CORONER’S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of [Redacted] Williams**
Citation:	**[2026] ACTCD 2**
Decision Date:	10 March 2026
Before:	Coroner Temby
Findings:	[66] – [68]
Catchwords:	**CORONIAL LAW** – suicide by sodium nitrite ingestion – palliative sedation - availability of voluntary assisted dying – decision not to conduct a hearing – manner and cause of death – whether matters of public safety arise
Legislation Cited:	*Coroners Act 1997* ss 13, 34, 34A, 52
Cases Cited:	Finding into death without inquest regarding the death of Jessinda Kiroyan (COR 2019 2493), Deputy State Coroner English, 19 March 2021
Texts Cited:	‘Do Patients Without a Terminal Illness Have the Right to Die’, Katie Engelhart, *New York Times*, 1 June 2025
Representation:	S. Richards (Counsel Assisting the Coroner) Minter Ellison Lawyers (for Clare Holland House and its practitioners)
File Number:	CD 98 of 2023

CORONER TEMBY:

Introduction

1. [Redacted] Williams was a school teacher and small business owner. She was married to her husband, [Redacted] Williams, for around 50 years. She had close relationships with her family, including her three children and two sisters, and a large network of friends.

2. Ms Williams had a number of hobbies, including cooking, gardening and music. She was also active in the community, and received a Medal of the Order of Australia (OAM) for her voluntary work in community advocacy, recognising her service to community health. As a result of her involvement with the coronial system after the death of her son [Redacted] in 2010, Ms Williams became a respected advocate for those with mental health issues and for a more effective and restorative coronial process in the ACT.

3. Ms Williams was diagnosed with motor neuron disease (MND) in March 2022. MND is a term used to describe a group of diseases that affect nerve cells called motor neurons. Motor neurons carry messages from the brain to the muscles via the spinal cord. Gradually, MND causes a person’s muscles to weaken and waste away.

4. The range of symptoms varies from person to person, as does the speed with which a person’s condition deteriorates. There is no cure.

5. Ms Williams had been experiencing limb weakness prior to her diagnosis. Shortly after her diagnosis, Ms Williams decided that she wanted to be in control of the timing and manner of her death. She explored a number of options available to her, including with medical practitioners at Clare Holland House (which was at that time run by Calvary Health Care ACT (**CHH**) and from whom she received palliative care), as to what they could do to assist her.

6. Ultimately, she was unable to reach an agreement with CHH as to a suitable approach and she took her own life. By that time, her physical condition had deteriorated significantly and her quality of life was similarly reduced. She only had the capacity to perform small movements such as touching her device screen with one finger, feeding herself very small amounts of food and drinking from a partially filled cup. She could not walk or stand and she was losing the capacity to communicate. Her life expectancy was only a few months.

7. Ms Williams passed away on 27 April 2023. She was survived by her husband, Mr Williams, her two sisters, two of her children ([Redacted] and [Redacted]) and her grandchildren. It is evident that Ms Williams' family were her greatest supports in life, and have been fierce and loyal advocates for her in death and throughout the coronial process.

Jurisdiction

8. The Coroner's jurisdiction in relation to Ms Williams' death arises under s 13(1)(a) of the *Coroners Act 1997* (ACT) (*'the Act'*), which provides:

> **s13 *Coroners Act 1997* (ACT)**
>
> (1) A coroner must hold an inquest into the manner and cause of death of a person who—
>
> (a) dies violently, or unnaturally, in unknown circumstances; or
>
> (b) dies under suspicious circumstances; or
>
> (c) dies and the death appears to be completely or partly attributable to an operation or procedure; or
>
> (d) dies after having undergone an operation or procedure and in circumstances that, in the opinion of the Chief Coroner, should be better ascertained; or
>
> (e) dies and a doctor has not given a certificate about the cause of death; or
>
> (f) dies not having been attended by a doctor at any time within the period commencing 6 months before the death; or
>
> (g) dies after an accident where the cause of death appears to be directly attributable to the accident; or
>
> (h) dies, or is suspected to have died, in circumstances that, in the opinion of the Attorney-General, should be better ascertained; or
>
> (i) dies in care or custody.

9. In s13 of the Act, the term "inquest" is used to mean a coronial investigation. There can be a hearing for an inquest.

Required Findings

10. At the conclusion of the inquest, I must make the findings that are required by s 52 of the Act, which provides:

> **s52** ***Coroners Act 1997* (ACT)**
>
> (1) A coroner holding an inquest must find, if possible—
>
> (a) the identity of the deceased; and
>
> (b) when and where the death happened; and
>
> (c) the manner and cause of death; and
>
> (d) in the case of the suspected death of a person—that the person has died.
>
> (4) The coroner, in the coroner's findings—
>
> (a) must –
>
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
>
> (ii) if a matter of public safety is found to arise—comment on the matter;
>
> (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

Evidence

11. On my behalf, certain investigative steps were taken and the evidence I refer to in these findings is drawn from the following material produced during the investigation:

    a) Australian Federal Police Coronial Report;
    b) post mortem report of Professor Johan Duflou, dated 8 June 2023;
    c) the statements of Dr Jessica Mather-Hillon dated 19 February 2024 and 13 February 2025;
    d) the statement of Dr Sivaraj Rajadorai dated 16 February 2024;
    e) the statement of Dr Laura Pearce dated 11 March 2025;
    f) the statement of Toni Ashmore dated 30 June 2025;
    g) submission provided on behalf of Calvary Health Care ACT on 8 October 2025; and
    h) medical records produced by Calvary Health Care ACT, Canberra Hospital and the Surgery at Curtin.

12. Ms Williams' family were also active participants in the process and provided me with submissions, correspondence and information about Ms Williams which I considered as part of my investigation.

Circumstances prior to Ms Williams' death

13. On 6 March 2023, Ms Williams was admitted to CHH to allow for a period of respite for Mr Williams. Mr Williams was Ms Williams' full-time carer at that time.

14. On 7 March 2023, Ms Williams spoke to Ms Kate Bunyan, a CHH social worker, about her desire to access voluntary assisted dying (**VAD**) and her frustration that she could not access it in the ACT.

15. On 20 March 2023, Ms Williams was discharged from CHH to receive home-based palliative care. CHH provided regular assistance and care to Ms Williams from that point through its Home Based Palliative Care (**HBPC**) service.

