Voluntary Assisted Dying Board
Western Australia

Annual Report
2025–26

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Statement of Compliance

The Hon Meredith Hammat MLA
Minister for Health; Mental Health; Preventative Health

Dear Minister

Pursuant to section 155 of the *Voluntary Assisted Dying Act 2019* (WA), 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 2026.

Hon Colin Holt
Chairperson, Voluntary Assisted Dying Board
13 October 2026

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Overview

About this report

This annual report fulfils the requirement of section 155 of the *Voluntary Assisted Dying Act 2019* (WA) by reporting on the operations of the *Voluntary Assisted Dying Act 2019* for the 12 months to 30 June 2026.

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.

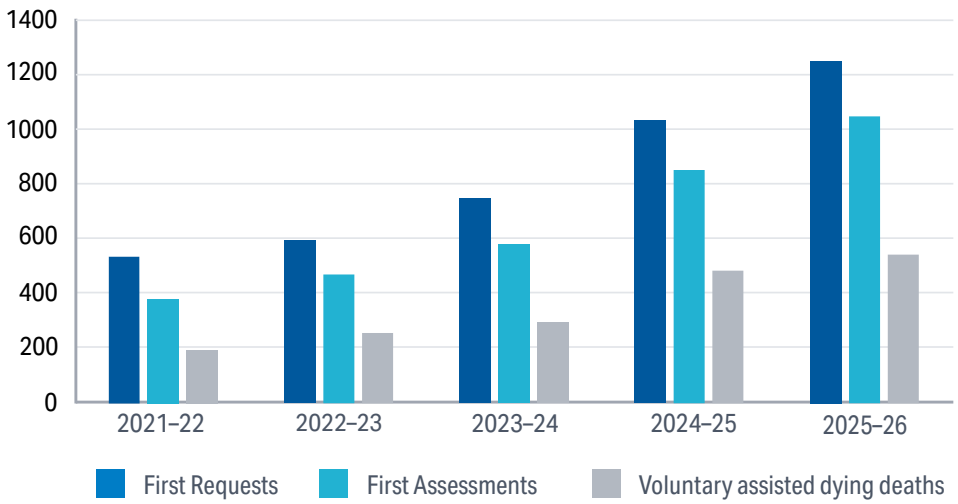
Data was extracted from VAD-IMS on 15 July 2026 to account for activity that occurred up to 30 June 2026. Footnotes are included throughout the report to assist with interpretation of the data. Percentages have been rounded to one decimal place and, due to rounding, totals may not summate to 100 per cent. Patients may undertake the same process step within the same or different time periods, therefore the activity count may be higher than the reported number of patients. This report also contains minor revisions to the 2021–22, 2022–23, 2023–24 and 2024–25 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 otherwise, 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. Medians are provided to one decimal place to account for instances where the median falls between 2 integers. Where appropriate and to minimise the risk of identification of individuals, cells corresponding to small counts (counts less than 5, and greater than zero) have not been provided (np). Additional suppression of values may be applied to prevent deduction from other available data.

Foreword

On behalf of the Voluntary Assisted Dying Board (the Board), it is my pleasure to present the fifth annual report on the operation of the Western Australian *Voluntary Assisted Dying Act 2019* (the Act).

The number of patients accessing voluntary assisted dying continues to increase year-on-year (Figure 1). In 2025–26, 1,249 people made a First Request for voluntary assisted dying, an increase of 21.0 per cent over the previous year (n=1,032) and an increase of 134.3 per cent over 5 years (n=533). In the reporting period, 541 people died by exercising the choice for voluntary assisted dying, a 12.0 per cent increase over the previous year (n=483) and a 181.8 per cent increase over 5 years (n=192). In 2025–26, voluntary assisted dying deaths represented 2.9 per cent of the total deaths in WA.

Figure 1. Increase in patients accessing voluntary assisted dying between 2021–22 and 2025–26



The Board acknowledges the exceptional commitment of clinicians, care navigators, voluntary assisted dying coordinators and clinical leads within health service providers, pharmacists and other support teams across WA Health. Their professionalism and compassion underpin the dependability of the voluntary assisted dying process.

As the new Chairperson of the Board, I am taking this opportunity to formally acknowledge the outstanding contribution of Dr Scott Blackwell to the establishment of voluntary assisted dying in WA.

Scott was a member of the Ministerial Expert Panel, Chairperson of the Implementation Leadership Group and inaugural Chairperson of the Board. His leadership, wisdom and people-first approach has ensured the design of a voluntary assisted dying service that is recognised for its quality, integrity and person-centred care.

Scott leaves us with a lasting legacy, and the culture of care and people-centred decision-making he has created will continue. On behalf of all Western Australians, thank you Scott!

I also welcome Dr Simon Towler, who joined the Board in July 2026 and brings his experience as a voluntary assisted dying practitioner and former Chief Medical Officer at the WA Department of Health.

Hon Colin Holt
Chairperson
Voluntary Assisted Dying Board

The Voluntary Assisted Dying Board of Western Australia pay its respects to all Western Australians who chose voluntary assisted dying in 2025–26.

The Board extends its condolences to their family members, friends and care givers. We recognise your loss and wish you well as you grieve.

A message from the outgoing Chairperson

The *Voluntary Assisted Dying Act 2019* (the Act) is a deeply personal and person-centred piece of legislation. The Act is about a person, a Western Australian person, a person who will die soon, who is suffering in a manner unacceptable to themselves and who asks for help. It provides a pathway for people in WA to die with dignity. I am eternally grateful, as outgoing Chairperson of the Board, to have had the opportunity to serve this person, and all those who have made the choice for voluntary assisted dying in our state.

Access to, and safe passage through this pathway, is essential to achieving the intent of the Act. It remains central to the Board's oversight as it monitors its operation through the information collected by the Board each year, personal reflections and feedback from participants and stakeholders.

One of my key reflections is the considerable growth in activity over the past 5 years, and the implications for service sustainability. Action on several fronts is urgently required:

- Delays within the WA Voluntary Assisted Dying Statewide Care Navigator Service occurring due to increased demand. The Board is concerned that these delays may contribute to additional suffering or reduced access to end of life choices. Additional resources are required to meet current and future demand.
- Similarly, the WA Voluntary Assisted Dying Statewide Pharmacy Service require dedicated facilities and resourcing to continue their high standards of safety and privacy in the context of current and projected increases in voluntary assisted dying activity.
- Growth in the number of trained and participating practitioners has not matched increasing demand, with a small cohort of participating practitioners continuing to be responsible for a substantial proportion of the clinical activity. A determined focus is needed to attract and retain doctors and nurse practitioners to work in the voluntary assisted dying service.

Voluntary assisted dying was driven by the people of WA advocating for the right to die with dignity and a rigorous, well-resourced process of parliamentary inquiry, expert advice and implementation. The Parliamentary Joint Select Committee's *My Life, My Choice* report recommended legislation, supported by a Ministerial Expert Panel that guided development of the Act. An Implementation Leadership Team then established an operational service to facilitate access to voluntary assisted dying across this vast state. The resulting model remains highly regarded across jurisdictions in Australia and internationally, and we celebrate this.

However, we underestimated the level of activity which is now more than 10 times higher than predicted at implementation. After 5 years, and with the increase in activity, it is timely to review the model of care, future resourcing and the immediate needs of the voluntary assisted dying service, which continues to deliver, despite personal and professional strain.

As outlined in current and previous annual reports, legislative reform is also needed:

- The *Criminal Code Act 1995* (Cth) requires amendment to remove the restrictions on the use of carriage services relating to some voluntary assisted dying service provision. A simple amendment would remove the Criminal Code's impact on voluntary assisted dying services for patients, particularly in rural and remote areas.
- Provision of Medicare Benefit Schedule item numbers for voluntary assisted dying services is now overdue. All States and the Australian Capital Territory have implemented voluntary assisted dying and this is now a normal part of health service delivery in Australia. New Zealand established a national scheme for payment items for assisted dying services as they are now an established part of their health system.
- Several changes are required to the Act to improve the patient journey through voluntary assisted dying. These are documented in this and previous annual reports from the Board. Victoria has recently made some changes to their original legislation. It is time for WA to do the same.

Left to right: Dr Simon Towler, Ms Linda Savage, Dr Gareth Wahl, Ms Maria Osman, Hon Colin Holt.

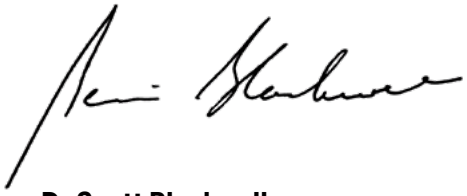
During 2025–26, I decided to step down as the Chairperson of the Board. It has been a privilege to contribute to the establishment of voluntary assisted dying in WA. At the commencement of 2026–27, Hon Colin Holt, who has been the Deputy Chairperson since the Board's establishment and served on the Parliamentary Joint Select Committee on End-of-Life Choices, will take over the role and I wish him well.

Words cannot express the feelings of gratitude that I have to all who have provided the essential, very personal service to those Western Australians who have made the choice for voluntary assisted dying over the last 5 years. Doctors, nurse practitioners, care navigators, voluntary assisted dying coordinators, pharmacists, and many, many more. Thank you, you are exceptional, as is your work.

I also wish to thank those who contributed to establishing the Board following implementation, and the secretariat for their ongoing support of the Board's work.

Thank you Colin Holt, Linda Savage, Maria Osman and Dr Rob Edis for joining me in creating the Board from the ground up and establishing the sound governance structures that underpin the work of the Board. It has been a remarkable experience for us to share. Thank you also to Dr Gareth Wahl, who joined us when Rob retired.

Although I am signing off as the Chairperson of the Board, I feel I will always belong to the remarkable Western Australian voluntary assisted dying community.



Dr Scott Blackwell

Chairperson (1 July 2021 to 30 June 2026)

Voluntary Assisted Dying Board

Year in review

Voluntary assisted dying in 2025–26 (including change from 2024–25)

First Requests	First Assessments	Consulting Assessments	Substance supplies	Voluntary assisted dying deaths
1,558 ▲ 17.2%	1,077 ▲ 22.7%	900 ▲ 24.5%	599 ▲ 8.9%	541 ▲ 12.0%

Patients found eligible to access voluntary assisted dying

Median Age	Male	Resided in metropolitan area	Born overseas
77.0	55.5%	72.4%	36.7%
Cancer-related diagnosis	**Female**	**Resided in regional area**	**Receiving palliative care**
66.7%	44.5%	27.6%	82.3%

Voluntary assisted dying deaths

Self-administration	Practitioner administration	39.8% of practitioner administrations occurred at the patient's home	35.4% of practitioner administrations occurred in a public hospital ward	90.7% of practitioner administrations via intravenous administration	2.9% ▲ 0.3%pt of total deaths in Western Australia in 2025–26
33 (6.1%)	508 (93.9%)				

Practitioners

Practitioners eligible to perform a role in 2025–26	New practitioners trained in 2025–26	Location of practice		Participated in 2025–26
167	32	68.9% Perth metropolitan	31.1% Regional	94 ▲ +17 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 2025–26, which assisted the Board's understanding of voluntary assisted dying in WA.

The Board is pleased that most of the feedback received during 2025–26 was positive, with 72 per cent (n=42) of reflections including positive remarks regarding the patient and family experience in accessing voluntary assisted dying. However, in 2025–26, the Board continued to receive reflections detailing barriers for patients accessing voluntary assisted dying as an end of life choice. The Board found 43 per cent (n=25) of reflections 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, and pride for family members and friends making this end of life choice
- 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
- inadequate resources which provide information on the voluntary assisted dying process and to support families following an assisted death is delaying access and causing further distress to vulnerable patients and families
- patients and family members request extension of eligibility criteria to access voluntary assisted dying to include long-term residents of WA and those who have lost decision-making capacity due to conditions such as dementia
- individual and institutional barriers to accessing voluntary assisted dying in private facilities causes distress and delays to patients which impacts their ability to exercise their end of life choice.

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, and pride for family members and friends making this end of life choice

'…The VAD process gave my mother-in-law great relief, respect and peace. After suffering for an extended period, having had a full life with little to look forward to, [she] was able to make her own choice with regard to her end of life.

She was exhausted and she was suffering. If VAD was not an option she would have been in great torment, without dignity and only existing - not living - and only existing because of modern medicine. …Thank you VAD team from the bottom of her families heart.'

- Family member

'…It took all of fifteen minutes and for that we were eternally grateful. Peaceful and quick, her slipping into the next realm, just as she had wanted….VAD provided that for both our mum and we her family and friends and for that we feel blessed.'

- Family member

"…The VAD …legislation allowed my mum to pass with dignity, grace, good humour, on her terms and allowed her to live independently until the very end.

It gave both her and her loved ones the opportunity to reflect, make peace, say goodbyes, honour her life and spirit.

- Family member

'Whilst the whole idea of VAD was extremely confronting to those who loved mum, it wasn't for her. She was ready to go. That she could do this in her own way and under her terms was marvellous. … This allowed me to feel proud of my mum in a way that is difficult to explain. I can only thank everyone for giving us this amazing choice.'

- Family member

'It takes great courage for a sick person to take this step. But what a wonderful way to move on without having to suffer unnecessary pain.'

- Family member

'As the VAD was administered, he was surrounded by his mother, wife and 3 adult children. … I found it a beautiful way to say goodbye and to know that his suffering was at an end with his loved ones by his side.'

- Family member

'The experience provided a wonderful, peaceful and dignified death for my husband. It is a relief to see my husband out of pain and to give him a peaceful death with family around him.'

- Family member

'…[my partner] chose dignity. He chose peaceful. He chose his time. Not prolonged unnecessary pain, not losing himself to this illness but going out on his terms in a loving, tender, controlled moment. We were together at the end as we were every day for 25 years. It was perfect….

I still miss [him] every day and my heart aches for the future stolen from us… but I will forever be grateful for not having to watch the love of my life suffer needlessly….'

- Family member

'…I am grateful that my sister was able to choose VAD because it was what she wanted. While we can't predict the future and if she still could have had some more good days, what I do know for certain is that she died peacefully, surrounded by the people she loved, and able to say what she needed to say.'

- Family member

'[my husband] was a man who took responsibility for his actions, and for him to be respected for his wishes to leave this world was the greatest gift for him with his dignity and self-worth restored.'

- Family member

'…all adult children could come from the east and we had time together and could be around him when he went so peacefully. My husband was so brave during this time – I don't know if it was more difficult for him than it was for us. …. I think that we were privileged that he didn't die suddenly or in intense pain.'

- Family member

'When the burden of living with the illness becomes too much to bear, the person should have the right to make the very brave decision to choose assisted dying. … Nevertheless, it was heartbreaking to say our last goodbyes, but we find comfort in knowing he is now resting in peace. He had earned his rest!! He went out on his own terms, with dignity!!'

- Family member

'That day was beautiful and respectful when [my husband] won his battle and got to leave on his own terms surrounded by his beloved family and friends. So peaceful.'

- Family member

'A safe and dignified process. Everything [my partner] could have wished for. She died with her self-respect and dignity intact. She was able to choose the time… It was her choice and a choice available for others which should never be revoked.'

