, 43.4%).

Primary diagnosis

In 2024–25, the majority of patients found eligible at First Assessment had a cancer-related primary diagnosis (n=555, 71.9%), which is similar to 2023–24 (n=375, 71.4%, Figure 7). 'Other' diagnoses included congestive heart failure and end stage renal failure.

Figure 7: Patients by primary diagnosis group in 2021–22, 2022–23, 2023–24 and 2024–25



In 2024–25:

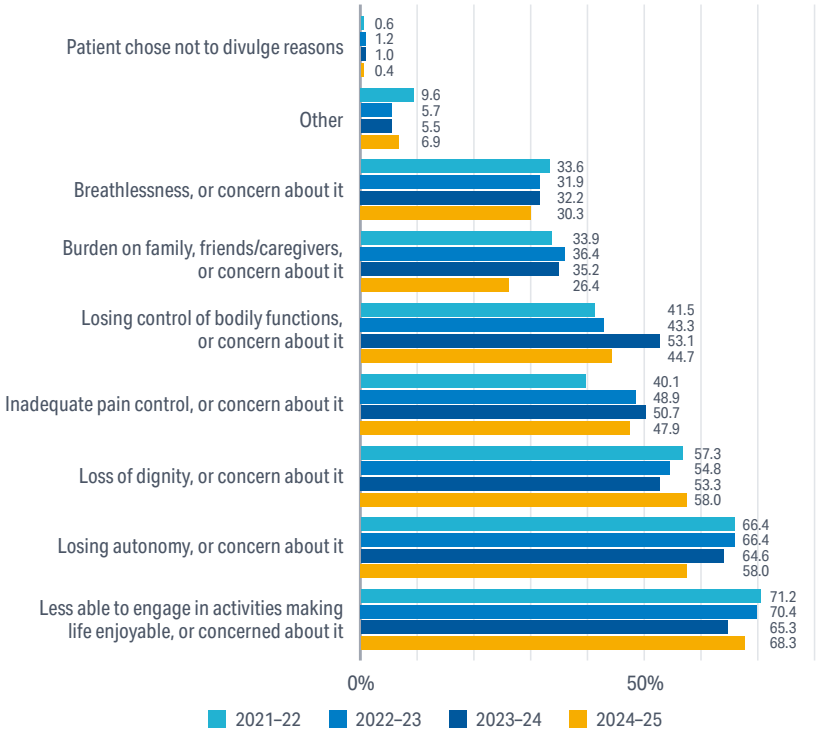
- the most common primary diagnosis in men and women was lung cancer
- the most common cancers were cancers of the brain, breast, colon or rectum, lung, pancreas and prostate
- the most common neurological diagnoses were motor neurone disease, Parkinson's disease and progressive supranuclear palsy
- the most common respiratory-related diagnoses were chronic obstructive pulmonary disease, interstitial lung disease and pulmonary fibrosis.

Reason for accessing voluntary assisted dying

Patients are eligible to access voluntary assisted dying if they meet all eligibility criteria including having at least one disease, illness or medical condition that will on the balance of probabilities cause death within a period of 6 months, or 12 months for neurodegenerative conditions, and is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. During the First Assessment, while not part of the assessment of eligibility, patients are asked to nominate their reasons for requesting voluntary assisted dying from a list of options given.

In 2024–25, the most common reasons given by patients assessed as eligible during the First Assessment were being less able to engage in activities making life enjoyable, or concern about it (n=527, 68.3%) followed by losing autonomy, or concern about it (n=448, 58.0%) and loss of dignity, or concern about it (n=448, 58.0%, Figure 8).

Figure 8: Patient reason for accessing voluntary assisted dying in 2021–22, 2022–23, 2023–24 and 2024–25



Palliative care

Palliative care aims to improve the quality of life of anyone with a life-limiting condition, their family and carers, and plays an important role in how a person approaches the end of their life. During the First Assessment process, patients are asked if they are currently receiving, or have previously received, palliative care.

In 2024–25, most patients assessed as eligible were receiving palliative care at the time of the First Assessment (n=648, 83.9%), which is similar to 2023–24 (n=440, 83.8%). Patients receiving palliative care at the time of First Assessment were most commonly receiving community or home-based palliative care (n=322, 49.7%, Table 4).

Table 4: Palliative care information collected during First Assessment in 2021–22, 2022–23, 2023–24 and 2024–25[10]

Patients receiving palliative care at time of First Assessment		2021–22	2022–23	2023–24	2024–25	Total	% of total
No		**52**	**59**	**85**	**124**	**320**	**15.4**
If no, have they received within last 12 months?	No	43	50	73	107	**273**	85.3
	Yes	9	9	12	17	**47**	14.7
Yes		**302**	**364**	**440**	**648**	**1,754**	**84.6**
If yes, from where?	Community or home-based palliative care	171	174	211	322	**878**	50.1
	Consultation in a hospital	55	99	135	200	**489**	27.9
	Specialist palliative care unit	63	66	76	99	**304**	17.3
	General practitioner	58	72	88	77	**295**	16.8
	Outpatient clinic	23	44	31	41	**139**	7.9
	Consultation in a facility	12	13	19	26	**70**	4.0
Total		**354**	**423**	**525**	**772**	**2,074**	**100.0**

10 For patients currently receiving palliative care, more than one care type can be recorded.

Table 5: Demographic characteristics of patients assessed as eligible for voluntary assisted dying in 2021–22, 2022–23, 2023–24 and 2024–25

Characteristic	2021–22	2022–23	2023–24	2024–25	Total	% of total
Patient age						
18–29	2	0	0	3	**5**	0.2
30–39	3	8	3	6	**20**	1.0
40–49	9	2	16	16	**43**	2.1
50–59	31	39	38	56	**164**	7.9
60–69	86	102	110	155	**453**	21.8
70–79	118	137	175	249	**679**	32.7
80–89	80	100	143	221	**544**	26.2
≥90	25	35	40	66	**166**	8.0
Patient region						
Metropolitan	278	320	392	570	**1,560**	75.2
Goldfields	8	5	7	7	**27**	1.3
Great Southern	22	29	28	39	**118**	5.7
Kimberley	4	5	4	2	**15**	0.7
Midwest	8	13	20	40	**81**	3.9
Pilbara	3	3	4	2	**12**	0.6
South West	19	33	56	90	**198**	9.5
Wheatbelt	12	15	14	22	**63**	3.0

Characteristic	2021–22	2022–23	2023–24	2024–25	Total	% of total
Gender						
Male	205	249	301	445	**1,200**	57.9
Female	149	174	224	327	**874**	42.1
Other	0	0	0	0	**0**	0.0
Aboriginal or Torres Strait Islander origin						
No	347	417	521	761	**2,046**	98.6
Aboriginal	7	6	4	11	**28**	1.4
Torres Strait Islander	0	0	0	0	**0**	0.0
Aboriginal and Torres Strait Islander	0	0	0	0	**0**	0.0
Born overseas						
No	207	261	314	488	**1,270**	61.2
Yes	147	162	211	284	**804**	38.8
English first language						
No	35	30	39	38	**142**	6.8
Yes	319	393	486	734	**1,932**	93.2
How well does the patient speak English						
Not at all	2	2	1	4	**9**	0.4
Not well	1	5	5	11	**22**	1.1
Well	16	17	6	32	**71**	3.4
Very well	335	399	513	725	**1,972**	95.1

Characteristic	2021–22	2022–23	2023–24	2024–25	Total	% of total
Patient ancestry						
Australian	151	177	226	355	**909**	43.8
Chinese	3	5	3	7	**18**	0.9
Dutch	13	9	12	16	**50**	2.4
English	107	133	154	244	**638**	30.8
German	8	14	13	15	**50**	2.4
Indian	7	4	4	2	**17**	0.8
Irish	11	15	10	14	**50**	2.4
Italian	11	7	13	10	**41**	2.0
New Zealander	5	5	6	15	**31**	1.5
Scottish	11	22	33	35	**101**	4.9
South African	2	5	4	8	**19**	0.9
Other	25	27	47	51	**150**	7.2
Assisted by interpreter during First Assessment						
No	352	418	520	761	**2,051**	98.9
Yes	2	5	5	11	**23**	1.1
Usual living circumstances						
Lives with family	215	251	304	449	**1,219**	58.8
Lives alone	115	143	172	258	**688**	33.2
Lives with others	24	29	49	65	**167**	8.1

Characteristic	2021–22	2022–23	2023–24	2024–25	Total	% of total
Relationship status						
Divorced	60	79	75	123	**337**	16.2
Married/De facto	176	191	260	399	**1,026**	49.5
Never married	29	44	44	60	**177**	8.5
Separated	17	13	26	30	**86**	4.1
Widowed	71	96	120	159	**446**	21.5
Not reported	1	0	0	1	**2**	0.1
Highest level of education						
Primary school	10	14	9	27	**60**	2.9
High school	138	191	220	335	**884**	42.6
Year 12 graduation	51	37	73	97	**258**	12.4
Trade certificate	42	73	79	107	**301**	14.5
Advanced diploma and diploma	38	31	58	75	**202**	9.7
Bachelor degree	49	46	58	93	**246**	11.9
Postgraduate degree	26	30	27	35	**118**	5.7
Not reported	0	1	1	3	**5**	0.2
Diagnostic group						
Cancer-related	241	309	375	555	**1,480**	71.4
Neurological	51	55	56	69	**231**	11.1
Other	32	29	49	74	**184**	8.9
Respiratory-related	30	30	45	74	**179**	8.6

Consulting Assessment

Once a patient has been assessed as eligible for voluntary assisted dying during the First Assessment, the Coordinating Practitioner must refer the patient to another medical practitioner for a Consulting Assessment. The Consulting Practitioner conducts an independent assessment of the patient's eligibility for voluntary assisted dying.

Since 1 July 2021, 1,915 patients have completed a Consulting Assessment, with 716 patients assessed in 2024–25. This represents an increase of 45.5 per cent over the number of patients who completed a Consulting Assessment in 2023–24 (n=492).

In 2024–25, 722 Consulting Assessments were completed as some patients had more than one Consulting Assessment[11]. This represents an increase of 45.6 per cent over the number of Consulting Assessments in 2023–24 (n=496). Since 1 July 2021, the number of Consulting Assessments has increased year-on-year, with the number of Consulting Assessments in 2024–25 being an increase of 122.8 per cent over the number of Consulting Assessments in 2021–22 (n=324, Figure 1). Of the Consulting Assessments completed in 2024–25:

- 98.3 per cent of assessments (n=710) had an eligible outcome, this is similar to 2023–24 (n=487, 98.2%)
- 1.7 per cent of assessments (n=12) had an ineligible outcome, this is similar to 2023–24 (n=9, 1.8%).

A referral for determination was completed as part of 3 Consulting Assessments in 2024–25. All referrals in 2024–25 were made regarding the patient's disease, illness or medical condition.

11 The data includes forms with a status of valid and void.

Final Request and Final Review

Final Request

Patients found eligible after a Consulting Assessment then complete a Written Declaration, before making a Final Request to the Coordinating Practitioner for access to voluntary assisted dying.

The *Voluntary Assisted Dying Act 2019* (the Act) specifies a designated period of 9 days between the First Request and Final Request. An exception to the 9-day designated period can be made if both the Coordinating Practitioner and Consulting Practitioner believe the patient is likely to die or to lose decision-making capacity in relation to voluntary assisted dying before the end of the 9-day designated period.

Since 1 July 2021, 1,710 patients made a Final Request to access voluntary assisted dying and 24.6 per cent (n=421) of these patients made the Final Request within the 9-day designated period. The median number of days between First Request to Final Request was 13 days.

Since 1 July 2021, 1,711 Final Requests were completed as one patient had more than one Final Request. Of the patients who made a Final Request, 75.3 per cent resided in the Perth metropolitan region (n=1,288) and 24.7 per cent resided in regional areas (n=423). Patients residing in the Perth metropolitan area were more likely to make a Final Request within the 9-day designated period (n=324, 25.2%) than regional patients (n=97, 22.9%).

