QUEENSLAND
COURTS

CORONERS COURT OF QUEENSLAND

Reasons for Decision
(including Findings, Comments and Referrals)

CITATION:	**Inquest into the death of ABC (a pseudonym)**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	Central
CCQ FILE NO(s):	CCMS 2023/2350
DELIVERED ON:	11 September 2024
DELIVERED AT:	Mackay (by email)
HEARING DATE(s):	20-21 February 2024
FINDINGS OF:	Coroner D J O'Connell, Central Coroner
CATCHWORDS:	Inquest – VAD substance supplied to a self-administration VAD patient but unused and not returned nor disposed of – Use by a non-VAD patient – a better system of protecting self-administration VAD substances against misuse by non-VAD patients

REPRESENTATION:

Counsel Assisting	- Mr J M Aberdeen (Counsel)
For the Family:	- Ms A (a pseudonym) (Next-of-Kin)
For Queensland Health & various QH entities	- Ms A. Freeman (Counsel) instructed by Minter Ellison Lawyers

Reasons for Decision

[1]. On 16 May 2023 ABC was located unresponsive at their residence sitting in a lounge chair. It was determined they had passed away. An opened VAD self-administration oral substance medication kit was located nearby, its' contents were empty, and it appeared to have recently been consumed. ABC was not a VAD patient, their spouse was, but when their spouse was unable to use their supplied VAD self-administration oral substance they later received a practitioner administered VAD IV substance and they passed away in hospital on 8 May 2023. The unused and unrequired VAD self-administration oral substance that ABC had used to end their life had not been returned, as required, for appropriate disposal.

[2]. This inquest investigated whether QVAD[1] personnel appropriately sought return of the unused self-administration VAD substance, and whether the process for self-administration VAD substances could be made safer by it remaining under the control of an authorised health professional, while balancing the recognition of privacy, compassion, and autonomy interests of patients and their families.

[3]. Due to the sensitive nature of the inquest subject matter, I made a Non-Publication Order[2] to de-identify the parties involved, give a measure of anonymity to the medical personnel and staff involved in the VAD process, and held the inquest in Brisbane even though the incident occurred in a regional locality within the Central Coroner catchment area. As a Non-Publication Order has been made in this matter any reporting, use of, or commentary on this case should adopt appropriate methods to ensure that the Non-Publication Order is not breached.

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[1] Exhibits B1 and B7 set out VAD Terminology and QVAD Operational Structure and Functions. The structure and terminology acronyms of the administration is likely confusing to many when first being encountered. Indeed the independent Qld Health Review into the death was further reviewed due to claimed incorrect terminology or assumptions of responsibilities (although I am not entirely clear of the issues because it had no direct bearing on the Inquest Issues). I simply highlight the difficulties some encountered, and that includes myself whilst I was initially working my way through understanding the administration of the entire QVAD process. With familiarity it became clearer.

[2] At the Pre-Inquest Conference on 17 January 2024 the Non-Publication order was made. A copy is annexed (Annexure B) for ready reference by the media to ensure no inadvertent breach of it occurs should any reporting of these Reasons occurs.

Tasks to be performed

[4]. My primary task under the *Coroners Act 2003* is to make findings as to who the deceased person is, and how, when, where, and what, caused them to die[3]. In ABC's case there is no real contest as to who, when, where or what caused them to die. The real issue was directed to the 'how' they died, that is, establishing why they could be in possession of a self-administration VAD substance when they were not a VAD patient.

[5]. Accordingly, the List of Issues for this Inquest were reasonably straight forward: -

1. The information required by section 45(2) of the *Coroners Act 2003*, namely: who, how, when, where, and what, caused ABC's death;

2. In respect of the death of ABC-
   a. were the prescribed timelines for the return of the unused self-administration VAD substances observed?
   b. if such timelines were not observed, to what extent (if any) did they contribute to the death?
   c. if such timelines had been observed, would this death likely have been prevented?

3. Are the currently mandated VAD procedures pertaining to the supply of VAD substances for self-administration and the recovery and disposal of unused self-administration VAD substances, adequate to minimize the risk of the unauthorised use of self-administration VAD substances or could they be made safer (e.g. by minimising the time they are not under the direct control of an authorised health professional whilst still maintaining appropriate recognition of the privacy, compassion, and autonomy interests of patients and their families)?

[6]. The second task in any inquest is for the Coroner to make comments on anything connected with the death investigated at an inquest that relate to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future[4].

[7]. The third task is that if I reasonably suspect a person has committed an offence[5], committed official misconduct[6], or contravened a person's professional or trade, standard or obligation[7], then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate.

[8]. In these findings I address these three tasks in their usual order, section 45 'Findings', section 46 'Coroners Comments', and then section 48 'Reporting Offences or Misconduct'. I have used headings, for convenience only, for each of these in my findings.

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[3] *Coroners Act 2003* s. 45(2)(a) – (e) inclusive
[4] Ibid s.46(1)
[5] Ibid s.48(2)
[6] Ibid s.48(3)
[7] Ibid s.48(4)

Factual Background & Evidence

[9]. The matter is quite straight forward. ABC and their spouse were married for many years and were elderly. The spouse suffered a period of ill health and received a diagnosis that their condition was terminal. Appropriate steps were taken under the VAD laws for that spouse to qualify as a VAD patient. Nothing turns on any of that. The VAD patient elected to receive a self-administration VAD substance and the relevant steps were undertaken where ABC was nominated as the patient's contact person[8]. ABC's entire work life was in a particular trade industry and was not within any field of medicine or even an associated field.

[10]. The VAD substance was prepared in Brisbane at the one pharmacy in Queensland approved to prepare it (clearly because of how dangerous a medication it is) and it was personally delivered[9] to the patient and contact person at their location which in this case was in a regional town[10]. No doubt because the VAD substance is so potent, and dangerous to life, a staff member from QVAD in Brisbane personally accompanied the self-administration VAD substance to the regional location to deliver it to the VAD patient. The VAD substance was then left with them with an instructional booklet[11] of how[12] to consume it. At that time ABC commented that they would prefer someone like a nurse to be present to prepare and see administered the VAD oral substance[13]. Clearly they, as ordinary citizens, held concerns as to correctly mixing and administering the substance, no doubt because an error or miscalculation will likely prove catastrophic. What the VAD patient and Contact Person does with the medication is entirely up to them (as there is no practical oversight maintained by QVAD-SPS) although they were told to keep it in a safe place. Later I will contrast that with what occurs at hospital with such a like classified substance.

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[8] I will outline later just how a contact person is assessed (or in reality not assessed) as suitable for that role by QVAD.