16. On 23 March 2023, Ms Williams expressed to Ms Emma Warren, a CHH nurse, her strong wish to end her life given the impact that MND had had on her quality of life. Similarly, on 30 March 2023, when Ms Williams was formally admitted to CHH HBPC, Ms Williams told Ms Robyne Hingeley, a CHH Nurse Practitioner, that she wished to die, noting that she would access VAD if it was available in the ACT. Ms Williams noted that she had explored the availability of VAD overseas but said it would take too long.

17. Ms Hingeley spoke to a range of people at CHH about Ms Williams' case, including to Dr Mather-Hillon. Dr Mather-Hillon was (and is) a Palliative Care Consultant at CHH.

18. On 31 March 2023, Dr Mather-Hillon participated in a phone call with Ms Bunyan and Mr Williams. Dr Mather-Hillon noted that Ms Williams' condition had clearly deteriorated since she was discharged from CHH on 20 March 2023.

19. Dr Mather-Hillon first met Ms Williams on 3 April 2023 during a home visit with Ms Bunyan. Ms Williams told Dr Mather-Hillon that she had significant anxiety, that she felt an overwhelming loss of control and a similarly high wish to die. She felt that she had a short window of tolerance for continuing her life given her impending loss of dexterity in her upper limbs, loss of voice and increasing difficulty breathing.

20. Ms Williams stated that she wished to end her life and had plans for how she could hasten death, either by stopping eating and drinking, or by suicide. She asked Dr Mather-Hillon whether there was anything else she could offer her. Dr Mather-Hillon stated that palliative sedation therapy (**PST**) was a possibility.

21. Dr Mather-Hillon outlined for Ms Williams the mechanics of a PST plan. She explained that it would involve an intentional reduction of consciousness with sedation proportionate to symptoms and background symptom control, with Ms Williams' family largely being responsible for the physical caring, including managing personal hygiene and providing medications as needed.

22. Ms Williams was pleased that the proposed plan could be implemented at her home, but she was concerned about the expected duration of the therapy. Dr Mather-Hillon advised her that the duration of PST was variable and unpredictable and could take two weeks. That length of time was unacceptable to Ms Williams, however Dr Mather-Hillon said that that was all she could offer. Dr Mather-Hillon also discussed counselling options, including talking with pastoral care and psychosocial teams, however Ms Williams declined pastoral care intervention and did not consent to psychosocial talking therapies.

23. Dr Mather-Hillon discussed the possibility that Ms Williams had raised of voluntarily ceasing to consume food and fluids. Dr Mather-Hillon provided advice to Ms Williams as to particular steps that Ms Williams could take to reduce her discomfort in the event that she chose to take that path.

24. On 6 April 2023, Dr Laura Pearce conducted a home visit to Ms Williams' house to provide a second opinion as to the use of PST in Ms Williams' case. At the time, Dr Pearce was a Staff Specialist for the CHH community based palliative care team. When she met Ms Williams, Dr Pearce observed that Ms Williams was in considerable musculoskeletal pain.

25. Dr Pearce noted that Ms Williams made it clear that she planned to end her life and had acquired the means to do so. Dr Pearce noted that Ms Williams was determined

to die before she became fully dependant on her family or others and that she was determined to maintain independence and dignity.

26. Dr Pearce recalled discussing PST with Ms Williams and her family. At that time, she considered that Ms Williams' prognosis was a few weeks to several months.

27. Dr Pearce explained what PST involves, as Dr Mather-Hillon had done, and suggested that that it could be undertaken at Ms Williams' home. Dr Pearce was content to assume responsibility for the administration of PST with community nurses. Dr Pearce advised Ms Williams that it would take a few days for her to die.

28. Ms Williams and her family were happy with this plan. Dr Pearce subsequently discussed the plan with Dr Mather-Hillon and Ms Bunyan.

29. Dr Mather-Hillon and Dr Pearce spoke to Ms Williams by phone on 14 April 2023. Dr Mather-Hillon recalled that Ms Williams' suffering was clear and that Ms Williams had an intention to die by suicide and a plan to carry it out. Ms Williams advised that she felt that her condition had deteriorated in the preceding two weeks.

30. Dr Mather-Hillon referred me to medical notes that identified that PST was to potentially start on 28 April 2023, at home if possible, with admission to CHH to be arranged if Ms Williams' care needs became too high for her family at home, or if sedating agents beyond those she could take at home were required.

31. It is clear from Dr Mather-Hillon's statement and from the information provided by Dr Pearce that, by mid-April 2023, a PST at home plan had been discussed with Ms Williams and her family on more than one occasion in the context of Ms Williams' wish to end her life. It is also clear that both Dr Mather-Hillon and Dr Pearce explained the mechanics of how PST would work, with both doctors noting how the relevant sedatives would be adjusted in accordance with Ms Williams' needs and supported by pain relief as required.

32. The key difference between the advice that Dr Pearce gave to Ms Williams, and the advice that Dr Mather-Hillon had given, was in relation to the expected duration of the plan. While Dr Mather-Hillon noted that it could take two weeks before Ms Williams died, Dr Pearce told Ms Williams that it would take a few days. It was clearly important to Ms Williams that the period be as short as possible. It is similarly clear that this advice was influential in Ms Williams wishing to pursue the PST plan when Dr Pearce discussed it with her, when she had not been interested in the plan when it was raised by Dr Mather-Hillon.

33. While no agreement or commitment had been reached as to the path that Ms Williams would pursue by the time Drs Pearce and Mather-Hillon spoke to Ms Williams on 14 April 2023, it is apparent that Ms Williams indicated that she did wish to pursue PST and she nominated a particular date (28 April 2023) for it to commence. Ms Williams' medical notes, signed by Dr Pearce shortly after the conclusion of the call, record that one or both of the doctors advised Ms Williams that:

    a) admission to CHH could be arranged if Ms Williams' care needs became too high for her family at home, or if sedating agents beyond those she could take at home were required; and
    b) Dr Mather-Hillon would conduct a home visit on 21 April 2023 to discuss the plan in detail with Mr and Mrs Williams.