- Family member

"He might never use it but having that choice available gave him control over his future and reassurance that he would not be forced to endure suffering and loss of dignity beyond what he considered acceptable. Once his VAD approval was in place, life continued remarkably normally. … He continued to live rather than simply wait for death.

The day itself remains one of the most extraordinary experiences of my life. … There was sadness, of course, but there was also peace. There was no panic, no crisis, and no desperate struggle.

As a nurse with forty-five years of experience, I have witnessed death in many forms. I have seen suffering, fear, pain, and prolonged decline. Yet what I witnessed that afternoon was unlike anything I had ever seen before. It was the most peaceful death I have ever experienced.

Dad died exactly as he had hoped—surrounded by family, with dignity intact, having made his own decisions and said his own goodbyes. His death was not defined by illness but by choice, courage, and love.

- Family member

'[my wife]'s ongoing pain was too much for her and VAD was the final and only solution. My wife left this earth with dignity and love from me and my family. VAD is a great option for people to consider.'

- Family member

'Dad was surrounded by everything that mattered to him. Outside the window were his beloved home-grown roses. Around the room were family photos capturing decades of life and love. He held a cushion with Mum's image on it, keeping her close as he always had….

Within minutes, Dad slipped away peacefully. There was no flinch, no sound, no visible struggle—just a gentle passing… It was the most beautiful ending we could never have imagined.

Since then, when friends hear about our experience of the VAD process and see the final family photos, they respond with a mixture of awe and amazement. Many say how brave Dad was to make that choice.

What I feel most strongly, however, is gratitude. Gratitude that Dad was able to leave this world on his own terms, surrounded by the people and memories he loved most. Gratitude that the process was handled with such dignity and care.

I honestly believe our experience was something many families might quietly wish for—a peaceful, loving farewell rather than a prolonged and uncertain ending. It is a choice that has left a lasting impression on me and, I suspect, on many of us who were there that day.'

- 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

'...what a blessing [the Statewide Care Navigator Service] is, they sent to us an angel. [Care navigator] was a gentle hand with just the right amount of support and guidance, seamlessly administered at every step of the way...All of us never feeling anything but acceptance and respect...'

- Family member

'...The process of getting us through the approval was delicately and judiciously worked on by our amazing VAD Assigned Doctor... Every engagement in the approval process felt considerate and caring and everything clearly explained.... [practitioner]'s willingness to simply be a sounding board and coach / mentor us through the ups and downs was invaluable, I can't imagine doing this without this. ... So in a way I feel like the VAD was as much an end of life counselling service as well as VAD....'

- Family member

'...The VAD process was brilliant. [practitioner, care navigator and pharmacist] were all wonderfully compassionate and supportive during the final stages of my Mum's life...'

- Family member

'...There is truly not much more to add when one has had a near perfect experience from the beginning - first contact - to the inevitable end with the care navigator and the 10/10 life doctor chosen by the care navigator....'

- Family member

'The VAD process was professional from start to finish. Their compassion was outstanding and everyone we were involved with was just lovely. [care navigator] was outstanding in keeping us up to date.'

- Family member

' ... [care navigators/practitioners] were compassionate and kind throughout, considerate to both our feelings. They communicated clearly, they were there for [my partner] and I at all times.

I cannot express my gratitude enough to them for respecting [my partner] and his decision and giving him the opportunity to go out on his terms, and for the support during and after that they showed to me...'

- Family member

'I cannot commend the VAD team at [public hospital] enough for the way it was offered, explained and finally administered.'

- Family member

'All VAD representatives/practitioners were informative, compassionate and respectful. They ensured that I was aware of all aspects of the process and were professional in their conduct.'

- Family member

'Everyone was approachable and the whole process clear and concise. The empathy from doctors and navigators... Amazing!'

- Family member

'The VAD Care Navigators helped us through one of the most stressful moments of our lives. They treated us with respect, consideration and compassion, what is more they were efficient and prompt which was necessary in our case. ... Once we were able to contact the navigators it was very well managed and they moved swiftly and compassionately. I am in awe at the job they do.'

- Family member

'As a daughter, I am deeply grateful for how respectful and compassionate the voluntary assisted dying process was for my dad and our family. The practitioner who supported us throughout was truly exceptional—kind, patient, and profoundly respectful—taking the time to explain each step and ensuring my dad's wishes were honoured with dignity. Every part of the process was handled with care, and the compassion shown to our family was deeply reassuring.'

- Family member

'I found the whole process emotionally draining, but with the support from the VAD navigators I was able to get through a very difficult ride. Once again thank you for making my mother's wishes come true.'

- Family member

'Firstly, the VAD staff at [public hospital] were outstandingly caring and professional… Their thoughtful forward advice enabled our children to be there for him and turn what has been such a worrying desperate process for him into almost an enjoyable, enriching family experience where we were all supporting his decision, enabling him to pass from this world as he wanted. My absolute appreciation and love to you all.'

- Family member

'The doctors involved treated dad with professionalism, compassion, and immense respect, which reassured us that he was in very capable hands. …While the doctor quietly prepared a simple cannula for dad, [care navigator] gathered the family outside to explain how the process would unfold. [Care navigator]'s explanation was calm, factual, and compassionate. [Care navigator] reassured us that anyone who felt uncomfortable could step away at any time. There was no expectation—only support.'

- Family member

'[care navigator]'s manner was immediately reassuring—empathetic, thoughtful, and deeply respectful. [Care navigator] listened carefully to dad and to all of us. It became clear to [care navigator] that dad's wishes aligned exactly with what VAD was designed to offer. [Care navigator] also sensed that dad was ready and wanted the process to move forward without unnecessary delay. [Care navigator] patiently answered every question we had and explained each step.'

- Family member

'The VAD service and staff are amazingly good. They are helpful, informative, cheerful, caring, understanding and so prepared to help with real care.'

- Family member

Inadequate resources which provide information on the voluntary assisted dying process and to support families following an assisted death is delaying access and causing further distress to vulnerable patients and families

'…I only wish we were referred sooner however for 12 months mum was told by her GP and specialists that "she didn't qualify for a VAD referral"….'

- Family member

'…My mum had been in the [regional hospital] and told a doctor that she wanted help to die. The doctor said no and that was it. She had also spoken to the nurses and they told her they could not help…. I had checked the website for information…It took me a long time to find the Navigation Service details….'

- Family member

'This process was very difficult to locate until we asked the appropriate people… Online I found it just keeps sending you to everywhere but what you are looking for. Once we asked a nurse at a neuro appointment the gates opened up and everything from there was easy…'

- Family member

'My concern is … my GP and other GPs in the clinic were simply unaware of the VAD process. They were not conscientious objectors and were happy to help but they were unaware how to proceed. We independently made contact with the Navigator Service after reading a pamphlet online and finding the phone number towards the end of the document (hiding a light under a bushel). This stumble took up valuable time in a very rapidly worsening situation.'

- Family member

'My thoughts turn to how to have this beautiful process more practically understood and available … To have pamphlets made for doctor's surgeries that clearly state current applicability of the terms "palliative care" and "end of life"; how and when they are used. From experience there is confusion—especially in older people and for people where English is a second language, and even with modern usage.

For pamphlets relating to VAD to clearly explain the processes that are available … I am quite sure these pamphlets would relieve a considerable amount of mental anguish for people with terminal illness and also relieve pressure on public services overall.'

- Family member

'The patient and his family underwent significant distress when they were unable to find anyone in the hospital to witness his written declaration on a weekend. … The family did not feel they could call on anyone else in the community.'

- Health practitioner

'After my dad's passing, I watched my mother … struggle to navigate her grief without guidance or support. … As a family, we were left unsure of how to help one another, without the tools or resources to understand how to move forward together. This experience has highlighted the need for follow-up care for families after a voluntary assisted dying event. Because VAD is not a typical experience of loss, I strongly advocate for dedicated, compassionate support for immediate family members, so that healing, understanding, and connection are fostered, and no family has to face such profound and unfamiliar grief alone.'

- Family member

Patients and family members request extension of eligibility criteria to access voluntary assisted dying to include long-term residents of WA and those who have lost decision-making capacity due to conditions such as dementia

'…As I sit here thinking how blessed we were to fall into 1 of the 2 categories [for eligibility], I wonder if they will ever extend these out to include dementia/Alzheimer's patients. … They can have these meetings with the doctors and it can go on record this is what they want and have a chosen nominee/advocate to sign on their behalf. … if they have documented inclusive instructions with all parties then they should have choice. …If they have a nominated person/joint advocate then they could proceed. We all know how horrible these diseases are and the toll they take financially, emotionally and cost to government. Give people choice. I am so very thankful (although heartbroken) my husband and light of my life had choice.…'

- Family member

'Can you please help us advocate for dad to meet the permanent resident requirement as a New Zealand citizen who has permanently resided, raised… children, lived and worked in Western Australia for 25 years. He does not deserve to die in pain and suffering. He deserves to pass away peacefully on his own terms with dignity and the love and support of his… adult children and… grandchildren surrounding him. If other states can be flexible on their resident requirements on compassionate grounds, can't Western Australia also?…'

- Family member

'…I only wish this service could be provided to those dying from dementia like my father. He had to suffer for 4 long horrible years.…'

- Family member

'….The current exclusion of people who hold a New Zealand Special Category Visa from accessing Voluntary Assisted Dying (VAD) in Western Australia creates a significant equity issue for long-term residents of Western Australia who otherwise meet all eligibility criteria.

In my clinical experience, I have cared for several patients who were unable to access VAD solely because of this visa status. This has caused avoidable distress and suffering at the end of their disease trajectory, denying them the ability to choose the care that best aligns with their values in their final days. Requiring these individuals to urgently apply for permanent residency in order to access VAD places an unreasonable emotional and administrative burden on patients and their grieving families at an already vulnerable time. Many of these community members are long-term residents who have built their lives, families, and connections in Western Australia.…'

- Health practitioner

Individual and institutional barriers to accessing voluntary assisted dying in private facilities causes distress and delays to patients which impacts their ability to exercise their end of life choice

'[Patient] was admitted to the local faith based palliative care ward... [Patient] was advised by the hospital that she was unable to self-administer at said hospital and was told that [the] only option was to go home. [Patient] was sent home without any support or no offer of being transferred across to the [public] hospital ... the family ... were unsure what the next steps were given that it was a Sunday afternoon, and they had not been linked in to the community services.'

- Health practitioner

'a reflection about a patient experience with [private hospital] recently. My patient was going through the VAD assessment pathway however was told by the treating team that [patient] was not allowed to self-administer on [private hospital] grounds. ... [Patient] has been a patient for palliative care within their unit including for symptom control so [patient] is already a patient under them'

- Health practitioner

'Prior to coming to [public hospital] [the patient] was an inpatient at [private hospital] and it is of [the patient's partner's] understanding that [patient] did make a request to seek VAD, but nothing happened.....'

- 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.

Since 1 July 2021, 184 medical and nurse practitioners have completed the WA VAD Approved Training. 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. There were 167 practitioners eligible to perform the role of a Coordinating, Consulting or Administering Practitioner in 2025–26,[3] with 32 practitioners completing the training for the first time in 2025–26. In 2025–26, approximately half of eligible practitioners (n=94, 56.3%) completed either a First Assessment, Consulting Assessment or Practitioner Administration,[4] with 24 practitioners acting in a role for the first time in 2025–26. There were 11 practitioners who acted as a Coordinating, Consulting or Administering Practitioner in 2024–25 who did not act in a role in 2025–26. In 2025–26, 12 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 Eligible practitioner count includes practitioners who were eligible to perform a role at some point during the reporting period.

4 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

In 2025–26, 94 practitioners acted as either a Coordinating, Consulting or Administering Practitioner, which represents 17 more practitioners compared with 2024–25 (n=77). In 2025–26, participating practitioners are most likely to have acted as a Coordinating, Consulting or Administering Practitioner for between 2 to 10 patients (Figure 2).

In 2025–26, 94 practitioners accepted a First Request:

- this includes 21 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
- 9 practitioners were responsible for 51.6 per cent (n=578) of all accepted First Requests.

In 2025–26, 68 medical practitioners completed a First Assessment (Figure 2):

- this represents 13 more practitioners completing a First Assessment compared with 2024–25 (n=55)
- 8 practitioners completed 50.3 per cent (n=542) of all First Assessments.

In 2025–26, 80 medical practitioners completed a Consulting Assessment:

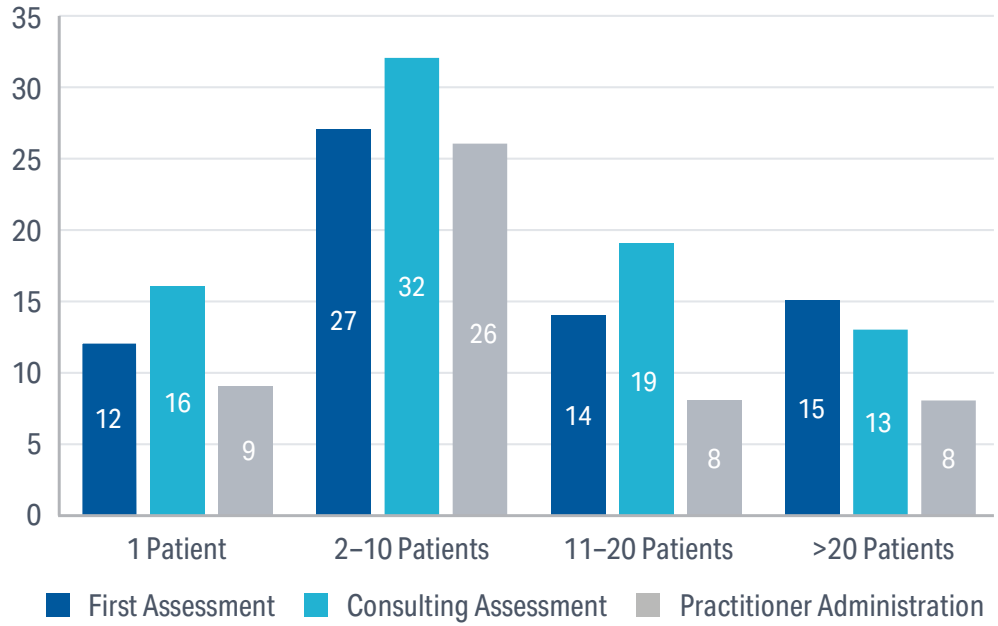
- this represents 14 more practitioners completing a Consulting Assessment compared with 2024–25 (n=66)
- 11 practitioners completed 50.6 per cent (n=455) of all Consulting Assessments.

In 2025–26, 51 practitioners acted as an Administering Practitioner:

- this represents 10 more practitioners acting as an Administering Practitioner compared with 2024–25 (n=41)
- 8 practitioners acted as the Administering Practitioner for 52.6 per cent (n=267) of all practitioner administrations.

Consistent with previous years, a small cohort of participating practitioners continue to be responsible for a substantial proportion of the clinical activity.

