Victoria (2019-)

Assisted suicide and euthanasia become legal in Victoria on 19 June 2019 when the Voluntary Assisted Dying Act 2017,[1] which passed the Legislative Council on 22 November 2017 by just two votes (22-18) came into full operation.[2]

Regulations were gazetted in September 2018.[3]

There have been nine reports on its operations issued to date by the Voluntary Assisted Dying Review Board, with the latest covering 1 July 2024-30 June 2025.

As of 30 June 2025, 1,675 people had their lives intentionally ended under the Act – 293 by euthanasia and 1,382 by assistance to suicide.

In the twelve-month period, July 2024-June 2025, 371 people died under the Act – an increase of 4.8% from the 371 deaths in July 2023- June 2024. 301 (77.4%) deaths in 2024-25 involved assistance to suicide and 88 (22.6%) were by euthanasia.

Deaths by euthanasia and assistance to suicide in the twelve months July 2024-June 2025 represent over 0.86% of all deaths in Victoria for that period, a rate only reached by Oregon after 26 years of legalised assisted suicide.

Eligibility criteria

The core eligibility criterion is set out in Section 9 (1) (d) of the Act:

> *the person must be diagnosed with a disease, illness or medical condition that—*
>
> *(i) is incurable; and*
>
> *(ii) is advanced, progressive and will cause death; and*
>
> *(iii) is expected to cause death within weeks or months, not exceeding 6 months; and*

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1 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/$FILE/17-061aa%20authorised.pdf

2 https://www.parliament.vic.gov.au/images/stories/daily-hansard/Council_2017/Council_Daily_Extract_Tuesday_21_November_2017_from_Book_20.pdf

3 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

(iv) *is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.*

The first three elements of this criterion are to be assessed by two doctors, only one of whom is required to have "*relevant expertise and experience in the person's disease, illness or medical condition*", the nature of such expertise and experience to be stated on Form 1 or Form 2 as set out in Schedule 1 of the Act.

None of the terms used in this provision are further defined in the Act nor is any guidance given in the Regulations as to how they are to be assessed.

During debate on the Bill it became clear that there are uncertainties around the meaning of "*incurable*" and "*will cause death*" so that, for instance an insulin dependent diabetic who declines to take insulin may qualify under this criterion. There have been some deaths under the Act (number not given) of people with diabetes.

In 2024-25, 29 applicants were categorised as having 'Other' life limiting conditions which were defined as including cardiovascular disease, dementia, diabetes, end stage kidney disease, end stage liver disease, HIV/AIDS, multiple organ failure, sepsis, stroke, and other rare non-malignant conditions.

The inclusion of diabetes, stroke and dementia are concerning.

It was also accepted that there are misdiagnoses[4] and errors in prognosis[5] so that there will inevitability be some wrongful deaths.

It is important to note that the fourth element in the criterion relating to "suffering" is specifically NOT to be assessed by the two doctors. It is entirely subjective and therefore entirely meaningless. A person is suffering in the required sense simply if the person asserts that this is the case.

This approach applies in Canada but notably not in the Netherlands or Belgium where the objective nature of the suffering – and the incapacity to relieve it – is a matter for professional assessment by the physician, including a relevant specialist.

There is no definition of suffering and therefore nothing to exclude forms of existential suffering such as loss of autonomy, lack of capacity to enjoy former hobbies, feeling a burden on family or financial concerns to be the only suffering experienced. There is absolutely no requirement for the person to be experiencing pain or other physical symptoms.[6]

Reasons for requesting assisted suicide or euthanasia

The Jan-June 2020 report states that "Loss of autonomy was frequently cited by applicants as a reason for requesting" assisted suicide or euthanasia, with other commonly reported reasons

[4] https://www.australiancarealliance.org.au/a_wrong_diagnosis

[5] https://www.australiancarealliance.org.au/a_wrong_prognosis_part_1

[6] https://www.australiancarealliance.org.au/access_to_palliative_care

including "being less able to engage in activities that make life enjoyable, losing control of body functions, and loss of dignity". Notably physical pain was not mentioned in this report.

No information on reasons for requests are given in any later reports.

