Western Australia (2021-)

Euthanasia and assistance to suicide became legal in Western Australia from 1 July 2021.

Increase in numbers

In the first year of legalised euthanasia and assistance to suicide, 191 people had their lives ended by these acts – 96 by intravenous administration of a lethal poison by a medical practitioner; 52 by oral administration of a lethal poison with the assistance of a medical practitioner; and 43 by self-administration of a lethal poison. These deaths accounted for approximately 1.14% of all deaths in Western Australia in 2021-22.

In the second year, 2022-23, the number of deaths increased by 33.5% to 255, representing 1.4% of all deaths in Western Australia that year. 45 deaths (17.65%) were by assistance to suicide (self-administration) and 210 (82.35%) by euthanasia (practitioner administration).

In the third year, 2023-24, the number of deaths increased by 14.5% to 293, representing 1.63% of all deaths. Just 15 of these deaths (5.1%) were by assistance to suicide, with 277 (94.9%) by euthanasia.

In the fourth year, 2024-25, the number of deaths increased by a massive 63.8% to 480, representing 2.68% of all deaths. Just 29 (6%) were self-administered with 451 (94%) of deaths by euthanasia.

132 of the deaths in 2024-25 took place in the fourth quarter (April-June 2025), representing 2.94% of all deaths in that quarter.

The rate in Western Australia of deaths by euthanasia and assistance to suicide (2.94%) after four years of legalisation is well over three times the rate of 0.86% in Victoria in its sixth full year of legalisation.

There are several factors that could be leading to this higher rate of deaths by assisted suicide and euthanasia compared to Victoria.

Where euthanasia is available as well as assisted suicide the international evidence suggests that there will be a significantly higher take up rate overall, with most people choosing euthanasia over assistance to suicide.

Between 1 July 2024 and 30 June 2025, the majority (94%) of cases in Western Australia involved practitioner administration, that is euthanasia, with 6% of cases involving self-administration.

This rate of euthanasia compared to assisted suicide is over 5 times that in Victoria (18.9%) in 2023-24. In Victoria, practitioner administration is only permitted where the person lacks the physical capacity to self-administer or digest the lethal poison (*Voluntary Assisted Dying Act 2017*, Section 46 (c)(i)) whereas under Western Australia's Act, a patient's concerns about self-administration are sufficient to justify practitioner administration (*Voluntary Assisted Dying Act 2019*, Section 56(2) (b))

Unlike in Victoria, the Act allows a medical practitioner to **initiate** a conversation about euthanasia or assistance to suicide without any indication that a person has even considered it or would be likely to consider it without such prompting.

Additionally, the Act attempts to conscript all medical practitioners into facilitating euthanasia and assistance to suicide by mandating that if a person makes a request for euthanasia or assistance to suicide the medical practitioner must either accept the request and begin the assessment process or refuse the request and hand them a 16 page promotional pamphlet which includes contact details for

the Statewide Care [sic] Navigator Service which is funded to facilitate access to euthanasia and assistance to suicide.

Death practitioners

Of the 63 practitioners who have actively killed a person between 2021 and 2025 by administering a prescribed lethal substance, 17 of them have killed 21 or more people each and a further 12 have killed between 11 and 20 people each.

Of the 41 practitioners who actively killed a person in 2024-25 by administering a prescribed lethal substance, 7 of them killed 233 people between them – an average of 33 per killer at an average rate of one person every 11 days.

It is not surprising that the Board reports concerns about practitioner "fatigue".

From 1 July 2024 the State of Western Australia has been directly paying administrative practitioners a fee for service to kill people.

90.8% of people assessed between 2021 and 2025 had no previous relationship with the medical practitioner who assessed them. This lack of any previous knowledge of the person increases the chances of missing depression, coercion or lack of decision-making capacity, as well as errors in diagnosis from lack of familiarity with a person's medical history.

Eligibility criteria and inevitable wrongful deaths

The Voluntary Assisted Dying Act 2019 allows the prescription by a medical practitioner for self-administration, or administration by a medical or nurse practitioner, of a lethal dose of poison in order to cause the death of an adult who has requested the prescription and who is assessed by two medical practitioners as having a condition that will "*on the balance of probabilities*" cause death within 6 months or, in the case of a neurodegenerative condition cause death within 12 months.