In 2024–25:

- 646 Final Requests were completed, an increase of 48.8 per cent from 2023–24 (n=434)
- 26.3 per cent of Final Requests (n=170) were made within the 9-day designated period, a decrease from 27.4 per cent in 2023–24 (n=119). Of these:
  - 37.6 per cent (n=64) were made because it was the opinion of the Coordinating Practitioner and Consulting Practitioner that the patient was likely to die before the end of the 9-day designated period, representing a decrease from 54.6 per cent in 2023–24 (n=65)
  - 62.4 per cent (n=106) were made because it was the opinion of the Coordinating Practitioner and Consulting Practitioner that the patient would lose decision-making capacity in relation to voluntary assisted dying before the end of the 9-day designated period, representing an increase from 45.4 per cent in 2023–24 (n=54).

While a patient can make the Final Request in the designated period this data does not represent patients who went on to administer the voluntary assisted dying substance within the designated period.

Final Review

The request and assessment process concludes with the Final Review. The Coordinating Practitioner completes a Final Review to ensure that the voluntary assisted dying request and assessment process has been completed in accordance with the Act. As part of the Final Review, the Coordinating Practitioner must make sure that the patient has decision-making capacity in relation to voluntary assisted dying, is acting voluntarily and without coercion, and still wants to access voluntary assisted dying. Since 1 July 2021, 1,706 patients have completed the Final Review, with 643 patients reviewed in 2024–25. In 2024–25, one patient was unable to proceed as the practitioner could not certify that the patient still had decision-making capacity.

Patients who withdrew

In addition to the patients who died prior to administration of a voluntary assisted dying substance, since July 2021, 24 patients who commenced the request and assessment process have withdrawn, including 6 patients in 2024–25. In 2024–25, all patients who withdrew did so prior to an Administration Decision being made.

Administration Decision

If the patient has been confirmed as eligible at the Final Review, they may make an Administration Decision. This decision is made in consultation with, and on the advice of, the Coordinating Practitioner. Administration of the voluntary assisted dying substance may be through one of 2 options:

1. self-administration
2. practitioner administration.

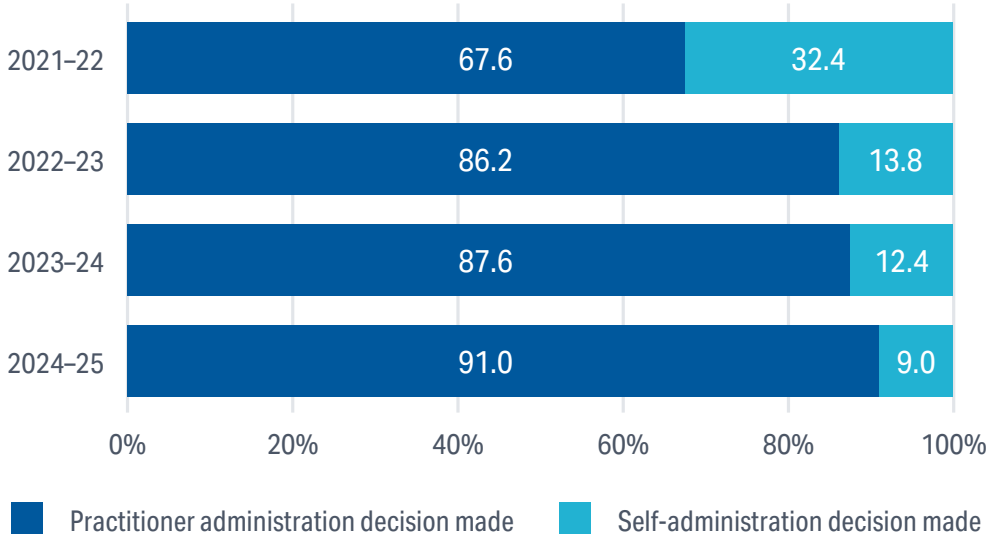
Self-administration of a voluntary assisted dying substance requires the patient to prepare and ingest the substance by swallowing or via a percutaneous endoscopic gastrostomy (PEG) or nasogastric (NG) tube. The patient must be able to complete these actions entirely by themselves. If a patient is unable to independently undertake these actions or is concerned about their ability to undertake these actions, self-administration is not a suitable option, and a practitioner administration decision is made. Practitioner administration of a voluntary assisted dying substance may be assisted oral ingestion, assisted ingestion via PEG or NG tube, or intravenous (IV) administration. More than one Administration Decision may be made if a patient changes their administration option (e.g., from self-administration to practitioner administration or vice versa).

Since 1 July 2021, 1,678 patients have made an Administration Decision, including 647 patients in 2024–25. This represents an increase of 50.5 per cent over the number of patients who made an Administration Decision in 2023–24 (n=430).

In 2024–25, 668 Administration Decisions were made[12]. Of these:

- 91.0 per cent (n=608) were practitioner administration decisions, an increase from 87.6 per cent (n=396) in 2023–24 (Figure 9)
- 9.0 per cent (n=60) were self-administration decisions, a decrease from 12.4 per cent (n=56) in 2023–24.

Figure 9: Administration Decisions made in 2021–22, 2022–23, 2023–24 and 2024–25



The data shows a continued preference amongst patients for the voluntary assisted dying substance to be administered by an Administering Practitioner. In 2024–25, 60.7 per cent (n=369) of patients with practitioner administration decisions expressed concerns about self-administering the substance themselves.

The prescription process commences after an Administration Decision has been made and, in the case of self-administration, after the appointment of a Contact Person who will have obligations under the *Voluntary Assisted Dying Act 2019*, including notifying the Coordinating Practitioner if the patient dies and giving any unused voluntary assisted dying substance to an Authorised Disposer.

12 The data includes forms with a status of valid, void and revoked.

Supply of the voluntary assisted dying substance

Supply of the voluntary assisted dying substance is a tightly controlled process initiated at the request of the patient. An Authorised Supplier at the Statewide Pharmacy Service can supply the voluntary assisted dying substance after receipt and authentication of a prescription from the Coordinating Practitioner.

If the patient has decided to self-administer, the Authorised Supplier can supply the voluntary assisted dying substance directly to the patient, their Contact Person or to someone else collecting the substance on the patient's behalf. If the patient has decided to have the voluntary assisted dying substance administered by a medical practitioner or nurse practitioner (known as the Administering Practitioner), the Authorised Supplier will supply the substance directly to the Administering Practitioner, who will take responsibility for the substance until it is used. The Statewide Pharmacy Service travel to regional locations to ensure access to the voluntary assisted dying substance and to provide supporting information for patients and participating practitioners across WA.

Since 1 July 2021, 1,368 patients, Contact Persons or Administering Practitioners have been supplied a voluntary assisted dying substance. Since 1 July 2021, the number of supplies of a voluntary assisted dying substance has increased year-on-year, with the number of supplies in 2024–25 (n=550) being 132.1 per cent over the number of supplies in 2021–22 (n=237, Figure 1).

In 2024–25:

- 534 patients, Contact Persons or Administering Practitioners were supplied a voluntary assisted dying substance
- 14 patients had more than one supply, due to changing administration decision or prescription, substance expiry or deciding not to proceed with administration at the planned time
- 550 supplies occurred, a 60.8 per cent increase from 2023–24 (n=342). This included:
  - 90.9 per cent (n=500) supplies of the substance for practitioner administration, an increase from 89.2 per cent (n=305) in 2023–24
  - 9.1 per cent (n=50) supplies of the substance for self-administration, a decrease from 10.8 per cent (n=37) in 2023–24.

Deaths

Voluntary assisted dying deaths

Since 1 July 2021, 1,219 patients have died following administration of a voluntary assisted dying substance:

- 89.2 per cent of patients died after practitioner administration (n=1,087, Figure 10)
- 10.8 per cent of patients died after self-administration (n=132).

In 2024–25:

- there were 480 deaths recorded following administration of a voluntary assisted dying substance. This represents an increase of 63.8 per cent over the number of voluntary assisted dying deaths in 2023–24 (n=293)
- voluntary assisted dying deaths represented 2.6 per cent of the 18,380 total deaths in WA[13] (Table 6), an increase from 1.6 per cent in 2023–24[14]
- the age range of patients when they died following administration of a voluntary assisted dying substance was between 23 and 101 years and the median age was 77 years.

Since 1 July 2021, the number of voluntary assisted dying deaths has increased year-on-year, with the number of voluntary assisted dying deaths in 2024–25 being an increase of 151.3 per cent over the number of voluntary assisted dying deaths in 2021–22 (n=191, Figure 1, Figure 10). The number of voluntary assisted dying deaths increased in each quarter of 2024–25, from 103 deaths in quarter 1 to 132 deaths in quarter 4.

13 Total death registrations in WA sourced from The Registry of Births, Deaths and Marriages, Department of Justice (2025).

14 Voluntary Assisted Dying Board Annual Report 2023–24.

Figure 10: Voluntary assisted dying deaths by administration type in 2021–22, 2022–23, 2023–24 and 2024–25

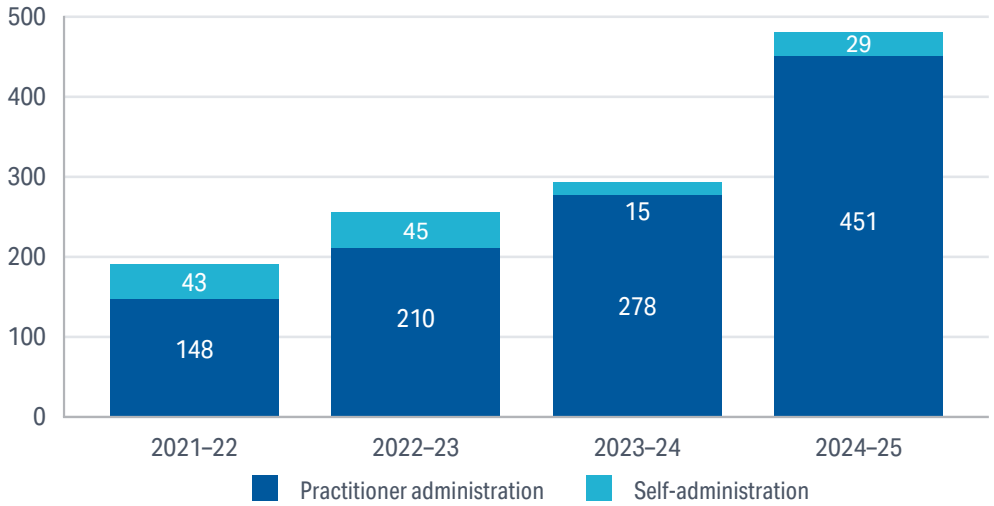


Table 6: Voluntary assisted dying deaths as a percentage of total deaths registered in WA in 2024–25

Health region	Patients who died following administration of a voluntary assisted dying substance	Deaths registered in WA[15]	Deaths by voluntary assisted dying as a percentage of deaths registered in WA
Perth metropolitan	347	14,668	2.4
Goldfields	6	307	2.0
Great Southern	20	544	3.7
Kimberley	0	209	0.0
Midwest	28	488	5.7
Pilbara	2	117	1.7
South West	67	1,499	4.5
Wheatbelt	10	516	1.9
Total	**480**	**18,380**	**2.6**

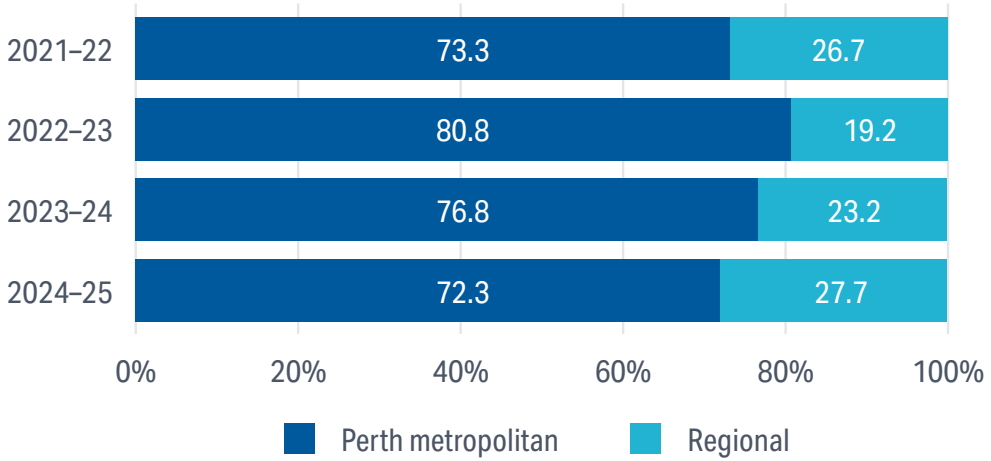
15 Total death registrations for WA include deaths in Christmas Island, Cocos (Keeling Islands) and where a person was normally domiciled or had property in WA. These have not been allocated to a health region.