[9] Two members of QVAD-SPS (they have a staff of about 20 to attend to supply of 591 doses of the VAD substance in the first six months, in the first year of operation, possibly a very 'demand heavy' period as it was the first access to the programme) fly from Brisbane with the medication to wherever the patient resides, so it could be Cairns, Mt Isa etc. It is not sent by a courier service even though physically that is possible (it is just a small package, about one-third of a shoebox in total size). I think that procedure underlines or highlights just how dangerous the medication could be if it fell into the wrong hands. In addition, I was told persons in *very remote* locations (a step further than just remote) who accessed VAD was just 4 persons out of 591, so 0.67% (or just 2/3rds of 1 percent). Whilst any such location was said to be 'very remote' each are accessible to the RFDS (Royal Flying Doctors Service) and in evidence I was told QVAD clinicians could get access to RFDS for transport to remote locations. Of course that is precisely how people in these remote localities access their medical help if they cannot travel to an appropriate centre. In fact very remote, and remote, VAD patients are just 1.17% in the first 6 months, so 98.83% are outer regional, inner regional and major city. Patients at a distance is a very tiny cohort (see TT 1-92 at LL10-39).

[10] Due to the Non-Publication Order made in this matter the locality where they lived is not to be identified, hence the generic terminology for events, persons, and locations. Ordinarily it is delivered to their residence or hospital, depending on where they may presently be situated.

[11] Somewhat akin to a step-by-step IKEA instructional manual, although with the VAD medication there is no opportunity to 're-assemble' if the first assembly attempt fails. Such is the catastrophic effect of the medication on a person after it is consumed.

[12] It must be consumed in a particular way, and timing, to ensure its' objective of ending life occurs, otherwise the person may suffer a devastating, but not fatal, assault on their general health.

[13] This is a very telling feature of the case and would reflect the mindset of many elderly persons in these circumstances.

[11]. The VAD patient and ABC then suffered a bout of Covid and were hospitalised. Each person commenced to recover from Covid and ABC was discharged from hospital and returned home but their spouse remained in hospital because their overall health was very poor, most likely due to Covid being overlaid with their underlying health issues.

[12]. The VAD patient's health reached a stage where they were unable to swallow, and so it was not possible that the self-administration VAD substance was able to be taken by them. The VAD patient then re-elected for a medical practitioner administered VAD substance and the relevant paperwork for this was undertaken. That medical practitioner administered VAD substance was then supplied and later administered to the VAD patient and they passed away. Of some interest to me is that the then VAD procedures did *not* require the return of the self-administration VAD substance *in exchange* for the medical practitioner administered VAD substance, so in fact this patient had two doses simultaneously made available to them[14].

[13]. After the VAD patient passes away ABC becomes, most understandably, very despondent and overcome with grief such that their adult child described that ABC was 'quite unable to function'. The adult child had spent some months living with ABC and the VAD patient as the end-of-life process was approaching and so had a good insight into their state of mind. ABC was observed to be so despondent that their adult child made an appointment with ABC's General Practitioner for assessment of ABC's mental health.

[14]. ABC had previously suffered a period of depression and had been prescribed medication for this, but they ceased to take it at a time when they were caring for their spouse. The fact that ABC had been medically diagnosed with depression and took medication was not something the VAD authorities considered, or even enquired on, when approving them to be a Contact Person. Indeed, there are simply no checks or enquiries of the Contact Person's suitability for that position. They simply need to state they are over 18 years of age and provide a name and contact details. These are not checked against anything remotely 'official'[15]. At the inquest it was conceded[16] that a person is required to undergo greater identity checks to enter a Nightclub in Brisbane, than to become a Contact Person. Under the current regime the person may have a significant criminal history or extensive mental health issues, yet not one background check is made.

[15]. Grief is a very ordinary process experienced by a person when someone close passes away. The level of grief experienced is compounded by the closeness of the relationship and no doubt the years of that relationship. It is not at all unusual that ABC would suffer profound grief when their spouse passed away as they had been married for a long

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[14] That situation is now remedied following this incident. It is surprising, and defies logic, at least to my mind, that there was not implemented a system to ensure a VAD patient could never have available two VAD doses. Perhaps that demonstrates an absence of practical thought in the implementation or mechanics of the programme.

[15] Indeed, a person does not even need to show any proof of identity, for example a driver's licence, rather they simply are required to put a name, address and relationship on a form. There is no verification process whatsoever.

[16] See TT1-77 at LL14-31 where the Acting Executive Director of the VAD Authority agreed there were, in effect, simply no checks of the Contact Person for identity or suitability that is conducted. I find this situation very troubling when they become responsible for a medication which has just one medicinal objective, to end life. Situations for its' potential misuse are readily imagined and occurred in this case.

period of time and were very close. In fact if ABC had experienced no or very little grief that would be a very unusual situation.

[16]. It is easiest if I now set out a very short timeline of important events:-

a. *1 January 2023* - the VAD programme becomes available to eligible persons in Queensland;
b. *27 March 2023* - the spouse is assessed as eligible for VAD;
c. *2 April 2023* - the Contact Person is appointed and signs the Form 8;
d. *3 April 2023* - the spouse chooses the option for self-administration of the VAD substance;
e. *5 April 2023* - prescription for self-administration was issued by the co-ordinating practitioner;
f. *11 April 2023* - the QVAD pharmacist checked the prescription (and presumably filled the prescription);
g. *17 April 2023* - ABC telephoned QVAD-SPS and requested supply of the VAD oral substance;
h. *24 April 2023* –
    i. delivery of the VAD oral substance was scheduled;
    ii. the spouse was admitted to hospital with Covid;
    iii. the VAD oral substance was delivered to ABC for their spouse. The VAD patient and ABC requested a VAD nurse be present[17] when they decide to consume the medication;
i. *26 April 2023* - the spouse's medical conditions were not resolving, and their general condition is deteriorating, so they revoked the self-administration decision and opted for a practitioner administration of the VAD substance [that revocation then invokes the requirement for the unused oral VAD substance to be returned by 10 May 2023. The obligation is on the Contact Person, not the QVAD personnel];
j. *8 May 2023* - the QVAD pharmacist and QVAD Care Co-ordinator travel to the spouse's hospital location and deliver the intra-venous VAD substance to clinicians. The oral VAD substance is not then 'swapped', nor 'exchanged', at that time, rather the patient then has in existence two supplied VAD substances doses;
k. *8 May 2023* –
    i. the spouse passes away after the health practitioner administration of the IV VAD substance;
    ii. the QVAD Care Co-ordinator reminds ABC to return the unused VAD oral substance[18];
l. *10 May 2023* - the date for return of the unused VAD oral substance passes without it being returned or appropriately disposed of;
m. *12 May 2023* - the VAD Review Board emails the QVAD-SPS to request follow-up of the return of the unused VAD oral substance. QVAD-SPS attempts to telephone ABC but there is no contact. In a later exchange of text messages with ABC's adult child they are prompted to return the unused VAD oral substance;

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[17] Not an unreasonable, nor unusual, request of persons in their 80's and completely unfamiliar with medications or the VAD process.
[18] And I note that the QVAD staff stayed whilst the VAD IV substance was administered, which is what I propose should occur for oral substances.

n. *13 May 2023* - no steps taken, a Saturday;
o. *14 May 2023* - no steps taken, a Sunday;
p. *15 May 2023* - there was no attempt by QVAD-SPS to seek return of the unused VAD oral substance[19];
q. *16 May 2023* - ABC's adult child remains so concerned for ABC's mental well-being that they attend ABC's General Practitioner clinic to reschedule an earlier[20] appointment for ABC to attend his doctor. ABC's adult child *initiates*[21] contact with the QVAD Care Co-ordinator to advise that they hope to return the unused VAD oral substance to a pharmacy the following day. ABC's adult child returns home to find ABC deceased, sitting in an armchair, in the lounge room with the open VAD oral substance self-administration kit opened on the dining room table, and it was evident that ABC had consumed the VAD oral substance.