So, people with a 49% chance of living longer than 6 (or 12) months qualify. Given that doctors make errors in both diagnosis of a terminal condition and in prognosis, the law will inevitably lead to unnecessary premature deaths of people who were either not terminally ill or may have had years to live.

In one case in 2022-23 the person took the lethal poison 503 days (1 year 4 months) after making a first request and being assessed as having 6 months (or possibly 12 months for a neurological disorder) to live.

There were at least two cases each in 2023-24 and 2024-25 of people dying more than two years after being assessed as having 6 months (or possibly 12 months for a neurological disorder), including one case where death was 2 years 8 ½ months after the assessment and one where death was 2 years 4 ¼ months after the assessment.

As neither of the two assessing medical practitioners is required to have any specialist qualifications relevant to the alleged condition or even have any experience in caring for people with that condition there is an increased chance of such errors as well as of a failure to inform the person of all available treatments.

Nor does either practitioner need to have any expertise in palliative care and there is no requirement to refer the person for a specialist palliative care consultation.

In 2024-25, 16.5% of people assessed as eligible for euthanasia and assistance to suicide had not received any palliative care in the past 12 months and a further 2.6% were not currently receiving any palliative care. The report does not provide any information on why palliative care was not being received. If it was not needed at all what was the nature of the "unrelievable suffering" justifying euthanasia? If it was needed but not available why is the delivery of a lethal poison by the Statewide Pharmacy Service funded by the State but not the delivery of pain and symptom relief through palliative care?

Access to palliative care is uneven in Western Australia – especially in regional and remote communities. However, the WA Government has established the Western Australian Voluntary Assisted Dying Statewide Care Navigator Service and a Regional Access Support Scheme to provide financial and logistical support to people in remote and regional communities to easily access euthanasia and assistance to suicide. Equal access to euthanasia and assistance to suicide is established under the Access Standard. The Statewide Pharmacy Service "*will actively engage with regional residents to ensure safe, timely and appropriate supply of the*" lethal poison.

In 2023-24 the Statewide Pharmacy Service reported meeting its benchmark for delivery of the lethal poison to persons in regional Western Australia of 5 days or less in 100% of cases.

There is no equivalent support for access to gold standard palliative care, or palliative medicines, so some people will die unnecessarily by euthanasia and assistance to suicide for lack of financial resources to access effective treatment or palliative care.

Decision-making capacity and freedom from coercion

Sections 26 and 37 of the Act provide for a referral by either assessing medical practitioner to "a registered health practitioner with the appropriate skills" to assess the person's decision-making capacity – but only at the discretion of the assessing medical practitioner if he or she "is unable to determine" if the person has the required decision-making capacity.

There were NO referrals for expert assessment of decision-making capacity or freedom from coercion in Western Australia in 2021-22; only 2 in 2022-23; 1 in 2023-24 and none in 2024-25.

The medical literature shows that diagnosis with a terminal condition can adversely impact on decision-making capacity and that even specialists are not always experts in accurately determining decision-making capacity.

The Act requires practitioners who wish to participate in assessing for or administering euthanasia and assistance to suicide to undergo approved training. The approved training consists of online modules prepared by Ben White and others from the Queensland University of Technology.

Under similar approved online training modules prepared by the same team for Victoria, there is a very brief section that covers assessing voluntariness, including assessing the absence of coercion, totalling just over 5 minutes, made up of a 2 minute 20 second video and a set of slides which take a further 2 minutes 50 seconds to read.

This minimal, perfunctory "training" obviously cannot guarantee that Western Australian practitioners will never miss the signs of coercion or abuse given the well-documented evidence of failure by professionals in Australia to identify elder abuse.

So, there will inevitably be wrongful deaths of Western Australians coerced or subtly pressured into requesting euthanasia or assistance to suicide.

Waiving the waiting period

One of the claimed safeguards in the Act is a requirement for a nine-day period between making a first request and a final request.

