ACT Voluntary Assisted Dying Oversight Board

Oversight Report

3 November 2025 to 30 June 2026



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Acknowledgement of Country

The ACT Voluntary Assisted Dying Oversight Board acknowledges the Ngunnawal people as Traditional Custodians of the lands, waters and skies of the ACT, and recognises any other people or families with connection to the lands of the ACT and region.

The Board pays its respects to Elders past and present and acknowledges the continuing culture, knowledge and connection to Country of Aboriginal and Torres Strait Islander people.

The Board respects the perspectives and experiences of Aboriginal and Torres Strait Islander people and recognises the importance of equity and cultural safety in the ACT health system.

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Overview

About this Report

This is the inaugural Oversight Report of the ACT Voluntary Assisted Dying Oversight Board (**the Board**).

This report complements the Health and Community Services Directorate's (**HCSD**) Annexed Annual Report of the Board and provides a more detailed account of the Board's monitoring and oversight during the inaugural reporting period.

This report covers the period from commencement of voluntary assisted dying in the ACT from 3 November 2025 to 30 June 2026. As this represents approximately 8 months of operation, the information presented in this report should be interpreted in the context of an 8-month reporting year. Future reports will cover full financial years.

Data in this report

The data presented in this report is primarily drawn from the Voluntary Assisted Dying Information Management System (**VAD IMS**).

The VAD IMS records information submitted throughout the voluntary assisted dying pathway, including statutory notifications provided by authorised practitioners. Information recorded in the VAD IMS is a key source of data for the Board's monitoring and oversight functions.

Throughout this report, care has been taken to distinguish between people, requests and voluntary assisted dying pathways. A person may make more than one request or commence more than one pathway, in particular circumstances, and may therefore be represented more than once.

The term *pathway* is used to describe a person's progression through voluntary assisted dying. The term *case* is used where the Board is referring to an individual matter considered through its retrospective case-review or compliance functions, or when referring to a specific legal proceeding.

Reflections of the Chair

I am pleased to present the first report of the ACT Voluntary Assisted Dying Oversight Board. The Board commenced on 3 November 2025, the day that voluntary assisted dying became available as an end-of-life choice in the ACT.

Voluntary assisted dying is about choice, control, connection and compassion. It is the ultimate demonstration of consumer empowerment. The Board is committed to ensuring the scheme works, meets the needs of the people using the service, has appropriate safeguards, and supports those people delivering the service.

Given this is our first report, we have included additional information about the scheme and how it operates to build community awareness and understanding of voluntary assisted dying.

On behalf of the Board, I acknowledge the individuals, families and carers who have engaged with voluntary assisted dying during its first 8 months of operation. Behind every request and every figure in this report is an individual navigating serious illness, personal choice and the end of life. We acknowledge and respect the courage, dignity and personal circumstances that accompany end-of-life decision-making.

The Board continues to hear from families and health professionals about the importance of voluntary assisted dying as an option for end-of-life care in the ACT. People working in the scheme shared with us that it has been one of the greatest privileges of their professional careers. Families have spoken of the care, respect and dignity they experienced. We thank everyone who has shared their experience of voluntary assisted dying with us.

During this period, I met with stakeholders to discuss the scheme and the role of the Board, including Dying with Dignity ACT, Health Care Consumers' Association, Palliative Care ACT, ACT Disability, Aged and Carer Advocacy Service and the ACT Health Services Commissioner.

In my role, as Chairperson, I attended:

- Quarterly meetings of the Trans-Tasman Voluntary Assisted Dying Board Chair Forum, comprising Board Chairs from around Australia and New Zealand, to discuss shared issues.
- The launch of Go Gentle Australia's 'The State of VAD' report in Parliament House, Canberra in March 2026.
- The International Conference on Assisted Dying and Other End of Life Care (ICEL5) in Brisbane with Cathie O'Neill in April 2026.

These events provided opportunities to build relationships with researchers, advocates, board members from other jurisdictions and people working in other schemes.

Monitoring and oversight

The Board independently monitors the operation of the *Voluntary Assisted Dying Act 2024* (**the Act**) through consideration of individual cases, scheme activity, statutory notifications and other relevant information. This oversight enables the Board to identify emerging issues, monitor the operation of legislative safeguards and consider how the voluntary assisted dying scheme is functioning in practice.

The Board does not approve individual eligibility decisions or authorise a person's progression through the pathway. Those decisions are made by the practitioners and other decision-makers given those functions under the Act.

During our first reporting period, we focused on establishing and refining oversight arrangements, developing governance processes and building an evidence base from which to perform our ongoing monitoring functions.

Thank you

We express our deep gratitude to the authorised practitioners, care navigators, pharmacists, managers and support staff who contributed to the establishment of the voluntary assisted dying scheme in the ACT. This includes the members of the Clinical Advisory Committee and the Consumer and Community Consultative Group which provided valuable input during establishment and implementation of the scheme.

The introduction of a new end-of-life choice required exceptional commitment, collaboration and professional judgement. Health practitioners and support services worked across organisational and professional boundaries while adapting to new legislative responsibilities, clinical processes and information requirements. Throughout the inaugural year, the workforce has demonstrated a steadfast dedication to supporting members of our community at a profoundly important stage of their lives. Their willingness to embrace new responsibilities, navigate complex processes and work collaboratively across services has been essential to establishing and delivering safe, lawful and person-centred voluntary assisted dying care.

We particularly acknowledge the care, respect and humanity shown to individuals and their families throughout the voluntary assisted dying pathway. We are incredibly respectful of the role and emotional responsibilities that friends and family may carry. By honouring your loved one's preferences at the end of life, you have made a meaningful contribution to their well-being and the manner in which they wished to approach the end of their journey.

We thank all those involved for their professionalism, courage and commitment to supporting dignity, autonomy and compassionate care during times of significant vulnerability. The progress made in establishing and delivering the ACT's voluntary assisted dying scheme to date is a direct reflection of their dedication and their shared commitment to improving end-of-life care for the people of the ACT.

I am thankful to the chairs of other jurisdictional boards for their support and guidance in the establishment of the scheme. We have had the opportunity to learn from their experience and to review their reports.

We are grateful to the Secretariat for their support. Despite a continuous workload and team changes, you have maintained a remarkably high standard of work, for which we are thankful.

On a personal note, I want to thank my Board colleagues for their professionalism, commitment and generosity in sharing their experience and insights as we developed and refined our policies and processes to support our role in overseeing the scheme.