Location of residence

In 2024–25, the majority of patients who died following administration of a voluntary assisted dying substance resided in the Perth metropolitan region (n=347, 72.3%, Table 6, Figure 11). This has decreased from 76.8 per cent in 2023–24 (n=225). Regional residents accounted for 27.7 per cent of deaths (n=133), an increase from 23.2 per cent in 2023–24 (n=68).

In 2024–25, the proportion of deaths due to administration of a voluntary assisted dying substance in the Perth metropolitan region was 2.4 per cent, which is lower than regional WA (3.6 per cent, Table 6).

Figure 11: Patient deaths by health region in 2021–22, 2022–23, 2023–24 and 2024–25



Administration type

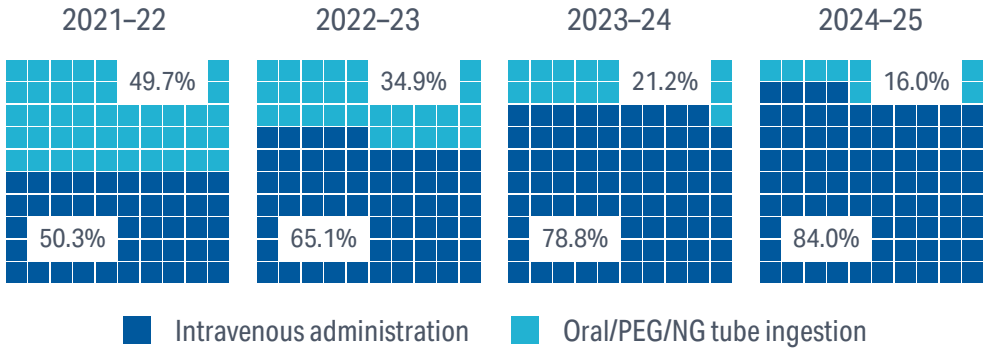
In 2024–25, there was a similar preference for practitioner administration of the voluntary assisted dying substance as compared with 2023–24. In 2024–25:

- 94.0 per cent of patients died after practitioner administration (n=451), a decrease from 94.9 per cent in 2023–24 (n=278, Figure 10)
- 6.0 per cent of patients died after self-administration (n=29), an increase from 5.1 per cent in 2023–24 (n=15).

In 2024–25, there was an increased preference for intravenous administration of the voluntary assisted dying substance:

- 84.0 per cent of patients (n=403) died after intravenous administration of the voluntary assisted dying substance, an increase from 78.8 per cent in 2023–24 (n=231, Figure 12)
- 16.0 per cent of patients (n=77) died after Oral/PEG/NG tube administration of the voluntary assisted dying substance, a decrease from 21.2 per cent in 2023–24 (n=62).

Figure 12: Oral/PEG/NG tube ingestion compared to intravenous administration in 2021–22, 2022–23, 2023–24 and 2024–25



Process timeframes

The Voluntary Assisted Dying Board (the Board) monitors the length of time between the different stages of the voluntary assisted dying process to understand the operation of voluntary assisted dying, identify barriers to access and monitor voluntary assisted dying substance in the community.

First Request to death

In 2024–25:

- the median number of days between First Request and death, following administration of a voluntary assisted dying substance, was 24 days, an increase from 21 days in 2023–24 (Figure 13)
- the median number of days for patients residing in the Perth metropolitan region and from regional areas were 21 and 30 days respectively (Table 7)
- the range of days between First Request and death was 1 day to 857 days.

The data demonstrates that the voluntary assisted dying process supports patients who make a First Request when they are close to death and those preparing for death.

Figure 13: Number of days between First Request and death in 2021–22, 2022–23, 2023–24 and 2024–25

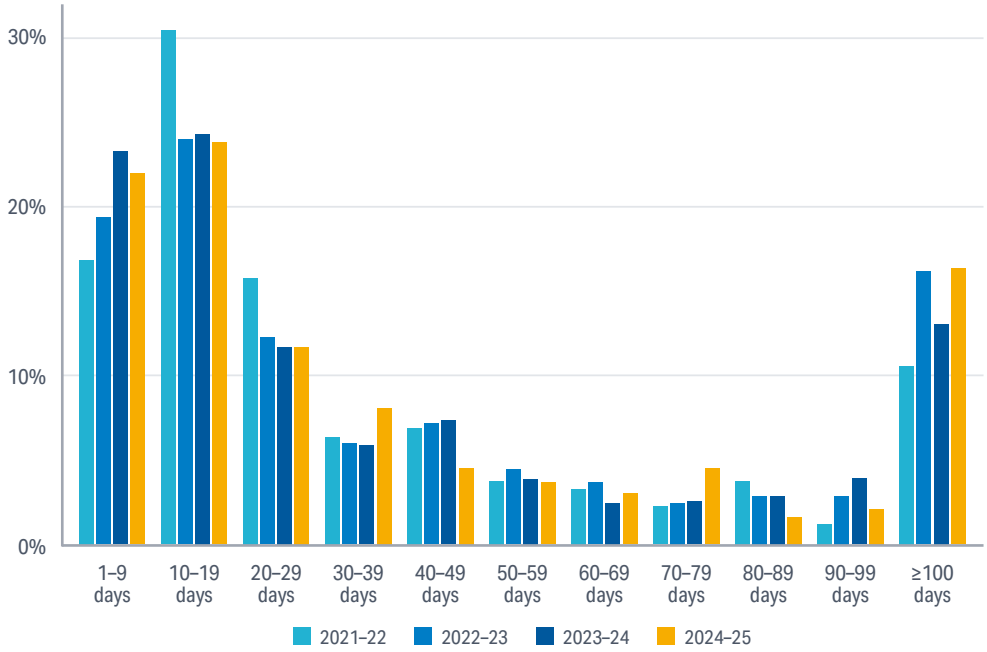


Table 7: Day range between First Request and death in 2021–22, 2022–23, 2023–24 and 2024–25

	2021–22		2022–23		2023–24		2024–25	
	Perth metropolitan	Regional	Perth metropolitan	Regional	Perth metropolitan	Regional	Perth metropolitan	Regional
Shortest number of days	3	4	2	2	2	2	1	1
Longest number of days	213	224	503	282	778	984	758	857
Median number of days	20	22	26	22	19	27	21	30

Supply to death

In 2024–25:

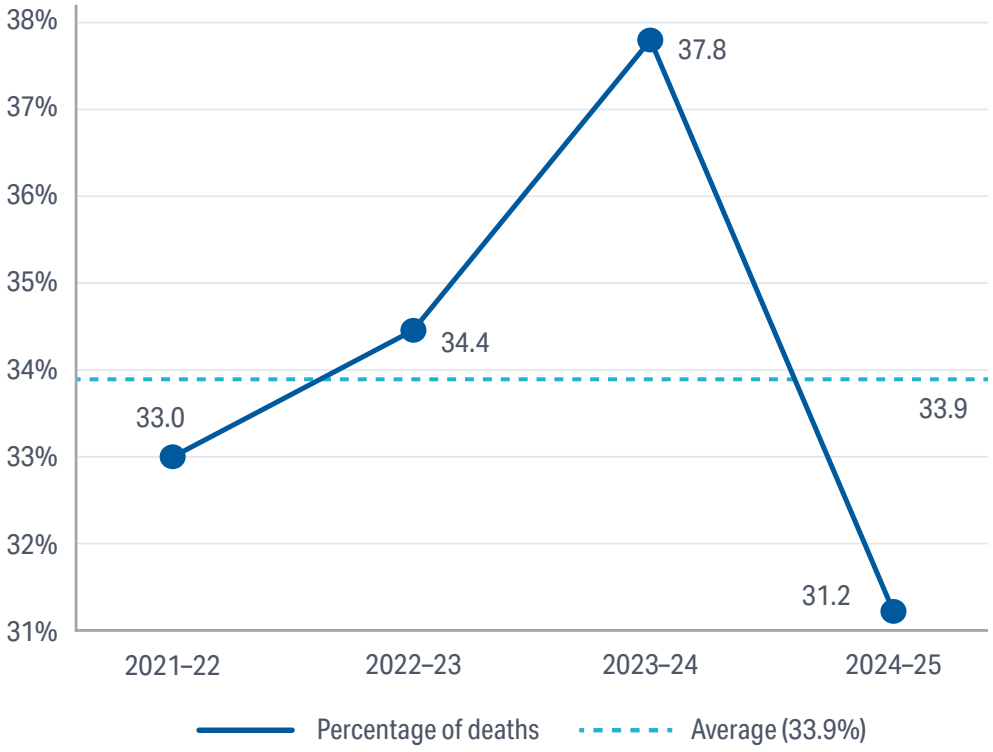
- the median number of days between supply and death, following administration of a voluntary assisted dying substance, was one day for practitioner administration and 5 days for self-administration
- nine in 10 patients died within 5 days of supply of the voluntary assisted dying substance (n=430, 89.6%)
- the longest number of days between supply and death for practitioner assisted Oral/PEG/NG tube administration was 278 days and self-administration was 745 days.

Since 1 July 2021, 8.6 per cent of patients, where a voluntary assisted dying substance was supplied, died prior to substance administration (n=118). On each occasion where this occurred the Board has received notification of substance disposal.

Death prior to administration of a voluntary assisted dying substance

Since 1 July 2021, 33.9 per cent of patient deaths (n=624) occurred prior to administration of a voluntary assisted dying substance including 31.2 per cent of patients in 2024–25 (n=218, Figure 14, Figure 15)[16,17]. In 2024–25, the majority (n=163, 74.8%) died after the completion of the Request and Assessment process (Figure 15).

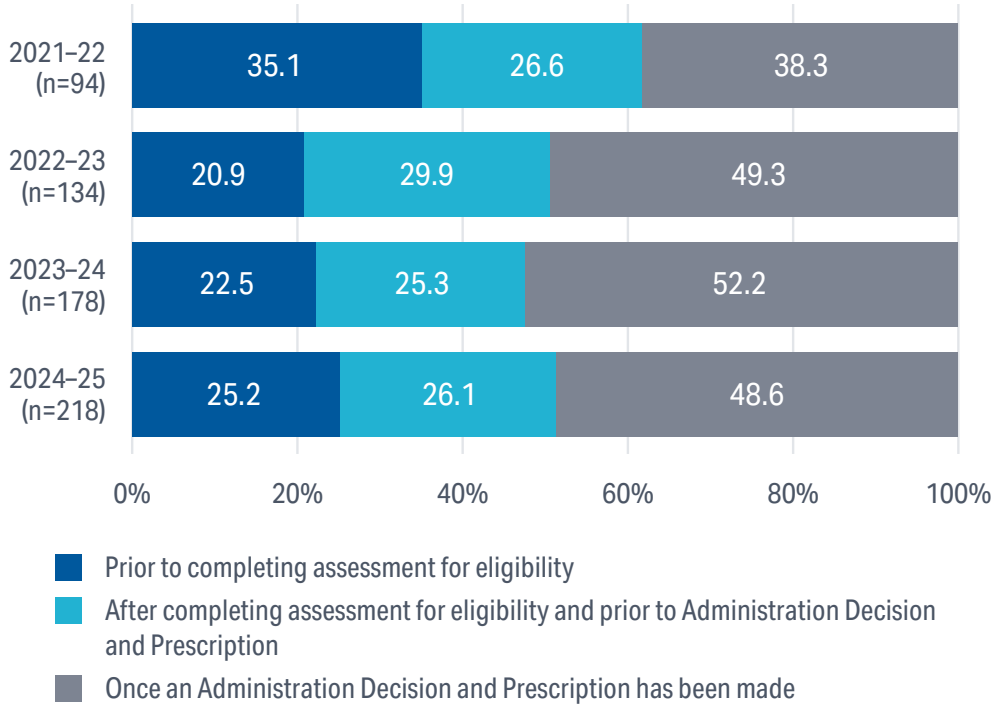
Figure 14: Voluntary assisted dying patient deaths occurring prior to administration of a voluntary assisted dying substance in 2021–22, 2022–23, 2023–24 and 2024–25



16 Includes patients who were still accessing voluntary assisted dying and excludes patients who either withdrew from the process or were not found to be eligible at any stage of the process.

