Voluntary Assisted Dying Act 2017

How notifications to the Coroners Court of Victoria will be made, as required, under the Act

Acting State Coroner, Caitlin English

10 May 2019
Coroners Act 2008 (Vic)

Preamble

“The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of (certain types of) deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.”
‘Reportable’ deaths

Section 4(2) of the Coroners Act 2008

2. … the deaths are—
   (a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
   (b) a death that occurs—
      (i) during a medical procedure; or
      (ii) following a medical procedure where the death is or may be causally related to the medical procedure—
          and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or
   (c) the death of a person who immediately before death was a person placed in custody or care; or
   (d) the death of a person who immediately before death was a patient within the meaning of the Mental Health Act 2014; or
   (e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer; or
   (f) the death of a person who is subject to a non custodial supervision order under section 26 or 38ZH of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
   (g) the death of a person whose identity is unknown; or
   (h) a death that occurs in Victoria if a notice under section 37(1) of the Births, Deaths and Marriages Registration Act 1996 has not been signed and is not likely to be signed; or
   (i) a death that occurs at a place outside Victoria if the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death and the cause of death is not likely to be certified by a person who is authorised to certify in that place; or
   (j) a death—
      (i) of a prescribed class of person; and
      (ii) that occurs in prescribed circumstances.
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<th>National Coronal Information Service ‘NCIS’</th>
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<td>• Established in 2000 is a national database of coronial information</td>
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<td>• Is managed by Monash University</td>
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<td>• The first database of its kind in the world</td>
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<td>• Contains information on all Coroners’ Court cases</td>
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<th>Coroners Prevention Unit ‘CPU’</th>
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<td>• 2005 Victorian Parliamentary Law Reform Committee review of the <em>Coroners Act 1985</em></td>
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<td>• Recommended establishing a research unit with capacity to utilise the NCIS</td>
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<td>• Identify trends and clusters of deaths that required further investigation</td>
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<td>• CPU established in late 2008, commenced investigating cases in 2009</td>
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<th>Victorian Suicide Register ‘VSR’</th>
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<td>• CPU developed the VSR over a 4-year period and it commenced in its current form in 2013</td>
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<td>• Looking at underlying suicide phenomena, to identify prevention opportunities</td>
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<td>• One of the themes that emerged from the data was that of suicides of people who experienced an irreversible deterioration in physical health</td>
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Consequential amendments in the VAD Act

Amendment of the Births, Deaths and Marriages Registration Act 1996

119 Registration

After section 40(1) of the Births, Deaths and Marriages Registration Act 1996 insert—

"(1A) The Registrar, on being notified by a doctor of a death under section 37 and in accordance with section 67 of the Voluntary Assisted Dying Act 2017, must register the death in the Register by making an entry about the death that records—

(a) the cause of death as the disease, illness or medical condition that was the grounds for a person to access voluntary assisted dying; and

(b) in the case that the Registrar is notified in accordance with section 67(1)(a)(ii) or (iii), that—

(i) the person was the subject of a voluntary assisted dying permit, and accessed voluntary assisted dying by self-administering, or being administered by the person’s co-ordinating medical practitioner the voluntary assisted dying substance specified in the permit; and

(ii) voluntary assisted dying was the manner of death."
“For a small number of people at the end of their life, having a personal choice may mean having control over the timing and manner of their impending death to alleviate suffering they can no longer tolerate. The Voluntary Assisted Dying Bill 2017 balances a compassionate outcome for these people at the end of their lives who are suffering, and providing community protection through the establishment of robust safeguards and comprehensive oversight...”

“The bill recognises that only people who are already dying may access voluntary assisted dying, and as such, their death should not be treated as unexpected or avoidable. For this reason, a voluntary assisted dying death will not be a 'reportable death' under the Coroners Act 2008. This will not preclude the coroner from investigating a death, but this will not be an automatic requirement.

As people may only access voluntary assisted dying if they are suffering from a disease, illness or medical condition that will cause death, this disease, illness or medical condition should be recorded as their cause of death.”

The Hon. Ms Jill Hennessy MP (then Minister for Health)
21 September 2017
Consequential amendments in the VAD Act

Division 2—Amendment of the Coroners Act 2008

121 Reportable death

After section 4(2) of the Coroners Act 2008 insert—

(3) Despite subsection (2), the death of a person who has been administered or self-administered a voluntary assisted dying substance within the meaning of the Voluntary Assisted Dying Act 2017 in accordance with that Act is not a reportable death.
10 Obligation of registered medical practitioner to report death

(1) Subject to subsection (2), a registered medical practitioner who is present at or after the death of a person must report the death without delay to a coroner or the Institute if the death is a reportable death.

Penalty: 20 penalty units.

…

(3) The Institute must refer to a coroner a report of a reportable death received from a registered medical practitioner under subsection (1) or (2) as soon as practicable after receipt of that report.
Division 3—Notification of cause of death

67 Notification of disease, illness or medical condition of person to the Registrar and Coroner

(2) A registered medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death and reasonably believes or knows the person was the subject of a voluntary assisted dying permit must notify the Coroner of—

(a) the registered medical practitioner's reasonable belief or knowledge that the person—

(i) was the subject of a voluntary assisted dying permit and the voluntary assisted dying substance specified in the permit was not self-administered by the person or administered to the person; or

(ii) was the subject of a self-administration permit and accessed voluntary assisted dying by self-administering the voluntary assisted dying substance specified in the permit; or

(iii) was the subject of a practitioner administration permit and accessed voluntary assisted dying by being administered the voluntary assisted dying substance specified in the permit; and

(b) the disease, illness or medical condition that was the grounds for the person to access voluntary assisted dying.
• If the death of a person is, or may be, due to the self-administration or administration of a VAD substance, other than in accordance with the VAD Act, the Coroner can investigate the death pursuant to section 14 of the *Coroners Act 2008*

• If the Coroner is satisfied that the death is not in accordance with the VAD Act, then the death would be a reportable death and could be investigated in the usual manner
The CA&E receives a notification of a VAD-related death, pursuant to section 67 of the VAD Act.

The CA&E accepts the notification as a notification of a VAD-related death and, in the interim, generates a Coroners Court reference number.

CA&E staff obtain the standard preliminary information about the death notification.

CA&E notify the State Coroner, Duty Coroner and the Court’s Principal Registrar of a VAD-related death.
Questions?

Caitlin English
Acting State Coroner

65 Kavanagh Street, Southbank, VIC 3006
T: 1300 309 519
e: courtadmin@coronerscourt.vic.gov.au
www.coronerscourt.vic.gov.au