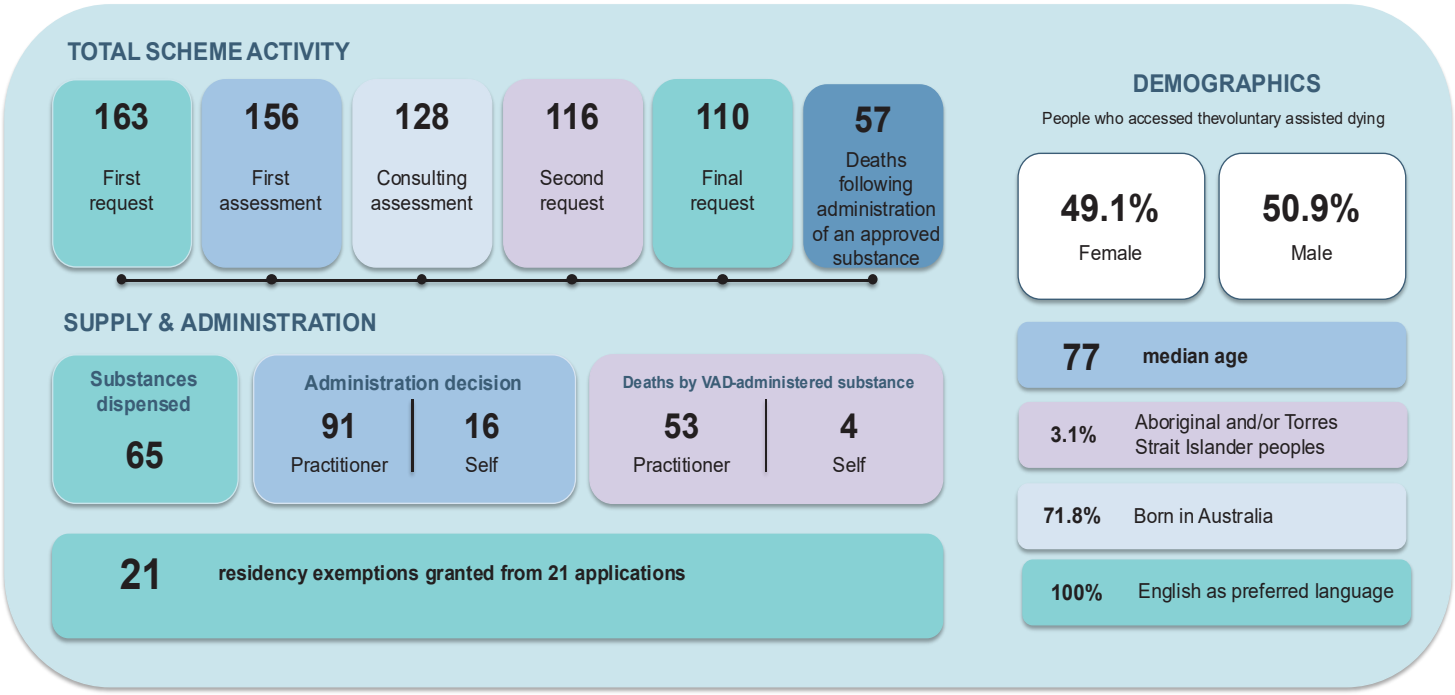


Ms Darlene Cox
Chairperson
ACT Voluntary Assisted Dying Oversight Board



Image: ACT Voluntary Assisted Dying Oversight Board members.
Back row, left to right; Margaret Parker, Catherine O'Neill and Meredith Whiting.
Front row, left to right: Darlene Cox (Chair) Christopher Bourke and Robert Farrugia (Deputy Chair). *Absent from photograph:* Clara Tuck Meng Soo.

The Year in Review



Further detail and analysis are provided throughout this report.

This snapshot reflects activity of the voluntary assisted dying scheme from commencement on 3 November 2025 to 30 June 2026. Voluntary assisted dying pathways may extend across reporting periods, and some people were partway through the pathway on 30 June 2026. Numbers at successive steps therefore do not necessarily align, including where an approved substance had been supplied but administration had not occurred by the reporting date.

Overview of the ACT Scheme

Under the ACT scheme, a person who meets the legislative eligibility requirements may choose to access an approved substance for the purpose of ending their life. Voluntary assisted dying provides an end-of-life choice, alongside palliative care and ongoing treatment (where appropriate).

The scheme is established by the Act and commenced on 3 November 2025 following an 18-month implementation period.

The Act establishes eligibility requirements and safeguards that operate across the voluntary assisted dying pathway. These begin with a person's first request and continue through independent eligibility assessments, subsequent requests and decisions, and, where a person chooses to proceed, prescription, supply and administration of an approved substance.

The Voluntary Assisted Dying Care Navigator Service (**VAD CNS**) operates within Canberra Health Services (**CHS**) and provides information and navigation support to people considering or accessing voluntary assisted dying, including assistance connecting individuals with authorised practitioners and relevant services.

Eligibility in the ACT

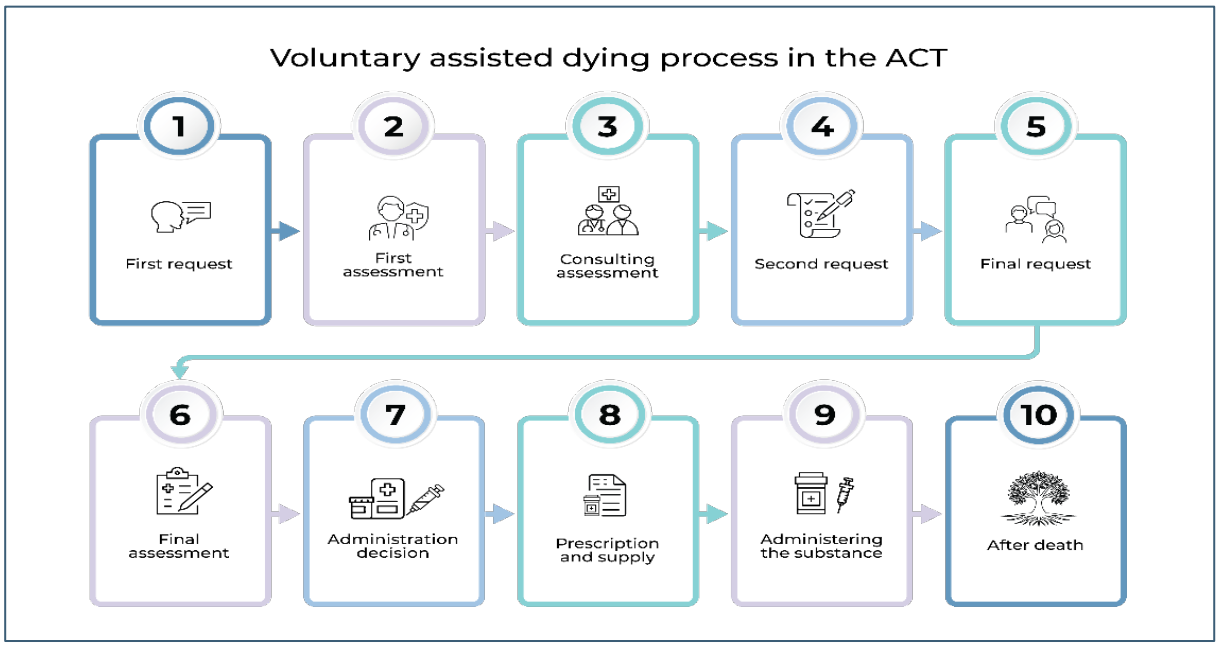
To be eligible to access voluntary assisted dying in the ACT, a person must:

- Be 18 years or older;
- Have a diagnosed condition that is advanced, progressive and expected to cause death, either on its own or in combination with other diagnosed conditions;
- Be approaching their end of life;
- Be suffering intolerably because of their relevant condition or conditions;
- Have decision-making capacity in relation to voluntary assisted dying;
- Be making their decision to access voluntary assisted dying voluntarily and without coercion; and
- Have lived in the ACT for at least the last 12 months or have been granted a residency exemption by the Director-General of HCSD.

The voluntary assisted dying pathway

The 10-step pathway

The voluntary assisted dying pathway in the ACT comprises 10 key steps. While these steps reflect the legislative requirements of the scheme, each person's experience of the pathway is individual. People may choose to progress at different rates, pause between steps or choose not to continue at any point.



Step 1: First request

A first request is the starting point of a person's voluntary assisted dying pathway. It is the first of three formal requests required under the Act. The request must be made by the person seeking access to voluntary assisted dying and communicated in a clear, voluntary and unambiguous manner. The request is made to an authorised practitioner and once accepted by them, the person formally commences the pathway.

People seeking assistance to identify an authorised practitioner can contact the VAD CNS.

During the reporting period, **163 first requests were accepted by authorised practitioners**.