17 Notifications of deaths may be received after the completion of each year and recorded in the year the death occurred.

Figure 15: Voluntary assisted dying process stage of patients who died prior to administration of a voluntary assisted dying substance in 2021–22, 2022–23, 2023–24 and 2024–25



Practitioner administration

When a patient dies via practitioner administration, the Administering Practitioner is required to record the circumstances in which the administration took place, including the time that elapsed between administration of the substance and death, the location of administration, and complications relating to the administration of the substance[18].

Time to death after practitioner administration

In 2024–25, after practitioner intravenous administration:

- the median time to death was 6 minutes, a decrease from 7 minutes in 2023–24
- 97.3 per cent of patients died within 15 minutes (Table 8)
- time elapsed between substance administration and death ranged from 1 minute to 45 minutes.

In 2024–25, after practitioner assisted oral ingestion or assisted ingestion via PEG or NG tube:

- the median time to death was 22 minutes, an increase from 19 minutes in 2023–24
- 83.3 per cent of patients died within 60 minutes (Table 9)
- time elapsed between substance administration and death ranged from 4 minutes to 4 hours 44 minutes.

18 No data on length of time to death, administration location or complications is collected by the Board regarding deaths occurring via self-administration of the voluntary assisted dying substance.

Table 8: Length of time to death of patient via intravenous administration in 2021–22, 2022–23, 2023–24 and 2024–25

Length of time to death	2021–22	2022–23	2023–24	2024–25	Total	% of total
≤ 15 minutes	90	155	222	392	**859**	95.9
≥ 16 minutes	6	11	9	11	**37**	4.1
Total	**96**	**166**	**231**	**403**	**896**	**100.0**

Table 9: Length of time to death of patient via assisted oral ingestion, assisted ingestion via PEG or NG tube in 2021–22, 2022–23, 2023–24 and 2024–25

Length of time to death	2021–22	2022–23	2023–24	2024–25	Total	% of total
≤ 29 minutes	42	30	40	32	**144**	75.4
30 to 60 minutes	6	9	5	8	**28**	14.7
≥ 61 minutes	4	5	2	8	**19**	9.9
Total	**52**	**44**	**47**	**48**	**191**	**100.0**

Administration location

As in 2023–24, the primary location for practitioner administration of the voluntary assisted dying substance in 2024–25 was the patient's home (n=200, 44.3%, Figure 16, Table 10). In 2024–25, there was an increase in the percentage of administrations occurring in a public hospital ward, from 28.4 per cent in 2023–24 (n=79) to 33.5 per cent in 2024–25 (n=151). There was an increase in the percentage of administrations occurring in residential aged care from 5.8 per cent in 2023–24 (n=16) to 7.5 per cent in 2024–25 (n=34).

Figure 16: Patient deaths by practitioner administration location in 2021–22, 2022–23, 2023–24 and 2024–25

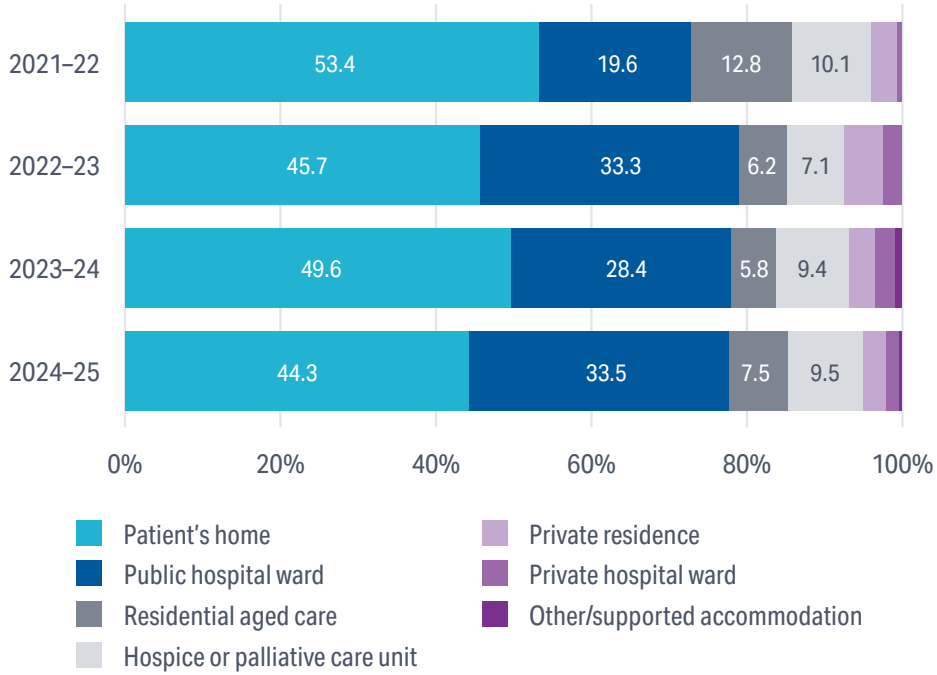


Table 10: Number of patient deaths by practitioner administration location in 2021–22, 2022–23, 2023–24 and 2024–25

Practitioner administration location	2021–22	2022–23	2023–24	2024–25	Total	% of total
Patient's home	79	96	138	200	**513**	47.2
Public hospital	29	70	79	151	**329**	30.3
Hospice or palliative care unit	15	15	26	43	**99**	9.1
Residential aged care	19	13	16	34	**82**	7.5
Private residence	5	11	9	14	**39**	3.6
Private hospital ward	1	4	7	7	**19**	1.7
Other/ Supported accommodation	0	1	3	2	**6**	0.6
Total	**148**	**210**	**278**	**451**	**1,087**	**100.0**

Complications

At the time of administration, practitioners are required to notify the Board of any complications that occur during the administration. In 2024–25, 96.0 per cent of deaths following practitioner administration (n=433) were reported without complication, which is similar to 2023–24 (95.7 per cent, n=266). There were 18 complications reported in 2024–25 (4.0 per cent of deaths).

Intravenous line complications (n=6) and other complications (n=7) were the most frequently recorded complications in 2024–25, followed by regurgitation/vomiting (n=3), seizure (n=1) and worsening pain or discomfort (n=1). Complications reported as 'other' included coughing following administration of the voluntary assisted dying substance, delayed loss of consciousness, transient pain following intravenous administration and syringe assembly difficulties. All patients with reported complications died after administration of the voluntary assisted dying substance. The Board completed case reviews of all reported complications.

Implementation

Notifications to the Voluntary Assisted Dying Board

The Voluntary Assisted Dying Board (the Board) receives notifications, via submission of approved forms, at each stage of the voluntary assisted dying process as required by the *Voluntary Assisted Dying Act 2019* (the Act). Submission of forms ensure that the Board is notified progressively of the patient's participation in the voluntary assisted dying process, including the outcome of each assessment, and to confirm compliance with the Act.

Since 1 July 2021, the number of forms received by the Board has increased year-on-year (Table 11). In 2024–25, 8,349 forms[19,20,21] were received by the Board, representing a 50.3 per cent increase in activity from 2023–24 (n=5,556) and a 128.6 per cent increase in activity from 2021–22 (n=3,652). The number of forms increased in each quarter of 2024–25, from 1,885 in quarter 1 to 2,278 in quarter 4.

Forms where there were increases of over 50 per cent in 2024–25 when compared with 2023–24 include:

- Administering Practitioner Transfer Forms (increase of 203.7 per cent)
- Authorised Disposal Forms (increase of 108.3 per cent)
- Administering Practitioner Disposal Forms (increase of 82.3 per cent)
- Coordinating Practitioner Transfer Forms (increase of 74.1 per cent)
- Practitioner Administration Forms (increase of 63.2 per cent)
- Authorised Supply Forms (increase of 60.5 per cent).

19 Forms are counted based on when they were submitted to the Board and not the date of the activity in the form.

20 The number of forms submitted does not constitute the number of individual persons requesting access to voluntary assisted dying, nor the activity at each stage of the process.

21 The data includes forms with a status of valid, void and revoked. A valid form is considered complete and correct at the time of submission to the Board. Forms that are assigned a status of void or revoked were previously valid forms:

- a form is assigned a status of 'void' when a subsequent Consulting Assessment Form is submitted, or a form has been superseded by another valid submission
- an Administration Decision and Prescription Form or Contact Person Appointment Form is assigned a status of 'revoked' when a patient has revoked their administration decision or appointment of a Contact Person.

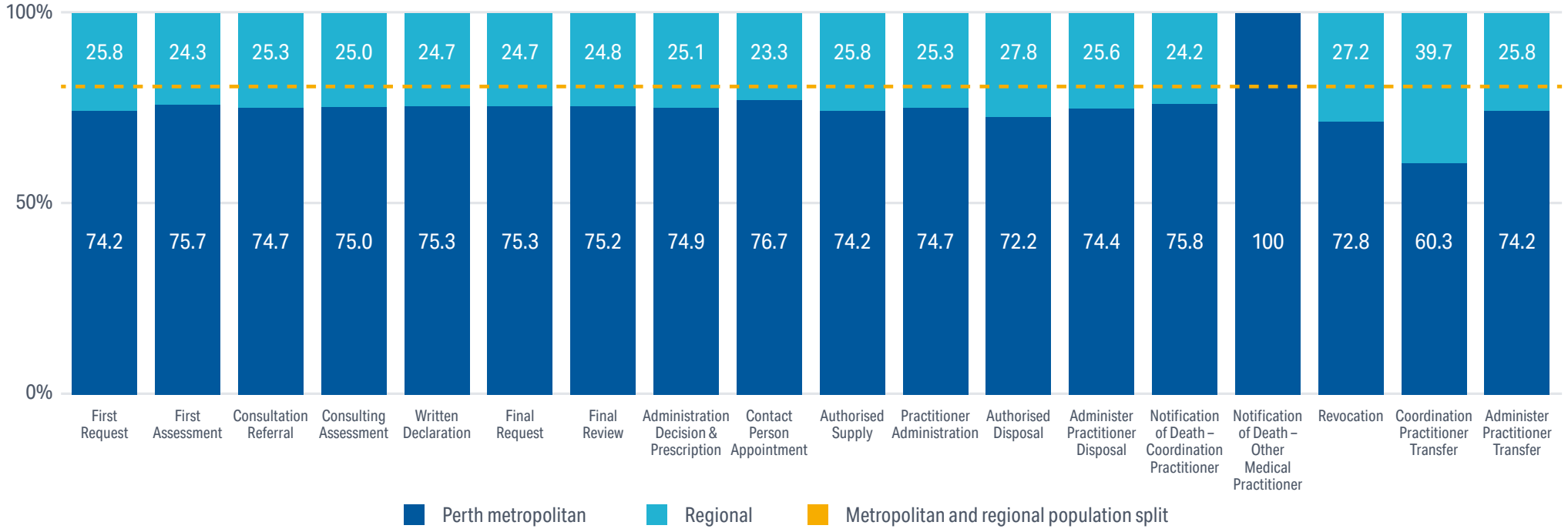
Table 11: Number of forms with a status of valid, void and revoked submitted in 2021–22, 2022–23, 2023–24 and 2024–25

					All time		
Form title	2021–22	2022–23	2023–24	2024–25	Total	Perth metropolitan	Regional
First Request	725	753	968	1,332	**3,778**	2,804	974
First Assessment	383	472	595	879	**2,329**	1,764	565
Consultation Referral	337	406	505	743	**1,991**	1,488	503
Consulting Assessment	324	397	496	722	**1,939**	1,454	485
Written Declaration	293	363	450	658	**1,764**	1,329	435
Final Request	284	347	434	645	**1,710**	1,287	423
Final Review	284	346	433	643	**1,706**	1,283	423
Administration Decision and Prescription	284	354	450	670	**1,758**	1,317	441
Contact Person Appointment	93	50	54	60	**257**	197	60
Authorised Supply	237	283	342	549	**1,411**	1,047	364
Practitioner Administration	147	211	277	452	**1,087**	812	275
Authorised Disposal	13	22	12	25	**72**	52	20
Administering Practitioner Disposal	90	148	203	370	**811**	603	208
Notification of Death – Coordinating/Administering Practitioner	114	175	199	265	**753**	571	182
Notification of Death – Other Medical Practitioner	2	0	0	3	**5**	5	0
Revocation	9	17	29	37	**92**	67	25
Coordinating Practitioner Transfer	17	25	27	47	**116**	70	46
Administering Practitioner Transfer	16	37	82	249	**384**	285	99
Total	**3,652**	**4,406**	**5,556**	**8,349**	**21,963**	**16,435**	**5,528**

Since 1 July 2021, the number of forms received from regional WA as a proportion of the state was higher than the corresponding population of regional WA as a proportion of the state population (Figure 17).