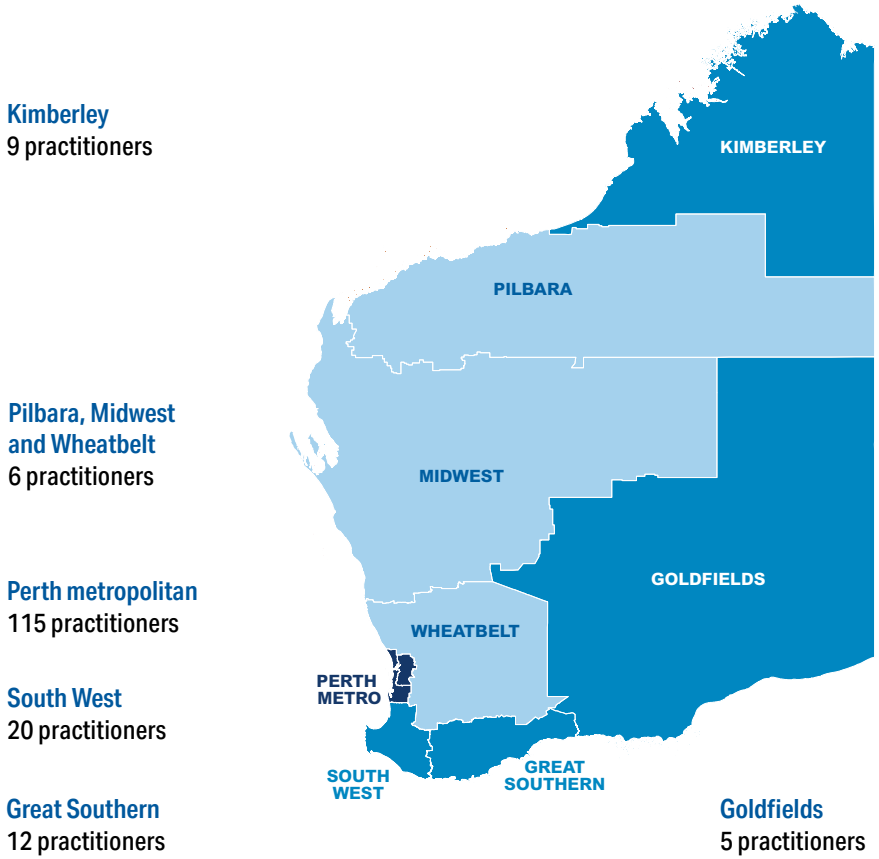
Figure 2: Number of practitioners who completed a First Assessment, Consulting Assessment and Practitioner Administration in 2025–26



Location of practice

Practitioners who were eligible to perform a role in 2025–26 had nominated practice addresses[5] across all regions (Figure 3). In 2025–26, almost two thirds of practitioners who acted as a Coordinating, Consulting or Administering Practitioner were based in the Perth metropolitan region (n=59, 62.8%).

Figure 3: Distribution of practitioners who were eligible to participate as a Coordinating, Consulting or Administering Practitioner in 2025–26



5 Practitioners nominate their work address when registering to use the Voluntary Assisted Dying Information Management System (VAD-IMS). Regions are based on a practitioner's recorded address at the end of 2025–26.

Practitioner specialty

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 45.5 per cent (n=76) of practitioners who were eligible to perform a role in 2025–26 (Table 1).

Table 1: Specialties recorded for practitioners who were eligible to participate as a Coordinating, Consulting or Administering Practitioner in 2025–26

Practitioner specialty	Total	% of total
General practice	76	45.5
Nurse practitioner	15	9.0
Emergency medicine	12	7.2
Anaesthesia	11	6.6
General registration only	8	4.8
Psychiatry	6	3.6
Geriatrics	5	3.0
Haematology	5	3.0
Intensive care medicine	5	3.0
Other specialty	29	17.4

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 eligible practitioners as some practitioners hold more than one registration type.

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 WA Voluntary Assisted Dying 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, 4,006 people have made a First Request to access voluntary assisted dying.[7] In 2025–26:

- 1,249 people made a First Request to access voluntary assisted dying, an increase of 21.0 per cent over the number of people who made a First Request in 2024–25 (n=1,032). Of these:
  - 916 people (73.3%) made only one First Request, of which 742 (81.0%) were accepted and 174 (19.0%) were refused
  - 333 people (26.7%) made more than one First Request.[8]
- 1,558 First Requests were made as some people made more than one First Request (Table 2). Of these:
  - 71.9 per cent of First Requests were accepted (n=1,120), an increase from 68.2 per cent in 2024–25 (n=907)
  - 28.1 per cent of First Requests were refused (n=438), a decrease from 31.8 per cent in 2024–25 (n=422).

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

8 A patient may have made more than one First Request. Scenarios include:
- if a medical practitioner refused a patient's First Request and the patient made a First Request to another medical practitioner
- if a patient was assessed as ineligible or withdrew at any point during the request and assessment process then at a subsequent date made a new First Request and was assessed again.

A practitioner being ineligible to participate in the voluntary assisted dying process was the most common reason a First Request was refused in 2025–26 (n=218, 49.8%). Conscientious objection to voluntary assisted dying was recorded as the reason in 12.6 per cent (n=55) of First Requests that were refused, which is an increase from 8.3 per cent (n=35) in 2024–25.

In 2025–26, First Requests were made by persons residing in each region of WA, with 71.6 per cent (n=1,116) 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 20.1 per cent from the previous year, with increased requests across most health regions (Table 2). In 2025–26, the 28.4 per cent of First Requests made by persons residing in regional WA was the highest annual percentage recorded to date.

In 2025–26, the highest age-specific First Request rates were recorded in the Great Southern region (234.7 per 100,000 persons aged 18 and above), followed by the South West region (114.0 per 100,000 persons aged 18 and above). In comparison, the Perth metropolitan region had an age-specific First Request rate of 58.5 per 100,000 persons aged 18 and above. The Pilbara region had the lowest age-specific First Request rate (17.6 per 100,000 persons aged 18 and above) (Table 2).

Table 2: Number and rate of First Requests made by health region in 2025–26, compared with 1 July 2021 to 30 June 2026

Health region	2025–26	2025–26 age-specific rate (per 100,000)[9]	Total	% of total
Perth metropolitan	1,116	58.5	3,920	73.4
Goldfields	31	69.6	88	1.6
Great Southern	123	234.7	384	7.2
Kimberley	16	53.8	47	0.9
Midwest	41	75.2	165	3.1
Pilbara	8	17.6	29	0.5
South West	182	114.0	565	10.6
Wheatbelt	41	63.2	139	2.6
Total	**1,558**	**66.0**	**5,337**	**100.0**

9 Age-specific rates calculated using population data sourced from the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health (2026). Population data is based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) (Preliminary) for the period 2021-2024 and has been projected by the Epidemiology Directorate for the 2025 calendar year. Beer's coefficient has been used to determine persons aged 18 years and older.

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, 3,276 patients have completed a First Assessment to assess eligibility for voluntary assisted dying, with 1,048 patients assessed in 2025–26. This represents an increase of 23.1 per cent over the number of patients who completed a First Assessment in 2024–25 (n=851). Since 1 July 2021, nearly all patients who underwent a First Assessment did not have a previous relationship with their Coordinating Practitioner (n=3,090; 90.7%), which has remained consistent year-on-year.

In 2025–26, 1,077 First Assessments were completed as some patients had more than one First Assessment.[10] This represents an increase of 22.7 per cent over the number of First Assessments in 2024–25 (n=878). Of the First Assessments completed in 2025–26:

- 87.7 per cent of assessments (n=944) had an eligible outcome, which is a similar percentage to the 87.9 per cent (n=772) in 2024–25
- 12.3 per cent of assessments (n=133) had an ineligible outcome, which is a similar percentage to the 12.1 per cent (n=106) in 2024–25.

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, 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 and they are assessed as ineligible, the voluntary assisted dying process stops.

10 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.

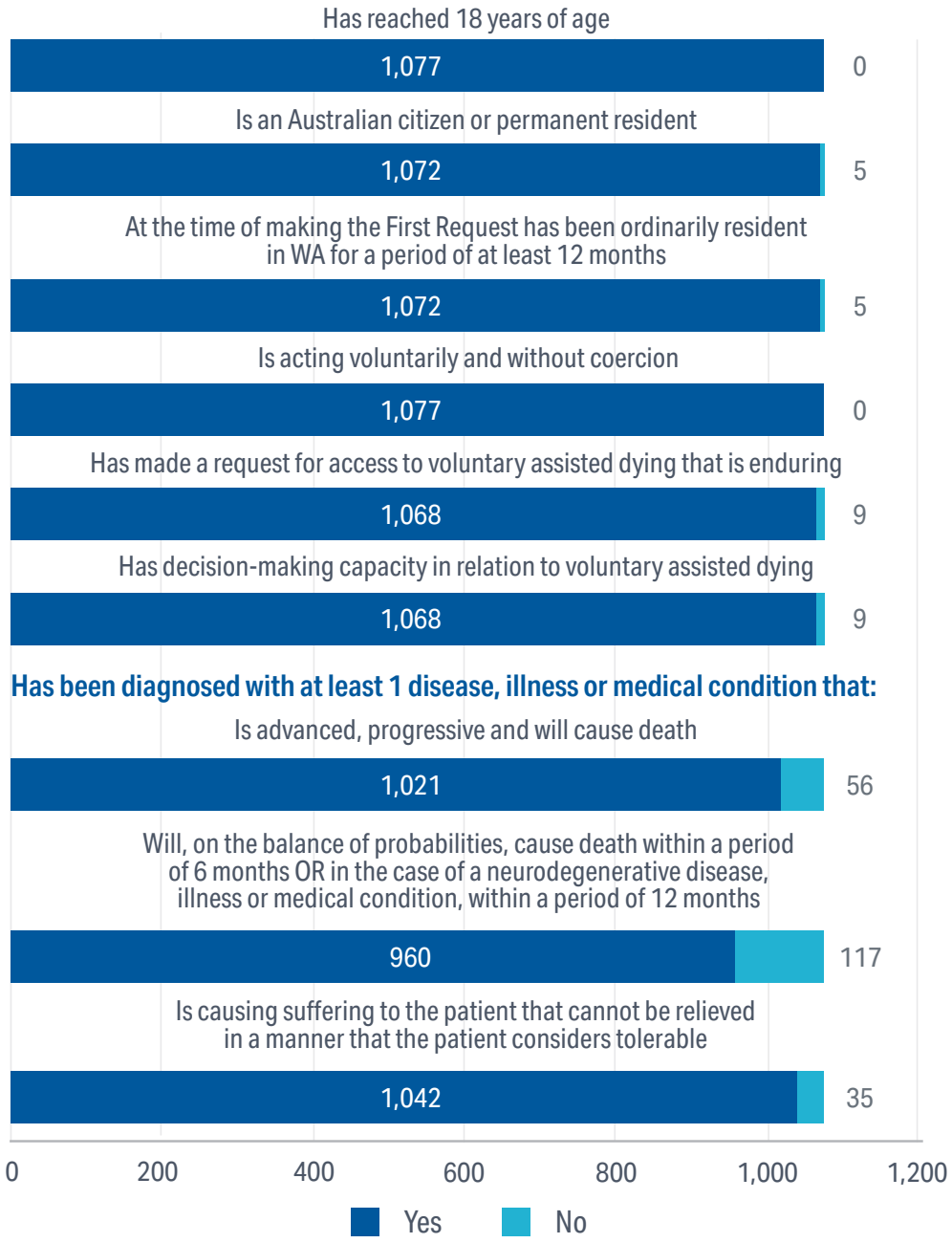
In 2025–26, the most common reason patients were found to be ineligible was because they had not been diagnosed with at least one disease, illness or medical condition that would, on the balance of probabilities, cause death within a period of 6 months or, in the case of a neurodegenerative disease, illness or medical condition, within a period of 12 months (n=117, 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 2025–26, with one referral made for each of these patients. All referrals in 2025–26 (n=6) were made regarding the patient's disease, illness or medical condition.

Figure 5: Eligibility of patients undertaking a First Assessment in 2025–26

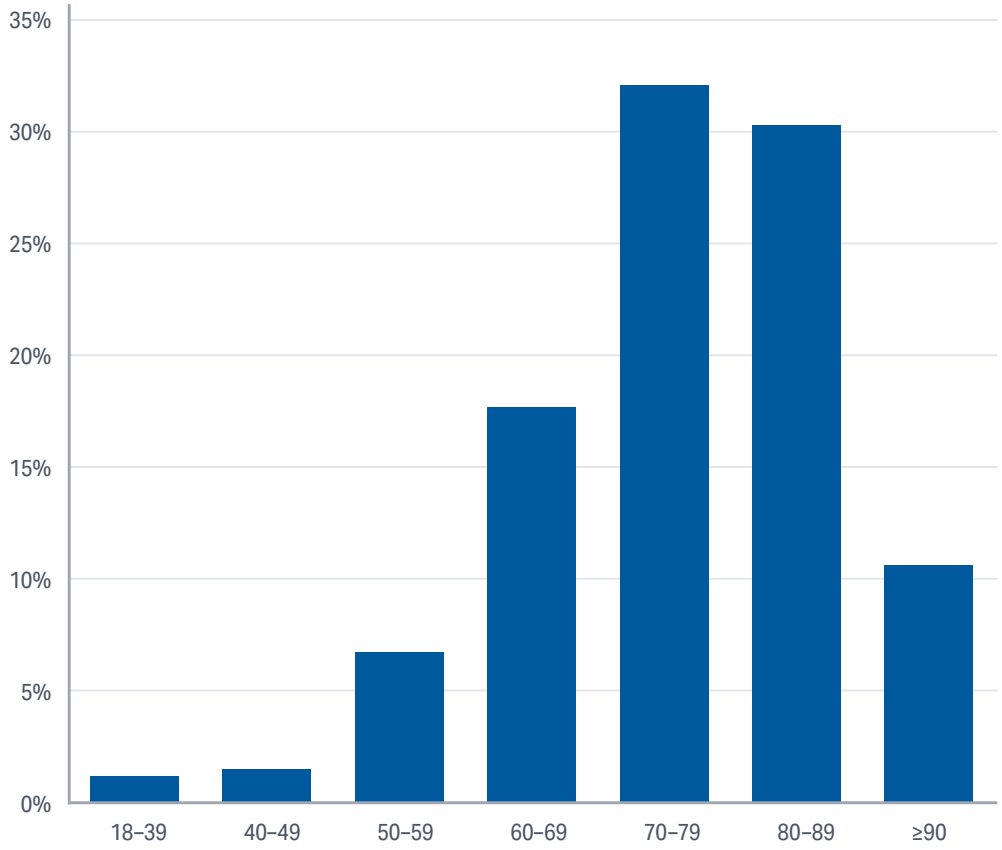


Profile of eligible patients requesting access to voluntary assisted dying

In 2025–26, there were 944 First Assessments completed where patients were assessed as eligible to access voluntary assisted dying, bringing the total number of First Assessments completed with eligible patients to 3,018 since 1 July 2021.