Step 2: First assessment

The first assessment is the first of two independent assessments of whether a person meets the eligibility requirements for voluntary assisted dying. The authorised practitioner who accepted the first request then becomes the person's coordinating practitioner and undertakes the first assessment.

The coordinating practitioner must consider whether the person meets the eligibility requirements, including their residency, relevant condition, decision-making capacity, and whether they are making the request freely and voluntarily. The coordinating practitioner must ensure the person receives the information required under the Act, including information about other relevant treatment and palliative care options.

Where the coordinating practitioner determines that eligibility requirements have not been met, the person is advised of the outcome and reasons for the decision, along with information about alternative care and support options.

During the reporting period, **156 first assessments were completed**. **Table 1** presents the eligibility outcomes of these first assessments. The first assessment provides the first formal determination of whether a person meets the eligibility requirements before progressing further through the pathway. A person assessed as ineligible at a first assessment may choose to make another first request.

The most common reason for ineligibility was that a person was not considered to be approaching their end of life. The Board recognises that being assessed as ineligible may be difficult for a person who is experiencing serious illness and suffering, including where they had hoped voluntary assisted dying would be available to them.

Table 1: Eligibility outcomes at first assessment

Eligibility outcomes at first assessment	Count	%
Total first assessments	156	100.0%
Found eligible	143	91.7%
Found ineligible	13	8.3%

Step 3: Consulting assessment

A person assessed as eligible at first assessment who wishes to continue through the voluntary assisted dying pathway must undergo a second independent eligibility assessment by another authorised practitioner. This authorised practitioner becomes the consulting practitioner.

During the reporting period, **128 consulting assessments were completed**. Of these, 127 resulted in a finding of eligibility and one resulted in a finding of ineligibility. **Table 2** presents these eligibility outcomes. Being assessed as ineligible at a consulting assessment does not prevent a person from requesting a further consulting assessment.

The requirement for 2 independent assessments provides for separate consideration of a person's eligibility before the person can choose to continue through the pathway.

Table 2: Eligibility of people following a consulting assessment		
Eligibility of people following a consulting assessment	Count	%
Total consulting assessments	128	100.0%
Found eligible	127	99.2%
Found ineligible	1	0.8%

Specialist referrals

Specialist opinion may be sought where an assessing practitioner requires additional expertise to determine whether an eligibility requirement is met. **Table 3** presents specialist referrals during the reporting period.

During the reporting period, 15 specialist referrals were recorded.

Table 3: Specialist referrals – assessment step		
Specialist referrals	Count	%
Total referrals made for specialist opinion	15	100.0%
First assessment	14	93.3%
Consulting assessment	1	6.7%

Step 4: Second request

Following the findings of eligibility at both the first and consulting assessments, a person who wishes to continue makes a written second request, witnessed in accordance with the requirements of the Act.

We acknowledge the contribution the volunteer witness program of Dying with Dignity ACT has made to supporting people to complete their second request.

116 second requests were received during the reporting period.

Step 5: Final request

A person who wishes to continue after their second request may make a final request to their coordinating practitioner. There is no minimum period between the second and final requests.

110 final requests were received during the reporting period.

Step 6: Final assessment

Following the final request, the coordinating practitioner must confirm that the person continues to have decision-making capacity in relation to voluntary assisted dying and is acting voluntarily and without coercion.

110 final assessments were completed during the reporting period.

Step 7: Administration decision

Following completion of the required requests and assessments, a person may choose self-administration or practitioner administration of an approved substance. The administration decision is informed by a person's preference and clinical needs, following discussion with their coordinating practitioner. This decision can be changed at any time prior to administration. **Table 4** presents administration decisions made during the reporting period.

People chose practitioner administration more frequently than self-administration during the reporting period.

107 administration decisions were made during the reporting period.

Table 4: Administration decisions by type and route

Administration decisions	Practitioner administration decision	Self-administration decision
Oral	13 (14%)	16 (100%)
NG/NJ/PEG	1 (1%)	0 (0%)
IV administration	77 (85%)	Not applicable
Total administration decisions made	**91**	**16**

Step 8: Prescription and supply

Once the required pathway steps have been completed, an approved substance is able to be prescribed and supplied through the Voluntary Assisted Dying Pharmacy Service (**VAD PS**). Once all requirements have been satisfied, the prescription is physically provided directly to the VAD PS. The VAD PS undertakes the required checks and coordinates supply of the approved substance in accordance with the person's chosen administration route.

During the reporting period, 65 instances of approved substances were dispensed.

Step 9: Administering an approved substance

Where practitioner administration is chosen, an authorised practitioner administers an approved substance in accordance with the requirements of the Act and relevant clinical protocols. Administration occurred across a range of locations during the reporting period, reflecting individual circumstances and preferences.

Number of deaths

57 people died following administration of an approved substance during the reporting period. Each of these deaths followed an individual pathway through

voluntary assisted dying, shaped by the person's circumstances, preferences and decisions about their end-of-life care.

The age range of people at the time of death following administration of an approved substance was 48 to 95 years, with a median age of 79 years.

Time to death after administration

For practitioner administration, information is collected about the approximate interval between administration of an approved substance and death. See **Table 5** below.

Table 5: Time to death after administration of an approved substance

Length of time to death	Enteral/oral	Intravenous administration
Less than 10 minutes	1 (8%)	17 (39%)
Between 10 and 20 minutes	1 (8%)	14 (32%)
Between 20 and 30 minutes	4 (31%)	9 (20%)
Between 30 minutes and 1 hour	1 (8%)	4 (9%)
Between 1 and 2 hours	3 (23%)	0 (0%)
More than 2 hours	1 (8%)	0 (0%)
Unknown	2 (15%)	0 (0%)

Where the coordinating practitioner is unable to reliably verify the interval between administration and death from the information available to them (for example when they are not present at the time of death), the interval is recorded as 'unknown' rather than reporting a timeframe that cannot be confirmed.

Equivalent information is not routinely collected following self-administration because a person who chooses self-administration is not required to have another person physically present at the time of administration or death.

Step 10: After death

Following a death associated with voluntary assisted dying, relevant statutory notifications and administrative processes are completed.

People requesting or participating in voluntary assisted dying

The demographic information in this section provides a picture of the people who engaged with voluntary assisted dying during its first 8 months of operation. While these characteristics help the Board understand who is entering the pathway, they do not capture the individual circumstances, experiences or reasons that may influence a person's decision to consider voluntary assisted dying. Given the relatively small numbers and limited period of operation, demographic characteristics should be interpreted cautiously.

Likewise, the available data are not yet sufficient to determine whether particular groups experience different levels of access to voluntary assisted dying. **Table 6** presents the gender, Indigenous status and preferred language of people who made a first request in the reporting period.

Table 6: Demographic characteristics of people who made a first request

Gender	Count	%
Female	80	49.1%
Male	83	50.9%
Other	0	0.0%
Indigenous status	**Count**	**%**
Aboriginal and/or Torres Strait Islander people	5	3.1%
Neither Aboriginal nor Torres Strait Islander origin	157	96.3%
Unknown	1	0.6%
English as preferred language	**Count**	**%**
Yes	163	100%
No	0	0%
Unknown	0	0%

Age

A person must be at least 18 years of age to access voluntary assisted dying in the ACT.

During the reporting period, **the median age of people at the time of their first request was 77 years.** Ages ranged from 28 to 102 years. **Table 7** presents the age groups of people at first request.