One contact person is quoted as reporting of a person who requested and was given a prescription for a lethal poison but did not use it before dying naturally, peacefully and calmly: "*She had always planned to have the medication as **a plan B should her disease progress past bearable**, however she died peacefully and calmly from natural causes in hospital*."

It is evident from this account that lethal poisons are being prescribed and supplied for people who are not experiencing unbearable suffering and whose fear of a difficult death could be addressed with expert care rather than palliated with the prescription of a placebo which is actually a lethal poison.

The Jan-Jun 2021 report mentions that reasons for withdrawal of requests may include an "*improvement in condition and thus no longer meeting eligibility criteria*". Of course, this possibility of an improvement in condition is excluded for the 25 percent of applicants who progress to a final request within 11 days of first raising it.[7]

Mental illness

Section 9 (2) of the Act provides that:

*A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the **Mental Health Act 2014**.*

The force of the word "only" is the key to understanding the limited usefulness of this provision in protecting persons with mental illness.

It does not preclude a person with a profound mental illness but who also has another "*a disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act from accessing assisted suicide or euthanasia.

Nor does it explicitly preclude a mental illness from itself being considered to be "*a disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act. For example, a person with anorexia who is expected to die within 6 months as a result of refusing treatment could qualify or even a person with treatment resistant suicidal ideation. It remains to be seen whether the Act will be applied in this way.

Sections 18 (1) and 27 (1) provide respectively that if the co-ordinating medical practitioner or the consulting medical practitioner:

is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, [he or she] must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.

It is entirely up to the assessing doctors to form their own view as to their expertise in assessing decision-making capacity. This provision is weaker than the corresponding provision in Oregon which

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[7] https://www.bettersafercare.vic.gov.au/sites/default/files/2021-08/VADRB%20August%202021%20report%20FINAL.pdf

refers to "*impaired judgement*"[8] rather than a lack of "*decision-making capacity*" which is defined in section 4 in purely cognitive terms, taking no account of the effects, say, of depression or demoralisation on a person judging what is truly in his or her best interests.

Under section 36 of the Act the two people witnessing the signature on the written declaration must certify in writing "*that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying*". This hardly adds any extra assurance to the process as the witnesses do not need to have any expertise or prior knowledge of the person.

There is a provision in section 68 of the Act for a person who is considered by VCAT (Victorian Civil and administrative Tribunal) to have "*a special interest in the medical treatment and care of the person*" assessed as eligible for assisted suicide or euthanasia to apply to VCAT for a review of the decision that the person has decision-making capacity.

The July-December 2020 Report stated that over the first 18 months of the Act's operation 17 people (3% of 562 applicants) had been referred for a specialist opinion on their decision-making capacity. This dropped to 14 in the second 18 months (1.75% of 801 applicants). There is no information available on the outcome of these referrals. There were no referrals for specialist opinion on decision-making capacity of applicants in the 12 months from July 2024-June 2025 and just **35 (1%)** in total between 19 June 2019 and 31 July 2025.

The section in the prescribed training which doctors must undergo before participating as assessing or consulting doctors that covers assessing decision making capacity totals less than 5 minutes – a video that runs for 2 minutes 10 seconds and then a series of slides that takes about 2 minutes 20 seconds to read through5

The amount of this brief material that addresses "red flags" totals about 41 seconds.

Disability

Section 9 (3) of the Act provides that "A person is not eligible for access to voluntary assisted dying only because the person has a disability, within the meaning of section 3(1) of the **Disability Act 2006**."

Once again the key word is "*only*".

Nothing precludes a person with a disability – physical or intellectual – from accessing assisted suicide or euthanasia provided the person meets the other eligibility criteria.

Nothing precludes the person's disability from being considered as "*a disease, illness or medical condition*" expected to cause death within 6 months.

There are no explicit provisions to protect people with disability from discriminatory assessment under the required processes by doctors who would consider a person with a particular disability as "better off dead".