34. Dr Mather-Hillon recalled that, on about 17 April 2023, she met with the Head of Department and the Home Base Palliative Care Clinical Care Consultant (**Home Base CNC**) at CHH to discuss Ms Williams' case. The Home Base CNC did not consider that PST at Ms Williams' home was possible given COVID-related impacts on staffing resources, home base nursing shortages, a lack of specialist palliative care nurses working in the community at night and the absence of a CHH protocol for palliative sedation in the community. Dr Mather-Hillon noted that it was these factors (and not, as some people had assumed, the fact that CHH was operated by a faith-based healthcare system (CHH) at the time), which influenced the care that it was able to give Ms Williams in the community.

35. On 20 April 2023 Dr Mather-Hillon spoke to Ms Williams by phone, to inform her that PST was no longer possible in a community setting. Ms Williams expressed concerns about maintaining her autonomy if admitted to CHH.

36. On 21 April 2023, Dr Mather-Hillon attended a telehealth appointment with Dr Hughes, Consultant-Liaison Psychiatrist, and Mr and Mrs Williams. Ms Williams told Dr Hughes that she wished to end her life as a result of the suffering the MND was causing her, both physically and mentally. Dr Hughes expressed the opinion that Ms Williams did not have a psychiatric illness that was contributing to her decision to end her life.

37. Also on that day, Dr Mather-Hillon made a home visit to Ms Williams with Dr Sivaraj Raadorai (known as Dr Raj), Palliative Care Physician and Deputy Medical Director for Palliative Care at North Canberra Hospital and CHH. Dr Raj had been one of Ms Williams' treating doctors when she had been an inpatient of CHH. Dr Raj visited Ms Williams with Dr Mather-Hillon to provide a further opinion as to the possible use of PST in Ms Williams' case. He was aware that Dr Mather-Hillon supported the use of PST due to Ms Williams experiencing significant existential distress from her rapid decline in function and expressing an intention to end her life.

38. Dr Mather-Hillon noted that Ms Williams had experienced further physical deterioration, as reflected in her hospital notes, with her functional decline causing ongoing psychological distress. Dr Raj noted that Ms Williams was in a deteriorating palliative phase with functional decline. She was chair bound but was able to use her upper limbs and communicate verbally.

39. Dr Raj considered that Ms Williams' prognosis at that time was in the range of 3 to 6 months. Ms Williams' family have queried Dr Raj's recollection of Ms Williams' prognosis, however in the context of their recollection that Dr Pearce's assessment of Ms Williams' prognosis was in the order of several weeks, it does not seem to me that Dr Pearce's view was necessarily inconsistent with that of Dr Raj. While she did assess Ms Williams' prognosis as being a few weeks at the shorter end of her range, she also said that Ms Williams might live several months.

40. Despite the advice given by the CHH Home Base CNC, Dr Raj advised Ms Williams that, if PST was approved, it could start at home with particular medications (as are available to all patients in the ACT, as assessed as appropriate by qualified palliative care physicians), but that if stronger medications were required, Ms Williams would need to be admitted as an inpatient at CHH for safety and logistical purposes. While there is some inconsistency between the recollections of Dr Mather-Hillon and Dr Raj on the one hand, and Ms Williams' family on the other, as to what was discussed during this visit, Dr Raj's recollection of the advice he gave is consistent with the contemporaneous entries in Ms Williams' medical notes that were completed by Dr Raj. I accept that he gave that advice.

41. Ms Williams' family submitted that the plan envisaged by Dr Raj was very different to the plan that Ms Williams had been offered earlier in April, that PST at home would be possible, overseen by Drs Pearce and Mather-Hillon. In my view, the plan envisaged by Dr Raj was consistent with the advice that Drs Pearce and Mather-Hillon had given to Ms Williams on 14 April 2023, being that PST could be commenced at home, with admission to CHH being a possibility if Ms Williams' care needs became too high for her family or if sedating agents beyond those she could take at home were required.

42. Given the resourcing issues that the Home Base Palliative Care CNC had identified, it is possible that the implementation of PST at home might have been more difficult than Drs Pearce and Mather-Hillon had envisaged and that it was more likely that Ms Williams would need to be admitted if insufficient nursing resources were available to assist Ms Williams at home. However, the substance of the plans proposed by Drs Pearce, Mather-Hillon and Raj were the same.

43. Dr Raj noted that this form of PST was not acceptable to Ms Williams. She maintained her concerns about being admitted to CHH. In circumstances where, as Ms Williams' family recalled, Dr Raj advised Ms Williams that drug administration (type and volume) would be at the discretion of the doctor who was on duty at CHH, Ms Williams would no doubt have felt a degree of uncertainty as to how she would be cared for if she was admitted.

44. Dr Mather-Hillon stated that she and Dr Raj had a further discussion with Ms Williams about the logistics of PST, noting again that sedation would be titrated according to Ms Williams' symptoms and that the duration of the therapy could not be predicted with any certainty, with the likely duration being one to two weeks but possibly longer or shorter than that. As noted earlier, this was consistent with the advice that Dr Mather-Hillon had initially given Ms Williams, but was inconsistent with the shorter estimate of a few days that Dr Pearce had given Ms Williams.

45. As also noted earlier, the longer timeframe had been unacceptable to Ms Williams when Dr Mather-Hillon advised her initially and, consistently with that position, Dr Mather-Hillon stated that Ms Williams was distressed at the thought of being sedated for two weeks. She asked whether it could be expedited. Drs Raj and Mather-Hillon informed Ms Williams that they could not control the duration of PST and could not escalate the use of medication to artificially shorten her life.

46. Drs Raj and Mather-Hillon appear to have left the option of Ms Williams pursuing PST open, although Dr Raj recorded that the form of PST available to Ms Williams was not acceptable to her, and she would much rather end her own life. This is consistent with Ms Williams' family's recollection that Ms Williams rejected the plan that had been offered. They say that Ms Williams articulated that she had been left with no choice but to take her own life. I accept that that was Ms Williams' position following the 21 April 2023 consultation.

47. On 24 April 2023, Ms Williams told Ms Hingeley that she was going to end her life and wanted to know what Mr Williams should do when he found her. Ms Hingeley subsequently discussed the matter with Dr Raj.

48. Dr Raj stated that he called the Australian Federal Police's coronial liaison team (the **AFP Coroners Team**) on 24 April 2023, in his capacity as the after-hours on-call palliative physician for the ACT. He said that he did so in order to obtain an answer to a query that the Williams family had raised with respect to their obligations if Ms

Williams made a non-fatal attempt at suicide. He said that, consistently with advice he had received from the on-call psychiatry team and his medical indemnity provider, the AFP Coroners Team said that the ACT Ambulance Service (ACTAS) should be contacted.