Table 7: Age at first request

Age group	Count	%
<50	6	3.7%
50–59	12	7.4%
60–69	30	18.4%
70–79	44	27.0%
80+	71	43.6%

Geographical location

Geographic data show variation in engagement with the voluntary assisted dying pathway across areas of the ACT when compared with population distribution. However, given the small numbers of people accessing voluntary assisted dying and differences in the population age profile, mortality and other demographic characteristics, the data in **Table 8** are indicative only and should not be interpreted as demonstrating differences in access to voluntary assisted dying across the ACT.

The Board will continue to monitor geographic patterns as the dataset develops and consider whether any information emerges of barriers to equitable access.

Table 8: Geographic distribution of people at first request

Town centre	Count of people at first request	% of those first request	% of ACT population living in town centre
Belconnen	41	25.1%	23.4%
Gungahlin	11	6.7%	19.4%
North Canberra	24	14.7%	13.5%
South Canberra	15	9.2%	7%
Tuggeranong	27	16.5%	19.8%
Weston Creek	18	11%	5.4%
Woden Valley	20	12.2%	8.7%
Molongolo	0	0	3.5%
Non-ACT	7	4.3%	n/a

Note: ACT population data taken from *Australian Bureau of Statistics*, *2021 Census QuickStats,* 28 June 2022. *Percentages are rounded.*

Residency exemptions

A person who has not lived in the ACT for the preceding 12 months may apply to the Director-General of HCSD for a residency exemption. Residency exemption decisions are made by the Director-General based on the requirements of the Act and are administered by HCSD, rather than the Board.

During the reporting period, 21 residency exemption applications were received and granted.

Of the 21 approved residency exemptions, 11 were living in border communities. The remaining 10 were granted to people who had resided in the ACT for less than 12 months but were receiving ongoing medical care in the ACT, including some who had relocated to the ACT to receive care and support from a family member.

A person may apply for and be granted a residency exemption prior to making a first request for voluntary assisted dying without committing to proceed through the voluntary assisted dying pathway. Additionally, some people who receive a residency exemption may later be assessed as not meeting the eligibility requirements. As a result, residency exemption numbers are distinct from those who made a first request.

There were 7 people granted residency exemptions who subsequently progressed through the pathway and were assessed as eligible.

Relevant conditions

Eligibility for voluntary assisted dying requires a person to have one or more diagnosed conditions that meet the eligibility requirements of the Act.

As shown in **Table 9**, cancer was the most frequently recorded relevant condition. A person may have more than one relevant condition recorded and may therefore be represented in more than one category.

Table 9: Relevant conditions recorded at first assessment

Relevant conditions	Count	% of recorded conditions
Cancer (malignancy)	92	52.0%
Neurological disease	32	18.1%
Respiratory disease	17	9.6%
Cardiovascular disease	13	7.3%
All other conditions	23	13.0%

Access to palliative care

Palliative care may be provided by general practitioners, treating specialists and other health professionals as an integrated part of a person's usual care, or through specialist palliative care services for people with more complex palliative care needs. A person may therefore receive palliative approaches to care without having been referred to, or identifying their care as being provided by, a specialist palliative care service.

Approximately **66 per cent** of people who registered interest in accessing voluntary assisted dying reported prior involvement with palliative care services.

This measure does not capture all primary or specialist palliative care a person may have received and should not be interpreted as meaning that the remaining proportion received no palliative care.

The Board will continue to monitor available information and the relationship between voluntary assisted dying and palliative care as the scheme matures.

Authorised practitioners and workforce

Health practitioners' participation

A distinctive feature of the ACT legislation is that appropriately experienced nurse practitioners may act as coordinating or consulting practitioners, as well as practitioners who administer the approved substance. Where a nurse practitioner

undertakes one of the two eligibility assessments, the other assessment must be undertaken by a medical practitioner.

The ACT is one of three Australian jurisdictions, alongside Queensland and Tasmania, that permits suitably qualified registered nurses to act as administering practitioners.

To be authorised to work in a voluntary assisted dying role, practitioners must complete mandatory training, satisfy relevant legislative requirements and be formally authorised by the Director-General of HCSD. **Table 10** summarises the eligibility requirements for each practitioner role.

Table 10: Practitioner role eligibility

	Coordinating Practitioner	Consulting Practitioner	Administering Practitioner
Medical practitioners (a) specialist registration, and: (i) at least 1 year of specialist practice or (ii) 5 years of generalist practice, (b) generalist registration with at least 5 years of generalist practice	✓	✓	✓
Nurse practitioners at least 1 year of relevant experience	✓	✓	✓
Registered nurse with at least 5 years of clinical experience	✗	✗	✓

During the reporting period, 43 practitioners completed mandatory training and were authorised to participate in the scheme. One authorised practitioner subsequently withdrew their authorisation voluntarily.

The authorised workforce includes medical practitioners, nurse practitioners and registered nurses across a range of clinical disciplines.

The Board acknowledges the commitment demonstrated by the practitioners who undertook the training and participated during the establishment of the ACT voluntary assisted dying scheme. We also acknowledge the assistance provided by New South Wales Voluntary Assisted Dying Support Service in supporting training for the ACT workforce. Training will continue to be offered throughout the year on demand.

Table 11 presents the professions of the 43 authorised practitioners, while **Table 12** outlines their areas of specialty practice.

Table 11: Profession of authorised practitioners

Profession of authorised practitioners	Count	%
Medical practitioner	18	41.9%
Nurse practitioner	5	11.6%
Registered nurse	20	46.5%

Table 12: Specialty of authorised practitioners

Specialty of authorised practitioners	Count	%
Palliative care	8	18.6%
Medical oncology	8	18.6%
Emergency medicine	6	14.0%
Intensive care medicine	4	9.3%
Gerontology	3	7.0%
General Practice	8	18.6%
Other	6	14.0%

Practitioner activity

Although 43 practitioners were authorised during the reporting period, eligibility assessment activity was concentrated among a smaller group of 14 practitioners.

That group of authorised practitioners routinely undertook first and/or consulting assessments, forming the core assessment workforce during the reporting period.

Table 13 illustrates the distribution of first, consulting and final assessment activity among these practitioners during the reporting period.

Assessment activity was undertaken by both medical practitioners and nurse practitioners. Nurse practitioners accounted for **39 per cent** of recorded assessment activity during the reporting period, demonstrating the practical value of the ACT's model.

Table 13: Assessment activity by practitioner profession

Assessment activity by practitioner profession	Count	%
Medical practitioner	239	61%
Nurse practitioner	155	39%

Twenty registered nurses were authorised to act as administering practitioners during the reporting period. Administration activity was nevertheless concentrated among authorised practitioners within the VAD CNS and a small number of other authorised practitioners.

The Board will continue to monitor participation across the authorised workforce as part of its consideration of workforce sustainability.

Practitioner remuneration models

A range of remuneration arrangements operate in the ACT to support participation by authorised practitioners.

Practitioners providing voluntary assisted dying services within the scope of salaried employment, including relevant CHS employees, provide those services through their existing employment arrangements.

The ACT Government also provides arrangements to support authorised practitioners who undertake voluntary assisted dying work outside salaried public health employment. These include contracted arrangements for dedicated voluntary assisted dying work and remuneration for eligible activities associated with service delivery, including administrative requirements, that may not otherwise be remunerated through the Medicare Benefits Schedule (**MBS**).

Together, these approaches provide flexibility for practitioners to participate through different employment and practice settings. The arrangements formed part of the workforce model introduced for commencement of the scheme and provide an opportunity to understand how different approaches support practitioner participation and workforce capacity.

Broader health workforce participation

Not all health practitioners participate in voluntary assisted dying services. The Act provides for a practitioner to decline to participate, including because of conscientious objection, while also establishing obligations including the mandatory provision of information in certain circumstances.