[17]. From the above it is clear that the system, and its' purportedly rigorous 'checks and balances', had several operational flaws. The real tragedy is that it took just 107 days of the new laws' operation for the flaws to be fatally exposed[22]. It was, in my respectful opinion, not a well-considered law.

[18]. Firstly, there is no logical reason for a VAD patient to have issued to them <u>two</u> VAD substances at the same time. Clearly if a new one is required the existing one should be exchanged. Secondly, the unused VAD oral substance, which was then no longer required, was not in the control of the QVAD personnel, rather all they could do was take gentle steps to prompt the Contact Person to return the unused oral substance. Understandably the Contact Person is then going through a period of significant grief. No doubt the QVAD personnel would find it very difficult, one would think impossible, to impose any harsh deadlines, or take a stern approach to its' return. What are they to do? Impose a fine or some other penalty if it is not returned within the 14 days? This does not seem a very tactful nor compassionate approach to a grieving person. Of course, this is all predicated on the Contact Person still having control of the VAD oral substance. Thirdly, why is such a dangerous medication removed from the direct and immediate control of a health practitioner until it is ready to be used? Many will identify that this issue is the very centre of the flaw in the current system.

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[19] Whilst 13 & 14 May 2023 were weekend days it suggests a lack of urgency in ensuring compliance with dates by a Health Service. That no steps at all were taken Monday 15 May 2023 is the most surprising. Perhaps QVAD-SPS staff thought they would be 'badgering' the Contact Person too much, but this highlights yet another flaw of leaving the medication with the Patient/Contact Person. All this required 'follow-up' is eliminated if the revised process I recommend is implemented. I am sure QVAD-SPS staff feel they are in somewhat of a predicament chasing for return of the unused substance in the circumstances of this case (ABC experiencing profound grief), and I agree with them. They have been given a very difficult and delicate task, one which need not eventuate with an alternate and safer system.

[20] One had already been booked by telephone but the adult child wished an earlier date.

[21] Again no steps had been taken by QVAD-SPS that day (now the fifth day after return was required) until the adult child takes steps.

[22] And at inquest I was told that there have been numerous 'near misses' or errors. I shall speak of these later. What this highlights is that ABC's case is not the only concerning incident to occur, simply the only one required to be reported to a Coroner. Of concern to me is that other 'near misses' seem not to have caused any documented concern to be raised to the VAD board or others by higher management.

[19]. What was made clear to me at the inquest, and I accept, is that there was no breach of the protocol or legislative processes by any of the QVAD personnel in how they approached this situation. The obligation was solely on ABC to return the substance, there is no obligation on the QVAD staff. Any breach of the programme's requirements or time limits was in fact solely done by ABC. One must realise that at that time ABC was then effectively housebound, being a rather elderly person overcoming the effects of Covid and dealing with the loss of their spouse. They are not well-placed to think and act promptly, diligently, or clearly. They are in a health-fatigued situation and grieving.

[20]. I think it is necessary for me to also highlight that the current approach of QVAD-SPS or the QVAD Care Co-Ordinator reminding the Contact Person to return the unused VAD oral substance is also a reminder to the Contact Person that they have at their disposal a step-by-step guide to a peaceful, and certain, exit from life. Unwittingly the QVAD personnel are reminding the Contact Person that that 'option' is in their control. I do not think that the compassionate approach thought to be achieved by the government, and their legislation, is in fact what operates in practice.

[21]. I can now make certain Findings.

List of Inquest Issues Answers

Coroners Act s. 45(2): 'Findings'

[22]. Dealing with the list of issues for this inquest my Findings are as follows: -

[23]. Issue 1. My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:

a. Who the deceased person is – ABC[23],
b. How the person died – ABC died from the intentional administration to themself of a VAD oral substance which was not prescribed for use by them,
c. When the person died – 16 May 2023[24],
d. Where – suppressed in these published Reasons for Decision as a Non-Publication Order was made, and
e. What caused the person to die – VAD oral substance toxicity[25], and the significant underlying conditions of ischaemic heart disease, emphysema, COVID-19 (SARS-CoV-2) infection[26]

[24]. Issue 2. In respect of the death of ABC–

a. were the timelines prescribed timelines for the return of the unused self-administration VAD substances observed? - Clearly the answer is No.
b. if such timelines were not observed, to what extent (if any) did they contribute to the death? – I find that it presented an opportunity to ABC that they took.
c. if such timelines had been observed, would this death likely have been prevented? – If the VAD oral substance had been returned within time, then the

[23] A pseudonym is used due to the Non-Publication Order
[24] See Exhibit A1 QPS Form 1
[25] This is all that is necessary to state for one to know the actual medical cause of death.
[26] See Exhibit Z7, Preliminary Examination Report (restricted access exhibit)

death could possibly have been prevented (or would continued follow-up for its' return simply reminded them that they held a painless end-of-life substance?)[27].

[25]. Issue 3. Are the currently mandated VAD procedures pertaining to the supply of VAD substances for self-administration and the recovery and disposal of unused self-administration VAD substances, adequate to minimize the risk of the unauthorised use of self-administration VAD substances or could they be made safer (e.g. by minimising the time they are not under the direct control of an authorised health professional whilst still maintaining appropriate recognition of the privacy, compassion, and autonomy interests of patients and their families)?

[26]. The currently mandated VAD procedures for self-administration are, in my view, inadequate to provide for medication safety and to prevent deliberate misuse. I recommend that the self-administration processes be changed. I make further comments in this regard below.

Coroners Act s. 46: 'Coroners Comments' (Recommendations)

[27]. This inquest is not a discussion about the necessity or otherwise for the VAD laws, rather it is whether the laws (or perhaps better stated, their processes) as to the self-administration VAD oral substance can be made safer.