In 2025–26, eligible patients had a median age of 77.0 years, and were most frequently recorded within the 70–79 age group (n=303, 32.1%), followed by the 80–89 age group (n=286, 30.3%, Figure 6).

Figure 6: Distribution of patient age at First Assessment in 2025–26



In 2025–26:

- a greater proportion of eligible patients were male (n=524, 55.5%) than female (n=420, 44.5%, Table 5)
- approximately 3 out of every 10 eligible patients resided in regional WA (n=261, 27.6%), an increase from 26.2 per cent in 2024–25 (n=202)
- 0.8 per cent of patients assessed as eligible were of Aboriginal and/or Torres Strait Islander origin (n=8)
- approximately 1 out of every 3 eligible patients were born overseas (n=346, 36.7%)
- 5.9 per cent of eligible patients did not identify English to be their first language (n=56)
- patients assessed as eligible were most likely to report being married or in a de facto relationship at the time of First Assessment (n=469, 49.7%)
- two thirds of patients assessed as eligible reported living with family or others at the time of First Assessment (n=634, 67.2%)
- patients assessed as eligible most commonly reported high school as their highest level of education (n=416, 44.1%).

Primary diagnosis

In 2025–26, the majority of patients found eligible at First Assessment had a cancer-related primary diagnosis (n=630, 66.7%, Table 3).[11]

Since 1 July 2021:

- the most common cancer-related primary diagnoses were malignant neoplasms of the bronchus or lung (ICD-10 category code of C34)
- the most common nervous system-related diagnoses were spinal muscular atrophy and related syndromes (ICD-10 category code of G12)
- the most common circulatory system-related diagnosis was heart failure (ICD-10 category code of I50)
- the most common respiratory system-related diagnoses were other chronic obstructive pulmonary diseases and other interstitial pulmonary diseases (ICD-10 category codes of J44 and J84 respectively).

11 Based on the International Classification of Diseases 10th Revision (ICD-10) – Australian modification – 12th Edition.

Table 3: Patients by primary diagnosis ICD-10 chapter or category in 2025–26, compared with 1 July 2021 to 30 June 2026

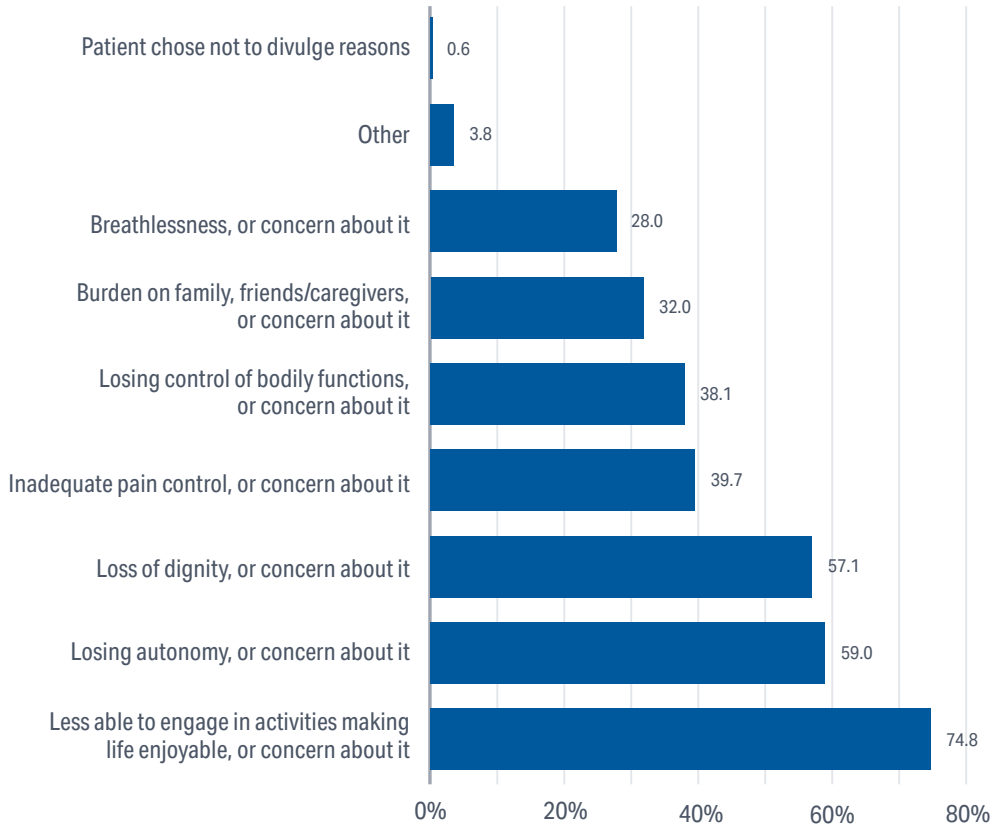
ICD-10 chapter or category of primary diagnosis for patients found eligible at First Assessment	2025–26	Total	% of total
Chapter II Neoplasms (C00-D48)	**630**	**2,094**	**69.4**
• Malignant neoplasm of bronchus and lung (C34)	103	320	10.6
• Secondary malignant neoplasm of other and unspecified sites (C79)	99	230	7.6
• Neoplasm of uncertain or unknown behaviour of oral cavity and digestive organs (D37)	38	164	5.4
• Malignant neoplasm of pancreas (C25)	26	92	3.0
• Malignant neoplasm of brain (C71)	21	90	3.0
• Secondary malignant neoplasm of respiratory and digestive organs (C78)	29	85	2.8
• Mesothelioma (C45)	21	82	2.7
• Malignant neoplasm of breast (C50)	19	63	2.1
• Neoplasm of uncertain or unknown behaviour of male genital organs (D40)	13	62	2.1
• Malignant neoplasm of oesophagus (C15)	20	59	2.0
• Malignant neoplasm of ovary (C56)	14	57	1.9
• Malignant neoplasm of stomach (C16)	18	53	1.8
• Other malignant neoplasms of skin (C44)	15	45	1.5
• Malignant neoplasm of prostate (C61)	12	43	1.4
• Malignant neoplasm of liver and intrahepatic bile ducts (C22)	15	39	1.3
• Other C00-D48 category not specified above	167	610	20.2
Chapter VI Diseases of the nervous system (G00-G99)	**89**	**314**	**10.4**
• Spinal muscular atrophy and related syndromes (G12)	50	193	6.4
• Other G00-G99 category not specified above	39	121	4.0
Chapter IX Diseases of the circulatory system (I00-I99)	**63**	**170**	**5.6**
• Heart failure (I50)	34	102	3.4
• Other I00-I99 category not specified above	29	68	2.3
Chapter X Diseases of the respiratory system (J00-J99)	**99**	**271**	**9.0**
• Other chronic obstructive pulmonary disease (J44)	55	141	4.7
• Other interstitial pulmonary diseases (J84)	32	92	3.0
• Other J00-J99 category not specified above	12	38	1.3
Chapter XI Diseases of the digestive system (K00-K93)	**16**	**39**	**1.3**
Chapter XIV Diseases of the genitourinary system (N00-N99)	**15**	**38**	**1.3**
Other ICD-10 category not specified above	**32**	**92**	**3.0**
Total	**944**	**3,018**	**100.0**

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 2025–26, the most common reasons were being less able to engage in activities making life enjoyable, or concern about it (n=706, 74.8%) followed by losing autonomy, or concern about it (n=557, 59.0%) and loss of dignity, or concern about it (n=539, 57.1%, Figure 7).

Figure 7: Patient reason for accessing voluntary assisted dying in 2025–26



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 2025–26, most patients assessed as eligible were receiving palliative care at the time of the First Assessment (n=777, 82.3%), a slight decrease from 2024–25 (n=648, 83.9%). Patients receiving palliative care at the time of First Assessment were most commonly receiving community or home-based palliative care (n=370, 47.6%, Table 4).[12] There has been a year-on-year increase in patients who were receiving palliative care at the time of First Assessment in the form of consultations in a hospital, with 36.2 per cent of patients receiving this type of palliative care compared with 18.2 per cent in 2021–22.

Table 4: Palliative care information collected during First Assessment in 2025–26, compared with 1 July 2021 to 30 June 2026[13]

Patients receiving palliative care at time of First Assessment		2025–26	Total	% of total
No		**167**	**487**	**16.1**
If no, have they received within last 12 months?	No	154	**427**	87.7
	Yes	13	**60**	12.3
Yes		**777**	**2,531**	**83.9**
If yes, from where?	Community or home-based palliative care	370	**1,248**	49.3
	Consultation in a hospital	281	**770**	30.4
	Specialist palliative care unit	119	**423**	16.7
	General practitioner	105	**400**	15.8
	Outpatient clinic	37	**176**	7.0
	Consultation in a facility	34	**104**	4.1
Total		**944**	**3,018**	**100.0**

12 See health.wa.gov.au/Articles/F_I/Guide-to-specialist-palliative-care-services for further information on the types of palliative care services.

13 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 2025–26, compared with 1 July 2021 to 30 June 2026

Characteristic	2025–26	Total	% of total
Patient age			
18–39	11	**36**	1.2
40–49	14	**57**	1.9
50–59	63	**227**	7.5
60–69	167	**620**	20.5
70–79	303	**982**	32.5
80–89	286	**830**	27.5
≥90	100	**266**	8.8
Patient region			
Metropolitan	683	**2,243**	74.3
Goldfields	13	**40**	1.3
Great Southern	65	**183**	6.1
Kimberley	8	**23**	0.8
Midwest	30	**111**	3.7
Pilbara	5	**17**	0.6
South West	112	**310**	10.3
Wheatbelt	28	**91**	3.0

Characteristic	2025–26	Total	% of total
Gender			
Male	524	**1,724**	57.1
Female	420	**1,294**	42.9
Other	0	**0**	0.0
Aboriginal and Torres Strait Islander origin			
No	936	**2,982**	98.8
Aboriginal and/or Torres Strait Islander	8	**36**	1.2
Born overseas			
No	598	**1,868**	61.9
Yes	346	**1,150**	38.1
English first language			
No	56	**198**	6.6
Yes	888	**2,820**	93.4
How well does the patient speak English			
Not at all or not well	6	**37**	1.2
Well	80	**151**	5.0
Very well	858	**2,830**	93.8

Characteristic	2025–26	Total	% of total
Patient ancestry			
Australian	454	**1,363**	45.2
Dutch	25	**75**	2.5
English	277	**915**	30.3
German	13	**63**	2.1
Indian	8	**25**	0.8
Irish	17	**67**	2.2
Italian	9	**50**	1.7
New Zealander	14	**45**	1.5
Polish	8	**23**	0.8
Scottish	33	**134**	4.4
South African	9	**28**	0.9
Other	77	**230**	7.6
Assisted by interpreter during First Assessment			
No	>939	**>2,990**	>99.1
Yes	np	**np**	np
Usual living circumstances			
Lives with family	542	**1,761**	58.3
Lives alone	310	**998**	33.1
Lives with others	92	**259**	8.6

Characteristic	2025–26	Total	% of total
Relationship status			
Divorced	144	**481**	15.9
Married/De facto	469	**1,495**	49.5
Never married	68	**245**	8.1
Separated	36	**122**	4.0
Widowed	227	**673**	22.3
Not reported	0	**2**	0.1
Highest level of education			
Primary school	29	**89**	2.9
High school	416	**1,300**	43.1
Year 12 graduation	92	**350**	11.6
Trade certificate	133	**434**	14.4
Advanced diploma and diploma	87	**289**	9.6
Bachelor degree	130	**376**	12.5
Postgraduate degree	47	**165**	5.5
Not reported	10	**15**	0.5
Diagnostic group			
Cancer-related	630	**2,094**	69.4
Neurological	89	**314**	10.4
Other	126	**339**	11.2
Respiratory-related	99	**271**	9.0

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, 2,803 patients have completed a Consulting Assessment, with 891 patients assessed in 2025–26. This represents an increase of 24.3 per cent over the number of patients who completed a Consulting Assessment in 2024–25 (n=717).

In 2025–26, 900 Consulting Assessments were completed as some patients had more than one Consulting Assessment.[14] This represents an increase of 24.5 per cent over the number of Consulting Assessments in 2024–25 (n=723).

Of the Consulting Assessments completed in 2025–26:

- 98.0 per cent of assessments (n=882) had an eligible outcome, this is similar to 2024–25 (n=711, 98.3%)
- 2.0 per cent of assessments (n=18) had an ineligible outcome, this is similar to 2024–25 (n=12, 1.7%).

Nil referrals for determination were completed as part of the Consulting Assessments completed in 2025–26.

14 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, 2,490 Final Requests to access voluntary assisted dying were completed and 26.0 per cent (n=648) of these were made within the 9-day designated period.[15] Of the patients who made a Final Request, 74.7 per cent resided in the Perth metropolitan region (n=1,861) and 25.3 per cent resided in regional areas (n=629). Patients residing in the Perth metropolitan area were more likely to make a Final Request within the 9-day designated period (n=493, 26.5%) than regional patients (n=155, 24.6%). The median number of days between First Request to Final Request was 13.0 days.

In 2025–26:

- 780 Final Requests were completed, an increase of 20.9 per cent from 2024–25 (n=645)
- 29.1 per cent of Final Requests (n=227) were made within the 9-day designated period, an increase from 26.4 per cent in 2024–25 (n=170), and the highest annual recorded percentage to date. Of these:
  - 44.9 per cent (n=102) 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
  - 55.1 per cent (n=125) 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.

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, there were 2,486 Final Reviews completed, with 780 Final Reviews completed in 2025–26.[16]

15 Patients may complete more than one Final Request.

16 Patients may complete more than one Final Review.

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 2 options:

1. self-administration
2. practitioner administration.

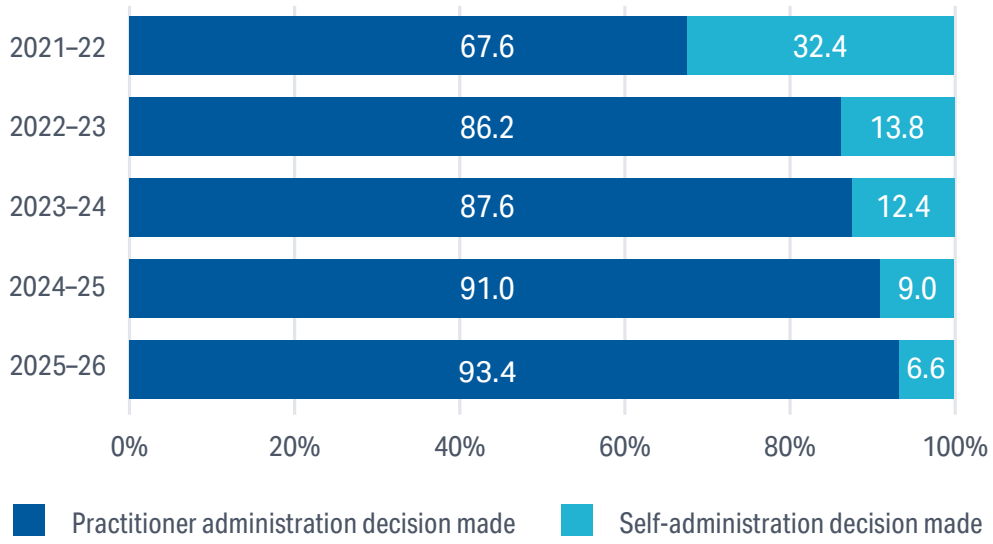
Self-administration of a voluntary assisted dying substance requires the patient to prepare and ingest the substance by swallowing or via a percutaneous endoscopic gastrostomy (PEG) or nasogastric (NG) tube. The patient must be able to complete these actions entirely by themselves. If a patient is unable 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) or if a patient commences a new request and assessment process.