49. Dr Raj also sought advice from the AFP Coroners Team more generally as to what should be done, and what his legal obligations were, in respect of a person whom he believed was intending to harm themselves by overdose of medication. He provided basic details about Ms Williams and her condition and some background to his query.

50. The AFP Coroners Team contacted ACT Police Operations, who advised that police would need to attend Ms Williams' house to conduct a welfare check. The AFP Coroners Team relayed that advice to Dr Raj. Dr Raj expressed the view that this was not medically necessary and would likely exacerbate the complex psychosocial situation that existed. Dr Raj stated that he was advised that the decision to conduct a welfare check was a police decision, and not a medical one.

51. As a result, general duties officers were dispatched to conduct a welfare check on Ms Williams. Mr Williams was upset that Dr Raj had shared Ms Williams' information with police and did not want police to speak to Ms Williams. He assured them as to her welfare and police decided not to speak to Ms Williams.

52. In the morning of 27 April 2023, Ms Williams and Mr Williams were joined at their house by their children, [Redacted] and Mr Williams (junior), and by Ms Williams' sister, [Redacted]. At around 9.45 am, Mr Williams (senior), [Redacted] and Mr Williams (junior) left the residence to go for a walk.

53. At around 10.30 am, Ms Williams asked [Redacted] to give her her handbag. [Redacted] did so, and then left the room to do some reading in another room of the house. At around 11.15 am, [Redacted] checked on Ms Williams and found her to be unresponsive. [Redacted] called Mr Williams to advise him that Ms Williams had passed away.

54. Ms Williams had consumed a solution containing sodium nitrite and left a note. Despite the challenges she had faced towards the end of her life, she expressed gratitude for the efforts of everyone who had tried to help her since she received her diagnosis.

55. Mr Williams and the children returned to the house. Mr Williams called CHH and a nurse and support worker from CHH attended the house. The nurse called police in the early afternoon.

Events subsequent to Ms Williams' passing

56. During the afternoon of 27 April 2023, a Forensic Medical Officer attended the house and declared Ms Williams' life extinct. Police also attended. Initially, ACT Policing Woden Patrol attended, however the matter was referred to Criminal Investigations, Major Crime – Gungahlin.

57. In all, four AFP officers from the Forensics Crime Scene team, six AFP officers from the Major Crime team and one AFP officer from the AFP Coroners Team attended Ms Williams' house over the course of around five hours. Not all officers were present at the same time. All of the AFP officers wore plain clothes and the forensics officers wore their uniform.

58. The AFP officers and forensics officers conducted an examination of the house and seized a number of items. They conducted records of conversation with Mr Williams (senior), [Redacted] and [Redacted], and with Mr Williams (junior) on 29 April 2023.

59. An examination of Ms Williams' electronic devices did not reveal anything of particular significance. They showed that Ms Williams' activities in March and April 2023 were consistent with her stated desire of ending her life and putting in place a plan to give effect to that desire. Her search history had been deleted to a certain extent and the devices did not reveal, for example, the source of the sodium nitrite or when it was acquired.

60. A post-mortem examination, consisting of an external examination and toxicology testing, was performed by Professor Johan Duflou on 2 May 2023. Toxicology results revealed the presence of a sufficiently high level of methaemoglobin to have caused death. The direct cause of death was found to have been sodium nitrite poisoning.

Decision not to conduct a hearing

61. I was urged by Ms Williams' family to hold a hearing under s 34 of the Act. In particular, Ms Williams' family sought a "*restorative 'round table' approach, where family members and palliative health care practitioners involved in Ms Williams' death would be given an opportunity to reflect on particular issues arising from Ms William's care and collaboratively discuss possible solutions to prevent future suicides*".

62. On 21 June 2024, I decided not to conduct a hearing, pursuant to s 34A of the Act. While I was not opposed to the idea of conducting a hearing using a round table approach as requested, I did not consider that a hearing was required as I was satisfied that the manner and cause of Ms Williams' death was sufficiently disclosed by the material available to me and that there were no matters of public safety which required further consideration. In summary:

a) I accepted the uncontentious finding of forensic pathologist Professor Duflou that Ms Williams died from sodium nitrite poisoning;
b) I accepted that this poisoning was self-inflicted by Ms Williams with the intent to take her own life, which is also uncontentious;
c) I considered that the absence of palliative end-of-life options that were suitable to Ms Williams was an issue that had been overtaken by the passing of VAD legislation in the ACT, noting that Ms Williams would have been an obvious candidate for such a scheme, and that this issue had advanced beyond any comments or recommendations I might meaningfully make regarding the particular circumstances of Ms Williams' death;
d) I did not consider, given the range of written material available to me, including statements from Ms Williams' family and from Ms Williams' treating clinicians, that any oral evidence was required in order for me to understand the circumstances of Ms Williams' death or to make appropriate findings;
e) I did not consider that the issues raised by Ms Williams' family as to Ms Williams' treatment at CHH while she was an inpatient there bore upon the manner or cause of her death in a way that would warrant exploration by way of a forum or hearing (but offered Ms Williams' family the assistance of the Coroner's legal and family liaison teams to set up a meeting with Ms Williams' treating clinicians if that would be useful to the family); and
f) similarly, I did not consider that the issues that Ms Williams' family had raised regarding the welfare check and investigation that were undertaken by police

were connected to the manner and cause of Ms Williams' death, nor that they gave rise to a matter of public safety in a way which would warrant a hearing.

63. In a letter to me dated 28 June 2024, Ms Williams' family reiterated that there were issues of public safety that should be considered and suggested that additional enquiries be undertaken before I made my final decision. Ms Williams' family provided a supplementary statement in relation to the circumstances of Ms Williams' death and identified a number of recommendations that they submitted I should make.

64. Having undertaken those further enquiries and considered the additional material that was provided in response to them, as well as the additional material that Ms Williams' family provided, I maintain my view that a hearing is not required in this matter. In particular, I maintain my view that this is not a matter in which any of the issues I am required to make findings about (as set out in paragraphs 66 to 68 below) are at all contentious and it is not a matter which, in my view, gives rise to any issues of public safety.