[28]. The drug used is classified as an S8 drug. That is the highest drug classification possible and so its prescribing, dispensing, and administration is very tightly controlled.

[29]. In a hospital an S8 drug is subject to a standard for secure storage. Stated very generally the S8 medication is kept in a drug safe (locked cupboard), within the locked drug storage area, and two staff must be present to sign it out. Its handling is highly monitored and subject to regular audits, usually at the end of every 8-hour shift to ensure accountability. Each hospital would have such a standard, usually termed a 'Substance Management Plan for Medicines'. When the medication is to be used the qualified medical staff keep it in their possession until it is administered to a patient. This is all required due to the 'dangerous' nature of the drug if misused.

[30]. As an S8 drug the self-administration VAD substance is also highly regulated as to:-

a. how it is prescribed (only after two doctors assess the patient's eligibility);
b. is so dangerous it is produced by just one pharmacy in Queensland and under very strict controls[28];
c. it is also hand-delivered by a VAD staff member who will travel from Brisbane to anywhere in the State to deliver it;

[27] And many persons with end-of-life illnesses have multiple S8 medications at home but those medications do not have a 'how to' booklet, nor are certified as a painless end-of-life, nor are grieving spouses reminded of the presence of that medication, a somewhat different situation for VAD substances to a layman.

[28] Indeed on the day this death was reported to me I tasked my assigned QPS Coronial Support Unit officer to attempt to obtain the pharmaceutical make-up of the drug but they were told it could not be disclosed even to the Coroner we were advised. Of course its constituent drug was simply printed on the label on the medication box.

d. it is kept in a secure locked box[29].

They are all necessary steps required as this drug has just one pharmacological purpose, that is to end a life[30].

[31]. It is the next step where to my mind the obvious flaw in the VAD self-administration process occurs[31]. The self-administration VAD oral substance[32] is then simply handed over for future use (purportedly for up to 12 months) to an ordinary citizen with no medical training, no health authority registration, and no professional body oversight whatsoever. The person has not even been screened by way of any 'character' test or any identification or assessment at all[33]. This highly dangerous drug can then, in practical terms, simply be left on the kitchen table of a patient's residence because where it is kept, how securely it is stored, where the keys to the lockbox are kept (if indeed the box remains locked), is entirely left with the patient or their Contact Person. Many will now appreciate my concern with the current self-administration process[34].

[32]. A senior administrator[35] for management of the QVAD programme told me that part of the systems they now[36] have in place included real-time monitoring[37] of the substance in the community. When explored a little further on this I was informed that it was simply a daily report that is produced internally to tell them how many VAD kits had been issued and were then in the community. I then applied some commonsense to this assertion that this daily report actually provides any real-time monitoring.

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[29] Up until it is presented with its key to a VAD patient, then what happens regarding its security is entirely left to the VAD patient and the VAD Contact Person. The VAD Contact Person later has the obligation for the appropriate return of any unused VAD Substance. The thought to widen who may return the unused substance neglects to address any deliberate misuse of the oral substance, say by the patient and Contact Person in a 'pact' acting together.

[30] Quite a different objective from any other drug or medication.

[31] And I remain completely perplexed at how anyone could have thought this approach correctly balanced the need for patient autonomy, compassion, and privacy against the potential for misuse of such a dangerous medication. It is an approach completely at odds (in fact it is the exact opposite) with every safe handling and secure storage approach for such a type of medication which applies just down the road at every hospital or other facility which has these medications.

[32] In its locked box but with the key.

[33] Indeed it is conceivable they are handing this dangerous drug to a person recently released from prison or a person with a documented history of significant mental illness. QVAD simply have not conducted any background or character checks, not even to require a Drivers Licence be produced.

[34] And I have not even reached the most obvious flaw of this case, that the Contact Person will very often be a close relative and greatly affected by grief when the VAD patient dies.

[35]The Acting Executive Director of the VAD unit. So the most senior of their administrative structure positions.

[36] This change was implemented after ABC's death.

[37] The terminology of real-time monitoring is usually associated with being able to view through data the then activities of a unit or item being monitored. For example, a trucking company may have GPS monitoring of their trucks to tell them where the truck is, what speed it is travelling, and other useful information they may wish to have so they may monitor the whereabouts of a truck or the driving behaviour of that truck driver. Producing a daily report as to how many VAD kits there are in the community is in no way real-time monitoring. Persons in authority should perhaps avoid using what they think is 'catchy' terminology unless the term actually applies. This exchange I had with the QVAD Acting Executive Director (effectively their senior management person) had me perplexed as to whether QVAD senior management understand what effective and practical solutions are to the issues in the current program as highlighted by ABC's death. Perhaps this is because I was told that the QVAD staff are almost entirely lawyers. One would think that with VAD being a health-related issue, operating within an established legal framework, that perhaps experienced (say 15+ years practical experience) health practitioners would constitute most positions as these people have the necessary practical experience to understand patients, their behaviours, and their needs.

[33]. It was conceded that this daily report does nothing to identify precisely where the substance is, how it was then being kept, or even as at that date if it had been consumed or not. This daily report is only updated after the death has been reported to QVAD, usually after it has been recorded with Births Deaths & Marriages (BDM) which has a notification policy with QVAD. Through my work as a Coroner I know that there is some weeks gap between a death certificate being issued for somebody (usually the day of death by a doctor) and it being recorded by BDM (sometimes this takes weeks, even a month[38]). QVAD is then notified after that BDM recording of the death.

A perfect or imperfect system?

[34]. ABC's death occurred just 107 days after implementation of the VAD scheme. They were a Contact Person who deliberately misused the VAD medication. Clearly any State-sanctioned euthanasia program can only have one measurable objective, that is precisely 100% compliance and that no innocent, nor unintended, person is in any way harmed. The evidence from the inquest from a doctor with QVAD[39] was that there has already been a number of 'near misses', if I use that term, where various people have required the intervention of a health practitioner administering a supplementary IV VAD dosage to ensure that patient's death. She gave examples of how one patient was still alive after 20 hours[40], and another who consumed alcohol before they took their VAD medication and then promptly vomited up a significant portion of it and lived for 6 hours[41]. This was very stressful for each family. Each of these patients required additional and immediate medical practitioner oversight and intervention to ensure they passed[42]. It appears reasonable to conclude that without that further VAD intervention these people may well have been left very significantly health-compromised[43] by, in my view, the failure of the current system.

[35]. Accordingly, ABC's death is not simply some 'one-off' anomaly or solitary aberration. No one objectively analysing the programme can rightly say it has been working perfectly except for ABC's death. There has already been an unintended death and several very near misses as the QVAD doctor explained. Thankfully a health practitioner was present to take immediate action for each of the 'near misses'. The current system is imperfect. Further calamity and heartbreak await for patients and families if nothing changes.