Since 1 July 2021, 2,448 patients have made an Administration Decision, including 779 patients in 2025–26. This represents an increase of 20.4 per cent over the number of patients who made an Administration Decision in 2024–25 (n=647).

In 2025–26, 798 Administration Decisions were made.[17] Of these:

- 93.4 per cent (n=745) were practitioner administration decisions, an increase from 91.0 per cent (n=608) in 2024–25 (Figure 8)
- 6.6 per cent (n=53) were self-administration decisions, a decrease from 9.0 per cent (n=60) in 2024–25.

Figure 8: Administration Decisions made in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26



The data shows a continued preference amongst patients for the voluntary assisted dying substance to be administered by an Administering Practitioner. In 2025–26, 57.0 per cent (n=425) 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.

17 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 WA Voluntary Assisted Dying 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 WA Voluntary Assisted Dying 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, supply of the voluntary assisted dying substance has been made for 1,948 patients, which may have been supplied to the patient, their Contact Person or their Administering Practitioner.

In 2025–26:

- supply of the voluntary assisted dying substance was made for 585 patients, which may have been supplied to the patient, their Contact Person or Administering Practitioner
- 14 patients had more than one supply, due to changing Administration Decision or prescription, substance expiry or change of Administering Practitioner
- 599 supplies occurred, an 8.9 per cent increase from 2024–25 (n=550). This included:
  - 92.8 per cent (n=556) supplies of the substance for practitioner administration, an increase from 90.9 per cent (n=500) in 2024–25
  - 7.2 per cent (n=43) supplies of the substance for self-administration, a decrease from 9.1 per cent (n=50) in 2024–25.

Deaths

Voluntary assisted dying deaths

Since 1 July 2021, 1,764 patients have died following administration of a voluntary assisted dying substance:

- 90.5 per cent of patients died after practitioner administration (n=1,597, Figure 9)
- 9.5 per cent of patients died after self-administration (n=167).

In 2025–26:

- there were 541 deaths recorded following administration of a voluntary assisted dying substance. This represents an increase of 12.0 per cent over the number of voluntary assisted dying deaths in 2024–25 (n=483)
- voluntary assisted dying deaths represented 2.9 per cent of the 18,551 total deaths in WA[18] (Table 6), an increase from 2.6 per cent in 2024–25[19]
- the median age of patients who died following administration of a voluntary assisted dying substance was 78.0 years.

18 Total death registrations in WA sourced from The Registry of Births, Deaths and Marriages, Department of Justice (2026).

19 Voluntary Assisted Dying Board Annual Report 2024–25.

Figure 9: Voluntary assisted dying deaths by administration type in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26

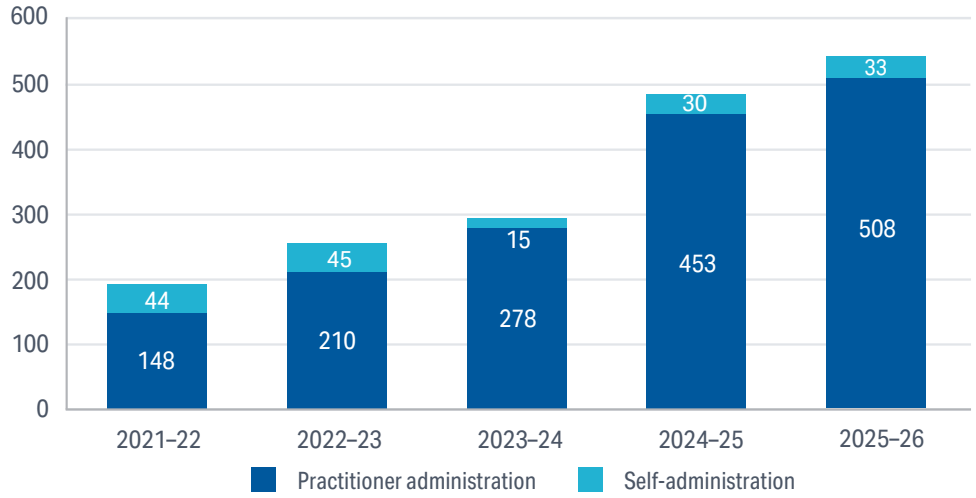


Table 6: Voluntary assisted dying deaths as a percentage of total deaths registered in WA in 2025–26

Health region	Patients who died following administration of a voluntary assisted dying substance	Deaths registered in WA[20]	Deaths by voluntary assisted dying as a percentage of deaths registered in WA
Perth metropolitan	400	14,853	2.7
Goldfields, Kimberley and Pilbara	10	609	1.6
Great Southern	33	579	5.7
Midwest	16	461	3.5
South West	67	1,487	4.5
Wheatbelt	15	532	2.8
Total	**541**	**18,551**	**2.9**

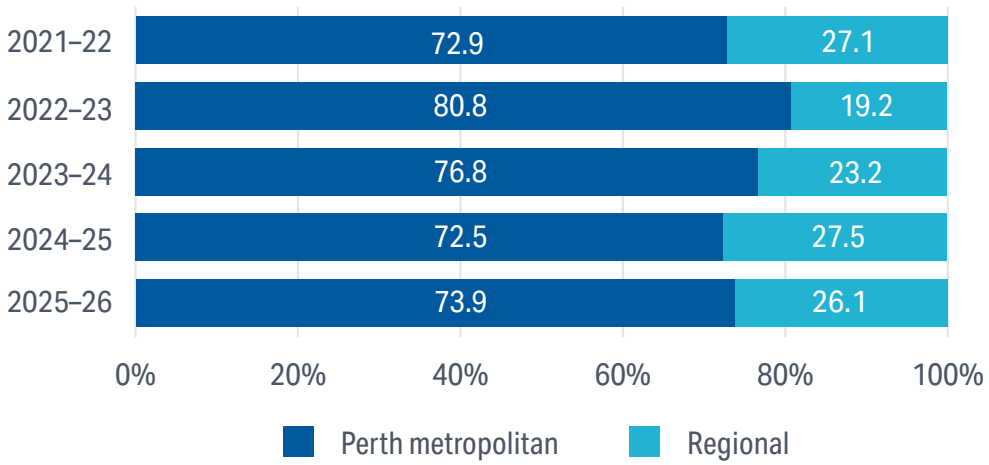
20 Total death registrations for WA include deaths in Christmas Island, Cocos (Keeling Islands) and where a person was normally domiciled or had property in WA but a WA postcode was not available for place of death. These have not been allocated to a health region.

Location of residence

In 2025–26, the majority of patients who died following administration of a voluntary assisted dying substance resided in the Perth metropolitan region (n=400, 73.9%, Table 6, Figure 10), an increase from 72.5 per cent in 2024–25 (n=350). Regional residents accounted for 26.1 per cent of deaths (n=141), a decrease from 27.5 per cent in 2024–25 (n=133).

In 2025–26, the proportion of deaths due to administration of a voluntary assisted dying substance in the Perth metropolitan region was 2.7 per cent, which is lower than regional WA (3.8%, Table 6).

Figure 10: Percentage of patient deaths by health region in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26



Administration type

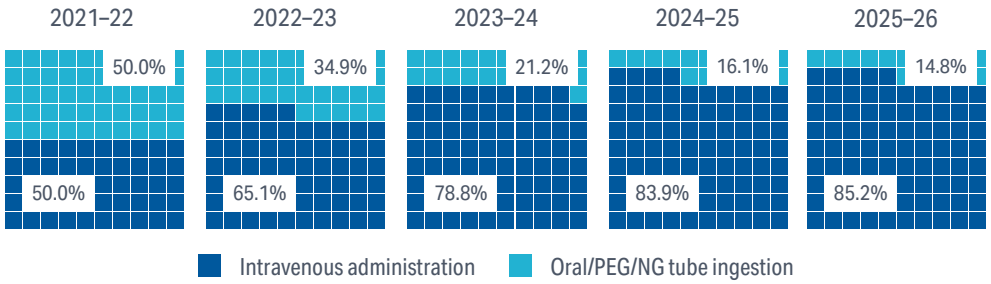
In 2025–26, there was a similar preference for practitioner administration of the voluntary assisted dying substance as compared with 2024–25. In 2025–26:

- 93.9 per cent of patients died after practitioner administration (n=508), which is similar to the 93.8 per cent in 2024–25 (n=453, Figure 9)
- 6.1 per cent of patients died after self-administration (n=33), which is similar to the 6.2 per cent in 2024–25 (n=30).

In 2025–26, there was an increased preference for intravenous administration of the voluntary assisted dying substance:

- 85.2 per cent of patients (n=461) died after intravenous administration of the voluntary assisted dying substance, an increase from 83.9 per cent in 2024–25 (n=405, Figure 11)
- 14.8 per cent of patients (n=80) died after oral/PEG/NG tube administration of the voluntary assisted dying substance, a decrease from 16.1 per cent in 2024–25 (n=78).

Figure 11: Oral/PEG/NG tube ingestion compared to intravenous administration in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26



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 2025–26:

- the median number of days between First Request and death, following administration of a voluntary assisted dying substance, was 20.0 days (Figure 12), a decrease from 24.0 days in 2024–25
- the median number of days for patients residing in the Perth metropolitan region and from regional WA were 18.0 and 24.0 days respectively (Table 7)
- the least and most number of days between First Request and death was 1 day to 1,007 days respectively.

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 12: Percentage of patient deaths by number of days between First Request and death in 2025–26

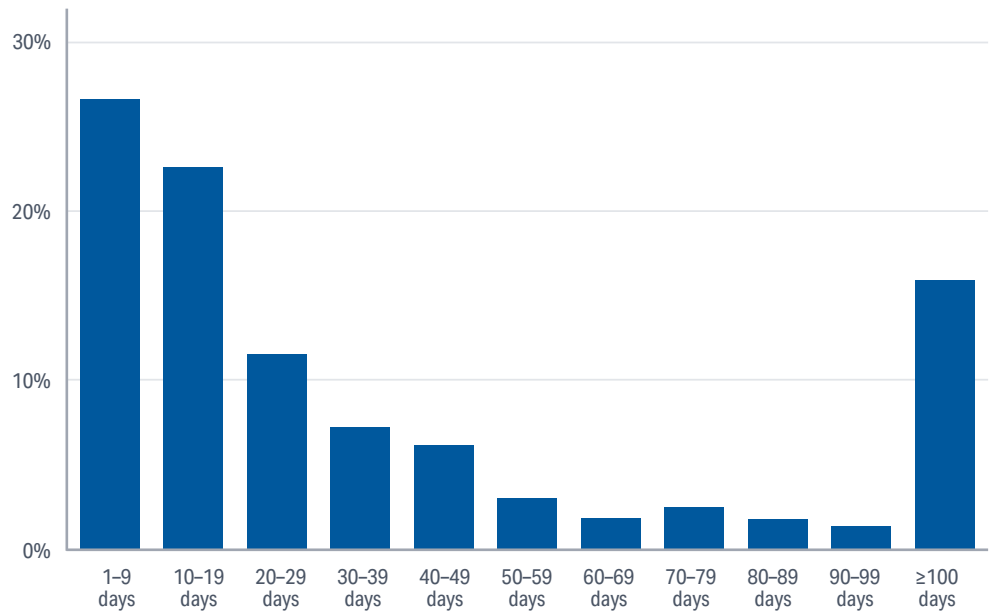


Table 7: Number of days between First Request and death in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26

	2021–22		2022–23		2023–24		2024–25		2025–26	
	Perth metropolitan	Regional	Perth metropolitan	Regional	Perth metropolitan	Regional	Perth metropolitan	Regional	Perth metropolitan	Regional
Shortest number of days	3	4	2	2	2	2	1	1	1	1
Longest number of days	213	224	503	282	778	984	758	857	1,007	597
Median number of days	20.0	23.0	26.0	22.0	19.0	27.0	21.0	30.0	18.0	24.0

First Assessment to death

In 2025–26, 93.0 per cent of patients (n=503) who died following administration of a voluntary assisted dying substance, died within 6 months of their First Assessment, or where they were diagnosed with a disease, illness or medical condition that is neurodegenerative,[21] administered within 12 months of their First Assessment.

Supply to death

In 2025–26:

- the median number of days between supply and death, following administration of a voluntary assisted dying substance, was 0.5 days[22] for practitioner administration and 7.0 days for self-administration
- nine in 10 patients died within 5 days of supply of the voluntary assisted dying substance (n=489, 90.4%)
- the longest number of days between supply and death for practitioner assisted oral/PEG/NG tube administration was 408 days and self-administration was 541 days.

Since 1 July 2021, 7.9 per cent of patients, where a voluntary assisted dying substance was supplied, died prior to substance administration (n=153). On each occasion where this occurred the Board has received notification of substance disposal.

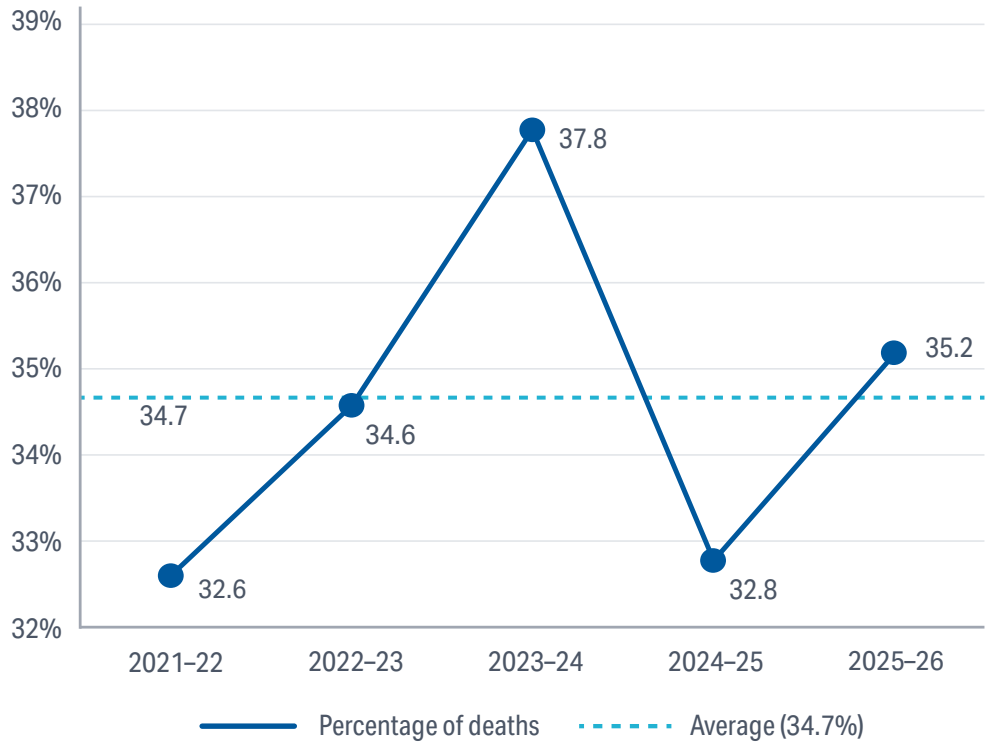
21 ICD-10 Chapter VI Diseases of the nervous system (G00-G99) have been used as a representative for neurodegenerative diseases, illnesses and medical conditions.