It is a requirement of the Act that approved forms be given to the Board within 2 business days of a specified event taking place. This aims to ensure that key tasks in the voluntary assisted dying process are completed and documented in a timely manner and that the process can continue to progress for a patient seeking access to voluntary assisted dying. In 2024–25, 97.4 per cent of forms were submitted to the Board within 2 business days. Where failure to give a form to the Board within the required timeframe is an offence under the Act, a referral has been made to the Director General of the WA Department of Health (as Chief Executive Officer).

Figure 17: Percentage of forms with a status of valid, void and revoked by health region submitted in 2021–22, 2022–23, 2023–24 and 2024–25[22]



22 Metropolitan and regional population data sourced from the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health (2025). Data is based on the Australian Bureau of Statistics (ABS) population data for the 2024 calendar year for persons aged 18 years and older.

Statewide services to support voluntary assisted dying

The Department of Heath facilitates access to voluntary assisted dying for eligible Western Australians by providing:

- information, training and support through the End of Life Care Program
- information, coordination and support through the Statewide Care Navigator Service
- services for the supply of the voluntary assisted dying substance through the Statewide Pharmacy Service.

End of Life Care Program

The End of Life Care Program support the implementation of voluntary assisted dying through management of the Western Australian Voluntary Assisted Dying Approved Training (WA VAD Approved Training), provision of resources and educational materials, policy administration and contract management of the statewide services. The Voluntary Assisted Dying Board (the Board) notes the priority areas for the End of Life Care Program in 2024–25 included:

- introduction of registration for the WA VAD Approved Training via the Voluntary Assisted Dying Information Management System
- provision of information resources and educational materials through the WA Department of Health website and reviewing resources to ensure they are fit for purpose
- delivery of the *Statutory Review of the Voluntary Assisted Dying Act 2019 – Final Report*
- implementation of the fee-for-service practitioner remuneration model commencing on 1 July 2024
- conducting a survey of the voluntary assisted dying workforce to inform workforce strategies
- translation of the Approved Information booklet required to be provided to persons making a First Request into 16 languages.

Statewide Care Navigator Service

The Statewide Care Navigator Service (SWCNS) was established to provide information, support and assistance to anyone involved with voluntary assisted dying, including patients, patient families and carers, members of the community, voluntary assisted dying practitioners, health care workers and other service providers.

The SWCNS is critical to the success of voluntary assisted dying in WA. The care navigators provide information about voluntary assisted dying in WA, help make the connection with a practitioner who is willing and eligible to participate in voluntary assisted dying, assist people to access available support services and coordinate care for patients throughout the voluntary assisted dying process. In addition, the SWCNS manages the Community of Practice and coordinates information and training sessions to build and support the voluntary assisted dying workforce. The SWCNS also offers education and information sessions for health care workers and the community regarding voluntary assisted dying.

Since the inception of the SWCNS, a total of 57,117 interactions have been recorded including contact from 2,862 patients, 333 healthcare workers and 117 other persons[23,24]. The SWCNS has responded to 158 training requests.

23 Includes support persons seeking information on behalf of someone else.

24 Data supplied by the Statewide Care Navigator Service.

During 2024–25, the SWCNS provided:

- 18,807 interactions (an increase of 13.4 per cent from 2023–24) with patients, families and carers, healthcare workers and practitioners, including 1,092 new requests for support
- care for an average of 228 new patients per quarter, an increase from 200 per patients per quarter in 2023–24
- support for an average caseload of 408 patients per quarter (combined new referrals and ongoing follow ups), an increase from an average caseload of 354 patients in 2023–24, with 89.8 per cent of individual patients requiring more than one interaction.

The SWCNS provided a range of support services during 2024–25 with the distribution of services remaining consistent with support services provided in 2023–24. Care coordination (n=5,403, 36.8%) was the most common type of primary interaction[25], followed by ongoing care (n=4,826, 32.9%, Table 12). The number of primary interactions seeking a practitioner to provide voluntary assisted dying services increased by 19.1 per cent in 2024–25 (n=1,747) as compared with 2023–24 (n=1,467).

Table 12: Statewide Care Navigator Service primary interactions in 2021–22, 2022–23, 2023–24 and 2024–25[26,27]

Primary interaction type	2021–22	2022–23	2023–24	2024–25	Total	% of total
Care coordination	1,796	2,892	4,516	5,403	**14,607**	35.7
Ongoing care	2,036	2,494	4,323	4,826	**13,679**	33.5
Enquiry/information request	1,058	1,158	1,698	1,911	**5,825**	14.2
Seeking practitioner	634	802	1,467	1,747	**4,650**	11.4
Bereavement support	2	207	343	359	**911**	2.2
Administration support	1	104	214	361	**680**	1.7
Other	228	68	57	56	**409**	1.0
Support request – individual	7	10	38	7	**62**	0.2
Support request – family/carer	3	13	13	0	**29**	0.1
Regional Access Support Scheme	8	3	9	12	**32**	0.1
Total	**5,773**	**7,751**	**12,678**	**14,682**	**40,884**	**100.0**

25 A primary interaction is defined as a key episode of care. Subsequent interactions may occur following a primary interaction.

26 Bereavement support, administration support, support request – family/carer and support request – individual was initially captured in 'Other' and have been reported separately since 2022–23.

27 This table contains minor revisions to the 2021–22, 2022–23 and 2023–24 data where new information was received or updated.

The Board recognises that since 1 July 2021, the number of primary interactions by the SWCNS has increased year-on-year, with the number of primary interactions in 2024–25 being an increase of 154.3 per cent over the number of primary interactions in 2021–22 (Table 12). Furthermore, over this period, the primary interactions of care coordination, ongoing care and seeking a practitioner have increased 200.8 per cent, 137.0 per cent and 175.6 per cent respectively.

The Board acknowledges the continued dedicated work of the SWCNS in providing a responsive, person-centred care navigation service which facilitates equitable access across metropolitan and regional areas in 2024–25, with achievements including:

- continuing to grow, evolve and optimise services in the context of increased demand, complexity and person-driven care requirements
- delivering education and training episodes including 2 health professional forums and 2 practitioner training workshops
- progressing research relating to the experiences of patients and support networks seeking access to voluntary assisted dying
- implementing a grief and bereavement screening tool for patients and those providing support to patients
- developing an Aboriginal Care Framework for service improvement, including targeted staff training to inform culturally safe practice
- continuing to deliver the 'This is my stop' story sharing podcast episodes to support increased community understanding and awareness of voluntary assisted dying, particularly for families and patient support networks
- receiving frequent positive feedback from patients, family members, carers and practitioners regarding the SWCNS via an anonymous feedback survey, but also via the personal reflections received by the Board.

The Board understands the ongoing challenges raised by the SWCNS to include:

- the number of people seeking access to voluntary assisted dying has increased more rapidly than the number of trained voluntary assisted dying practitioners, with a small proportion of practitioners providing the majority of services. This impacts the ability of the SWCNS to successfully link patients to a practitioner and poses difficulties in transferring practitioner roles during periods of leave, particularly for patients residing in regional areas
- increasing caseload across the SWCNS team with resulting impacts on staff well-being and deterioration in patient access to voluntary assisted dying through delays in care provision
- reprioritisation of services to focus on meeting increased patient activity, with subsequent decreased involvement in education and awareness
- the impact of the *Commonwealth Criminal Code Act 1995* on the use of carriage services to facilitate timely and efficient care provision
- the ongoing impact of senior clinicians at health service facilities who are unwilling to support patient choice to access voluntary assisted dying, creating barriers to access for assessment and care provision.

Regional Access Support Scheme

The Regional Access Support Scheme (RASS) was developed under the Access Standard required by the *Voluntary Assisted Dying Act 2019* (the Act) and is managed by the SWCNS. The RASS provides financial support to ensure that regional residents are not disadvantaged in their ability to access voluntary assisted dying including travel for practitioners, patients, support persons and interpreters involved in the voluntary assisted dying process. The RASS can also be utilised for completion of the WA VAD Approved Training by a medical practitioner or nurse practitioner who cares for regional patients.

In 2024–25, there were a total of 180 requests that met the defined RASS criteria in support of 106 patients and 13 practitioners who were not associated with a particular patient (Table 13). This is an increase from the 131 requests in support of 78 patients and practitioners in 2023–24. More than 9 of every 10 requests (n=166, 92.2%) were made for travel of a practitioner to a patient for face-to-face care, with the remainder being requests to support the completion of practitioner training (n=14, 7.8%)[28].

In 2024–25, RASS requests were received from all regions apart from the Kimberley. In accordance with the Access Standard under the Act, the RASS has been used to support travel for regionally based practitioners to attend face-to-face workshops to support their completion of the WA VAD Approved Training. These practitioners have indicated their intent to provide patient care in areas with insufficient practitioner workforces to meet patient demand. Despite the RASS, the SWCNS continue to report increasing challenges in locating practitioners who are willing to accept patients which involves either flights or travel beyond a single day within metropolitan driving capacity, highlighting the need for more regional practitioner uptake. The SWCNS acknowledges the nurse practitioners who have stepped into administrating practitioner roles using the RASS to meet the needs of patients requesting voluntary assisted dying.

Table 13: Regional Access Support Scheme requests by health region in 2021–22, 2022–23, 2023–24 and 2024–25

Health region	2021–22	2022–23	2023–24	2024–25	Total	% of total
Perth metropolitan	2	53	43	21	**119**	21.1
Peel	29	30	23	41	**123**	21.8
Goldfields	13	2	6	9	**30**	5.3
Kimberley	2	4	5	0	**11**	2.0
Midwest	0	4	11	15	**30**	5.3
Great Southern	20	19	13	19	**71**	12.6
Pilbara	2	3	1	3	**9**	1.6
South West	22	20	20	35	**97**	17.2
Wheatbelt	18	10	8	24	**60**	10.6
Practitioner training support[29]	0	0	1	13	**14**	2.5
Total	**108**	**145**	**131**	**180**	**564**	**100.0**

28 One RASS request may involve several types of support, such as travel and accommodation, such that overall, RASS request numbers may not be equal to the total number of RASS requests by type.

29 Indicates a RASS request for practitioner training support not associated with an individual patient.

Statewide Pharmacy Service

The Statewide Pharmacy Service (SWPS) ensures that the voluntary assisted dying substance is provided in a manner that is safe, equitable, patient-centred and meets regulatory requirements for the handling of such medicines. The SWPS offer expert guidance on the prescribing, storage, administration and disposal of the voluntary assisted dying substance. Additionally, the SWPS provides comprehensive education and support to patients, families, practitioners and other key stakeholders. The role of SWPS pharmacists as Authorised Suppliers ensures the substances are provided directly to the patient or their representative, or to the Administering Practitioner anywhere in WA. The SWPS is funded by the WA Department of Health and provides services and medications at no cost to the patient.