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[38] And the Acting Executive Director had little idea of the timeframe, see TT 1-68 at LL 1-20. Perhaps they are not dealing with this issue regularly enough to be aware of the potential time delays.
[39] TT 1-95 at LL10-27.
[40] Ordinarily death occurs within 10 – 30 minutes.
[41] And what of the frail patient with Parkinson's Disease or other hand shaking tremors? What if they spill most of the oral substance contents before consuming? Canada was alive to this and elected for health practitioner assisted, or overseen, substance administration.
[42] One even required a supplementary dose of IV VAD substance.
[43] To what degree one can only speculate.

The Contact Person suitability checks

[36]. The evidence given was that the Contact Person undergo no background checks at all. Background checks were thought to be too intrusive on their privacy. It was conceded in evidence[44] by the Acting Executive Director of QVAD that there are in fact more stringent checks conducted for a person to enter a nightclub in Brisbane than the person to be handed this dangerous medication. To my mind this is a very clear anomaly in the approach, one which I cannot reconcile, possibly because no one can reconcile it.

[37]. It seems to me that no considered thought has been given to the possibility that the Contact Person proposed could be someone with an extensive criminal history for drug or other serious offences, indeed they could have recently been released from prison. I appreciate what I am suggesting is at the extreme end of the range, but it demonstrates that there is simply no checking of the suitability or background of the Contact Person[45].

[38]. Many will understand that the Contact Person will be someone who is emotionally very close (such as a family member) to the VAD patient[46]. That then introduces another consideration. This person has a strong family and close personal connection to the VAD patient, so this person will be more greatly affected by grief with the passing of the VAD patient.

[39]. Clearly with such a dangerous substance it should, in my view, remain under the direct control of an authorised health professional (Hospital, palliative care doctor or nurse, general practitioner) and when the VAD patient has made their decision as to where and when they wish to take the VAD substance the health professional then attends their residence, or suitable location of their choosing, and the authorised health professional can then bring the substance with them, provide it to the Contact Peron or VAD patient, oversee its' correct set out, and then step back while it is consumed. Once

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[44] TT 1-77 at LL27-28. And I am not critical of the Acting Executive Director for their concession, rather I welcome their candour in their answer. They have not designed this system, rather they simply administer it. I suspect no-one when designing this system has turned their mind to analogous ID or background check situations to see how unacceptable (in my view) the present Contact Person screening process is.

[45] Further to expand for the reader the darker possibilities you must realise that the substance provided is in a set quantity of millilitres. It does not matter if the patient weighs 40 kg or 265 kg (in my coronial cases I have seen such sizes of people) and so the amount provided is simply enough to ensure *any* person successfully ends their life. All VAD patients will be at an end-of-life stage of general health, or in serious failing health. Usually, they would be at the lower end of the weight scale and certainly their bodily general reserves will be very compromised by their underlying illness. That means that the quantity of VAD substance provided could easily end the lives of two persons. It is not reaching too far to suggest a valid VAD patient could enter the VAD programme with a suicide pact with their spouse. As a Coroner I see couples faced with failing health issues doing such a joint pact regularly without the VAD scheme. It is also possible that an enterprising VAD patient knowing their life will soon end due to health issues may sell the product to another who is in such poor quality of life that they wish to end their life but do not qualify for the VAD programme. A more sinister thought would be that a scheming child could utilise the VAD substance to end the life of their VAD parent and then poison (or 'encourage') their other parent to consume the remaining substance (and the particular "flavour" of the VAD substance could readily be hidden in a number of fragrant or bitter foods) so they either access an inheritance earlier or not have to care for an elderly parent. Coroners see such scenarios. I apologise if the above scenarios appear overly pessimistic but none of them is inconceivable, and I regularly see 'end-of-life' pacts between spouses, who employ a variety of methods, some much gentler than others. There is, as I propose in the Recommendations, a safer method which still preserves the required dignity, autonomy, and privacy of a VAD patient.

[46] And an attempt to quantify the relationship was done and it appeared that a close familial relationship existed in about 2/3rds of cases.

death is confirmed then they certify that the person is passed away; surely a more compassionate and less stressful approach for the patient and Contact Person.

Why a Health Practitioner should be present at the death, and the timing and choosing of the place of death

[40]. Why should a health professional be present at the location when someone dies? Answered simply is because complete autonomy allowed to a lay person has too many risks and can bring about an uncertain or inappropriate outcome.

[41]. In a home setting of a lay person such possible situations to occur are:-

a. incorrectly mixing or incorrectly consuming the mixtures, or at the very minimum great stress in ensuring the steps are appropriately followed[47];
b. being unsure as to when the patient has actually passed away, is it 10 minutes or 1 hour, do the family continually check?;
c. who to call to have complete the Life Extinct certificate[48]? Call the QAS, call the QPS? These marked emergency services vehicles will then be appearing in the street outside the house. A Contact Person's very first task after their loved one's death should not have to be a 000 call;
d. there is no oversight as to the location of the death. Theoretically[49] any of the following could occur:-
    i. a couple goes to their favourite public lookout over the ocean to take the medication at sunrise or sunset[50];
    ii. an elderly couple go to their nearby local park where they had sat at a bench daily, which bench happens to be next to the children's playground equipment;
    iii. a man who lives alone and with no local family and very few friends attends his local Leagues Club or Public bar at 3.00 PM each day as this is his daily social outing[51], and after a few drinks then quietly mixes and consumes his VAD kit in the Bar.

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[47]One can only imagine the potential for bickering between two elderly people, one in significant health distress, who have to read and reread the instruction manual (possibly many times) and ensure they are getting everything correct and following the procedures. The instructional booklet (exhibit Z.16a) is 17 instructional pages long, but with information that is well set-out and includes photographs of important 'steps'. Whilst it is a good booklet the potential for distress in this situation is patent. It is far easier if a health practitioner is present to unpack the kit, lay out its contents in the appropriate order, and then guide the parties as to how it is mixed, order in which it is consumed (and that sufficient is consumed) and that the timing of consumption (yes that is a factor) is correct (all three factors have an effect on the outcome). One must remember that the VAD patient held the oral substance but changed to IV administration as they then could not properly swallow.

[48]The very first piece of paperwork completed after a person dies is a Life Extinct certificate. Doctors, nurses, police officers, and paramedics amongst others all have authority to complete such a certificate. They cannot be completed by a layperson without appropriate qualifications or a funeral director. It is these simple practical steps which seem to have not even being considered in the VAD self-administration programme.

[49] And I am reluctant to have to provide these examples but unusual circumstances and locations of deaths is a very familiar circumstance to a Coroner. Unfortunately it occurs regularly, but never publicly broadcast.

[50] Many will recall the infamous photo taken at Hervey Bay of QAS officers accommodating a dying lady's last wish of seeing and smelling the ocean one last time. It is a realistic, and often thought of, request.