22 Median falls between 0 and 1 days.

Death prior to administration of a voluntary assisted dying substance

Since 1 July 2021, 34.7 per cent of patient deaths (n=936) occurred prior to administration of a voluntary assisted dying substance including 35.2 per cent of patients in 2025–26 (n=294, Figure 13, Figure 14).[23, 24] In 2025–26, the majority of these patients died after the completion of the Request and Assessment process (n=245, 83.3%) (Figure 14).

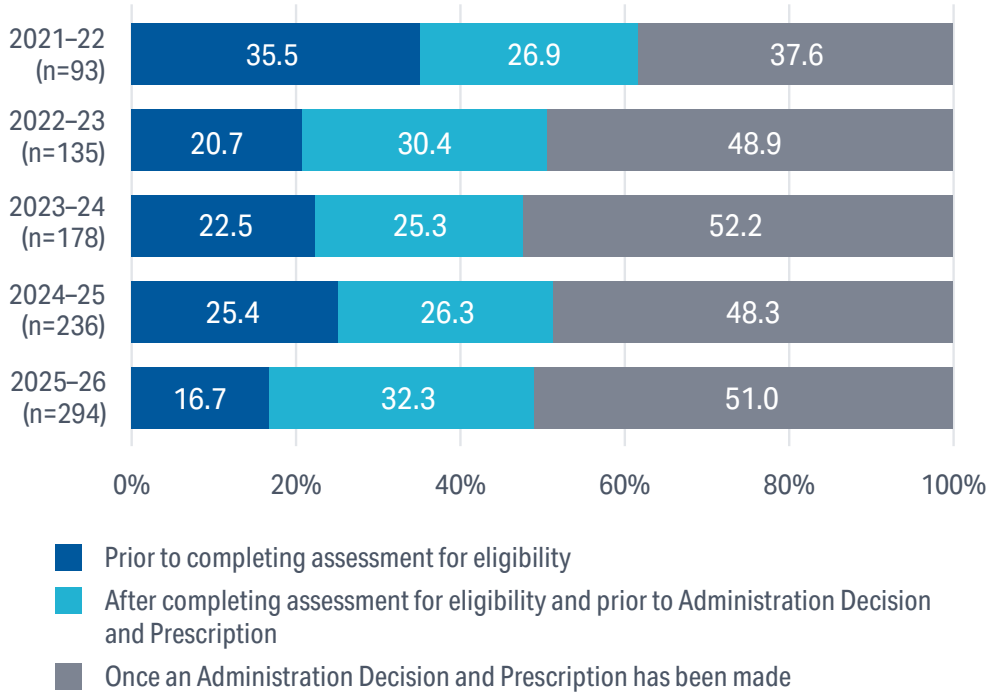
Figure 13: Voluntary assisted dying patient deaths occurring prior to administration of a voluntary assisted dying substance in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26



23 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.

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

Figure 14: 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, 2024–25 and 2025–26



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.[25]

Time to death after practitioner administration

In 2025–26, after practitioner intravenous administration:

- the median time to death was 6.0 minutes, which is the same median time recorded in 2024–25
- 97.8 per cent of patients died within 15 minutes (Table 8)
- the time elapsed between substance administration and death ranged from 1 minute to 30 minutes.

In 2025–26, after practitioner assisted oral ingestion or assisted ingestion via PEG or NG tube:

- the median time to death was 20.0 minutes, a decrease from 22.0 minutes in 2024–25
- 78.7 per cent of patients died in less than 30 minutes (Table 9)
- the time elapsed between substance administration and death ranged from 8 minutes to 1 hour 9 minutes.

25 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 2025–26, compared with 1 July 2021 to 30 June 2026

Length of time to death	2025–26	Total	% of total
≤15 minutes	451	1,312	96.5
≥16 minutes	10	47	3.5
Total	**461**	**1,359**	**100.0**

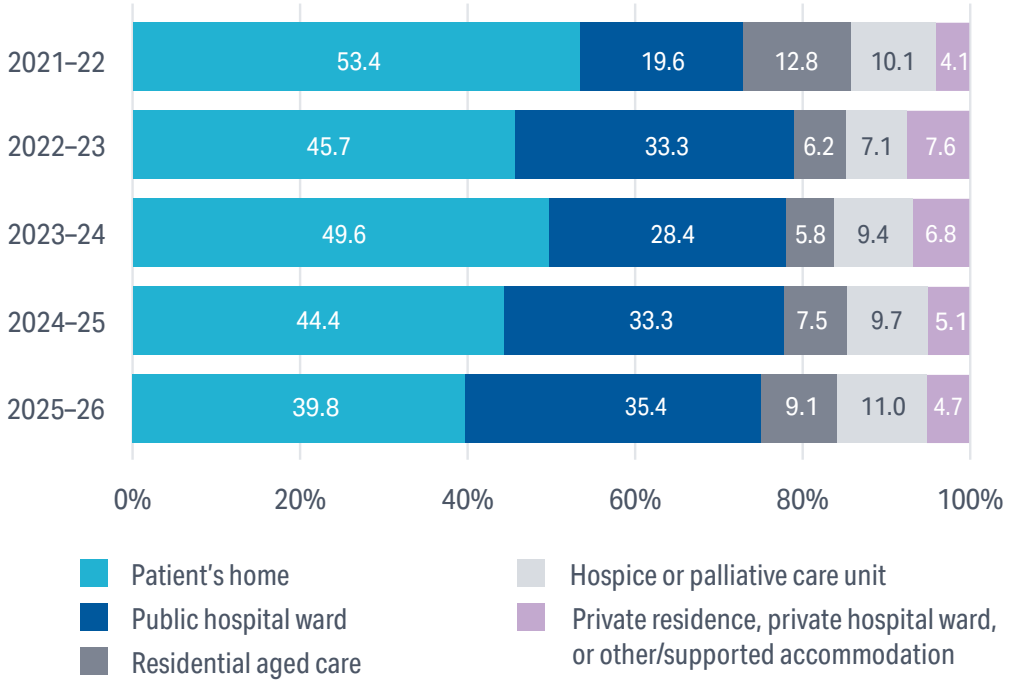
Table 9: Length of time to death of patient via assisted oral ingestion, assisted ingestion via PEG or NG tube in 2025–26, compared with 1 July 2021 to 30 June 2026

Length of time to death	2025–26	Total	% of total
≤29 minutes	37	181	76.1
≥30 minutes	10	57	23.9
Total	**47**	**238**	**100.0**

Administration location

In 2025–26, the 2 most frequent locations for practitioner administration of the voluntary assisted dying substance were the patient's home (n=202, 39.8%) and at a public hospital ward (n=180, 35.4%, Figure 15). In 2025–26, there was a decrease in the percentage of practitioner administrations occurring at the patient's home (n=202, 39.8%) compared with 2024–25 (n=201, 44.4%).

Figure 15: Patient deaths by practitioner administration location in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26



Complications

At the time of administration, practitioners are required to notify the Board of any complications that occur during the administration. In 2025–26, 98.2 per cent of deaths following practitioner administration (n=499) were reported without complication, an increase from 2024–25 (96.0 per cent, n=435). There were 9 complications reported in 2025–26 (1.8 per cent of deaths).

In 2025–26, reported complications included intravenous line complications, regurgitation/vomiting and other complications, which included patients coughing or gasping. All patients with reported complications died after administration of the voluntary assisted dying substance. The Board completed case reviews of all reported complications.

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. In 2025–26, 10,023 forms[26, 27, 28] were received by the Board, representing a 20.1 per cent increase in activity from 2024–25 (n=8,347, Table 10)
- the number of Coordinating Practitioner Transfers has increased year-on-year, with the number of Coordinating Practitioner Transfer forms in 2025–26 (n=93) being an increase of 102.2 per cent from 2024–25 (n=46)
- 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 16).

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 2025–26, 97.5 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).

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

27 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.

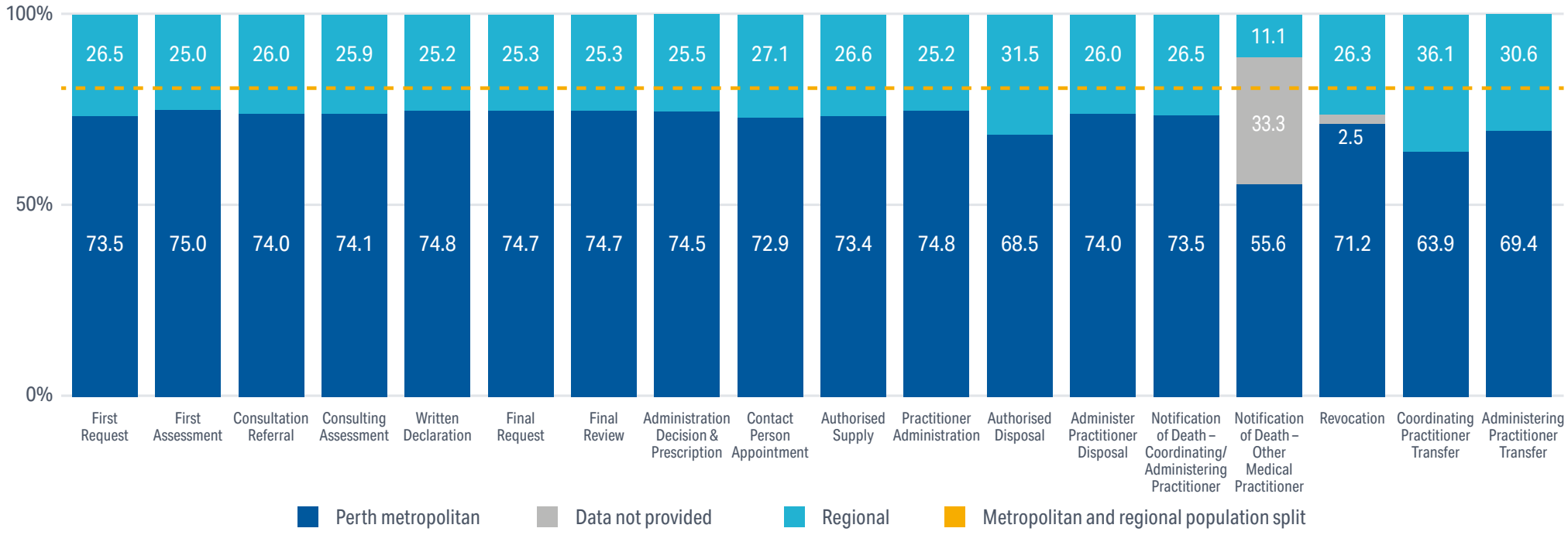
28 The data includes forms with a status of valid, void and revoked. A valid form is considered complete and correct at the time of submission to the Board. Forms that are assigned a status of void or revoked were previously valid forms:

- 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 10: Number of forms with a status of valid, void and revoked submitted in 2025–26, compared with 1 July 2021 to 30 June 2026

		All time		
Form title	2025–26	Total	Perth metropolitan	Regional
First Request	1,556	5,334	3,919	1,415
First Assessment	1,077	3,406	2,553	853
Consultation Referral	914	2,905	2,149	756
Consulting Assessment	901	2,840	2,105	735
Written Declaration	803	2,567	1,919	648
Final Request	781	2,490	1,861	629
Final Review	780	2,486	1,858	628
Administration Decision and Prescription	799	2,557	1,904	653
Contact Person Appointment	53	310	226	84
Authorised Supply	600	2,011	1,477	534
Practitioner Administration	509	1,596	1,194	402
Authorised Disposal	17	89	61	28
Administering Practitioner Disposal	488	1,299	961	338
Notification of Death – Coordinating/Administering Practitioner	346	1,099	808	291
Notification of Death – Other Medical Practitioner	np	>5	>4	np
Revocation	>25	>117	>83	>30
Coordinating Practitioner Transfer	93	208	133	75
Administering Practitioner Transfer	276	660	458	202
Total	**10,023**	**31,984**	**23,678**	**8,306**

Figure 16: Percentage of forms with a status of valid, void and revoked by metropolitan or regional WA submitted in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26[29]



29 Metropolitan and regional population data sourced from the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health (2026). Population data is based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) (Preliminary) for the period 2021-2024 and has been projected by the Epidemiology Directorate for the 2025 calendar year. Beer's coefficient has been used to determine persons aged 18 years and older.

Statewide services to support voluntary assisted dying

The WA Department of Health 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 WA Voluntary Assisted Dying Statewide Care Navigator Service
- services for the supply of the voluntary assisted dying substance through the WA Voluntary Assisted Dying Statewide Pharmacy Service.

End of Life Care Program

The End of Life Care Program supports the implementation of voluntary assisted dying through management of the Western Australian Voluntary Assisted Dying Approved Training (WA VAD Approved Training), administration of the practitioner fee-for-service model, 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 2025–26 included:

- review and enhancement of the WA VAD Approved Training program content
- transfer of the WA VAD Approved Training modules onto the WA Department of Health's Learning Management System, allowing monitoring of progression through the training
- ongoing management of the fee-for-service remuneration model for practitioners, with the program being extended until June 2029
- progression of recommendations from the Statutory Review of the *Voluntary Assisted Dying Act 2019* – Final Report
- provision of information resources[30] and educational materials through the WA Department of Health's website, and reviewing resources to ensure they are fit for purpose
- partnering with the Board, the WA Department of Health's Chief Health Statistician and Demand and Capacity Modelling team to model annual demand growth
- finalisation of the review of the Managing Voluntary Assisted Dying Mandatory Policy.

Statewide Care Navigator Service

The WA Voluntary Assisted Dying 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 support networks, 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, 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.

30 Includes an information brochure for patients and the community which was developed in collaboration with the Board, and resources targeted at junior doctors regarding the required steps after receiving a First Request for voluntary assisted dying.

Since the inception of the SWCNS, a total of 77,100 interactions have been recorded including contact from 3,887 patients, 409 healthcare workers and 148 other persons.[31, 32] The SWCNS has responded to 206 standalone training requests with additional training delivered in relation to patient care.

During 2025–26, the SWCNS provided:

- 19,965 interactions (an increase of 6.1 per cent from 2024–25) with patients, families and carers, healthcare workers and practitioners, including 1,180 new requests for support
- care for an average of 256 new patients per quarter, an increase from 228 new patients per quarter in 2024–25
- support for an average caseload of 450 patients per quarter (combined new referrals and ongoing follow ups), an increase from an average caseload of 408 patients in 2024–25, with 90 per cent of individual patients requiring more than one interaction.