In 2024-25 this was waived in over one out of four (26.3%) cases of final requests. For 64 (10% of all cases) people the nine-day period was waived on the grounds the person was likely to die within that period and for 106 (16% - one in six of all cases) people the nine-day period was waived on the grounds the person was likely to lose decision-making within that period.

If a medical practitioner assesses a person as likely to lose decision-making capacity within 9 days, there must already be signs of that impending loss. These signs should raise doubts about the current decision-making capacity of the person.

In at least two cases each in 2022-23 and in 2023-24 the person was assisted to suicide or euthanased within 2 days of making a first request.

Complications

In 2021-22, of the 52 acts of "assisted oral ingestion" of the poison, 4 (7.7%) resulted in complications including "regurgitation/vomiting, coughing and the length of time for the substance to take effect.

In 2022-23, of the 210 acts of practitioner administration, 12 (5.7%) involved complications, including 7 cases of intravenous live complications; and at least one case each of coughing, burning of the throat following assisted oral ingestion, transient agitation and pain following injection following intravenous administration. There was also one case where the person was described as experiencing "worsening of pain or discomfort".

In 2023-24 of the 277 acts of practitioner administration, 12 (4.3%) involved complications, including 5 cases of intravenous live complications; one case of regurgitation/vomiting; one case of worsening of pain or discomfort; and at least one case each of coughing and/or burning of the throat following assisted oral ingestion, hiccups with gastric reflux, involuntary muscular contractions, and delayed loss of consciousness. All patients with reported complications died after administration of the voluntary assisted dying substance.

In 2024-25 of the 433 acts of practitioner administration 18 (4%) involved complications. This included 6 cases of intravenous line complications; 3 cases of regurgitation/vomiting, one case of seizure; one case of worsening pain or discomfort; with other complications including coughing following administration of the voluntary assisted dying substance; delayed loss of consciousness; transient pain following intravenous administration and syringe assembly difficulties.

No data is collected on the time between administration and loss of consciousness.

However, from July 2021 to June 2025, in 19 (9.9%) of the 191 cases of assisted oral or PEG tube ingestion, the person took more than one hour to die. In 2022-23 one person took 6 hours and 29 minutes to die and in 2024-25 one person took 4 hours and 44 minutes.

No data on administration location, length of time to death or complications is collected by the Voluntary Assisted Dying Board regarding deaths occurring via self-administration of the prescribed lethal poison. However, it is likely that there is a similar or higher rate of complications. We will never know.

No witness for assisted suicide

Additionally, there is nothing in the Act to require any independent witness when the prescribed lethal poison is ingested when "self-administration" is chosen. This can take place weeks, months or even years after it is prescribed without any requirement for an updated assessment of decision-making capacity, diagnosis, prognosis, suffering or voluntariness.

Without a witness required we will never know if the lethal poison was ingested voluntarily or whether the person was cajoled, bullied, tricked or even physically forced to ingest it.

Section 82 of the Act prohibits any mention of the ingestion of the prescribed lethal poison on the death certificate of a person who dies from ingesting it and Section 168 ensures that any such death is not reportable to the Coroner.

Together these provisions make it almost impossible that wrongful deaths by improper – even murderous – administration of a prescribed lethal substance will ever be identified, let alone prosecuted.

Reckless of this danger, the Board is advocating to allow non-practitioners – presumably including family members – to actively assist a person to "self-administer" the deadly poison!

Legal fiction – not a death by suicide

Section 12 of the Act provides that ingesting a lethal poison prescribed under the Act to be ingested to cause death is not legal suicide. This means it will not appear in the suicide statistics for Western Australia.

In Victoria, as in Western Australia, there were claims made during debate on the euthanasia legislation that it would prevent the suicides of people with terminal illness by providing them with an alternative. In Victoria, it was claimed that the new law would prevent 50 such 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.

So, we have no reason to expect a reduction in the official suicide rate in Western Australia as a result of the legalisation of assistance to suicide and euthanasia, but, sadly, can anticipate a rise in the total number of suicides if deaths by ingestion (or administration) of a lethal poison prescribed under the Act are also counted.