[51] I quite frequently have reported to me such persons and it is their friends at the bar who notify QPS to conduct a welfare check when they have not appeared at the bar for a few days. Effectively this is their local family or acquaintances who have their best interests in mind.

No doubt people can see how unwise these location decisions are when viewed by a member of the public, but to the VAD patient it may seem to be just a simple and, to their mind, acceptable final decision. I would highlight that one of the VAD nurse practitioners gave an example of how they advised a patient that their choice of location was inappropriate and so at the nurse's urging an alternate location for providing the medication was chosen. This only occurred because the health practitioner was present and was able to provide independent and timely guidance as to what is appropriate.

[42]. I feel confident that health professionals will have the appropriate level of experience to ensure the safe handling[52] of the VAD substance. They also have the appropriate compassion and objectivity to ensure any reasonable requirements of a VAD patient as to time, date, and place of their choosing will be met[53].

[43]. It was said in evidence[54] that complete patient autonomy means that the patient can wake at 2.00 AM and then decide that they want to die and can do so straight away. I appreciate that (although it seems very unlikely a scenario) and that my approach does not facilitate that. For the revised approach patients would be told that for the oral administration election that the prescription will be requested, they will then be notified once it is filled and that the medication kit is now held at the Brisbane pharmacy awaiting their request for it to be delivered, but that 7 days' notice for its' delivery is required.

[44]. Is this entirely unreasonable? Not really, because for an IV administration there is a similar delay whilst the prescription is filled and then the IV VAD medication delivered. I do not think this would stop a person from entering the VAD program. One must remember that from first consideration of deciding to enter the VAD program the patient must successfully undergo two successful doctor assessments before becoming qualified to participate. That will take time on its own[55].

[45]. To me a revised approach achieves the compassion required for the VAD patient and their family, whilst always ensuring the most dangerous of pharmaceutical products is kept under the direct control at all times of an authorised health professional, and the substance cannot be misused[56]. Ensuring health practitioner retention until its' use shall also ensure the VAD oral substance is stored in an appropriate temperature environment[57].

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[52] And I refer to the evidence of one QVAD witness (name redacted due to VAD law requirements), who is a Registered Nurse and QVAD-SPS Clinical Nurse Co-ordinator that when delivering a VAD oral substance to a certain patient that the patient's living arrangements in a share-household meant the QVAD employee was concerned as to medication safety and so would not deliver it, rather an alternate arrangement for its provision was made. Quite simply they would not leave it solely with the patient in that household. This was a wise clinical decision, and one which aligns more to the balance necessary for medication safety v patient autonomy.
[53] I am very confident that if a patient chose sunset at home as their time of choosing that a health practitioner would accommodate that request. They are a caring profession.
[54] Raised by a doctor for QVAD
[55]And we are talking about an end-of-life programme, a very significant decision which requires appropriate checks and balances and time. It is not fast-food delivery.
[56] And it is under the control of two health professionals at all times so the health professionals cannot misuse it.
[57] It was unclear if the oral substance medication would maintain its' efficiency if stored at a house at room temperature, which conceivably could be Birdsville.

[46]. Regrettably the current VAD self-administration processes has, in my view, not been adequately thought through as to its practical application in the real world. The current self-administration process is open to improper use, and as I have also outlined above there is potential for sinister misuse. Of some concern to me is that Queensland Health itself, prior to the inquest, conducted a review of the incident and that Reviews' Recommendations[58] is simply to further tighten the existing procedures for recovery of unused VAD substances. It did not identify or comment on, what to me at least, is the obvious flaw in the process even though the scope of the Review included '*any other safeguards that are in place with respect to voluntary assisted dying substances in the community when a self-administration decision is made*'. Perhaps it was not considered within scope to suggest a significantly revised approach, or perhaps independence from the department for such reviews, which is what a Coroner brings, is what is required.

Financial Cost of Coroner Comments/Recommendations (and the proposed changes to VAD oral substance administration)

[47]. It was put to me that I should not make any Comments on changing the present VAD oral substance process as there was no material before me to determine the financial viability or cost of any such changes. That is certainly a true observation, that there is no financial analysis, nor costings, placed before the inquest. What this overlooks is that s.46 *Coroners Act 2003* does not include any requirement that a financial costing is provided, whether detailed or otherwise, before any Comment is made and, at least to my knowledge after 12 years of being the Coroner, I am not aware of a financial analysis of a Coroner's comments being required before that Comment is made.

[48]. A Coroner conducts their investigation. Any Comments made, obviously, should have an elementary consideration of costs to ensure that any Comment or suggestion is not completely fanciful nor financially outlandish, but there is no legislative obligation, nor indeed procedural precedent, that a Coroner must provide or consider a detailed financial analysis before making any s.46 Comments. Indeed, neither a Commonwealth initiated Royal Commission nor a State established Commission of Inquiry requires any financial analysis, detailed or otherwise, before their Comments or Recommendations are made[59].

[49]. Accordingly, whilst a financial analysis of any Coronial Comments is not strictly required, cost is of course something I bear in mind. To my mind my Comments in this matter are very readily achievable from a cost perspective, in fact on a cursory financial analysis of the current process against what I propose should occur it may be that my proposed process is more cost effective. My Recommendation effectively simply delays the already undertaken trip to deliver the VAD oral substance to the time when it is to be administered. There are no additional travel costs as that is already incurred under the current practise, the only additional expense is the few hours at the location whilst the VAD oral substance is then mixed and observed to be self-administered, and then confirming the deceased's passing. There is of course no required follow-up for

[58] And I am greatly condensing down to the focus of what was recommended.

[59] Not that an inquest is entirely strictly analogous to a Royal Commission or Commission of Inquiry, merely these are also legal proceedings in the nature of an inquiry and conducted without a detailed financial analysis of potential Recommendations.

return or disposal of any unused substance as the attending health practitioner has then removed it themselves. Hardly any great additional expense.

The Cause of Death that is recorded.

[50]. What is stated on the deceased's death certificate is an area I should comment on. The VAD laws provide that a person who dies because of the administration of VAD substance in accordance with this Act does not die by suicide[60], rather have died due to their underlying illness or medical condition[61]. ABC was not a VAD patient and so cannot be considered to have died in accordance with the Act. The forensic pathologist on the Form 30 issued indicated, correctly in my view[62], that the person died due to a VAD substance toxicity[63].

[51]. The legislative approach is simply a device of "deeming", to say that a VAD person died due to their underlying illness, but that is not the reality. This appears to have been done for perhaps[64] insurance purposes, but that could readily be achieved simply by legislative provision. Simply saying someone did not die of the VAD substance but rather their underlying terminal medical condition appears to be somewhat of a 'soothing' approach towards families. Arguably many families would seek such an approach to be used in many other death situations[65] but accurately stating the actual medical cause of death is a requirement, although I accept that sometimes it may appear as very harsh. Perhaps the approach taken by the government was to steer away from a seemingly harsh reality and embrace what is thought to be a more palatable cause of death for the family's sake. That seems to a degree to be unusual as the cause of death would hardly be a surprise to their family, nor likely upsetting to them, because the deceased will very likely have openly discussed their decision amongst the family, and of course the Contact Person should be very aware of the Patient's decision. Perhaps reality is a position the legislature found too difficult to embrace?