Compliance with these obligations is not readily measurable through statutory notification data. The Board therefore considers available feedback and stakeholder information to inform whether issues affecting access are emerging.

Workforce sustainability

The Board considers workforce sustainability critical to the success of the scheme.

During the reporting period, assessment and administration activity was concentrated among a relatively small group of authorised practitioners. Continued concentration of activity within a small workforce may create vulnerability to changes in demand, practitioner availability and competing clinical responsibilities. A

sustainable workforce is important not only to service capacity, but to ensuring that people considering voluntary assisted dying can access appropriately trained practitioners when they need them.

Broader participation across the authorised workforce may support service resilience and reduce reliance on a relatively small number of practitioners. The Board will continue to monitor workforce participation and capacity, including the extent to which existing workforce and remuneration arrangements support practitioner participation.

Pathway outcomes and access

Process timeframes

The Board monitors the time between key steps of the voluntary assisted dying pathway to understand how the scheme is operating and identify potential barriers or emerging issues.

While timeframes can provide useful information, timeframes alone should not be interpreted as service performance measures. Progression through the voluntary assisted dying pathway is influenced by the person's circumstances, preferences and readiness to proceed. There is no single 'typical' experience of the voluntary assisted dying pathway. Some people wish to progress quickly, while others choose to pause for significant periods between steps or choose not to proceed.

Progression through the pathway occurs at the person's request and with their ongoing consent, and variation in timeframes should not, by itself, be interpreted as evidence of service delay or constraint.

Time from first request to death following administration

Among people who died following administration of an approved substance, **the median period between first request and death was 20 days**, ranging from 2 to 216 days.

The range of timeframes displayed in **Table 14** reflects that people progress through the pathway according to their individual circumstances and choices.

Table 14: Days between first request and death following administration of an approved substance

Day range	Count	%
0-9	14	24.6%
10-19	14	24.6%
20-49	13	22.8%
50-99	8	14.0%
100+	8	14.0%

Supply to administration

The time between the supply of an approved substance and administration of the substance differs substantially according to administration type.

For self-administration the median time between supply and death following administration was 11 days, and the longest interval between supply and death was 39 days.

For practitioner administration the median time between supply and death following administration was 0 days, reflecting that practitioners would usually be supplied an approved substance on the person's preferred day of administration.

This difference reflects the nature of the two administration pathways. Practitioner administration is generally coordinated for an agreed date and time, while people who choose self-administration may retain an approved substance and decide if and when they wish to use it.

As presented in **Table 15**, some people who commence the voluntary assisted dying pathway die without an approved substance being administered.

Table 15: Deaths prior to administration of an approved substance

Deaths prior to administration	Count	%
Died of their relevant condition before the administration of an approved substance	18	90%
Died of another cause	2	10%

During the reporting period, **20 people who had commenced the voluntary assisted dying pathway died prior to administration of an approved substance**. Most died from their relevant condition, while a smaller number died from another cause.

There are a several reasons why a person may die before administration of an approved substance. A person's condition may deteriorate more quickly than anticipated, they may die at different stages of the pathway, or they may decide not to continue. Death before administration should therefore not, by itself, be interpreted as evidence of delay or unsuccessful access.

The Board will continue to examine these pathway outcomes, including the step reached before death, to identify whether any recurring or systemic access issues emerge.

Complications

The Act and the Voluntary Assisted Dying Regulation 2025 (**the Regulation**) do not define 'complication'. A broad approach has therefore been taken to recording reported issues during the administration process, including matters such as difficulty obtaining intravenous access.

Information about complications presented in **Table 16** is drawn from the statutory *Notification of Death* form submitted following a death associated with voluntary assisted dying.

The information available reflects what can appropriately be reported by the practitioner completing the notification and may not provide a complete clinical account of the administration in every case.

Table 16: Complications by administration method

Reported complications	Practitioner administered	Self-administered
None reported	44 (83%)	4 (100%)
Problem obtaining IV access	2 (4%)	0 (0%)
Other complications	1 (2%)	0 (0%)
Unknown	6 (11%)	0 (0%)

Information provided through the statutory notification following a death may be completed by a coordinating practitioner who was not present at the time of administration or at the time of death. 'Unknown' is recorded where the practitioner completing the notification is unable to reliably verify whether a complication occurred.

Of the practitioner administrations for which complication information was available, the **majority had no reported complications.**

The reported issues were considered through relevant clinical and oversight processes, and the Board did not identify a systemic safety concern from the complications reported during the reporting period.

The Board will continue to monitor reported complications and contribute to work with other jurisdictions to improve consistency in how complications are defined and reported.

Administration location

Practitioner administration occurred across a range of settings during the reporting period, including private residences, hospice or palliative care units, public hospitals and residential aged care facilities. Where practicable and consistent with legislative, clinical and logistical requirements, the person's preferences inform the location of administration. Where a preferred location could not be accommodated, an alternative location was agreed with the person.

Table 17 identifies where administration took place for practitioner administration of an approved substance.

The Board acknowledges the work undertaken to enable administration in a range of locations and multiple care settings.

Table 17: Practitioner administration locations

Practitioner administration locations	Count	%
Public hospital (ward other than palliative care)	13	24.5%
Hospice or palliative care unit	17	32.1%
Residential aged care facility	5	9.4%
Private residence	18	34.0%

Access and equity

The Board considers equitable access to voluntary assisted dying an important area for ongoing monitoring. Available information includes demographic and geographic patterns, pathway timeframes, administration locations, workforce capacity, case review, service information, feedback and emerging research.

The available data do not yet provide a sufficient basis to draw conclusions about equity of access across the ACT community. Scheme data primarily describe people who have engaged with voluntary assisted dying and cannot, by themselves, identify people who may have wanted to access voluntary assisted dying but did not enter the pathway. Understanding equitable access therefore requires consideration not only of who appears in the data, but also, over time, of who may not be represented. Demographic characteristics recorded within the scheme also provide only limited information about the cultural, religious, social and other factors that may influence an individual's awareness of attitudes towards or decisions to access voluntary assisted dying.

The Board notes the importance of continuing to understand how voluntary assisted dying is experienced across the ACT's culturally and linguistically diverse community. Differences in participation should not, on their own, be interpreted as evidence of an access barrier. Cultural and religious beliefs, personal preferences, awareness of voluntary assisted dying and accessibility of information and services may all influence participation, and the available data do not currently enable the Board to determine the relative influence of these factors.

During the reporting period, **no requests for interpreter support or interpreter-related exemptions were recorded.** While this provides some information about the people who engaged with the scheme, it does not establish whether language or communication barriers affected people who did not enter the pathway.

The Board will continue to monitor demographic patterns and interpreter-related information alongside other sources, including feedback and research, for emerging evidence of access barriers. Longer-term data and broader sources of information will be required to understand whether particular groups experience different barriers to access.

Supporting services

A range of clinical and supporting services contribute to the operation of voluntary assisted dying in the ACT. This section provides a brief overview of key services supporting delivery of the scheme. The Board acknowledges the significant contribution of the many teams not included here, including those providing leadership, policy, legal, digital and data support.

For people considering voluntary assisted dying, navigating the pathway may occur alongside serious illness, changing care needs and decisions involving family, carers and treating teams. Supporting services assist people to navigate these practical, clinical and emotional dimensions alongside the statutory requirements of the pathway.

Voluntary Assisted Dying Care Navigator Service

The Voluntary Assisted Dying Care Navigator Service (**VAD CNS**) provides a central point of contact for voluntary assisted dying in the ACT. The VAD CNS assists with navigation, coordination, referrals and administrative requirements. It operates within CHS clinical governance arrangements and comprises a team of nurses, medical practitioners, a social worker and administrative officers.