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8 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf

People with disability are more likely to experience undiagnosed depression especially following initial acquisition of a disability or adverse developments in their physical, psychological or social condition.[9]

The Act explicitly provides for requests for assisted suicide or euthanasia to be made by gestures. It is not made explicit in the Act whether or not an accredited interpreter is required in this case. A recent court case in the Netherlands determined that "*hand squeezes, nods, eye blinking and crying were all sufficient signs of*" a request for euthanasia.[10]

The January-June 2020 Report cites "fear of losing bodily functions" as a reason given for requests for assisted suicide or euthanasia. The loss of bodily functions, such as incontinence or difficulties in walking, are disabilities. It is disability discrimination to approve of a fear of such disabilities as a reasonable motive for assistance to end a person's life.

Coercion

The Act requires the two assessing doctors, as well as the witness to an administration request in the case of euthanasia, to certify that the person requesting assisted suicide or euthanasia is "*acting voluntarily and without coercion*".

Assessing doctors will be required to complete training approved by the Secretary of the Department of Health on "*identifying and assessing risk factors for abuse or coercion*".

The section in the prescribed training which doctors must undergo before participating as assessing or consulting doctors that covers assessing voluntariness, including assessing the absence of coercion, totals just over 5 minutes, including a 2 minute 20 second video and slides which take a further 2 minutes 50 seconds to read. This obviously cannot guarantee that assessing doctors never miss the signs of coercion or abuse given the well-documented evidence of failure by professionals in Australia to identify elder abuse.[11]

There is no provision for anyone to seek a review at VCAT of an assessment by the two doctors that a person is acting "*voluntarily and without coercion*" in requesting assisted suicide or euthanasia. A family member or friend who becomes aware that a person is being coerced has no formal recourse under the Act at all.

There is no mention of coercion in the six-monthly reports.

A death on April Fool's Day 2020

Most of the alleged "safeguards" under the Act could be reasonably characterised as "tick a box" safeguards. There are several forms to be filled in by the "coordinating medical practitioner" and lodged with the Voluntary Assisted Dying Review Board, culminating in an application for either a self-administration permit or a practitioner administration permit.

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[9] https://www.australiancarealliance.org.au/better_off_dead

[10] https://www.australiancarealliance.org.au/euthanasia_consent_by_gestures

[11] https://www.australiancarealliance.org.au/bullying_or_coercion

Under section 49 of the Act, and clause 7 of the *Voluntary Assisted Dying Regulations 2018* the Secretary for Health and Human Services (or their delegate under s113 of the Act) has 3 business days to issue the permit or refuse to issue the permit.

Section 49 (3) states that "*the Secretary may refuse to issue a voluntary assisted dying permit if the Secretary is not satisfied the request and assessment process has been completed as required by this Act*".

It is a matter of concern that the Act does not make it explicit that the Secretary must not issue a permit unless satisfied the request and assessment process has been completed as required by this Act.

On 1 April 2020 (April Fool's Day) a person died by ingestion of a lethal substance prescribed for the person by Dr Nick Carr after he had been issued with a self-administration permit for the person by the Secretary on Friday, 11 February 2020, the same day the application for the permit, along with an allegedly complete set of the required forms, was submitted at 12.31pm. Assuming the Secretary knocked off issuing permits authorising Victorians to commit suicide by 5.00 pm on a Friday afternoon this was a 4 hour 29 minute or less turnaround time.

Clearly all the Secretary could do in that time was see if all the boxes were ticked.

In this case it turns out that Dr Carr had falsely ticked several of the key boxes so that his application for a permit for a person to be prescribed with a lethal substance to cause the person's death falsely asserted that the two witnesses required under section 36 of the Act had witnessed that "*the person making the declaration appeared to freely and voluntarily sign the declaration; and that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying; and that, at the time the person signed the declaration, the person appeared to understand the nature and effect of making the declaration.*"

This is clearly a key alleged safeguard in relation to decision-making capacity, voluntariness, and the absence of coercion.

However, Dr Carr – who had previous to this case already been involved with between 8 and 10 other applications for permits under the Act – clearly did not explain to the two witnesses what they were supposedly solemnly testifying to or check whether they actually read and understood the relevant sentences in the Written Declaration (Form 3, Schedule 1 of the Act) as both purported "witnesses" signed the form notwithstanding that the person had NOT signed the form. In other words, both witnesses explicitly committed perjury by signing a false declaration.

This suggests that there may well be other cases where both the applicant and the witnesses do sign the form – even in the right order – but the assertions made by the witnesses are of little or no weight.