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[60] Suicide is not a medical Cause of Death nor even recorded as such on a Death certificate, rather the medical cause is recorded, e.g. Hanging.

[61] Section 8

[62] And no submission was made to me that this is the incorrect approach in this case, ABC's death.

[63] The particular medication substance is stated, rather than 'VAD substance toxicity', so I have deliberately used terminology to avoid broadcasting the substance's constituent.

[64] It has not been made clear to me why the legislation has such a deeming provision, but Hansard records that the Government said it was for insurance purposes, obviously life insurance. It may be that 'privacy' of the deceased is sought from those who later view the Death Certificate which records the Cause of Death (for example any entities required to view it for Estate Administration purposes), and this is possibly a more valid reason but being a State-sanctioned end-of-life method which seemingly has very broad community support this may not really be an issue. Any legitimate insurance issue could readily be addressed in the VAD legislation to prohibit a VAD death being an insurance policy disqualifying event.

[65] Coroners are regularly requested to have a Cause of Death not imply, nor infer, any intentional self-inflicted harm by the deceased that caused the death.

Where did this draft Law go wrong?

[52]. So how did we get to this situation and where did it all go so wrong? I set out briefly why the situation is as encountered by ABC so their family knows. I set out in much greater detail the events in Appendix A for the Government's consideration.

Two options presented to Government

[53]. Essentially when considering the legislation, as to self-administration, the Government was presented with two options. The first by noted VAD experts Professor Ben White and Professor Lindy Wilmot who provided their paper and even a Model Bill. Their approach was that the self-administration would always be under the supervision of a health practitioner. The alternate proposed by the Queensland Law Reform Commission (QLRC) was for the substance to simply be given to the patient for them to use at any time over the next 12 months. Most people can recognise that there is required a balance between medication safety and security on one hand, and patient autonomy and privacy on the other. To my mind the Model Bill as proposed achieved the appropriate balance between the two competing tensions, and, with great respect, the QLRC proposal swung the pendulum too far in favour of patient autonomy. The flaw with patient autonomy being the major consideration is highlighted by the factual circumstances of this case.

[54]. Perhaps those involved who put forward the current process simply did not have enough practical experience in seeing such circumstances as joint suicides between longstanding couples facing difficult health futures, and even assisted suicide and then suicide between such couples. Coroners do see such factual circumstances, and on an all-too-frequent basis. I have had reported to me several such instances since this inquest was held with those persons not having qualified for access to the VAD program[66].

Good Governance

[55]. Good Government, and governance, means laws should aim to consider, balance, and implement rules to advance its citizens' interests and their well-being, whilst adequately protecting them from harm or unforeseen consequences. It requires very wise and considered thought.

[56]. I appreciate that the laws passed by the Government for voluntary assisting dying were novel for Queensland but is not a concept that is novel when considered worldwide[67]. The parliament passed oral substance administration laws which, in my respectful observation, did not have an appropriate balance struck between patient autonomy[68] and

[66] Perhaps the nature of my work means I am simply over-exposed to such circumstances, or perhaps it is the reality that others, thankfully, do not get to see. QAS and QPS also would readily see such situations as they are part of the matrix of such Reportable Deaths under the *Coroners Act*.

[67] Such euthanasia laws have been operating in some countries for over 20 years now.

[68] And it seems the level of patient autonomy is simply to provide the medication in a locked box with an instruction booklet and 'hope' that the patient and contact person does the right thing. The evidence proved that this approach has resulted in the loss of one life (and not the VAD patient) and very nearly the catastrophically

lethal medication safety. As I said earlier, any state sanctioned system to legally end a person's life can only have one calculable target, that is simply a 100% success rate. 99% success means that people are left alive and are now further medically incapacitated, 101%, as occurs in ABC's case, means people who were not even a VAD patient have lost their life.

[57]. The implemented VAD oral self-administration laws unfortunately overwhelmingly favoured patient autonomy and this has led to an outcome which has caused very significant distress to the family and a life has been unnecessarily lost, which loss was, in my respectful opinion, avoidable if appropriate considerations for lethal medication safety had been implemented. I consider that if there had been implemented the procedures outlined in the Model Bill then ABC would never have been in a position where they had the VAD oral medication solely at their disposal at a time when suffering from significant grief.

Coroners Act s. 48: 'Reporting Offences or Misconduct'

[58]. The *Coroners Act* section 48 imposes an obligation to report offences or misconduct.

[59]. In view of my findings set out above there does not appear to be any breach of the law by any the QVAD–SPS personnel even though the return of the substance was overdue. There is no positive obligation on those personnel to ensure that a used oral substance is returned, rather that obligation is held by the Contact Person, who in this case was a person who intentionally misused the oral substance. Many will appreciate that my Recommendation arising from this inquest should eliminate the risk of recurrence of the factual circumstances which occurred in this case.

[60]. I do hope that the Government is wise enough to read and consider these Reasons, and then act appropriately and implement the required changes to the VAD oral substance administration system. As a Coroner I continue to see longstanding couples making very difficult decisions when faced with one having a terminal or debilitating general health condition for which there is no medical cure. The situation, and its occurrence, is more prevalent than what the Government may appreciate, and persons should not be placed in a position where they can be led into unwise decisions due to grief and an overwhelming despondency caused by the loss of their loved one.

Coroner DJ O'Connell

Delivered at Mackay

11 September 2024

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scarring of other lives because people either cannot follow the instructions or are somewhat cavalier in their approach. The programme's approach is, stated very bluntly, simply *the hope* that people will do the right thing with no oversight at all of what they do after the medication is provided to them.

Annexure 'A'

[1]. The Model Bill for the VAD laws were proposed by Professors Ben White and Lindy Wilmott. It stipulated that the VAD substance was to be under the supervision of a medical practitioner "*at all times*", that is a medical practitioner was expected to attend self-administration with the VAD substance. No doubt that is because our medical practitioners, registered nurses, and health practitioners are world-class professionals and possess the necessary experience, sensitivity, dedication and professionalism. They also have the necessary independence and objectivity as to where a VAD patient wishes to have it administered and to see it is administered correctly[69]. In addition if a health practitioner is present they can assist the family members and reassure them that certain end-of-life circumstances[70] exhibited by the patient are normal and are causing no additional distress or discomfort to the patient. This would be a reassuring voice for distressed family members at that time as they are very unfamiliar with the experience[71].