65. Nevertheless, in the following section of my report I have considered each of the issues that Ms Williams' family raised.

Findings

Identity of the deceased

66. The deceased is [Redacted] Williams. Ms Williams was identified by Mr Williams when police arrived at the house.

When and where the death happened

67. Ms Williams died on 27 April 2023 in her home at [Redacted] in the ACT.

Manner and cause of death

68. Ms Williams died by suicide, and the cause of death was sodium nitrite poisoning.

Consideration of possible matters of public safety

69. Ms Williams' family has identified a number of matters which they say raise matters of public safety, namely:

   a) Ms Williams' treatment when she was residing at CHH in March 2023;
   b) the accessibility of information about end-of-life options and the absence of appropriate end-of-life options open to Ms Williams;
   c) the retraction of a 'palliative sedation at home plan' that Ms Williams reached with CHH;
   d) the appropriateness of the welfare check that police conducted in the days leading up to Ms Williams' suicide; and
   e) the appropriateness of the police investigation that was conducted at Ms Williams' house in the hours after her death.

70. I have addressed these issues below. I also considered whether the availability of sodium nitrite and its use in suicides might be a matter of public safety, however, despite the availability of public information which identifies how sodium nitrite may be used to die by suicide, there are few reported suicide cases in the ACT involving the use sodium nitrite (two people in 2020, one person in 2022 and Ms Williams' case in 2023). Further, sodium nitrite is widely used for legitimate purposes in many different

areas and restricting access to it would be impractical. I note that Victorian Deputy State Coroner Caitlin English discussed this issue in detail in her 2021 report into the death of Jessinda Kiroyan (Finding into death without inquest, Coroners Court of Victoria, COR 2019 2493).

Ms Williams' treatment when she was residing at CHH in March 2023

71. Ms Williams' family raised issues as to the service offered to Ms Williams whilst she was resident at CHH. In particular, they identified that having to interact with a large number of carers was challenging, especially in having to regularly explain her care needs to, and receive assistance to undertake personal care tasks from, people she did not know. She identified two incidents which particularly distressed her.

72. Ms Williams' family stated that the prospect of being at CHH at a later stage of MND, at a time when she could no longer communicate her needs, was terrifying to Ms Williams. I accept that that was the case even though, as Ms Williams' family advised me, Ms Williams was deeply appreciative of the support she received from many of the staff at CHH. I do not, however, consider that the treatment that Ms Williams' received while residing at CHH in March 2023 is something that bears on the manner and cause of her death, nor that it raised a matter of public safety. For reasons which are set out below, her disinclination to be admitted to CHH was a subsidiary consideration in her decision to end her life.

73. Nevertheless, I have written to CHH to raise the issues that Ms Williams' family identified for their consideration.

Accessibility of information about end-of-life options and the absence of appropriate end-of-life options open to Ms Williams

74. Ms Williams' family submitted that:

    a) Ms Williams took her life because, in the absence of VAD in the ACT, the palliative end-of-life options available to her did not meet her needs;
    b) in the absence of VAD, or clear information about an acceptable palliative care end-of-life option, Ms Williams had spent considerable time and energy since her diagnosis researching end-of-life options and planning her suicide;
    c) Ms Williams was anxious to take her own life before her physical capacity to do so deteriorated to the point that she required assistance – she was concerned about exposing her loved ones to potential criminal liability for assisting her suicide; and
    d) while the ACT Government intended to introduce VAD in the ACT, the experience of other jurisdictions is that safeguards in the legislation will prevent some terminally ill people from being able to access VAD and, accordingly, patient-centred palliative care will always be needed.

75. Ms Williams' family also noted that, at the time a PST at home plan was discussed with them, they were not provided with a copy of the palliative sedation policy that operated in the ACT. In this respect, they noted that the policy that was produced during these coronial proceedings – the 'Consensus Statement on the Use of Palliative Sedation in the ACT' (**the Consensus Statement**) – appeared to be only in draft form and, if they had been provided with a copy of it, they would have '*picked up on the resourcing issue that Dr MH claims in her statement was the main reason the 'palliative sedation at home' plan was retracted*'. They noted that '*Dr MH's statement clearly shows that the barrier to the implementation of [Ms Williams'] plan was not a legal barrier, and nor was*

it a policy barrier. It was a practical resourcing barrier'. Ms Williams' family say that there is no clear, settled, government policy in relation to palliative sedation.

76. Ms Williams' family queried what can be done to improve the accessibility of information available to terminally ill Canberrans about end-of-life options.

Summary of response to issues raised by Ms Williams' family

77. It was not possible for any palliative end-of-life options to meet Ms Williams' needs because Ms Williams wished to die and she could not be offered a palliative care option that was directed to achieving that end within a timeframe that was acceptable to her. It is unfortunate that Ms Williams was not able to access VAD in the ACT at the time, as she would have been an obvious candidate for the VAD scheme that has recently commenced in the ACT (from November 2025). I note that there is a clear explanation on the ACT Government website about the VAD scheme.

78. The advice that was given to Ms Williams with respect to the possibility of her receiving PST at home is discussed in the next section of these findings, however, consistently with the view I have expressed above, I do not consider that Ms Williams was truly interested in PST as a palliative end-of-life option. She was only interested in that option if the duration of PST before her passing was a few days, but that timing could not be guaranteed.

79. It is correct that not all terminally ill people will be able to access VAD and, further, not all people with enduring suffering will be able to access VAD. It is therefore also correct that it is important for there to be good quality palliative care services which are open to such people. However, there are a range of public and private palliative care services which are provided in the ACT, and publicly available information about the nature of those services. I do not consider that it is necessary that there be publicly available information about the kinds of treatments and medications that might be offered to a person in need of palliative care, as that is something that is best explained to the person by a medical professional.

80. I also do not consider that it was necessary for Ms Williams to be provided with a copy of the government's policy in relation to PST, or that failure to do so raises a matter of public safety. The nature of PST was explained to Ms Williams on several occasions. There was some uncertainty with respect to the extent to which it could be provided to Ms Williams at home, but the issue that resulted in Ms Williams' rejection of the option was the fact that the duration of the therapy before she died could not be guaranteed.