In this case, the witnesses dated their signatures 6 February 2020.

On or before 8 February, Dr Carr submitted the Written Declaration – with no signature by the person by whom it had purportedly been made – to the Voluntary Assisted Dying Review Board. On 8 February 2020 he submitted a Final Review Form in which he falsely asserted that the Written Declaration had been signed by the person; and that it had been witnessed by the required two witnesses. On 9 February 2020 he submitted an application for a self-administration permit which included a claim that he had checked all the required forms.

On 10 February 2020, an officer of the Secretariat of the Voluntary Assisted Dying Review Board identified the Incomplete Written Declaration and communicated to Dr Carr as follows:

> *We are process checking your case VAD161 and have noted the Witness declaration is not signed and dated by the patient. Could you please arrange for the patient to sign and date this document before we can progress the case*.

Now while it is commendable that the officer actually noticed that the signature was missing it is concerning that this was seen as merely a clerical issue to be remedied by getting the missing signature. The officer did not demonstrate any concern that Dr Carr had made several false declarations; nor any concern that the two purported witnesses had committed perjury; nor any concern that an application for a permit for a lethal substance to cause the person's death had been made by Dr Carr without any evidence that the person was voluntarily requesting this.

The officer's instruction to Dr Carr surely should have made some reference to the need for witnesses to the person's signature.

In any case, Dr Carr continued with his cavalier approach to this serious matter. On 11 February he had the person sign the Written Declaration and falsely date the signature "06/02/20" and he then emailed it to the Voluntary Assisted Dying Review Board at 12.31 pm that day.

The extraordinary reply (within a minute as it is also recorded at 12.31pm) by an officer of the Secretariat was *"Dear Nick, Thank you, we have attached this to the file now and can progress the case*."

This was extremely negligent of the officer as it should have been apparent that there was still no properly witnessed signature by the person and therefore still no independent evidence that the request was being made voluntarily and without coercion.

The file was then progressed and the permit issued later that day.

This means that the Secretary (or delegate) either was not informed or paid no attention to the fact that a signature noted as missing on the Written Declaration Form on 10 February and subsequently inserted on the same form was falsely dated 6 February – the same date as the witnesses signatures, - and that therefore there was still no evidence, as required under the Act, that the person had freely and voluntarily made a declaration, while having the required decision-making capacity and appearing to understand the nature and effect of making the declaration.

In other words, a permit for the supply and use to cause the person's death of a lethal substance was issued by the Secretary (or delegate) on behalf of the State of Victoria for a person in violation of a key alleged "safeguard" under the Act dealing with the core requirements of voluntariness and decision-making capacity.

It is sadly ironic that this person died on April Fool's Day 2020. The Parliament and people of Victoria were fooled by the proponents of the *Voluntary Assisted Dying Act 2017* into believing that with its 68 alleged safeguards it was absolutely safe. Checking that boxes have been ticked can never make killing safe.

While the Medical Board made findings of unprofessional conduct against Dr Carr and fined him $12,000 no action seems to have been taken against the officers of the VARDB Secretariat or the Secretary of Health and Human Services for their egregious failures in this case.[12]

Dr Carr's $12,000 fine didn't cost him a cent as a pro-euthanasia fund raiser gave the money. The fund raiser described the failure by Dr Nick Carr to have the forms competed in accordance with the Act and to make honest declarations when submitting the forms, was described on the fundraiser page as "*a small, inadvertent error in the paperwork for a Voluntary Assisted Dying request. For an action early in 2020, that did not harm the patient nor benefit Dr Carr*".[13]

Euthanasia and assisted suicide enthusiasts see every alleged safeguard as a clerical hoop of no real importance to jump through. If you miss the hoop who cares!

State-issued permits

Form 3 in the Regulations sets out what a VADSAP or "voluntary assisted dying self-administration permit" will look like.[14]

"*This self-administration permit in respect of Mary Brown authorises Dr John Smith for the purpose of causing Mary Brown death, to prescribe and supply the substance specified in this permit to Mary Brown that is able to be self-administered; and is of a sufficient dose to cause death*".

The permit will be signed by the Secretary of the Department of Health and Human Services or his or her delegate.