[2]. The Queensland Law Reform Commission recommended at paragraph 11.121 that:-

a. "*The Draft Bill should support people who decide to self-administer without requiring the coordinating practitioner or another health practitioner to be present*".

That appears to be the genesis of where the Model Bill's requirement for a health practitioner to retain the VAD substance and see it self-administered appropriately, diverged. The QLRC Report at 11.191 added:-
"The Draft Bill should support a person to self-administer, without requiring the coordinating practitioner or another health practitioner to be present, and ensure the VAD substance is managed safely. To enable this, the Draft Bill provides for the appointment of a contact person where they have made a self-administration decision, ensuring a clear chain of responsibility for the substance once it has been supplied and in particular, the safe return and disposal" (my underlining emphasis added).

It is necessary that I critically appraise this departure from the Model Bill, as to what that can mean in practise.

[3]. As I said earlier a Contact Person can be anybody. There are no background checks, nor enquiry into their suitability. They do not even have checked their identity. Common-sense says that a Contact Person is most likely[72] to be a family member of the VAD patient, which whilst that means they will have a heightened sense of established compassion for the VAD patient, it also means they have a heightened level of grief when the patient passes. No doubt the Contact Person would be wholly engaged in

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[69] It is not as simple as mixing the medications and consuming. The Canadian model material in this respect clearly demonstrates the important small details to ensure it is consumed properly as each patient is in an end-of-life health state, and so very often frail and has many co-morbidities which could affect proper consumption of the VAD substance (even just Parkinson's disease could mean spilled medication if an open cup is used).
[70] Agonal breathing of a dying person whilst very normal may present to a family member unfamiliar with it as a very distressing circumstance.
[71] One can readily imagine family members without a health practitioner present being unsure if the patient has actually passed away and probably would not know how to check nor how long to wait. This simply causes them further distress in an already stressful and emotional situation. Hardly a 'compassionate' approach.
[72] The attempt to quantify this from QVAD data showed about 2/3rds were close family members. It is likely a little higher.

supporting the patient and then also having to deal with their own, and their families', grief. This is what occurred in this case. The Act then goes on to give a higher prominence to the prospect of the Contact Person being punished for not returning the VAD substance, which is a rather interesting approach and likely ignores the reality of the Contact Person's mind at that point in time. What purpose does the prosecution of a widower or close family member who fails to return the VAD substance within the 14 days actually serve? Are over-zealous authorities then simply compounding their grief and re-enforcing that they, in some way, failed? It is also possible that such a prosecution is also of a citizen who has done no misdeeds throughout their life, rather have been an upstanding, responsible, and conscientious contributor to society[73], yet now they would find themselves before a Court. It is hardly appropriate.

[4]. Should the Contact Person bear the responsibilities imposed on them? Is burdening the Contact Person with this duty fair to them or the patient, not to mention the remaining family? Clearly when the medication is so dangerous that in a hospital it will not leave the hands of a medical practitioner or health practitioner such as a nurse, then why is it simply handed to a member of the public?

[5]. There seems to be, at least to me, an absence of an explicable basis for the departure from the Model Bill by the QLRC model that was proposed. Perhaps there were very good reasons for the departure, but they have not been made known to me and I cannot see what they could be as this case of ABC tragically demonstrates. Regrettably in my view, and said with great respect, the QLRC recommendation has simply strayed too far into the field of individual autonomy (apparently on the basis that this is compassionate) without adequate consideration of medication safety. When the VAD substance has just one medicinal objective - death upon administration - surely medication storage and its' safety trump all other considerations. As I have said this is a substance that is the most dangerous of all medications currently manufactured, yet the VAD law has it provided to persons with no medical training, no regulatory oversight, and in a period of great personal and emotional turmoil; hardly a time of objective and rational thought processes and decision-making by a lay person.

[6]. One of the primary objectives of Government is to ensure good laws are made for the benefit of, and protection of, its' citizens from harm. It seems that the enacted VAD self-administration laws have strayed, and regrettably so, from the reasonable self-administration safeguards that were proposed in the Model Bill. This case demonstrates the tragic outcomes of failing to implement these safeguards. In my view it seems there should have been wiser judgment[74] when considering the appropriate method for self-administration. The Model Bill clearly shows a safer process for self-administration. It is readily implemented and can be done at very little cost. I recommend the Government make this change to the VAD laws.

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[73] This is precisely who ABC was. They seem to have never placed a foot wrong in life, rather they were a person who were a credit and great asset to their community.

[74] One cannot now say '*we are terribly sorry, but we relied on the experts, but we got it wrong*', rather two options were proposed and to my mind there was a failure to make a properly considered and reasoned choice between the two options. The choice made, to me, is difficult to reconcile when the medication is so dangerous as it has just one medicinal purpose, to end life. I am left somewhat perplexed by the decision taken. Merely saying other Australian jurisdictions also use the layman administered approach does not make it right, rather those jurisdictions also have, in my observations, a flawed approach.

Annexure 'B'

Copy of Non-Publication Order

For Coroner's Office Use:
2023/2350

Form 22
Version 6
QUEENSLAND
CORONERS ACT 2003
(Section 41)

AMENDED ORDER PROHIBITING PUBLICATION RELATING TO AN INQUEST OR PRE-INQUEST CONFERENCE

I, Magistrate O'Connell
(print name of person making the order)

- ☐ State Coroner
- ☐ Deputy State Coroner
- ☒ Coroner

PROHIBIT the publication of the following information relating to, or arising at, (i) the pre-inquest conference to be held at Mackay Courthouse on 17 January 2023; and (ii) the inquest to be held at Brisbane listed to commence on a date to be fixed.

Any information which identifies, or may tend to identify, any of the following –

(1) the Deceased person;

(2) any other member of the Deceased's family, including the Deceased's spouse (an approved VAD patient);

(3) any VAD substance (by either popular name, or by chemical composition), or any other thing provided to a VAD patient;

(4) details of any particular incident involving the administration of a VAD substance to a person (other than the Deceased); or

(5) any health practitioner involved in any VAD transaction; or any Hospital, or Hospital and Health Service associated with any VAD transaction;

(6) the town, city, or region, where the Deceased person, or members of his family, resided;

This Amended Order supercedes the Order made on 11 December 2023.

Details about the deceased:-					
Surname:	ABC (a pseudonym)	First name:			
Residential Suburb:	Regional Queensland			Residential Postcode:	****
Date of death:	16 May 2023				

Date of order: 22 December 2023

Place where order made: MACKAY, QUEENSLAND

Signature of coroner making the order:

Note: If a person does not comply with this order, he / she is liable to a maximum penalty of 150 penalty units. (section 41(2) of the Coroners Act 2003 and section 5 of the Penalties and Sentences Act 1992).

FORM 22 Version 6 – 8 October 2021