During 2024–25[30]:

- the SWPS experienced an increase in voluntary assisted dying substance supplies, supplying the prescribed voluntary assisted dying substance on 550 occasions, an increase of 60.8 per cent from 2023–24 (n=342, Table 14)
- there were 128 supplies of the voluntary assisted dying substance in regional WA, an increase of 132.7 per cent from 2023–24 (n=55)
- the proportion of supplies of the voluntary assisted dying substance in regional WA increased from 16.1 per cent in 2023–24 to 23.3 per cent in 2024–25
- the SWPS travelled to all health regions to supply the voluntary assisted dying substance, with the exception of the Kimberley
- fifty one per cent of requests for supply of the voluntary assisted dying substance were classified as urgent (n=339) an increase from 37 per cent in 2023–24 (n=162)[31,32].

In 2024–25, 98.8 per cent of all supplies to the Perth metropolitan area (n=417) occurred within 2 business days and all supplies to regional WA (n=128) within 5 business days of the patient or Administering Practitioner's requested timeframe. In 2023–24, all supplies in both the Perth metropolitan area and regional WA occurred within 2 and 5 business days respectively.

Since 1 July 2021, the number of supplies of a voluntary assisted dying substance has increased year-on-year, with the number of supplies in 2024–25 being a 132.1 per cent increase over the number of supplies in 2021–22 (Table 14).

The Board acknowledges the maintenance of high quality and safety standards and achievements of the SWPS in 2024–25 including:

- continuing to meet the ever changing and increasing service needs, including recruitment, improved communication and collaboration with the SWCNS
- responding to 339 urgent requests for supply. The primary reasons for urgent requests included clinical deterioration of patients, practitioner availability and patient factors including the expedited pathway and emotional distress
- undertaking service and quality improvement initiatives including expanding the service to provide on-call and out-of-hours support
- continuing to actively participate in practitioner training and community education opportunities across WA
- progressing research projects relating to community pharmacists' understanding of their role under the Act and exploring the non-technical skills of voluntary assisted dying pharmacists in Australia
- working to develop and manufacture a masking agent to improve the palatability of the oral voluntary assisted dying substance
- continuing to receive positive feedback from patients, families and participating practitioners.

In 2024, the SWPS was a finalist in the 2024 WA Health Excellence Awards – Excellence in Person-Centred Care.

30 Data supplied by the Statewide Pharmacy Service.

31 The urgency of requests for supply may be for a variety of reasons.

32 There are more requests for supply than supplies due to instances where the supply event being cancelled or there are multiple requests for supply as the details are changed or updated.

Table 14: Authorised supply of the voluntary assisted dying substance by health region where the supply occurred in 2021–22, 2022–23, 2023–24 and 2024–25[33]

Health region	2021–22	2022–23	2023–24	2024–25	Total	% of total
Perth metropolitan	203	244	287	422	**1,156**	81.9
Goldfields	1	0	2	1	**4**	0.3
Kimberley	3	0	1	0	**4**	0.3
Midwest	3	7	9	28	**47**	3.3
Great Southern	11	14	14	24	**63**	4.5
Pilbara	1	1	0	1	**3**	0.2
South West	14	17	28	73	**132**	9.3
Wheatbelt	1	0	1	1	**3**	0.2
Total	**237**	**283**	**342**	**550**	**1,412**	**100.0**

The Board understands the challenges experienced by the SWPS including:

- the existing location of the SWPS which provides inadequate space for SWPS staff and creates risks to information privacy and the secure storage of the voluntary assisted dying substance
- the impact of the *Commonwealth Criminal Code Act 1995* which prevents prescriptions via virtual means and often results in delays in supply of the voluntary assisted dying substance
- supporting practitioners with cannulation of patients who are often dehydrated and cachectic
- the lack of awareness of Authorised Disposers of their role under the Act, which the SWPS aims to address via education.

33 Health region where supply of the voluntary assisted dying substance occurs may not align with the patient's home address. e.g., supply of a voluntary assisted dying substance for regional residents may occur in the Perth metropolitan region.

Community of Practice

The Community of Practice is an informal collegial group of health practitioners who have completed the WA VAD Approved Training and staff from the SWCNS, SWPS and voluntary assisted dying coordinators within health service providers. In 2024–25, membership of the Community of Practice continued to grow, now comprising 126 members including 91 medical practitioners and 8 nurse practitioners who have completed the WA VAD Approved Training. The Community of Practice meets monthly so that practitioners and others involved in the voluntary assisted dying process in WA can share learnings in a confidential and collegiate space. Meetings alternate between online and in-person hybrid online formats to encourage the engagement of practitioners based in regional WA. Support for the Community of Practice is provided by the SWCNS.

In recognising the need for connection, mentoring, support and professional practice development, the SWCNS delivered the second annual full day professional development forum for participating practitioners and healthcare workers supporting access to voluntary assisted dying. This forum offered both virtual and in-person attendance options in collaboration with the SWPS and the Board, delivering ongoing practice development, professional support including for practitioner wellbeing, and providing an opportunity for networking, connection and sharing of experiences. The SWCNS has received positive feedback regarding the hosting of this forum and the support it provides to practitioners.

Participating practitioners wishing to join the Community of Practice can contact VADcarenavigator@health.wa.gov.au

Voluntary Assisted Dying Board

Voluntary Assisted Dying Board

On 1 July 2021, voluntary assisted dying became a choice for eligible Western Australians under the *Voluntary Assisted Dying Act 2019* (the Act). The development of the Act was preceded by the Parliamentary Joint Select Committee on End-of-Life Choices report My Life, My Choice and the Ministerial Expert Panel on Voluntary Assisted Dying Final Report.

The Act provides for the establishment of the Voluntary Assisted Dying Board (the Board). The Board was established to ensure proper adherence to the Act and to recommend safety and quality improvements.

Functions

The Act sets out the following functions for the Board:

- to monitor the operation of the Act
- to provide to the Minister for Health or the Chief Executive Officer of the WA Department of Health, on its own initiative or on request, advice, information and reports on matters relating to the operation of the Act, including any recommendations for the improvements of voluntary assisted dying
- 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 Commissioner of Police, the Registrar of Births, Deaths and Marriages, the State Coroner, the Chief Executive Officer of the WA Department of Health, Chief Executive Officer of the department of the Public Service principally assisting in the administration of the *Prisons Act 1981*, the Australian Health Practitioner Regulation Agency and the Director of the Health and Disability Services Complaints Office
- to conduct analysis of, and research in relation to, information given to the Board under the Act
- to collect, use and disclose information given to the Board under the Act for the purposes of performing its functions
- any other function given to the Board under the Act.

Membership and meetings

The Board consists of 5 members appointed by the Minister for Health for a period of up to 3 years with possible reappointment for subsequent terms. Dr Robert Edis retired at the end of 2024, with Dr Gareth Wahl being appointed to the Board at the start of 2025.

Dr Scott Blackwell (Chairperson)

Dr Blackwell is a General Practitioner and former Australian Medical Association WA Branch President. Dr Blackwell has expertise in palliative and aged care and was the Chairperson of the Implementation Leadership Team on voluntary assisted dying.

Hon Colin Holt (Deputy Chairperson)

Mr Holt was a Member of the Legislative Council of WA, representing the South West region, from 2009 to 2021. Mr Holt was the Deputy Chairperson of the Joint Select Committee on End-of-Life Choices. Mr Holt is a board member of the WA Country Health Service and Racing and Wagering WA and is the WA representative for Racing Australia.

Ms Maria Osman

Ms Osman is an experienced non-executive director and adviser specialising in human rights, diversity and gender matters. Ms Osman is a board member of the University of WA Public Policy Institute International Advisory Board, the Racial Justice Centre, the Gnaala Karla Booja Aboriginal Corporation and Yinhawangka Community and Social Outcomes Limited. Ms Osman was a member of the Ministerial Expert Panel on voluntary assisted dying and is an inductee into the WA Women's Hall of Fame.

Ms Linda Savage

Ms Savage is a lawyer and former Director of the Social Security Appeals Tribunal, legal member of the Administrative Appeals Tribunal and Member of the WA Legislative Council. Ms Savage is a board member of the University of WA Public Policy Institute International Advisory Board and Upswell Publishing, and a former board member of Dying with Dignity WA. In 2018, she was appointed as an Ambassador for Children and Young People in WA.

Dr Gareth Wahl

Dr Wahl is an experienced voluntary assisted dying practitioner, with a background in Emergency Medicine and Medical Administration. Dr Wahl is the Director Clinical Services, Women and Newborn Health Service and previously held the positions of Clinical Lead for End of Life Care for the WA Department of Health, and the Voluntary Assisted Dying Clinical Lead for the North Metropolitan Health Service[34].

Dr Robert Edis

Dr Edis is a Consultant Neurologist with a long-time interest in progressive neurological diseases including special experience in multidisciplinary team motor neurone disease care. Dr Edis strongly supports voluntary assisted dying to be available as an end of life choice for eligible people with these diseases[35].

34 Dr Wahl's term commenced on 1 January 2025.

35 Dr Edis' term ended on 31 December 2024.

The Board met monthly throughout 2024–25, with an additional special meeting held in July 2024 (Table 15). All meetings were held in accordance with the requirements of the Act. Additional workshops were held as part of the Board's performance review and preparation of the 2023–24 Annual Report.

Table 15: Board member term and meeting attendance in 2024–25

Board member	Term	Meetings attended 2024–25
Dr Scott Blackwell	1 July 2021 to 30 June 2027	13 of 13
Colin Holt	1 July 2021 to 30 June 2025 (Reappointed for a further 3 years, commencing 1 July 2025)	13 of 13
Maria Osman	1 July 2021 to 30 June 2026	13 of 13
Linda Savage	1 July 2021 to 30 June 2026	12 of 13
Dr Robert Edis	1 July 2021 to 31 December 2024	7 of 7
Dr Gareth Wahl	1 January 2025 to 30 June 2027	6 of 6

Board Performance

In line with its performance review policy, in 2024–25 the Board undertook an annual performance review. The Board Performance Review 2025, included:

- Board member self-assessment and one-on-one interviews with Board Chair
- Board member performance evaluation survey
- performance review workshop.

Board members were satisfied with the performance of the Board and noted progress against previously identified areas for improvement. In consideration of the feedback received throughout the performance review process, the following areas for action have been identified to build on the Board's strengths and increase the Board's contribution to the successful operation of voluntary assisted dying in WA:

- refine the Board's approach to professional practice improvement
- increased engagement with the Community of Practice
- ongoing quality improvement in monitoring and reporting
- review the operational structure of voluntary assisted dying in WA with the WA Department of Health
- maximise efficiency and effectiveness of the Board's meeting structure.

Board Support

The Voluntary Assisted Dying Board Secretariat Unit (Secretariat Unit) supports the day-to-day operations of the Board, including the management of the Voluntary Assisted Dying Information Management System (VAD-IMS), facilitating Board meetings, and implementing Board decisions.

Through the Secretariat Unit, the WA Department of Health provides corporate services, human resource support, records management, information and communications technology and other services to support the Board to deliver its functions and legislated obligations.

Directions and disclosures

In 2024–25, no directions were given by the Minister pursuant to section 123(1) or 152(2) of the Act. No disclosures of material or personal interest made by Board members under section 140(1) related to matters dealt with in this annual report.

Compliance with public sector standards and ethical codes

The Voluntary Assisted Dying Board Code of Conduct sets out the responsibilities and obligations of members of the Board and is the foundation on which the Board can provide good governance in its role. It was developed in line with the Public Sector Commission's Conduct Guide for Public Sector Boards and Committees. For 2024–25, there were no issues in relation to the Voluntary Assisted Dying Board Code of Conduct.

Monitoring the operation of the Act

The Voluntary Assisted Dying Board Monitoring Function Policy details the principles and processes that guide the Board's monitoring functions, including real-time and routine monitoring.