The permit will also directly authorise Mary Brown to "*use and self-administer the substance*" specified in the permit in order to cause her death.

This is clearly not just State sanctioned suicide but – in a world first since ancient times – **State authorised suicide of a particular, named person using a specified lethal substance**.

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[12] *Medical Board of Australia v Carr (Review and Regulation) [2023] VCAT 945 (14 August 2023),* http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCAT//2023/945.html

[13] https://www.mycause.com.au/p/320343/pay-nicks-vcat-fine

[14] http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/93eb987ebadd283dca256e92000e4069/D550921996E9F89BCA258313001B4FE5/%24FILE/18-142sra%20authorised.pdf

Form 4 in the Regulations sets out what a VADPAP or "voluntary assisted dying practitioner administration permit" will look like.

"*This practitioner administration permit is issued to Dr John Smith … this practitioner administration permit in respect of Jim Brown for the purpose of causing Jim Brown death, authorises Dr John Smith to administer the substance to Jim Brown*."

This is **State authorised euthanasia of a named individual by a named doctor using a specified lethal substance**. It was last done in Germany in the 1940s.

The Regulations specify that the Secretary of the Department of Health and Human Services or his or her delegate will have 3 business days from receiving a VADSAP or VADPAP application form (accompanied by five other forms) to either issue the permit or refuse to do so.

All that the Secretary or his or her delegate will do is to check that two doctors have ticked the right boxes and filled in the blanks on the six forms.

None of this checking of ticked boxes can possibly guarantee that the person who the Secretary or delegate will authorise to commit suicide or to be killed by euthanasia really:

- has the alleged condition;[15]
- actually has only six months to live;[16]
- is not being coerced overtly or subtly by impatient heirs or weary caregivers;[17]
- is not depressed; [18]
- is not missing out on effective treatment; [19]
- is not being discriminated against due to disability;[20] and
- could not have had their suffering relieved with appropriate palliative care[21].

The July 2023-June2024 Report notes that while the Secretary, Department of Health and Human services, or delegate, has three business days to determine an application, 98.66 per cent of permits were issued within two business days - such efficiency in ticking boxes!

Euthanasia

Section 48 of the Act allows for euthanasia (practitioner administration of the poison) as an alternative to assisted suicide in the case where a single doctor certifies that he or she is satisfied

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[15] https://www.australiancarealliance.org.au/a_wrong_diagnosis

[16] https://www.australiancarealliance.org.au/a_wrong_prognosis_part_2

[17] https://www.australiancarealliance.org.au/bullying_or_coercion

[18] https://www.australiancarealliance.org.au/mentally_ill_at_risk

[19] https://www.australiancarealliance.org.au/unaware_of_available_treatment

[20] https://www.australiancarealliance.org.au/better_off_dead

[21] https://www.australiancarealliance.org.au/access_to_palliative_care

that "*the person is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence*" and provides a reason for this incapacity in completing Form 8 of schedule 1 of the Act and Form 2 as set out in the Regulations .

The Board actively encouraged recourse to euthanasia in its January-June 2020 Report:

"*While self-administration might be appropriate for the applicant initially, it may not always be when close to death. Coordinating medical practitioners can apply for a new practitioner administration permit if the applicant has lost the physical capacity to swallow or digest the medication. Before an application for a practitioner administration permit can be made, the unfilled prescription must be destroyed, or if the medication has already been dispensed, it will need to be returned to the Statewide Pharmacy Service and disposed of. 'I was worried she wouldn't be able to swallow the medication.' – Contact person*."

The Reports do not provide any data on how often, if ever, this has occurred to date. It does indicate that the threshold for justifying euthanasia as the method of bringing about death is so low that vague concerns about an ability to swallow the (liquid) medication would be sufficient.

Assisted suicide

The processes for assisted suicide are deeply flawed.

The "*poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for the purpose of causing a person's death*" approved by the Secretary, prescribed by the doctor and issued by a pharmacist to the person will be 15 g of sodium pentobarbital.