81. Uncertainty in relation to the extent to which PST could be offered to Ms Williams at home was no doubt contributed to by the fact that PST is not a common therapeutic option. I also note that, as a result of Ms Williams' case, CHH is considering developing a guide for PST in the community and there is already a publicly available ACT Government policy with respect to the use of PST in adults. It is based on the Consensus Statement, which I note is now a finalised government policy, with both documents setting out the government's policy in relation to PST in the ACT.

82. I also observe that there must, unfortunately, be an acceptance that palliative care might not be sufficient to meet the particular expectations of everyone who seeks it. It is simply not medically possible to alleviate the suffering of everyone who is burdened by an incurable and enduring condition. Palliative care and other medical professionals make a meaningful impact on the lives of many in the community who are suffering but there are some, like Ms Williams, for whom there is no treatment or medication that can effect any improvement in their quality of life.

ACT Voluntary Assisted Dying (VAD) Scheme

83. The ACT VAD scheme commenced on 3 November 2025. The scheme is governed by the *Voluntary Assisted Dying Act 2024* (the **VAD Act**).

84. The VAD Act notes that one of the objects of the Act is to give individuals who are suffering and dying the option of requesting assistance to end their lives. Three of the principles which must be taken into account by a person in exercising a function under the Act are that:
    a) human life is of fundamental importance;
    b) an individual's autonomy, including autonomy in relation to end-of-life choices, should be respected; and
    c) every individual approaching the end of their life should be provided with high-quality, person-centred care and treatment, including palliative care, to minimise their suffering and maximise their quality of life.

85. Like other Australian jurisdictions that have enacted VAD legislation, there are eligibility requirements that must be met for a person to access VAD in the ACT. The key eligibility requirements are that the individual:

    a) is an adult;
    b) has been diagnosed with a condition that, either on its own or in combination with one or more other diagnosed conditions, is advanced, progressive and expected to cause death; and
    c) is suffering intolerably in relation to the relevant conditions.

86. An individual whose condition is solely a mental disorder or mental illness will not be eligible. An individual whose condition is solely a disability that substantially impairs their communication, learning or mobility and results in them needing services to support them to live with the disability will also not presently be eligible.

87. A condition will be considered to be 'advanced' if:

    a) the individual's functioning and quality of life have declined, or are declining, and are not expected to improve;
    b) any treatments for the conditions that are reasonably available and acceptable to the individual have lost any beneficial impact; and
    c) the individual is approaching the end of their life (which is not defined, save that the legislation provides that an individual may be approaching the end of their life even if it is uncertain whether their relevant conditions will cause death within the next 12 months).

88. There is a multi-step process that must be followed before a person can be assisted in ending their life. At a minimum, this will entail:

    a) the individual making a first request;
    b) the individual's coordinating practitioner deciding that the individual meets the eligibility requirements;
    c) the individual's consulting practitioner deciding that the individual meets the eligibility requirements;
    d) the individual making a second request;
    e) the individual making a final request;
    f) the individual's coordinating practitioner deciding that the individual meets the final assessment requirements; and

g) the individual making an administration decision.

89. According to information recently released by Health Minister Rachel Stephen-Smith, in the first three months since the VAD scheme commenced, 87 people registered for the scheme and 14 progressed through to their death under the scheme. Not all people who registered for the scheme were found to be eligible and a small number of people died from their underlying condition before their assessment process was completed. For the 14 people who completed each of the steps of the scheme, the average length of time from a person's first request to the administration of an approved end-of-life substance was 18 days, with the shortest period being five days.

90. While Ms Williams would have been an obvious candidate for VAD if it had been available prior to her passing, Ms Williams' family are correct in noting that some terminally ill people will not be able to access the ACT VAD Scheme. They note that one example of a circumstance where a terminally ill person will not be able to access VAD is where the person is under 18 years of age. The family also note that sometimes a person will experience intolerable suffering while an assessment is made as to whether they are eligible for VAD.

91. Further examples have been raised publicly in relation to the ACT VAD scheme, including:

a) people who lose decision-making capacity during the process provided for by the scheme and who therefore become ineligible to complete it; and
b) people who wish to give an advance care directive to access the scheme prior to losing decision-making capacity.

92. There will be other cases, too, of people who experience intolerable suffering and who may wish to access the VAD Scheme, but who will be ineligible for the scheme, for example because they are not approaching the end of their life. I note that the *New York Times* published an excellent article, written by Katie Engelhart, titled 'Do Patients Without a Terminal Illness Have the Right to Die' (1 June 2025), which discusses this issue in the context of Canada's Medical Assistance in Dying program.

93. Ms Williams' family are disappointed that it is too late for my findings, or the inquest itself, to contribute to the VAD debate or to facilitate any changes that could have benefited terminally ill Canberrans in the lead-up to VAD commencing in the ACT. However, as I wrote to Ms Williams' family in June 2024, my view is that this inquest, and my findings in relation to it, are not the occasion to debate the merits of VAD models nor the VAD scheme that the ACT legislature has settled upon. A great deal of consultation, thought and debate has been undertaken in the development of the ACT VAD scheme and, while Ms Williams would have been an obvious candidate for VAD, an inquiry into the advantages and disadvantages, and the benefits and risks of various VAD models would not have been appropriate in the context of my role in undertaking an inquest into Ms Williams' death. I have set out the nature of that role earlier in these findings.

94. I am also aware that Ms Williams' family directly contributed to the VAD debate through submissions and other representations and that Ms Williams' experience therefore did inform the VAD debate.

95. I also note that the ACT Government has committed to further consideration of options for consultation and potential reform in the future, once there has been an opportunity to consider and understand how the scheme operates in practice. Two areas the ACT

Government is currently investigating with respect to the possible expansion of the scheme are allowing people with dementia to access the scheme and allowing people to be assessed through telehealth appointments.

96. In the circumstances, there is little that I could usefully contribute to the question of the appropriateness of the VAD scheme in the ACT at this stage and no issue of public safety arises in that respect. Ultimately, the creation of a VAD scheme is the change in public policy (and law) that was needed to address the circumstances that Ms Williams' faced (and that other terminally ill Canberrans would have faced in the future without the VAD scheme). Ms Williams' family should take pride in the role they played in that occurring.

97. Accordingly, I make four short observations only.

98. Firstly, implementing a VAD scheme involves a significant development in public policy with significant implications for those who might seek to access the scheme, and for those involved in its administration. There are obvious safety, legal and ethical considerations at play and it is unsurprising that there are eligibility restrictions and other safeguards in place to protect patients and physicians.