The VAD CNS responds to a broad range of enquiries from people accessing voluntary assisted dying, family members, members of the public and health professionals. Enquiries include requests for information about access and eligibility requirements, support navigating the voluntary assisted dying pathway, appointment and practitioner coordination, and questions about relevant legislative and administrative requirements.

Care navigators and coordinating practitioners work closely with people and their families, carers and other significant people throughout the voluntary assisted dying pathway. They provide information and facilitate connections with clinical and other services that may assist with the management of their condition or symptoms. Support may also include information about end of life and after death planning and available bereavement support.

The VAD CNS provides the Board with important information about the practical operation of the scheme, including access, navigation and service delivery.

Psychosocial support

People accessing voluntary assisted dying, their families and carers, and practitioners involved in service delivery may have psychosocial support needs at different steps of the pathway.

The VAD CNS provides psychosocial support within the capacity of the service and facilitates referrals to other services where additional or specialised support is required. This may include access to counselling, social work, bereavement and other relevant support services.

Psychosocial support is available to practitioners and staff involved in voluntary assisted dying, including team debriefing, clinical supervision and individual support through relevant workplace and professional support arrangements.

The Board will continue to consider information about psychosocial support as part of its broader monitoring of the operation of the scheme.

Voluntary Assisted Dying Pharmacy Service

The Voluntary Assisted Dying Pharmacy Service (**VAD PS**) is the approved supplier and disposer of voluntary assisted dying substances in the ACT.

The VAD PS manages receipt and review of prescriptions, supply of an approved substance, education about safe handling and return or disposal arrangements. For people choosing self-administration, the pharmacy service provides an approved substance together with support and education regarding safe handling, storage and return arrangements. The VAD PS also provides specialised support to practitioners undertaking administration.

Community of Practice

The Voluntary Assisted Dying Community of Practice (**CoP**) provides a collegial, confidential, educational and peer-support forum for authorised practitioners participating in voluntary assisted dying services across the ACT.

The CoP met 5 times in the reporting period, with chairing responsibilities shared among members on a rotating basis.

The Voluntary Assisted Dying Oversight Board

Functions

The Act establishes the Board as an independent statutory oversight body to monitor and report on the operation of the Act.

Its functions include monitoring the operation of the Act and requests for voluntary assisted dying; recording and analysing information provided under the Act; researching matters relating to the operation of the Act; providing advice to the Minister for Health; and referring relevant issues to specified authorities where appropriate.

The Voluntary Assisted Dying Regulation 2025 (**the Regulation**) prescribes the information that must be kept by the Board about requests for, or access to, voluntary assisted dying. The Board does not make individual clinical eligibility decisions and does not approve a person's access to voluntary assisted dying.

Membership and meetings

The Board comprises 7 members appointed by the Minister for Health for terms of up to 3 years, with the possibility of reappointment.

Boar members bring a diverse range of professional expertise and lived experience to their oversight responsibilities, including clinical practice, law and consumer perspectives. Further information about the Board's membership, including individual member biographies, is available on the ACT Voluntary Assisted Dying Oversight Board webpage.

The Board held its first formal meeting on 18 November 2025. Meetings were initially held fortnightly before moving to a monthly schedule. **The Board met 10 times during the reporting period.**

Members also attended 3 pre-commencement meetings to develop a shared understanding of the legislative framework, the Board's statutory functions, and the operation of the ACT scheme.

The Board is supported by a Secretariat within HCSD. The Directorate also provides the administrative support and facilities required to enable the Board to exercise its functions.

No directions were given to the Board by the Minister under section 121 of the Act during the reporting period.

Monitoring

Monitoring the operation of the Act and requests for voluntary assisted dying is a core statutory function of the Board. During the reporting period, the Board established structured approach to retrospective review, supported by administrative compliance monitoring and analysis of information provided through the VAD IMS.

The Board's review is retrospective and does not involve approving individual eligibility decisions or a person's progression through the voluntary assisted dying pathway.

Reviews consider the recorded pathway, statutory notifications and relevant supporting information to assess the operation of the legislative safeguards, identify compliance matters and understand how the scheme is functioning in practice.

Initially, reviews focused on cases where a person had died following administration of an approved substance. This was subsequently expanded to include cases where a person died without administration or was assessed as ineligible.

During the reporting period, **the Board completed 87 case reviews.**

These reviews provided an important foundation for understanding the operation of the scheme during its establishment, including application of legislative requirements, practitioner documentation practices and the effectiveness of administrative processes. Matters identified through monitoring informed practitioner education, clarification of legislative and administrative requirements, improvements to information-management processes and ongoing compliance monitoring. Where matters related to service delivery, clinical governance or administration of the scheme, these were raised with CHS or HCSD within their respective responsibilities.

The Board's consideration of individual cases, alongside aggregate data and emerging compliance themes, has informed its early assessment of the scheme's operation. While the matters reviewed did not identify evidence of systemic failures affecting the scheme's core legislative safeguards, the Board recognises that the reporting period provides limited evidence base. As the scheme matures, monitoring will increasingly focus on recurring issues, emerging trends or opportunities for continuous improvement, including matters that may warrant consideration in future legislative or regulatory reviews.

Compliance

Monitoring compliance with the legislative safeguards established by the Act is fundamental to maintaining integrity of the ACT scheme and public confidence in its operation. The Board reviews compliance for the purpose of monitoring the scheme and to promote compliance with the Act.

The Board recognises the importance of proportionate compliance arrangements. Such arrangements support adherence to the Act without imposing unnecessary administrative burden on practitioners or people accessing voluntary assisted dying. The Board has adopted this approach when developing its framework for compliance monitoring.

During the reporting period, the Board's monitoring did not identify compliance concerns affecting the operation of the scheme's core safeguards. The Board did not identify compliance matters that affected a person's eligibility or presented a material risk to the person or others.

Section 119 of the Act includes the Board's function to refer relevant matters to specified persons and bodies. In 2025-26 the Board made no referrals, and no compliance notices were issued in relation to facility obligations.

Compliance monitoring and continuous improvement

During the reporting period, the Board established monitoring arrangements to examine compliance with legislative requirements and identify opportunities for continuous improvement. This included conducting case reviews and consideration of feedback from people involved in voluntary assisted dying.

During the reporting period, the Board identified **13 instances** of non-compliance with legislative requirements, predominantly related to documentation and statutory notification processes. These matters were considered through the Board's retrospective monitoring arrangements and informed clarification of requirements, practitioner education, improvements to administrative process and ongoing monitoring.

Based on the matters reviewed during the reporting period, the Board did not identify evidence that these instances affected eligibility determinations or compromised the operation of the scheme's core safeguards.

Monitoring also identified administrative and data-quality matters relating to completion of information within the VAD IMS. These matters informed improvements to administrative processes and enhancements to system controls and data validation.

The Board will continue to monitor the recurrence, significance and cumulative impact of compliance findings as the scheme matures. Compliance monitoring will increasingly focus on trends and recurrence across reporting periods. Quarterly compliance reporting will provide the Board with ongoing visibility of emerging themes, systemic risks and opportunities for continuous improvement.

Review of decisions

Certain decisions made under the Act may be reviewed by the ACT Civil and Administrative Tribunal (ACAT). Affected people may apply to ACAT for review of specified matters relating to eligibility and residency. The review framework provides an avenue for independent consideration of those decisions while preserving the privacy of people involved.

During the reporting period, one application concerning voluntary assisted dying was considered by the Tribunal. The published decision is publicly available through the ACAT website.

The Board will continue to monitor ACAT review activity where it is relevant to the operation of the scheme.