On 5 January 2019 the Minister for Health, Martin Foley, announced that The Alfred Hospital pharmacy would be "the sole service for dispensing" the lethal poison across Victoria. "*For people too sick to travel, the pharmacy service will deliver them their medication and provide information on administration*".[22]

The notion of a kind of "uber-poison" service to country Victoria - where there is a chronic shortage in ready access to palliative care medicines as needed - is particularly disturbing.

There is no requirement for any doctor or other health practitioner to be present when the poison is ingested.

The six-monthly (now annual) reports provide no data on how many people were alone when the prescribed lethal poison was ingested, or how many had just one other person present. There is no data provided on complications, on the length of time to loss of consciousness or the length of time to death.

The 2022/23 report mentions that there were "a number of cases where the time to death has been prolonged" but provides no data.

In Oregon, under a similar scheme, in 2018 for nearly two out of three (62.5%) people there was no physician or other healthcare provider known to be present at the time of death. One in eight (12.5%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose or had other complications or regained consciousness and died subsequently from the underlying illness. The interval from ingestion of

[22] https://www.premier.vic.gov.au/voluntary-assisted-dying-a-step-closer/

lethal drugs to unconsciousness was as long as four hours while the time from ingestion to death was as long as 21 hours.

Imagine these complications occurring for a person who is home alone when they ingest the poison.

The Act does not require any assessment of decision-making competence or absence of coercion at the time of ingestion nor does it set any time limit on the length of time between the poison being prescribed under a VADSAP and it being ingested. In Oregon the longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).

The Regulations provide the specifications for the locked box in which the Act requires the lethal poison issued under a VADSAP to be stored. It must be made of steel. It must be "*not easily penetrable*". It must be "*lockable with a lock of sturdy construction*".

The last two requirements are entirely subjective. What counts as "*not easily penetrable*" or as a "*lock of sturdy construction*"? Who knows? Almost any steel petty cash box could be thought to qualify.

There are no requirements for where the box containing the lethal poison is to be kept. However, section 126 of the Act does specifically exclude it from the usual protective requirements for dangerous medication in aged care services - so it may have t**o be kept under grannie's bed in her aged care room**. Nor are there any limits on how many keys there can be to the box or on who can have a key (or the code in case of a combination lock).

Where there is no witness we will never know if the person really self-administered the poison or if it was administered to them by a family member or other person under duress, surreptitiously or violently.

Seizures – link to pentobarbital dismissed by VADRB despite evidence from Oregon and from its use in executions

Three cases of people experiencing seizures after self-administration of a prescribed lethal substance have been reported in Oregon since 2017.[23]

In the Voluntary Assisted Dying Review Board minutes for 19 January 2023[24], it is initially minuted that after discussing a reported case of seizure following ingestion of a prescribed VAD substance "Board members with clinical expertise advised **it could not be** a result of the substance". Curiously this was subsequently revised to read "Board members with clinical expertise advised it **was probably not** as a result of the substance."

In either case this illustrates an extremely dismissive attitude by the Voluntary Assisted Dying Review Board to a report of a complication that has also been reported from Oregon and in relation to the use of pentobarbital in executions.

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[23] Oregon Public Health Division, *Oregon Death With Dignity Act: 2022 Data Summary, Table 1,*p.14 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf

[24] https://assets.nationbuilder.com/australiancarealliance/pages/171/attachments/original/1706315292/VARDB_Meetings_Jan-Jun_2023.pdf?1706315292

Pentobarbital has been used as a lethal substance in executions in the United States both as the first (sedative) drug in a two or three drug protocol and also in a one drug protocol.

Given the rarity of its use in medical procedures and the resulting paucity of data on its effectiveness, anaesthesiologists have repeatedly raised concerns over its use in executions. By extension these concerns are also relevant to its use in Victoria as a suicide drug to be taken at home, possibly alone, under the *Voluntary Assisted Dying Act 2017*.

Dr. David Varlotta, who is on the board of directors of the **American Society of Anesthesiologists**, has noted that pentobarbital "is not used in a clinical setting for clinical anesthesia." Dr. David Waisel, an anaesthesiologist and Harvard Medical School professor, said, "Pentobarbital has almost never been used for induction of anesthesia. If you look at the literature, there's one report from the '40s, maybe 2. We're experimenting, and we're taking a huge risk here just for the big desire to make sure we're killing people."[25]

Anecdotal reports from eyewitness of its use in executions suggest there are possible problems with the use of pentobarbital that could result in an inhumane death.