99. Secondly, in terms of the requirement that the individual be approaching the end of their life, the ACT VAD scheme is less restrictive than other jurisdictions in Australia, which contain prescribed maximum expected periods left to live. No interstate schemes permit advance care directives to be made.

100. Thirdly, I note that the ACT Government has published a fact sheet online about VAD in the ACT, which includes clear information about the ACT VAD scheme, including a summary of the eligibility requirements for a person to access the scheme and the steps that a person would need to follow through the assisted dying process. The webpage notes that further resources will be produced, in consultation with the community, including for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people.

101. Fourthly, as I have noted above, there will be a range of people who wish to access the ACT VAD scheme, but who are ineligible for a range of reasons. It is important that there be appropriate services to support them including, as Ms Williams' family submit, good quality palliative care.

Palliative care

102. Palliative care services are available in the ACT for people who have serious incurable diseases, from the moment a person is diagnosed, and for people nearing the end of their lives. The goal of palliative care is to improve quality of life. VAD will be available to eligible people alongside palliative care services.

103. Information about palliative care is available online, including through the ACT Government website, and from health practitioners, including general and specialist doctors, nurses and social workers.

101. Palliative care includes the provision of medication and other therapy to facilitate the relief of symptoms, counselling (including with respect to making decisions about medical treatment), the provision of information about available options to support the person's experience, referral to particular palliative care services and inpatient care.

102. Palliative care is provided by nurses, nurse practitioners, general practitioners, specialist doctors, aged care workers, therapists, allied health staff and other health professionals providing care for people with life-limiting illnesses. On its website, the ACT Government lists the following specific services:

> Primary services (clinical)
>
> > Community Care Program – Community Nursing and Allied Health teams give care to people who may have palliative care needs. We work with your GP who gives you medical support. We will refer you to a palliative care service if we can't manage your symptoms. You can talk with a community nurse for more information.
> >
> > ACT Motor Neurone Disease Service – This service provides care and support to people with motor neurone disease (MND). Their team includes doctors, social workers, physiotherapists, occupational therapists, speech therapists, dieticians, and a MND Regional Advisor. The clinic is based at the University of Canberra Hospital in Bruce.
> >
> > Canberra Health Service Renal Supportive Care Clinic – Renal supportive care is a personalised care program that cares for people with kidney disease. The clinic will work with you to find out what your symptoms are and help you manage them. The team works alongside palliative care to help you have the best quality of life and plan for your future.
>
> Primary Services (non-clinical)
>
> > Palliative Care ACT – Palliative Care ACT advocates for and promotes best quality palliative care in the ACT. The team provide education within the community and their volunteer service supports people and their families with care, compassion, respect and dignity.
> >
> > Community Options Palliative Care Support Program – The Palliative Care Program provides case management, in-home support and community-based support. They offer this service to people at the end of their life who wish to die at home or stay at home for as long as possible. They do not provide medical/clinical help.
> >
> > Community Service Providers – There are a range of community services that support members of their community with practical and counselling support, including when they may be at end-of-life. These include services such as Cancer Council, Dementia Australia or Meridian.
>
> Private Service Providers
>
> > Specialist Services – Canberra Health Services offer a range of specialist palliative care services for children, young people and adults. The Palliative Care Specialist Service provides palliative and end-of-life care including, where possible, at a person's preferred location, including at a person's home, in hospital, in an aged care home or in a hospice.
>
> Paediatric Palliative Care Service
>
> > The role of the Paediatric Palliative Care Service is to make sure quality palliative care is provided for all children or young people living with a life-limiting illness and to support their families. A paediatric palliative care nurse is based at Canberra Hospital and is able to work alongside of your paediatrician and the treating team to provide support either in hospital or at home.

103. It is clear from the above list that the ACT is served by a range of palliative care services, across clinical and non-clinical settings, and through public and private providers. The range of services available are clearly set out on the ACT Government website. The website does not identify the treatments that are available to a person receiving palliative care, but I do not consider that that is necessary. Treatment of a

patient is necessarily individualised and the treatment options – including the range of medications and therapies that might be suitable – should be a matter for discussion between the patient and the medical professionals who provide palliative care services.

104. Ms Williams' family believe that, if good quality palliative care had been available to Ms Williams then, even in the absence of VAD, her suicide (with the anxiety and other impacts that that caused Ms Williams, her family and first-responders) would have been avoided. However, having regard to the observations I have set out earlier in these findings, I do not consider that that is correct.

105. It was not the absence of good quality palliative care that led to Ms Williams' suicide. Ms Williams wished to die at home and within days of commencing a PST. She was open about that and said so repeatedly to the range of medical professionals with whom she interacted. Ms Williams was frustrated that she could not access VAD because that is the path she wished to take.

106. Ms Williams was offered medication for her pain and she was offered sedation to relieve her suffering. She was offered counselling. She was offered the option of PST at home or, if she required a stronger form of sedation, inpatient sedation at CHH. As I have noted, even if CHH had had the resources to implement a more comprehensive PST plan at home, the issue for Ms Williams was still that she wished for her death to be in the order of a few days, rather than a couple of weeks, and a timeframe for her death simply could not be guaranteed. As Dr Raj said, what Ms Williams wanted was a solution that hastened death, but that was not something that Ms Williams could be offered at that time. That is not what palliative sedation is and nor had it been represented to Ms Williams that it would achieve that goal.

Palliative Sedation Therapy

107. Toni Ashmore, Senior Director, Division of Cancer and Ambulatory Services, Canberra Health Services, provided a statement dated 30 June 2025. In her role, Ms Ashmore has had responsibility for the development and implementation of a Territory wide end-of-life and palliative care service through a network of providers in the ACT.

108. Ms Ashmore was also a member of the ACT Palliative Care Governance Committee and led the Working Group which developed the Consensus Statement for the Committee in 2020 and obtained endorsement from ACT Health for the Statement in 2021. The Consensus Statement applies to the use of PST across the ACT. I was provided with a copy of the Consensus Statement during the course of my investigation.

109. Ms Ashmore noted that the document was no longer a draft document, following its endorsement in 2021, but that a draft watermark remained on the document for a time thereafter. She noted that the watermark has now been removed.