Feedback

Feedback received during the reporting period frequently reflected gratitude for the care, communication and respect experienced by people and families engaging with voluntary assisted dying.

Quantitative data describe important aspects of how the scheme is operating but do not capture the full experience of people, families, carers and practitioners involved in voluntary assisted dying. The Board therefore values feedback as an important source of information about how the scheme is experienced in practice and considers it alongside quantitative data, case review and other monitoring information.

You can submit feedback on voluntary assisted dying in the ACT by emailing the Voluntary Assisted Dying Oversight Board at VADOversightBoard@act.gov.au or by posting the feedback form, available on the website, to:

Voluntary Assisted Dying Oversight Board

2-6 Bowes Street,

Phillip ACT 2606

Distinctive features of the ACT model

The ACT model contains several features that differ from voluntary assisted dying schemes operating elsewhere in Australia. These include:

- No prescribed prognostic timeframe to death
- No legislated minimum period between key requests
- Participation of nurse practitioners in eligibility assessment
- Penalties for non-compliance by health and care facilities.

The first 8 months of operation provide an early indication of those features operating in practice. The Board will continue to monitor their effect as the evidence base grows.

No prescribed prognostic timeframe to death

Unlike other Australian jurisdictions, the ACT does not require a person's relevant condition to be expected to cause their death within a specific timeframe. A person must nevertheless have a relevant condition which is advanced, progressive and expected to cause death and the person must be approaching the end of their life.

The Board has observed that assessment of whether a person is approaching the end of life necessarily requires the assessing clinician to consider prognosis, notwithstanding the absence of a fixed statutory timeframe.

The Board will continue to monitor the application of this requirement, including how the absence of a prescribed timeframe operates alongside other eligibility requirements.

The Board recommends that ongoing practitioner education continue to support understanding of the 'approaching end of life' requirement, including that the Act does not prescribe a specific timeframe to death.

No mandated minimum period between requests

The ACT does not prescribe a minimum or maximum period for the person's progression between key steps of the voluntary assisted dying pathway. This allows the pathway to respond to the circumstances and preferences of the individual, rather than imposing a mandatory waiting period at any point in the pathway. It also allows a person to determine when, and whether, they wish to progress between steps.

Nurse practitioners and eligibility assessments

The ACT model allows nurse practitioners to act as coordinating practitioners and undertake eligibility assessments within the parameters established by the Act. In the ACT, a nurse practitioner may undertake one of the two required eligibility assessments, with the other undertaken by a medical practitioner.

During the reporting period, nurse practitioners accounted for a substantial proportion of assessment activity. The Board will continue to monitor the contribution of different practitioner groups to workforce capacity and sustainability.

Facility obligations

The ACT scheme establishes specific obligations for health and care facilities to support access to information about voluntary assisted dying and protect people from inappropriate restriction or disadvantage because they are seeking or accessing voluntary assisted dying.

These include requirements concerning availability of residential aged care facility voluntary assisted dying policies and protection against withdrawal or refusal of care because a person is either accessing or may access voluntary assisted dying. Certain failures to comply with these obligations may constitute offences and attract penalties under the Act.

No compliance notices were issued in relation to facility obligations during the reporting period.

The Board considers continued monitoring of access within facilities important to ensuring the objects and safeguards of the Act operate effectively in practice.

Areas of focus

Commonwealth carriage-service restrictions

Commonwealth criminal law relating to the use of carriage services continues to affect the way some voluntary assisted dying communications can lawfully occur.

The practical effect is that certain aspects of the voluntary assisted dying pathway cannot be conducted using telephone, videoconference or electronic communications including via the internet, where doing so may engage Commonwealth offences. Electronic communication for information sharing and use of telehealth is important for health practitioners in their delivery of care. For people accessing voluntary assisted dying, requirements for in-person communication can present practical barriers, particularly where serious illness limits a person's ability to travel or attend appointments. While the ACT is a small jurisdiction, these barriers can still arise. In addition, the carriage laws introduce other practical barriers; for example, due to the current operation of the law all prescriptions for voluntary assisted dying substances are required to be provided in physical copy to a single pharmacy within the ACT.

The Board recommends that the ACT Government continue to call on the Australian Parliament for amendments to the *Criminal Code Act 1995 (Cth)* to remove limitations on providing voluntary assisted dying information via a carriage service.

Workforce remuneration

Workforce participation and sustainability remain important areas for ongoing monitoring and practitioner remuneration is one factor relevant to this.

As outlined earlier in this report, the ACT has introduced remuneration arrangements to support authorised practitioner participation across different employment and practice settings. Commonwealth Medicare arrangements, however, are not specifically designed for voluntary assisted dying service delivery. Practitioners may use applicable Medicare Benefits Schedule (**MBS**) items for eligible clinical services, while other activities associated with voluntary assisted dying may fall outside existing Medicare arrangements, such as administrative requirements, coordination and travel associated with service delivery. This means to some extent the scheme relies on the altruism of those authorised practitioners not working with publicly funded health services.

The Board will continue to monitor whether remuneration arrangements affect practitioner participation, workforce sustainability or access to voluntary assisted dying.

The Board considers it important that Commonwealth remuneration arrangements appropriately recognise the nature and complexity of voluntary assisted dying practice. The Board recommends that the ACT Government supports any review of the MBS to address practitioner remuneration for voluntary assisted dying services.

Research and data

The Board recognises that a strong evidence base is important to ongoing evaluation of the operation, safety and accessibility of voluntary assisted dying. Accordingly, a key strategic priority is to contribute meaningfully to the development of a consistent national approach to data collection, analysis and reporting. The Board is committed to collaborating with oversight bodies and health departments across Australian jurisdictions to improve the comparability of voluntary assisted dying data and to support a shared understanding of system performance.

In particular, the Board considers the development of nationally consistent measures and key performance indicators to be an important foundation for service improvement and future evaluation. Greater consistency in data collection and reporting will strengthen the ability of jurisdictions to support more consistent analysis of scheme activity, access, quality, safety and emerging trends. Through these collaborative efforts, the Board aims to support the ongoing evolution of voluntary assisted dying services and contribute to a growing evidence base that informs policy, practice and service development both within the ACT and nationally.

Conclusion

The first 8 months of voluntary assisted dying in the ACT provide an early view of the operation of the new scheme. The Board's monitoring during the reporting period did not identify a systemic failure affecting the integrity of the scheme's core safeguards. Early experience indicates that eligible people have been able to continue through the voluntary assisted dying pathway. However, the relatively short reporting period and available dataset limit the conclusions that can presently be drawn about longer-term effectiveness, equity of access and sustainability.

Behind every activity described in this report are people making deeply personal decisions at the end of life, their families and carers, and practitioners supporting them through a new legislative and clinical framework. Their experiences will remain an important part of the Board's understanding of how the scheme is operating in practice.

In particular, the Board has identified some areas that warrant future attention, including:

- continued monitoring of demographic patterns to identify whether particular communities experience barriers to accessing voluntary assisted dying;
- the long-term sustainability of the voluntary assisted dying workforce, including adequate remuneration models;
- reducing unnecessary administrative burden on people accessing voluntary assisted dying, practitioners and services;
- ongoing practitioner education about the 'approaching end of life' requirement, including the absence of a prescribed timeframe to death;
- development of a standardised minimum dataset for voluntary assisted dying across all Australian jurisdictions; and
- monitoring administration decisions and the factors influencing administration choice.

These matters will remain areas of focus as the scheme matures and a larger evidence base becomes available.