After the drug was administered to Eric Robert in South Dakota in October 2012, he "appeared to be clearing his throat and then began gasping heavily," and "his eyes remained opened throughout." His heart beat for 10 minutes after he stopped breathing, suggesting the drug was not fully effective.

When compounded pentobarbital was administered to Michael Lee Wilson on Jan. 9, in Oklahoma, he cried out, "I feel my whole body burning."[26]

Pentobarbital is considered a controversial substitute for sodium thiopental because its manufacture is often poorly regulated, and contaminated batches can cause excruciating pain prior to death.

Tanya Greene, advocacy and policy counsel on criminal justice issues for the ACLU, said the use of pentobarbitol in executions is unconstitutional as it violates the Eighth Amendment's protection against cruel and unusual punishment. Use of the drug in executions, she said, is "basically an experiment on human beings; the risk of extended, painful death is very high. The European manufacturer of pentobarbital objects to its use to kill and has stopped selling the drug to US states for use in executions."[27]

Richard Dieter, executive director of the Death Penalty Information Center in Washington, D.C., a group opposed to the death penalty, says Ohio's approach may be the direction other states follow.

Ohio is one of two states that use only a single drug in their executions, but Dieter says it's not clear whether pentobarbital will do what it's supposed to do. Dieter says the issue here, the effectiveness of the anesthesia, is not yet known.

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[25] https://deathpenaltyinfo.org/executions/lethal-injection/state-by-state-lethal-injection-protocols

[26] https://www.nytimes.com/2014/04/14/opinion/secret-drugs-agonizing-deaths.html

[27] http://nation.time.com/2014/01/10/oklahoma-convict-who-felt-body-burning-executed-with-controversial-drug/

"So a new drug, you know, may have the same purpose, but it doesn't mean it has the same effect on human beings. And there's no way to experiment on executions except by doing them, so there's going to be challenges," he says.[28]

Anaesthesiologist, Joel Zivot, M.D. swore an affidavit in the case of *Johnson v Lombardi* explaining in that pentobarbital carried a risk of causing seizures. *"Once it enters his bloodstream, the pentobarbital will interact with his scarring tissue, brain defect, and remaining meningioma, thereby triggering seizures. These seizures, in turn, will give Johnson muscle pain described as severe, extreme, and excruciating. This is in part because pentobarbital, pharmacologically, makes pain worse. The seizures will not be quick, and will prolong the execution"*[29]

Anaesthesiologist and Harvard Medical School professor, Dr David Waisel, has testified on the execution of Ray Blankenship "I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital. […] Only when a drug has been tested systematically on thousands of subjects, with their consent, can one begin to reliably assess how an untested use of a drug will affect human subjects. We do not have relevant data in similar populations for pentobarbital. Because we do not have sufficient data, there is no way to know, in any given case, how an overdose of pentobarbital will affect basically healthy inmates. Mr. Blankenship's reaction to the pentobarbital injection may be indicative of other inmates' reactions."[30]

On November 20, Missouri will perform a similar experiment on death row inmate Joseph Paul Franklin. Missouri will become the third state, after Texas and South Dakota, to inject an inmate with pentobarbital synthesized in a compounding pharmacy—a type of drug manufacturer that is not subject to Food and Drug Administration safety regulations. The pentobarbital may simply stop Franklin's heart, as intended. But if it is contaminated by tiny particles—as drugs manufactured by compounding pharmacies often are—the insides of Franklin's veins will feel as though they're being scraped with sandpaper as he dies, warns David Waisel, an associate professor of anesthesiology at Harvard Medical School.

Waisel says that pentobarbital that is not potent enough could result in a lingering death that "drags on and drags on and drags on. It would be awful."[31]

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[28] https://www.npr.org/2011/01/29/133302950/new-lethal-injection-drug-raises-concerns

[29] http://courtweb.pamd.uscourts.gov/courtwebsearch/mowd/ka7EsuYBhf.pdf#xml=http://courtweb.pamd.uscourts.gov/courtweb/PDFResult.aspx

[30] https://reprieve.org.uk/press/2011_06_30_execution_pentobarbital_blankenship/

[31] https://www.motherjones.com/politics/2013/11/ohio-lethal-injection-cocktail-execution-drugs/

No suicide prevention but likely suicide contagion

Legalising assistance to suicide for some people in Victoria undermines the commitment to **suicide prevention for all** by affirming that such people would be better off dead and supporting their suicide as a rational choice to be facilitated rather than prevented.