The Secretariat Unit supports the Board by monitoring forms submitted via VAD-IMS and engaging with participating practitioners to ensure the accurate completion of forms throughout the voluntary assisted dying process through daily monitoring, weekly compliance reviews and quarterly auditing and reporting.

Case reviews

In accordance with the Voluntary Assisted Dying Board Monitoring Function Policy, the Board undertakes monthly case reviews of a minimum of 20 per cent of closed individual patient episodes to monitor compliance with the Act. Patient episodes are identified for case review from a range of criteria including actual or suspected non-compliance, long-standing patients and patients who have made multiple First Requests. A patient episode may be closed at various points during the voluntary assisted dying process, including if the patient is assessed as not eligible, has withdrawn from the process or has died.

The Board completed 202 case reviews during 2024–25. Key actions arising from the case review process included:

- referral to the Director General of the WA Department of Health (as Chief Executive Officer) regarding timeliness of disposal of a voluntary assisted dying substance
- engagement with the WA Department of Health on amendments to the approved forms required to be submitted as part of the voluntary assisted dying process
- education for practitioners and contact persons
- acknowledgment of practitioners and statewide services providing exceptional care to patients
- modifying Secretariat Unit procedures for monitoring, data entry and follow up on use of interpreters in the voluntary assisted dying process.

Referrals

Section 118(c) of the Act details the function of the Board to make referrals of matters to other relevant regulatory and investigative bodies:

- Commissioner of Police
- Registrar of Births, Deaths and Marriages
- State Coroner
- Chief Executive Officer of the WA Department of Health
- Chief Executive Officer of the department of the Public Service principally assisting in the administration of the *Prisons Act 1981*
- the Australian Health Practitioner Regulation Agency
- the Director of the Health and Disability Service Complaints Office.

In 2024–25, the Board made referrals to the Health and Disability Service Complaints Office relating to failure to respond to a request for access to voluntary assisted dying in compliance with the Act (n=1) and to the Director General of the WA Department of Health (as Chief Executive Officer) relating to the timeliness of an authorised disposal of a voluntary assisted dying substance (n=1) and the timeliness of forms submitted to the Board (n=218).

Education, data and research

Education

In 2024–25, the Board published 4 editions of the Quality Practice Series. The Quality Practice Series is intended to be a series of tips, reminders and practice points for participating practitioners that focus on different areas of the voluntary assisted dying process. In 2024–25 editions of the Quality Practice Series[36] topics included:

- requirement to renew the WA Voluntary Assisted Dying Approved Training (WA VAD Approved Training)
- quarterly matching between VAD-IMS data and records from the Registry of Births, Deaths and Marriages
- WA Department of Health fee-for-service practitioner remuneration model
- updates to the WA Voluntary Assisted Dying Guidelines, Approved Information booklet, prescription and administration information and practitioner eligibility requirements
- use of referrals for determination in assessments
- sequencing of administration decisions and prescriptions
- planning for leave and transferring Coordinating Practitioner and Administering Practitioner roles
- completion of declaration of life extinct form
- recording primary and secondary diagnoses on assessment forms
- recording complications on Practitioner Administration Forms
- voluntary assisted dying workforce sustainability survey
- submission of personal reflections
- general reminders for VAD-IMS.

In 2024–25, the Board Chair engaged with the Community of Practice to share information and receive feedback from those participating in the voluntary assisted dying process. Topics discussed with the Community of Practice included:

- completion of medical certificate of cause of death forms
- recording eligible diagnoses on First Assessment and Consulting Assessment Forms
- activity sequencing
- public awareness of voluntary assisted dying
- sustainability of the practitioner workforce and supports available
- transfer of coordinating and administering practitioner roles
- practitioner remuneration.

36 Current and previous editions of the Quality Practice Series can be accessed from the Voluntary Assisted Dying Board website at health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying-board

Data and research

One of the functions of the Board is to conduct analysis and research in relation to information received throughout the voluntary assisted dying process. The Board's Research Policy sets the intended approach to research, aligned to strategic objectives. The policy includes research focus areas to support the Board's understanding of:

- awareness and understanding of voluntary assisted dying
- barriers to access and patient experience
- practitioner involvement in voluntary assisted dying and current workforce issues.

The Voluntary Assisted Dying Board Research Advisory Group was established in 2023–24 to provide multidisciplinary advice to the Board on all aspects of the research process. In 2024–25, the Voluntary Assisted Dying Board Research Advisory Group held 4 meetings, which included discussions of the Board's Research Plan, research projects being explored by the Board, the Statewide Care Navigator Service and Statewide Pharmacy Service and conferences attended by its members.

In 2024–25, the Board continued implementation and improvement of governance mechanisms to respond to requests for information in compliance with the provisions of the Act. This included preparations for the *Privacy and Responsible Information Sharing Act 2024*, which will come into force on 1 July 2026.

In accordance with the provisions of section 151 of the Act, the Board disclosed information in response to 21 requests for information during 2024–25, which is an increase from 6 in 2023–24. Data was released to support health service planning, quality improvement and education.

Stakeholder engagement

The Voluntary Assisted Dying Board Stakeholder Engagement Policy outlines a planned approach to engagement in support of the successful performance of the Board's functions under the Act. A strong culture of engagement and collaboration supports the Board to:

- develop sustainable partnerships
- build trust through open and transparent communication
- reduce risk by identifying and managing emerging issues
- provide stakeholders the opportunity to articulate concerns at an early stage.

In continuing its approach to stakeholder engagement, in 2024–25 the Board engaged with various stakeholders. The Board met with the previous Minister for Health and the Director General of the WA Department of Health to discuss the operation and recommendations for improvement of the Act, including themes raised in recommendations made by the Board.

Board meetings include a regular program of invited stakeholders throughout the year to discuss the operation of voluntary assisted dying and specific issues of interest to the Board. In 2024–25, invited stakeholders included the Statewide Care Navigator Service (SWCNS); Statewide Pharmacy Service (SWPS); voluntary assisted dying coordinators within health service providers (HSP Coordinators); Director General of the WA Department of Health; Chief Medical Officer; End of Life Care Program team and Clinical Lead, voluntary assisted dying practitioners and representatives from the Health and Disability Services Complaints Office, Palliative Care WA, Dying with Dignity WA, Silverchain, Neurological Council WA and a Victorian Bereavement Family Support Worker and Churchill Fellow.

In August 2024, February 2025 and June 2025, the Board conducted regional meetings and engagement activities in the Goldfields (Kalgoorlie), South West (Bunbury, Busselton and Margaret River), and Kimberley (Broome) regions respectively. Representatives from the SWCNS, the SWPS and the End of Life Care Program joined the Board in many of these regional engagement activities. The visits enabled the Board to monitor the operation of the Act and gain a better understanding of how voluntary assisted dying is operating by hearing from practitioners and patients about the successes and challenges of voluntary assisted dying in these regions. The Board met with voluntary assisted dying practitioners, held information sessions for health practitioners and the community, hosted a Community of Elders engagement and information session, and visited local health campuses. In 2025–26 the Board looks forward to further regional meetings and engaging with practitioners and the community in the regions.

The SWCNS hosted 2 forums for healthcare workers exploring voluntary assisted dying in practice in September 2024 and March 2025, attended by 190 healthcare workers. The Board Chair presented on the operations of the Board. The SWCNS also coordinated a professional development forum for voluntary assisted dying practitioners in May 2025, attended by approximately 29 participating practitioners, care navigators and pharmacists from metropolitan and regional areas. The Board Chair again presented on Board operations and Board Members participated in a panel discussion.

The Board continued to participate in interjurisdictional engagement in 2024–25. The Trans-Tasman Voluntary Assisted Dying Board Chair Forum comprising of Board Chairs from around Australia and New Zealand met quarterly to discuss shared issues. The Board Chair and Deputy Chair attended the Voluntary Assisted Dying Conference 2024 and the Board Chair attended the launch of Go Gentle Australia's 'The State of VAD' report in Parliament House, Canberra.

Other stakeholder engagement activities undertaken by Board Members during 2024–25 included meeting with South Australian Voluntary Assisted Dying Review Board and Secretariat Unit members, attending the Community of Practice and participating in annual Voluntary Assisted Dying Reflection Services.

Recommendations

The Voluntary Assisted Dying Board (the Board) has a function to provide the Minister for Health and Chief Executive Officer of the WA Department of Health with recommendations in relation to voluntary assisted dying. Board recommendations are informed by monitoring and stakeholder engagement activities, interjurisdictional review, and current research.

Amendment to the *Voluntary Assisted Dying Act 2019*

The Board has made recommendations that the *Voluntary Assisted Dying Act 2019* (the Act) be amended in each previous annual report and included recommendations for legislative change in its submission to the consultation to support the Statutory Review of the Act. The Statutory Review, completed in 2024, did not support the need for legislative change at this time.

Until the opportunity for legislative review arises again there will be need for responsive policy and sector guidance to support the safe operation of voluntary assisted dying in accordance with the principles of the Act.

Amendment to Commonwealth law

In the Board's first annual report in 2021–22, the Board recommended amendments to the *Criminal Code Act 1995* (Cth). The Board continues to hear from practitioners and statewide service providers that the telehealth restrictions imposed by the *Criminal Code Act 1995* (Cth) hinders the operation of voluntary assisted dying, particularly for patients in regional and outer metropolitan areas.

Education and awareness

In the 2022–23 and 2023–24 Annual Reports, the Board made recommendations for action to increase access to public information, build awareness of voluntary assisted dying as an end of life choice, and improve practitioner understanding of their obligations following the receipt of a First Request for voluntary assisted dying.

Progress made against recommendations in 2024–25 has included:

- health practitioner forums delivered by the Statewide Care Navigator Service (SWCNS)
- the Board participating in community and health practitioner information sessions as part of regional engagement activities
- the Board working with the WA Department of Health to develop a public information brochure on voluntary assisted dying
- the WA Department of Health developing translations of the approved information booklet 'Information about Voluntary Assisted Dying (VAD)' into 16 different languages
- the WA Department of Health sending correspondence to general practitioner practices outlining legislative obligations relating to a First Request
- voluntary assisted dying being incorporated into the 'Framework for bereavement support after an expected death in WA', which is available on the WA Department of Health website.

Workforce participation and support

In its first annual report in 2021–22, the Board identified that the pool of trained practitioners was inadequate to respond to requests for access to voluntary assisted dying and the Board has made recommendations relating to the need to increase and support the voluntary assisted dying workforce in each subsequent annual report.

Progress made against recommendations in 2024–25 has included:

- face-to-face training workshops delivered by the SWCNS and voluntary assisted dying coordinators within health service providers (HSP Coordinators)
- a voluntary assisted dying practitioner forum held by the SWCNS
- the WA Department of Health providing information to general practitioner practices, professional organisations and colleges regarding the introduction of the payment model for voluntary assisted dying services
- workshops held by the SWCNS and Statewide Pharmacy Service (SWPS) to support practitioners in cannulating patients
- the WA Department of Health conducting a workforce survey to understand barriers and enablers for medical and nurse practitioners completing the WA VAD Approved Training and providing voluntary assisted dying services.

The number of trained practitioners who have performed a role under the Act in 2024–25 increased by 54 per cent compared with 2021–22. However, over the same period, voluntary assisted dying activity including patient assessments, substance supply and deaths following administration of a voluntary assisted dying substance increased by over 120 per cent (Figure 1).

Care navigators and HSP Coordinators report ongoing challenges in linking patients to available practitioners that has impacted patient access to voluntary assisted dying. A small number of practitioners are carrying a large proportion of patient demand for services (see Practitioner participation section). Furthermore, some practitioners who previously accounted for a large proportion of patient services, have stepped away from providing these patient services in 2024–25, due to retirement, relocation or taking on different positions in the health system. The Board understands that burnout and fatigue of the workforce is a risk to the sustainability of voluntary assisted dying. Current practitioner numbers are not considered feasible or safe and recruitment of additional practitioners should be addressed as a matter of priority to address this risk.