The SWCNS provided a range of support services during 2025–26, with the distribution of services remaining consistent with support services provided in 2024–25. Care coordination (n=5,453, 37.6%) was the most common type of primary interaction,[33] followed by ongoing care (n=4,589, 31.7%, Table 11). The number of primary interactions related to an enquiry/information request increased by 14.7 per cent in 2025–26 (n=2,192) compared with 2024–25 (n=1,911).

The Board recognises that the demand for support services provided by the SWCNS continues to be high. In addition, the Board is aware of the limited ability for the SWCNS to sustain support services at current levels, which is reflected in the deterioration of its response times to patients in the second half of 2025–26 (Table 12). Furthermore, the Board understands that this has resulted in some patients who have made initial contact with the SWCNS waiting for longer than a week for a response, which is impacting patients' timely access to voluntary assisted dying services and support, causing distress to the patient and family.

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

32 Data supplied by the WA Voluntary Assisted Dying Statewide Care Navigator Service.

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

Table 11: Statewide Care Navigator Service's primary interactions in 2025–26, compared with 1 July 2021 to 30 June 2026[34]

Primary interaction type	2025–26	Total	% of total
Care coordination	5,453	20,065	36.2
Ongoing care	4,589	18,271	33.0
Enquiry/information request	2,192	8,017	14.5
Seeking practitioner	1,501	6,152	11.1
Bereavement support	348	1,262	2.3
Administration support	305	986	1.8
Other	64	471	0.9
Regional Access Support Scheme	37	71	0.1
Support request – individual	np	np	np
Support request – family/carer	np	np	np
Total	**14,492**	**55,389**	**100.0**

Table 12: Statewide Care Navigator Service's patient response times in 2021–22, 2022–23, 2023–24, 2024–25 and 2025–26

Patients responded to in timeframe (%)	2021–22	2022–23	2023–24	2024–25	2025–26 (1 July 2025 to 31 December 2025)	2025–26 (1 January 2026 to 30 June 2026)
≤2 business days	93.5	89.0	89.8	84.0	84.5	28.0
>2 business days	6.5	11.0	10.2	16.0	15.5	72.0

34 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.

The Board acknowledges the continued dedicated work of the SWCNS in providing a responsive, person-centred care navigation service which works to facilitate equitable access across metropolitan and regional WA in 2025–26, with achievements including:

- delivery and implementation of the Aboriginal Care Framework for service improvement
- ongoing service redesign and introduction of intake processes to improve patient access to voluntary assisted dying services and support
- delivering 2 practitioner workshops and 3 health professional forums, and supporting 90 new training requests
- receiving ethics approval for a research project exploring patient and family experiences when accessing voluntary assisted dying
- 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.

As reported to the Board, the SWCNS have noted the following challenges in the reporting period:

- increasing caseload across the SWCNS team with resulting impacts on staff well-being and deteriorating patient access to voluntary assisted dying through delays in care provision
- linking patients with a practitioner who is available to provide voluntary assisted dying services, particularly for patients located in regional WA and during periods of practitioner leave due to the small proportion of practitioners providing the majority of services
- supporting patients who are seeking access to voluntary assisted dying in private facilities, including contracted health entities, with variable support for this end of life care choice
- the impact of the Commonwealth *Criminal Code Act 1995* on the use of carriage services to facilitate timely and efficient care provision
- its reduced capacity to deliver education and awareness sessions for health professionals and the community.

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 WA VAD Approved Training by a medical practitioner or nurse practitioner who cares for patients located in regional WA.

In 2025–26, there were 165 requests that met the defined RASS criteria in support of 111 patients and 8 practitioners who were not associated with a particular patient (Table 13). This is a decrease from the 182 requests in support of 119 patients and practitioners in 2024–25. Almost 9 out of every 10 requests (n=154, 89.0%) were made for travel of a practitioner to a patient for face-to-face care.[35]

In 2025–26, RASS requests were received from all regions in WA and highlights the ongoing reliance on RASS to support equitable access to voluntary assisted dying across WA. In accordance with the Access Standard under the Act, the RASS has been used to support travel for regionally based practitioners to attend training sessions. 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 travel to provide voluntary assisted dying services to patients.

More than 40 per cent of approved RASS requests in 2025–26 (n=80, 48.5%) were made to support patients in the metropolitan or Peel regions (Table 13).

35 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. In 2025–26, the number of RASS requests by type was 173.

Table 13: Regional Access Support Scheme requests by health region in 2025–26, compared with 1 July 2021 to 30 June 2026

Health region	2025–26	Total	% of total
Perth metropolitan	29	**149**	20.4
Peel	51	**175**	23.9
Goldfields	np	**>30**	>4.2
Kimberley	np	**>11**	>1.6
Midwest	7	**36**	4.9
Great Southern	28	**99**	13.5
Pilbara	6	**15**	2.1
South West	21	**118**	16.1
Wheatbelt	10	**70**	9.6
Practitioner training support[36]	8	**23**	3.1
Total	**165**	**731**	**100.0**

Statewide Pharmacy Service

The WA Voluntary Assisted Dying Statewide Pharmacy Service (SWPS) ensures that the voluntary assisted dying substances are 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 substances. 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 2025–26:[37]

- the SWPS recorded an increase in voluntary assisted dying substance supplies, supplying the prescribed voluntary assisted dying substance on 599 occasions, an increase of 8.9 per cent from 2024–25 (n=550, Table 14)
- there were 129 supplies of the voluntary assisted dying substance in regional WA, which is similar to 2024–25 (n=128)
- the proportion of supplies of the voluntary assisted dying substance in regional WA decreased from 23.3 per cent in 2024–25 to 21.5 per cent in 2025–26
- 48 per cent of requests for supply of the voluntary assisted dying substance were classified as urgent (n=303) a decrease from 51 per cent in 2024–25 (n=339).[38, 39]

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

37 Data supplied by the WA Voluntary Assisted Dying Statewide Pharmacy Service.

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

39 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.

In 2025–26, all supplies to the Perth metropolitan area (n=470) occurred within 2 business days and all supplies to regional WA (n=129) within 5 business days of the patient or Administering Practitioner's requested timeframe. In 2024–25, 98.8 per cent of all supplies in the Perth metropolitan area occurred within 2 business days and all supplies in regional WA occurred within 5 business days.

Table 14: Authorised supply of the voluntary assisted dying substance by health region where the supply occurred in 2025–26, compared with 1 July 2021 to 30 June 2026[40]

Health region	2025–26	Total	% of total
Perth metropolitan	470	**1,626**	80.9
Goldfields	np	**np**	np
Kimberley	6	**10**	0.5
Midwest	16	**63**	3.1
Great Southern	32	**95**	4.7
Pilbara	np	**np**	np
South West	72	**204**	10.1
Wheatbelt	np	**np**	np
Total	**599**	**2,011**	**100.0**

The Board acknowledges the maintenance of high quality and safety standards and achievements of the SWPS in 2025–26 including:

- commencing supply of intraosseous devices to practitioners who have identified a patient with potentially difficult intravenous access
- publishing a peer-reviewed research article regarding the knowledge of community pharmacists on voluntary assisted dying and disposal of the voluntary assisted dying substance
- progressing a research project to understand factors which encourage or discourage pharmacists being part of the voluntary assisted dying workforce
- delivering education sessions to community members, health professionals and pharmacy students regarding voluntary assisted dying
- continued development of a masking agent to improve the palatability of the oral voluntary assisted dying substance
- undertaking service and quality improvement initiatives, including improving the information packs provided to patients who plan to self-administer the voluntary assisted dying substance
- continuing to receive positive feedback from patients, families and participating practitioners.

As reported to the Board, the SWPS have noted the following challenges in the reporting period:

- 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 inability for practitioners to use electronic prescribing for the voluntary assisted dying substance due to the Commonwealth *Criminal Code Act 1995*, which introduces delays to patient access
- supporting practitioners with cannulation of patients who are often dehydrated and cachectic
- the requirement for Authorised Disposers of the voluntary assisted dying substance to be senior pharmacists limiting access to safe and timely disposal of the voluntary assisted dying substance.

40 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 2025–26, membership of the Community of Practice continued to grow, now comprising of 157 members including 110 medical practitioners and 9 nurse practitioners who have completed the WA VAD Approved Training, and 38 members from supporting services and organisations which includes staff from the SWCNS and SWPS.

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.

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

Health service providers

Since the implementation of the Act, health service providers[41] have established systems and processes to support the delivery of voluntary assisted dying across the WA health system. This has included the introduction of Clinical Lead, practitioner and voluntary assisted dying coordinator roles to provide information, coordination and support to patients, families and practitioners throughout the voluntary assisted dying pathway.

These roles play an important role in facilitating access to voluntary assisted dying within their respective health services. They support local implementation of the Act, assist with practitioner recruitment and engagement, coordinate care, undertake voluntary assisted dying assessments and other statutory functions, provide clinical leadership and help ensure patients can access accurate information on the voluntary assisted dying process.

41 Health service providers are statutory authorities governed by a board and/or chief executive. These statutory authorities are responsible for delivering public health services or health support services as prescribed through service agreements. Health service providers which support the delivery of voluntary assisted dying services in WA include the East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and WA Country Health Service.

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; the Chief Executive Officer of the Department of the Public Service principally assisting in the administration of the *Prisons Act 1981* (WA); 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 Scott Blackwell retired in June 2026, and Dr Simon Towler was appointed to the Board in July 2026. Hon Colin Holt was designated as Chairperson from July 2026, and Ms Linda Savage was designated as Deputy Chairperson from September 2026.

Hon Colin Holt (Chairperson): Mr Holt was a Member of the Legislative Council of WA, representing the South West region, from 2009 to 2021. In 2018, Mr Holt was the Deputy Chairperson of the Parliamentary 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.[42]

Ms Linda Savage (Deputy Chairperson): 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. She is an Ambassador for the Commissioner for Children and Young People (WA) and for The Women's Legal Service of WA.[43]

Ms Maria Osman: Ms Osman is an experienced non-executive director and adviser specialising in human rights and diversity policy and community development. Ms Osman is a board member of the Racial Justice Centre, the Gnaala Karla Booja Aboriginal Corporation and Yinhawangka Foundation. 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.

Dr Gareth Wahl: Dr Wahl is an experienced voluntary assisted dying practitioner, with a background in emergency medicine and medical administration. Dr Wahl has previously undertaken leadership positions in the WA health system including as Clinical Lead (End of Life Care) at the WA Department of Health and Director Clinical Services for the Women and Newborn Health Service.

Dr Simon Towler: Dr Towler was among the first voluntary assisted dying practitioners in WA and cultivated a 35-year career in intensive care medicine. Dr Towler is the former Chief Medical Officer for the WA Department of Health and was the Clinical Lead for voluntary assisted dying in the South Metropolitan Health Service. Dr Towler was a member of the Ministerial Expert Panel that advised on the introduction of voluntary assisted dying and is currently the Deputy President of the Palliative Care WA Board. Dr Towler is also a board member of Lifeline WA.[44]

Dr Scott Blackwell (Chairperson, up to 30 June 2026): 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.[45]

42 Mr Holt was designated as Chairperson from 1 July 2026.
43 Ms Savage was designated as Deputy Chairperson from 29 September 2026.
44 Dr Towler's term commenced on 27 July 2026.
45 Dr Blackwell's term ended on 30 June 2026.

The Board met monthly throughout 2025–26, with an additional special meeting held in April 2026 (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 2024–25 Annual Report.

Table 15: Board member term and meeting attendance in 2025–26

Board member	Term	Meetings attended 2025–26
Dr Scott Blackwell	1 July 2021 to 30 June 2026	12 of 13
Colin Holt	1 July 2021 to 30 June 2028	10 of 13
Linda Savage	1 July 2021 to 30 June 2026 (Reappointed for a further 2 years, commencing 1 July 2026)	13 of 13
Maria Osman	1 July 2021 to 30 June 2026 (Reappointed for a further year, commencing 1 July 2026)	13 of 13
Dr Gareth Wahl	1 January 2025 to 30 June 2027	13 of 13
Dr Simon Towler	27 July 2026 to 30 June 2029	Appointed from 2026–27

Board performance

In line with its performance review policy, in 2025–26 the Board undertook an annual performance review. The Board Performance Review 2026 included:

- Board member self-assessment and one-on-one interviews with the Board's Chairperson
- Board member performance evaluation survey
- stakeholder 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:

- continue to improve the Board's governance processes
- provide regular feedback on the Board's activities to the Community of Practice
- use a variety of methods to provide education on the role of the Board to relevant stakeholders
- consider pathways to advocate for the development of clinical guidance materials
- consider future research opportunities.

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, communications, information and communications technology and other services to support the Board to deliver its functions and legislated obligations.

Directions and disclosures

In 2025–26, no directions were given by the Minister pursuant to section 123(1) or 152(2) of the Act.

In 2025–26, disclosures of material or personal interest were made by Dr Scott Blackwell and by Dr Gareth Wahl in relation to patient episodes which were subject to case review. Both members were not present during the consideration or decision-making by the remaining members of the Board of the respective case reviews. Disclosures of material and personal interest made by Board members under section 140(1) of the Act, were recorded in the minutes of the corresponding meeting, pursuant to section 140(2) of the Act.

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 Governance Manual for WA Government Boards and Committees. For 2025–26, 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. Daily monitoring, weekly compliance reviews and quarterly auditing and reporting of aggregate and trend data assist the Board in the performance of the Board's monitoring function.

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 228 case reviews during 2025–26. Key actions arising from the case review process included:

- referrals to the Director General of the WA Department of Health (as Chief Executive Officer)
- engagement with the WA Department of Health on the development of practitioner guidance and support when transferring roles
- education for practitioners and contact persons
- acknowledgment of practitioners and statewide services providing exceptional care to patients
- modifying Secretariat Unit procedures for the monitoring and reporting of delays in the Practitioner Administration and Notification of Death forms.

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, including:

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

In 2025–26, the Board made referrals to:

- the Health and Disability Services Complaints Office relating to failure to respond to a request for access to voluntary assisted dying in compliance with the Act (n=1)
- the Director General of the WA Department of Health (as Chief Executive Officer) relating to the provision of medical care and treatment to inpatients who have expressed a desire to access voluntary assisted dying (n=1), possible contravention of the Act requiring further investigation (n=2), failure to submit a Practitioner Administration Form to the Board (n=1) and the timeliness of forms submitted to the Board (n=255).

Education, data and research

Education

In 2025–26, 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 2025–26 editions of the Quality Practice Series[46] topics included:

- updates to the voluntary assisted dying substance protocols
- publication of a voluntary assisted dying information brochure for the community
- planning for leave and transferring Coordinating Practitioner and Administering Practitioner roles
- recording primary and secondary diagnoses on assessment forms
- security measures to protect data held by the Board
- timeliness of submission of forms to the Board
- maintaining practitioner and patient profiles within VAD-IMS
- witnessing of Written Declarations
- the use of interpreters throughout a patient episode
- Final Requests made within the designated period
- submission of Consultation Referral forms and notification of practitioners and patients of their outcome
- continuing professional development for practitioners
- submission of personal reflections
- general reminders for VAD-IMS.