People diagnosed with a terminal illness are at greatest risk of suicide within the first six months of diagnosis and often miss out on accurate diagnosis of depression and anxiety for which effective treatments are available.[32]

A study of US data comparing States which had legalised assisted suicide with those which have not has shown that legalising assisted suicide is associated with an increase in the overall rate of suicides of 6.5% and of the elderly (65 years and older) by 14.5%.[33]

This conclusion is supported by **evidence from Victoria**.

When arguing for the legalisation of assistance to suicide, then Minister for Health and Human Services, the Hon Jill Hennessy, claimed:
Evidence from the coroner indicated that one terminally ill Victorian was taking their life each week.[34]
She argued legalisation would prevent these 50 suicides each year.

Not only has there been no such decline, but there were 62 more suicides in Victoria in 2022 than in 2017, when this claim was made. The suicide rate among those aged over 65 years increased from 2019 to 2022 by 42 per cent in Victoria, where "voluntary assisted dying" was legal—five times the increase over the same period in New South Wales where it remained illegal.[35]

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[32] Nafilyan V, et al., "Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people", *The Lancet Regional Health - Europe* 2023;25: 100562, Published Online 14 December 2022, https://www.thelancet.com/action/showPdf?pii=S2666-7762%2822%2900258-7 ;
Fulton JJ, et al., "Psychotherapy targeting depression and anxiety for use in palliative care: a meta-analysis*", Journal of Palliative Medicine,* Jul 2018, Vol. 21: 1024-1037*,* https://www.liebertpub.com/doi/10.1089/jpm.2017.0576 ;
Schweighoffer R. et al., "A systematic review and bayesian network meta-analysis investigating the effectiveness of psychological short-term interventions in inpatient palliative care settings.", *Int J Environ Res Public Health*, 2022;19, https://www.mdpi.com/1660-4601/19/13/7711/pdf

[33] Jones, David A and D. Paton. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" *Southern Medical Journal* 108 (2015): 599–604, https://nottingham-repository.worktribe.com/OutputFile/981911

[34] https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2017/Assembly_Daily_Extract_Thursday_21_September_2017_from_Book_12.pdf

[35] https://jemh.ca/issues/open/documents/Did%20the%20Voluntary%20Assisted%20Dying%20Act%202017.pdf

Claims made that “voluntary assisted dying”, that is the intentional causing of a person’s death by self- or practitioner-administration of a lethal substance is not “suicide” were given shrift in the recent decision by the Federal Court in *Carr v Attorney-General (Cth) [2023] FCA 1500* which formally declared:

> *The term “suicide” … does apply to the ending of a person's life in accordance with, and by the means authorised by, the* Voluntary Assisted Dying Act 2017 *(Vic) and* Voluntary Assisted Dying Regulations 2018 *(Vic).*[36]

Amendment of the Act

The Voluntary Assisted Dying Amendment Act 2025 passed the Victorian Parliament and received assent on 25 November 2025. When it commences (on a day or days to be proclaimed or otherwise on 19 April 2027) the prognosis for eligibility for all conditions will be 12 months or less; health practitioners will be able to propose euthanasia to people; there will be a free choice between euthanasia and assistance to suicide; conscientiously objecting medical practitioners will be required to supply information about accessing euthanasia and assistance to suicide. These changes are likely to lead to a significant increase in euthanasia in Victoria.

Conclusion

On 19 June 2019 Victoria embarked on the fifteenth in a series of experiments in legalised euthanasia or assisted suicide begun in the Northern Territory in 1996. Each of these experiments has proved to be fatally flawed resulting in wrongful deaths. There is nothing in the design of the Victorian experiment or the data from the first 5 years of its operation to justify any expectation of better results.

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[36] https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2023/2023fca1500