The Board also has concerns about the increasing demands placed on the SWCNS and the SWPS. Since voluntary assisted dying became a legal end of life care choice in 2021–22, the number of primary service delivery interactions by the SWCNS and the number of authorised supplies by the SWPS has increased by over 130 per cent (Table 12, Table 14). The Board is aware that the SWCNS' capacity to respond to patient demand for their services in a timely manner has deteriorated as a consequence of considerable increased demand, with some patients dying or losing capacity before being connected with a practitioner. As with the available practitioner workforce, these statewide services are critical to the effective operation of voluntary assisted dying services in WA and need to have commensurate resourcing to meet these demands.

Practitioner remuneration

Many voluntary assisted dying practitioners are not eligible to claim reimbursement via the Medicare Benefits Scheme as there are no dedicated items for providing voluntary assisted dying services. Practitioners who elect not to charge private fees have frequently absorbed the costs of providing voluntary assisted dying care. The Board has made recommendations relating to the need for appropriate practitioner remuneration in each previous annual report.

The Board has welcomed the introduction of the payment model as a key support for the sustainable operation of voluntary assisted dying. The WA Department of Health has committed 2 years of funding for a fee-for-service payment model, implemented from 1 July 2024, to support equitable access to voluntary assisted dying as an end of life choice and practitioner participation in providing voluntary assisted dying services. The Board has observed that the introduction of the publicly funded payment model has allowed some community-based practitioners to increase their time allocation to voluntary assisted dying work and reduced the use of out-of-pocket patient fees.

Recommendations

- Continuation of funding to support the fee-for-service payment model, with consideration given to expanding the model to include support for practitioner mentorship and supervision of recently trained practitioners.
- Practitioner fee-for-service payment guidelines are improved to include guidance for those practitioners who may work within the public sector and who are not afforded dedicated paid time to undertake voluntary assisted dying work.

Voluntary assisted dying within the WA health system

The Board has made recommendations in every annual report relating to the establishment of service models within the WA health system, and the update of the mandatory policy, procedures and guidance to facilitate access to voluntary assisted dying as a lawful end of life choice.

Actions taken in 2024–25 to address these recommendations includes:

- Voluntary Assisted Dying Clinical Lead positions established and filled
- expansion of HSP Coordinator resourcing
- review of Mandatory Policy commenced
- review of Goals of Patient Care form commenced.

The Board is pleased to note that Voluntary Assisted Dying Clinical Lead positions are now established within each health service provider, however the Board understands that, due to the limited pool of practitioners working within the WA health system, these staff are frequently called upon to fulfill roles in the voluntary assisted dying process limiting their capacity to provide clinical leadership and drive organisational change.

The Board estimates that, of the 77 practitioners who performed a role under the Act in 2024–25, 30 work within the WA public health system. However, the Board understands that the staffing allocation across the WA health system, where dedicated paid time is provided to practitioners to take on practitioner roles under the Act, is less than 2 full-time equivalent employees across WA. The Board considers that the demands placed on existing practitioners are unrealistic, and there are inadequate numbers of trained practitioners working in the areas that deliver or typically intersect with patients requiring end of life care. The system remains reliant on practitioners seeing patients over and above their usual clinical caseload. Health service providers also use the services of external practitioners to provide services to patients who are cared for within public hospital settings.

All Australians have the right to have their healthcare choices recognised and respected[37]. Whilst the implementation of the Act established voluntary assisted dying as a lawful end of life choice, there is work to be done for voluntary assisted dying to be an accessible end of life choice for eligible people in WA. Patients accessing care via the WA health system may assume that, as a public patient, they would have equal access to voluntary assisted dying as an end of life choice. This is not always the case. The Board has heard that patients receiving care within public health service providers that contract the provision of health services to private entities are either at risk of being, or have been, obstructed in accessing voluntary assisted dying as an end of life choice or denied other end of life care due to their choice for voluntary assisted dying.

The Board has heard distressing stories from practitioners and family members of patients who have had First Requests for voluntary assisted dying ignored, have been blocked from accessing hospice care or have been subjected to forced transfers from publicly funded facilities in order to access the voluntary assisted dying process.

Recommendations

- The WA Department of Health, as System Manager, work with health service providers to:
  - establish and fund a consistent approach to the delivery of voluntary assisted dying services, including the establishment of dedicated voluntary assisted dying practitioner positions to meet increasing demand, and embed access to voluntary assisted dying as a core business function within the WA health system
  - ensure the use of contracted health entities by health service providers does not compromise patient access to voluntary assisted dying, palliative and hospice care
  - undertake practitioner recruitment to increase the number of trained practitioners working within the WA health system, with a focus on practitioners working in clinical fields that deliver or frequently intersect with end of life care (palliative care, oncology, respiratory, neurology, nephrology).
- The SWCNS, SWPS and HSP Coordinator staffing is increased to align with reported activity and projected future demand.

37 Australian Charter of Healthcare Rights (2nd edition), Australian Commission on Safety and Quality in Health Care, 2020.

Future focus

In the year ahead, the Board will continue to work closely with the Minister for Health, Chief Executive Officer of the WA Department of Health, statewide service providers, and medical and nurse practitioners to ensure the successful implementation of the Act.

Strategic Plan 2023 to 2026

The Voluntary Assisted Dying Board Strategic Plan 2023 to 2026 outlines how the Board will seek to fulfil its functions under the Act and make the most of its unique access to information, in support of the principles and intention of the Act, to ensure that voluntary assisted dying is available to all eligible Western Australians as a sustainable, person-centred, end of life choice. The Strategic Plan includes 6 strategic objectives:

- Contribute to community/health practitioner awareness and understanding of voluntary assisted dying, relevant to the person, their role, and their stage of life.
- Identify conditions or obstacles that may act to:
  - prevent or impede lawful access to voluntary assisted dying in WA
  - impact patient experience of voluntary assisted dying in WA.
- Continue advocacy and oversight to ensure workforce is skilled, supported, and sustainable.
- Use a range of data sources to monitor the implementation and operation of voluntary assisted dying in WA and understand emerging issues.
- Improve the utility and flow of information to support risk management, quality practice and planning.
- Build budget transparency, resources, and administrative structures to support responsive and accountable performance of Board functions.

Areas of focus in the coming year to support the successful performance of the Board's functions include:

- advocating for change in areas for improvement, as identified in the Board's recommendations
- supporting the flow of information in accordance with the Act and conducting research to increase the body of knowledge for voluntary assisted dying
- ongoing improvement of the Board's monitoring processes with a focus on case reviews and quality improvement
- refining the Board's approach to practice improvement via increased engagement with the Community of Practice and use of the Quality Practice Series
- continuing to build awareness of emerging issues and best practice to support the provision of evidence-based advice and recommendations for improvement.

Patients with dementia are generally excluded from accessing voluntary assisted dying. By the time the person has met the eligibility criteria related to prognostic timeframe as defined in the Act, the patient is unlikely to have decision-making capacity and is therefore assessed as ineligible for voluntary assisted dying. As the incidence of dementia increases, and in the absence of quality treatments for the disease, it is likely that the community will continue to advocate for access to voluntary assisted dying for patients with dementia. The Board observes that there is currently no clear consensus on how this could feasibly be implemented within the WA regulatory model and is seeking to grow its knowledge in this area to support the provision of quality recommendations and advice in the future.

Appendices

Appendix 1: Disclosures and legal compliance

Financial statements

In accordance with the *Financial Management Act 2006*, the WA Department of Health is the accountable authority for the financial management of the Voluntary Assisted Dying Board. The financial activity of the Voluntary Assisted Dying Board, including the remuneration of Board members, is provided within the Department of Health's 2024–25 Annual Report.

Section 175ZE of the *Electoral Act 1907*

Section 175ZE of the *Electoral Act 1907* requires bodies established by a minister to report details of marketing and communications expenditure in their annual reports. The Voluntary Assisted Dying Board did not incur expenditure of this nature in 2024–25.

Administrative processes

The Voluntary Assisted Dying Board Secretariat Unit has been established within the WA Department of Health under section 121 of the *Voluntary Assisted Dying Act 2019*. As the WA Department of Health is considered the accountable authority the following items from the Public Sector Commission Annual Report Guidelines for 2024–25 are included in the WA Department of Health's 2024–25 Annual Report: occupational safety, health and injury management; WA Multicultural Policy Framework; substantive equality; advertising, market research, polling and direct mail expenditure; disability access and inclusion plan outcomes; compliance with public sector standards and ethical codes; recordkeeping plans; agency capability review requirements and workforce inclusiveness requirements.

Section 155(2) of the *Voluntary Assisted Dying Act 2019*

Table 16: Section 155(2) of the *Voluntary Assisted Dying Act 2019* requires the inclusion of the following in the annual report

Voluntary Assisted Dying Act 2019 section 155(2)		Page reference
(a)	any recommendations that the Board considers appropriate in relation to voluntary assisted dying; and	58–61
(b)	any information that the Board considers relevant to the performance of its functions; and	51–57
(c)	the number of any referrals made by the Board under section 118(c); and	54
(d)	the text of any direction given to the Board under section 123(1) or 152(2); and	53
(e)	details of any disclosure under section 140(1) that relates to a matter dealt with in the report and of any resolution under section 142 in respect of the disclosure; and	53
(f)	statistical information that the Board is directed under section 152(2) to include in the report; and	53
(g)	information about the extent to which regional residents had access to voluntary assisted dying, including statistical information recorded and retained under section 152(1)(c), and having regard to the access standard under section 156.	7, 17, 18, 21, 24, 27, 30, 32, 34, 35, 36, 42, 43, 45, 46, 47, 48, 49, 57, 58, 67

Appendix 2: Key contact list

Voluntary Assisted Dying Board Secretariat Unit

Email: VADBoard@health.wa.gov.au

Website: health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying-board

Statewide Care Navigator Service

Email: VADcarenavigator@health.wa.gov.au

Phone: (08) 9431 2755

Website: health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying/Statewide-Care-Navigator-Service

Statewide Pharmacy Service

Email: StatewidePharmacy@health.wa.gov.au

Phone: (08) 6383 3088

Website: health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying/Statewide-pharmacy-service

End of Life Care Program, Department of Health

Email: EOLCare@health.wa.gov.au

Website: health.wa.gov.au/Articles/A_E/End-of-Life-Care-Program

or health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying

Join the Community of Practice

Email: VADcarenavigator@health.wa.gov.au

Phone: (08) 9431 2755

Appendix 3: List of figures and tables

Appendix 4: Voluntary assisted dying proposed national minimum dataset 2024–25 Western Australia[38]

Data from First Assessment Forms	
Number of First Assessments	878

Age group	18–39	40–49	50–59	60–69	70–79	80–89	≥90
	11	19	61	169	277	257	84

Gender	Female	Male	Other/self-described
	383	495	0

Residence	Major cities of Australia	Inner regional Australia	Outer regional Australia	Remote Australia	Very remote Australia
	638	120	94	19	7

Aboriginal and Torres Strait Islander origin	Aboriginal	Torres Strait Islander	Aboriginal and Torres Strait Islander	No
	11	0	0	867

Highest level of education completed	Did not complete secondary school	Completed secondary school	Completed post-secondary education	Not reported
	31	481	363	3

Use of interpreter	Yes	No
	13	865

Place of birth	Australia	Overseas
	557	321

38 Data in the appendix represents the number of valid, void and revoked forms submitted to the Voluntary Assisted Dying Board at each respective stage of the voluntary assisted dying process. As some patients may have completed a process step more than once in the period, this data does not represent the number of unique people completing each stage of the voluntary assisted dying process (excluding patient deaths).

Data from First Assessment Forms (continued)

Life-limiting condition	Cancer	Neurological	Respiratory	Other
	601	86	82	109

Palliative care	Yes	No
	692	186

Practitioner type	General Practitioner	Specialist	Other
	33	22	0

Data from Administration Decision and Prescription Forms

Administration route	Self-administration	Practitioner administration
	60	608

Data from Authorised Supply Forms

Number of substance supplies	Self-administration	Practitioner administration
	50	500

Data from Notification of Death and Practitioner Administration Forms

Voluntary assisted dying deaths	480

Manner of death	Self-administration	Practitioner administration	Substance not administered
	29	451	218

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This document can be made available in alternative formats.

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