In 2025–26, Board members engaged with the Community of Practice to share information and receive feedback from those participating in the voluntary assisted dying process. In addition to the topics raised in the Quality Practice Series, Board members discussed with the Community of Practice the role of the Board and scope for advocacy and legislative change.

46 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:

- practitioner and community 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 2025–26, the Voluntary Assisted Dying Board Research Advisory Group held 3 meetings, which included discussions of research projects being explored by the Board, the WA Voluntary Assisted Dying Statewide Care Navigator Service and WA Voluntary Assisted Dying Statewide Pharmacy Service, conferences attended by its members and research conducted into voluntary assisted dying by other parties or jurisdictions.

In 2025–26, the Board updated its governance mechanisms due to the *Privacy and Responsible Information Sharing Act 2024* (WA), which is in force from 1 July 2026.

In accordance with the provisions of section 151 of the Act, the Board disclosed information in response to 26 requests for information during 2025–26, which is an increase from 21 disclosures in 2024–25. 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 with the opportunity to articulate concerns at an early stage.

In 2025–26, the Board met with the Minister for Health and the Director General of the WA Department of Health to discuss the operation of the Act and recommendations for improvement, 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 2025–26, invited stakeholders included the WA Voluntary Assisted Dying Statewide Care Navigator Service (SWCNS); WA Voluntary Assisted Dying Statewide Pharmacy Service; voluntary assisted dying coordinators within health service providers; Deputy Director General (Clinical Excellence Division) of the WA Department of Health; Chief Medical Officer; End of Life Care Program team and Clinical Lead; voluntary assisted dying practitioners; representatives from Voluntary Assisted Dying Australia and New Zealand, the Health and Disability Services Complaints Office, Palliative Care WA, Dying with Dignity WA, Ageing Australia and Donate Life.

In 2025–26, Board members attended Community of Practice meetings and participated in the annual Voluntary Assisted Dying Service of Reflection. Presentations on the operations of the Board were provided at the WA Rotary Conference, the SWCNS Health Care Worker Forum, North Metropolitan Health Service general education day, and at a series of practitioner training days held across the South Metropolitan Health Service, North Metropolitan Health Service, and Goldfields region.

The Board continued to participate in interjurisdictional engagement throughout 2025–26. The Board Chairperson met quarterly with the Trans-Tasman Voluntary Assisted Dying Board Chair Forum and attended Go Gentle Australia's State of VAD Report Launch at Parliament House. Board members also attended the Power of Choice Exhibition opening night curated by Go Gentle Australia.

In 2026–27, the Board is looking forward to scheduling regional meetings and activities after placing their Regional Travel Program on hold throughout 2025–26.

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. The Board's recommendations are informed by monitoring and stakeholder engagement activities, interjurisdictional review, and current research.

The Board notes that progress made against recommendations in its previous annual reports has included:

- extension of the fee-for-service practitioner remuneration model, which now has more than 100 registered practitioners claiming through the system
- distribution of more than 13,000 copies of the Voluntary Assisted Dying – Information for patients, family and community brochure
- development of dedicated resources for junior doctors aimed at raising awareness of voluntary assisted dying and how to respond to a First Request
- approval of amendments to the Administering Practitioner Disposal Form, for roll out in 2026–27
- finalising the 2nd Implementation Plan for the WA End of Life and Palliative Care Strategy, incorporating voluntary assisted dying into the plan and priority actions to provide direction for end of life and palliative care across the WA health system and partnered organisations
- updates to the Voluntary Assisted Dying Mandatory Policy to consider recommendations from the *Statutory Review of the Voluntary Assisted Dying Act 2019* and strengthen requirements for WA Health entities to support patient accessibility, workforce well-being and reporting
- undertaking demand modelling to support evidence-based service planning for voluntary assisted dying in the WA health system
- ongoing advice and advocacy on the need for amendment to the *Criminal Code Act 1995* (Cth) and introduction of Medicare Benefits Schedule items for the provision of voluntary assisted dying services
- commencing a review of public resources and development of health professional training materials to increase awareness of voluntary assisted dying.

Following its monitoring of the operation of the *Voluntary Assisted Dying Act 2019* (the Act) during 2025–26, the Board makes the following recommendations.

Access to participating practitioners

Demand for voluntary assisted dying continues to increase and has outpaced growth in the number of practitioners actively participating in the system. While additional practitioners have completed the WA Voluntary Assisted Dying Approved Training in 2025–26, a substantial proportion of clinical activity continues to be undertaken by a relatively small cohort of practitioners (see Practitioner participation, page 17).

The Board is concerned that continued growth in demand, without a corresponding increase in practitioner participation, risks reduced access for patients, increased reliance on a small number of practitioners, and sector fatigue and burnout.

Current activity data indicates there was a ratio of over 20 assessments per participating medical practitioner. To meet projected demand, the existing practitioner pool will need to substantially increase their capacity, or the number of trained practitioners actively undertaking assessments will need to grow considerably.

Recommendation 1: Develop and implement strategies to increase the number of practitioners participating in voluntary assisted dying and support existing practitioners to remain engaged in the system and undertake voluntary assisted dying work sustainably.

Support for voluntary assisted dying within the WA health system

The Board recognises the critical role of statewide services and health service providers in supporting safe and equitable access to voluntary assisted dying across WA.

Activity throughout the voluntary assisted dying system has increased substantially since implementation of the Act. The Board observes that service demand has grown faster than staffing and operational capacity in several parts of the system, including care navigation, pharmacy services and local health service coordination.

Given the ongoing shortage of participating practitioners, these services perform a function that extends well beyond patient care coordination including the provision of critical operational, educational and workforce support that enables practitioners to continue participating in voluntary assisted dying and assists in maintaining service continuity across the State. The Board considers that these services play a vital role in sustaining the operation of the voluntary assisted dying system and mitigating risks associated with an insufficient practitioner workforce.

The Board is concerned that current care navigation services are no longer keeping pace with growth in demand. The Board understands that delays in connecting patients with eligible practitioners have increased, resulting in some patients dying or losing decision-making capacity before they can commence the voluntary assisted dying process, or before the process can be completed. As a result, activity reported by the Board may not accurately reflect actual demand for voluntary assisted dying services. The Board considers that constrained care navigation and coordination capacity is highly likely to have moderated growth in voluntary assisted dying activity and, without increased resourcing, will continue to act as a barrier to timely access for eligible Western Australians.

Continued growth in activity will require ongoing investment to maintain service quality and ensure equitable access for eligible Western Australians.

Recommendation 2: Ensure adequate and ongoing resources are available to support access to voluntary assisted dying across the WA health system, including statewide services, health service providers and associated support programs.

Impact of the Commonwealth *Criminal Code Act 1995*

The Board remains concerned about the impact of provisions within the Criminal Code that restrict the use of carriage services in aspects of the voluntary assisted dying process.

These provisions continue to create barriers for patients, particularly those residing in rural and remote WA where access to local participating practitioners may be limited. While the Regional Access Support Scheme plays a critical role in mitigating these barriers, access remains dependent upon the availability of practitioners willing and able to travel to support these patients.

Current legislative restrictions prevent electronic transmission of prescriptions for voluntary assisted dying substances. Although the WA Voluntary Assisted Dying Statewide Pharmacy Service has implemented processes to manage these restrictions, resulting workarounds increase resource demands without delivering any additional safety benefits.

Recommendation 3: Amend the *Criminal Code Act 1995* (Cth) to remove restrictions that impede the delivery of voluntary assisted dying services through telehealth and prevent electronic transmission of voluntary assisted dying prescriptions.

Awareness and understanding of voluntary assisted dying

The Board continues to receive feedback from patients, families and practitioners regarding a lack of awareness and understanding of voluntary assisted dying within the broader health system.

The Board has observed instances where medical practitioners have not recognised or appropriately responded to a First Request, have lacked knowledge of the voluntary assisted dying process, or have been unaware of their responsibilities under the Act, including notification, reporting and record-keeping requirements.

The Board is also concerned about low levels of community awareness regarding voluntary assisted dying as an available end of life choice. As a result, many people continue to seek access to voluntary assisted dying late in the course of their illness, leaving limited time to complete the process.

Late requests can add to the emotional burden on patients, families and carers,

place additional pressure on practitioners and statewide services, increase the risk that a person will die before completing the process, and contribute to practitioner fatigue and workforce sustainability concerns.

Recommendation 4: Increase community and health practitioner awareness of voluntary assisted dying, including education regarding the requirements of the *Voluntary Assisted Dying Act 2019*, referral pathways and available support services.

Amendments to the *Voluntary Assisted Dying Act 2019*

Through its monitoring functions and engagement with patients, families, practitioners and stakeholders, the Board has identified several areas for consideration in future amendments to the Act, in addition to those highlighted in previous annual reports and submissions.

Board membership

The Board notes increasing complexity and workload associated with its statutory functions, including monitoring, research, stakeholder engagement and advice to government. The current Board membership of 5 members can present challenges in maintaining quorum and ensuring access to the breadth of expertise required to support all of the Board's functions.

Recommendation 5a: Amend the *Voluntary Assisted Dying Act 2019* to increase Board membership from 5 to 7 members.

Eligibility time-to-death requirements

The Board continues to receive feedback regarding the operation of eligibility criteria requiring death to be expected within 6 months, or 12 months for neurodegenerative conditions.

The Board observes that these requirements may limit access for people with progressive conditions such as dementia and may delay engagement with the voluntary assisted dying process until late in the course of illness.

Recommendation 5b: Review the eligibility time-to-death requirements under the *Voluntary Assisted Dying Act 2019*, including consideration of standardising, extending or removing these requirements to improve equitable access and allow earlier engagement with the voluntary assisted dying process.

Transfer of care between participating practitioners

The Board has identified circumstances where the current transfer provisions create unnecessary administrative burden and impede continuity of care.

These circumstances include situations where a participating practitioner becomes unavailable and where temporary transfer arrangements are required during periods of practitioner leave.

Recommendation 5c: Amend the *Voluntary Assisted Dying Act 2019* to facilitate transfer of care between trained practitioners by:

- enabling patients to initiate transfer requests where a practitioner is unavailable and allowing transfer notifications to be submitted by the receiving practitioner
- introducing mechanisms for temporary transfers of care that maintain patient access while reducing administrative burden on participating practitioners.

Board's note on previous recommendations

The Board notes that several of these recommendations have been made in its previous annual reports. While progress has been achieved in some areas, including the introduction of practitioner remuneration, the Board notes that several issues identified since the commencement of voluntary assisted dying in WA remain relevant. Demand for voluntary assisted dying services continues to increase, workforce and service capacity remain constrained, and barriers to timely access continue to be reported. The Board considers that continued focus and investment will support the ongoing safety, accessibility and sustainability of voluntary assisted dying services in WA.

Future focus

In the year ahead, the Board will continue to work collaboratively with the Minister for Health, the Director General of the WA Department of Health, health service providers, and health practitioners to support the effective operation of the *Voluntary Assisted Dying Act 2019* (the Act) and ensure voluntary assisted dying remains a safe, accessible and person-centred end of life choice for eligible Western Australians.

The Voluntary Assisted Dying Board Strategic Plan 2023–2026 sets out the Board's approach to fulfilling its statutory functions and leveraging its unique access to information to support the objects and intent of the Act. During 2026–27, the Board will finalise and commence implementation of the Voluntary Assisted Dying Board Strategic Plan 2026–2029, which will guide the Board's strategic priorities over the next 3 years.

Key areas of focus for the coming year include:

- continuing to strengthen the Board's monitoring, compliance and oversight functions through ongoing review and improvement of monitoring processes and reporting frameworks
- understanding the outcomes and recommendations of the WA Department of Health led statewide service review to ensure future resourcing and care models meet the increasing demand for voluntary assisted dying services
- improving data quality, reporting capability and information governance through implementation of the Voluntary Assisted Dying Information Management System Data Quality Improvement Plan
- enhancing stakeholder engagement through regional outreach activities, continued collaboration with the Voluntary Assisted Dying Community of Practice, and publication of the quarterly Quality Practice Series
- continuing to provide timely reports, information and advice to the Minister for Health and the Director General of the WA Department of Health to support transparency and system-wide improvement
- ongoing collaboration with the WA Department of Health and the Queensland University of Technology on a national research project which assesses the operation of voluntary assisted dying laws in Australia
- progressing research into voluntary assisted dying knowledge, awareness and experience
- monitor emerging research and evaluation findings regarding access to voluntary assisted dying for patients with a diagnosis of dementia.

Appendices

Appendix 1: Disclosures and legal compliance

Financial statements

In accordance with the *Financial Management Act 2006* (WA), 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 WA Department of Health's 2025–26 Annual Report.

Section 175ZE of the *Electoral Act 1907*

Section 175ZE of the *Electoral Act 1907* (WA) 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 2025–26.

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's Annual Reporting Information for 2025–26 are included in the WA Department of Health's 2025–26 Annual Report: work health and safety 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	59-61
(b)	any information that the Board considers relevant to the performance of its functions; and	51-58
(c)	the number of any referrals made by the Board under section 118(c); and	55
(d)	the text of any direction given to the Board under section 123(1) or 152(2); and	54
(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	54
(f)	statistical information that the Board is directed under section 152(2) to include in the report; and	54
(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.	4, 7, 13, 18, 21, 24, 28, 31, 33, 35, 36, 37, 42, 43, 44, 46, 47, 48, 49, 60, 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

WA Voluntary Assisted Dying 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

WA Voluntary Assisted Dying 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, WA 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

Community of Practice

Email: VADcarenavigator@health.wa.gov.au

Phone: (08) 9431 2755

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Appendix 4: Voluntary assisted dying proposed national minimum dataset 2025–26 Western Australia[47]

Data from First Assessment Forms

Number of First Assessments	1,077

Age group	18–39	40–49	50–59	60–69	70–79	80–89	≥90
	np	np	70	191	336	325	126

Gender	Female	Male	Other/self-described
	493	584	0

Residence	Major cities of Australia	Inner regional Australia	Outer regional Australia	Remote Australia	Very remote Australia
	782	130	125	28	12

Aboriginal and Torres Strait Islander origin	Aboriginal and/or Torres Strait Islander	No
	np	>1,063

Highest level of education completed	Did not complete secondary school	Completed secondary school	Completed post-secondary education	Not reported
	34	585	446	12

Use of interpreter	Yes	No
	np	>1,072

Place of birth	Australia	Overseas	Not reported
	675	401	1

47 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
	673	119	107	178

Palliative care	Yes	No
	827	250

Practitioner type	General Practitioner	Specialist	Other
	42	26	0

Data from Administration Decision and Prescription Forms

Administration route	Self-administration	Practitioner administration
	53	745

Data from Authorised Supply Forms

Number of substance supplies	Self-administration	Practitioner administration
	43	556

Data from Notification of Death and Practitioner Administration Forms

Voluntary assisted dying deaths	541

Manner of death	Self-administration	Practitioner administration	Substance not administered
	33	508	294

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