Consistent with the Board's statutory functions, it makes 3 recommendations:

1. That ongoing practitioner education continues to support understanding of the 'approaching end of life' requirement, including that the Act does not prescribe a specific timeframe to death.
2. That the ACT Government continue to call on the Australian Parliament for amendments to the *Criminal Code Act 1995 (Cth)* to remove limitations on providing voluntary assisted dying information via a carriage service; and
3. That the ACT Government supports a review of the Medicare Benefits Schedule to address voluntary assisted dying authorised practitioner remuneration.

Key terms

Table 18 below provides plain English definitions for a selection of key terms relevant to voluntary assisted dying. Further and more detailed definitions for some of these and other terms can be found in the *Voluntary Assisted Dying Act 2024*.

Table 18: Key terms

Term	Definition
The Act	*The Voluntary Assisted Dying Act 2024*
ACT Civil and Administrative Tribunal (ACAT)	ACT Civil and Administrative Tribunal is an independent tribunal that hears and determines a range of matters, including reviews of certain administrative decisions.
Administration	The direct administration of a prescribed substance to the body of a person, by a person who is authorised to do so.
Administering practitioner	A medical practitioner, nurse practitioner or registered nurse who is authorised to administer an approved substance to a person if the person chooses practitioner administration.
Administration decision	A person's decision to either self-administer an approved substance, or have it administered by an administering practitioner, made in collaboration with their coordinating practitioner.
Advanced condition	A relevant condition/s is considered advanced if: a) the person's functioning and quality of life are declining and are not expected to improve; b) any treatments for the condition/s that are reasonably available and acceptable to the person have lost any beneficial impact; and c) the person is approaching the end of their life.
Approved substance	A medicine approved under section 56 of the Act for the purpose of causing a person's death.
Authorised voluntary assisted dying practitioner (authorised practitioner)	A medical practitioner, nurse practitioner or registered nurse who meets the eligibility requirements and has successfully completed the mandatory training. Medical and nurse practitioners are authorised to perform the role of coordinating or consulting practitioner and/or administering practitioner. Registered nurses can only be authorised as administering practitioners.
Carer	An individual who provides unpaid support to a family member or friend with a disability, mental illness, ongoing medical condition or age-related frailty.
Carriage service	Any electronic method of communicating, including telephone, internet, email, fax, videoconference or other online applications. Carriage services include online systems for accessing and storing information.

Term	Definition
Case	An individual compliance or legal matter in relation to voluntary assisted dying.
Coercion	The use of force, threats or intimidation to compel a person to act in a way that is against their will.
Conscientious objection	The objection by a person or organisation to performing a role or participating in the provision of voluntary assisted dying because it would conflict with their religious or personal beliefs or values, or because of moral concerns.
Consulting assessment	The second of two assessments to determine eligibility to access voluntary assisted dying, conducted by the person's consulting practitioner.
Consulting practitioner	The authorised voluntary assisted dying practitioner responsible for undertaking the consulting assessment.
Contact person	An adult appointed by a person who has made a self-administration decision. A contact person has specific responsibilities they must fulfil to support a person accessing voluntary assisted dying.
Coordinating practitioner	The authorised voluntary assisted dying practitioner who accepts a person's first request and coordinates their voluntary assisted dying process.
Decision-making capacity	Decision-making capacity refers to the ability of a person to make an informed and reasoned choice and is defined in detail at section 12 of the Act. Generally, a person has decision-making capacity in relation to voluntary assisted dying if they: • can be informed and understand the relevant facts that relate to a decision about accessing voluntary assisted dying; • understand the choices available to them; • can weigh up the consequences of those choices; • understand how the consequences affect them; and • can make a decision considering all the factors and communicate this decision in whichever way they are able.
Final request	The third of three clear and unambiguous requests a person must make to access voluntary assisted dying.
Final assessment	Conducted by the coordinating practitioner after receiving the person's final request.
First assessment	Conducted by the coordinating practitioner to determine whether the person is eligible to access voluntary assisted dying.
First request	A clear and unambiguous request to access voluntary assisted dying made by a person to an authorised practitioner. This is the first of three formal requests an eligible person is required to make to access voluntary assisted dying.

Term	Definition
Health practitioner	A person registered under the Health Practitioner Regulation National Law to practise a health profession. For example, a medical practitioner, nurse practitioner, registered nurse, or pharmacist. It does not include health professionals that work in self-regulated professions, such as social workers.
Interpreter	An interpreter who preferably holds a credential issued under a professional body such as the National Accreditation Authority for Translators and Interpreters (NAATI). The interpreter can facilitate communication during all steps in the voluntary assisted dying process when people who speak a language other than English (or require assistance to understand English) or people who use non-spoken language (for example, Auslan) are involved in conversations with the health practitioner.
Medical practitioner	A doctor registered under the Health Practitioner Regulation National Law and who has active registration with Ahpra.
Nurse practitioner	A nurse registered under the Health Practitioner Regulation National Law who is endorsed as a nurse practitioner and who has active registration with Ahpra.
Palliative care	Person and family-centred care for a person with an advanced, progressive and life-limiting condition, including the frail aged. Palliative care seeks to prevent and relieve suffering through the early identification, assessment and treatment of pain and other symptoms.
Pathway	The structured, multi-step process through which a person requests and, where eligible and choosing to continue, accesses voluntary assisted dying.
Practitioner administration	Administration of an approved voluntary assisted dying substance by an administering practitioner.
Progressive	An individual's condition is progressive if their condition is deteriorating and will continue to deteriorate.
Registered nurse	A nurse registered under the Health Practitioner Regulation National Law and who has active registration with Ahpra.
Relevant condition	A medical condition or disease which has been diagnosed either on its own or in combination with other diagnosed conditions, that is advanced, progressive, and expected to cause death.
Second request	The second of three clear and unambiguous requests a person must make to access voluntary assisted dying. It must be made in writing and signed by the person or their agent in the presence of two eligible witnesses and include specific statements required by the Act.
Self-administer/self-administration	Administration of an approved voluntary assisted dying substance by the eligible person.

Participant reflections

The following reflections have been shared by people with direct experiences of voluntary assisted dying in the ACT. Identifying details have been removed or modified where necessary to protect the privacy of individuals, families and health practitioners. Minor editorial changes have been made for clarity, while preserving the substance and intent of the original feedback.

Reflection from a family member

"From the very first point of contact with the Care Navigators, nurses and doctors of the ACT VAD team we were impressed with the dedicated time given to our family member, the understanding and compassion of all the team members and the genuine kindness that was demonstrated with every interaction.

Our family member identified herself as a retired nurse and was respected as a person, a patient and a nurse. The tone and language that was used was appropriate for both her level of understanding as well as the non-health literate family members present at appointments... we never felt rushed or like the staff had to rush off to another appointment.

We were given ample information and encouraged to contact the VAD team at any time if we had questions or concerns. This level of service remained consistent throughout every interaction we had with everyone in the VAD team."

Extract from feedback provided by family member of a person who accessed voluntary assisted dying.

It is difficult to articulate what it feels like to administer medications that bring an end to a person's intolerable suffering. It is harder still to put into words what it means to be entrusted with an individual and their loved ones during such an intimate and emotional moment.

The act of administering the medication is straightforward; the significance of the moment is not. There is something undeniably sacred about it.

To hear families say that voluntary assisted dying was the first dignified moment their loved one had experienced in a long time is a privilege beyond words.

It may sound unusual, but being able to serve people in the ACT who choose to die on their own terms has been one of the greatest privileges of my career.

Reflection provided by an authorised voluntary assisted dying practitioner.

Accessibility

Access enquiries about this publication should be directed to the ACT Health and Community Services Directorate.

GPO Box 158, Canberra City 2601 act.gov.au

Telephone: Access Canberra 13 22 81



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