110. Ms Ashmore noted that, during development of the Consensus Statement, the Working Group identified that PST was a well-recognised palliative care measure nationally and internationally to assist in providing relief where there are severe and refractory symptoms by lowering the patient's consciousness so that comfort can be achieved and maintained. Ms Ashmore further noted, however, that many health professionals and members of the community misunderstood the intent of PST and the difference between that therapy and euthanasia (or VAD). Ms Ashmore noted that the Consensus Statement highlights the difference between PST and euthanasia.

111. I was unable to find the Consensus Statement by undertaking an internet search. I did see a reference to it in another ACT Health guideline, being the 'Canberra Health Services Guideline – Use of Palliative Care Sedation Therapy (Adults)' (**Palliative Sedation Guideline**). The Palliative Sedation Guideline provides a comprehensive

explanation of what PST is, its purpose, the circumstances in which it is used, the professionals involved in assessing and delivering the therapy and the difference between PST and euthanasia or assisted dying.

112. The Palliative Sedation Guideline does not comment on the use of PST in the community. It states that the reference to a 'clinician' in the document may refer to a GP or Registered Nurse in a community setting and to a Registered Nurse, Nurse Practitioner or GP in a Residential Aged Care Facility setting but the focus of the Guideline is on the implementation of palliative sedation therapy in an inpatient setting.

113. I caused an enquiry to be made of those acting for CHH as to whether it is possible for PST to be carried out in the home using privately provided or funded nurses, should a family wish to take that option. This question was not answered, on the basis that privately provided or funded nurses work for nursing agencies are not Territory employees.

114. I was advised that it would be a matter for the nursing agencies as to whether they have palliative care nurses available with the requisite experience and accreditation to provide PST at home. I take it from that response that PST can be provided in a person's home, but the provision of PST in that context would be limited by the availability, experience and capacity of private practitioners. That could include limitations on the kinds of drugs that can be prescribed and administered in the community which may, of course, limit the effectiveness of PST in that setting.

115. Like the Palliative Sedation Guideline, the Consensus Statement is specific in terms of how PST is undertaken, including the nature of the drugs that are used and the nature of the professionals involved in assessing and delivering the therapy. The Consensus Statement also provides that education should be provided on the implementation of the guidelines and that PST should be an integral part of the professional skills of medical staff.

116. Also like the Palliative Sedation Guideline, the Consensus Statement does not mention how the principles set out in it could be implemented in a community setting. Although it defines a clinician in the same way as the Palliative Sedation Guideline, to include practitioners who operate in a community setting, there is no explicit discussion of how PST would be undertaken in the community.

117. CHH also had a guideline, produced by Calvary Healthcare ACT, on the administration of palliative sedation for patients admitted to CHH who required PST during the terminal phase of an illness. It did not diverge in any relevant sense from the above policies. This is consistent with Dr Mather-Hillon's statement that the fact that CHH was operated by a faith-based healthcare system (CHH) at the time had no bearing on the care that it was able to give Ms Williams with respect to the proposed PST.

118. Dr Mather-Hillon stated that it is not usual practice to offer patients and their families a copy of the Consensus Statement when engaging in discussion about end-of-life care options, as it is primarily a guidance document for clinicians on the use of PST. Nevertheless, Dr Mather-Hillon expressed the view that a patient information leaflet on palliative sedation could be beneficial. Dr Mather-Hillon noted that there is ongoing consideration at CHH with respect to the development of a policy, procedure or guideline for PST in the community (including in the home) in the ACT.

119. Accordingly, I consider that the issues raised by Ms Williams' family in relation to PST have been addressed. The Consensus Statement has been finalised and, while it is not readily accessible to the public, it is substantially replicated in another ACT Health guideline, being the Palliative Sedation Guideline, which is accessible online. As Dr Mather-Hillon has noted, there is ongoing consideration at CHH with respect to the

development of a policy, procedure or guideline for PST in the community (including in the home) in the ACT and, since Ms Williams' case, there has been specific training given to palliative care specialists on PST.

120. The extent to which PST can be provided in the home is clearly something that cannot be entirely provided by public providers such as CHH, given how resource intensive the therapy is, and the limits on the availability of the necessary resources. As Dr Mather-Hillon identified, PST is not a commonly used treatment option, which no doubt contributed to the uncertainty that existed as to whether a PST at home plan could be offered to Ms Williams. Her case has highlighted this issue, which CHH has had regard to in its consideration of a guideline for PST in the community.

Advice given to Ms Williams as to the PST at home plan

121. Ms Williams' family said that, in late March or early April 2023, Ms Williams had agreed a PST at home plan with her palliative care team, including Ms Hingeley and Drs Mather-Hillon and Pearce. They say that the plan proposed by Drs Pearce and Mather-Hillon was that, if Ms Williams indicated that she had had enough suffering and stopped eating, within a couple of days of refusing food her HBPC team would administer palliative sedation to her at home. Ms Williams' understanding of the plan was that she would probably lose consciousness within a couple of days after starting palliative sedation, and would probably pass away two to three days after that. She understood that the whole process would probably take about a week and that it could happen at home where her loved ones could be with her.

122. Ms Williams' family said that, contrary to the agreed plan, when Ms Williams told her team in mid-April 2023 that she wanted to set a date for activating the plan, it was retracted. Ms Williams' family understand that Dr Raj took action to prevent the plan from being carried out.

123. I have set out the relevant chronology earlier in these findings. It does not appear to me that a firm plan was offered to Ms Williams at any point. It is clear from the query Ms Williams raised with Drs Pearce and Mather-Hillon on 14 April 2025 as to whether PST was possible, and the outcome of that call – being that Dr Mather-Hillon would conduct a home visit with Mr and Mrs Williams on 21 April 2023 to discuss a plan in detail – that a plan had not been put in place by then.

124. Dr Mather-Hillon stated that she made numerous enquiries within CHH about Ms Williams' case and, as noted already, was advised on 17 April 2023 that PST at Ms Williams' home would not be possible due to resourcing constraints. This was communicated to Ms Williams on 20 April 2023.

125. Despite this, Drs Raj and Mather-Hillon offered a PST plan during their consultation with Ms Williams on 21 April 2023. The advice they gave her was consistent with the advice given to her on 14 April 2023, being that PST could start at home but that admission to CHH may be necessary if stronger medications were required. There may have been some uncertainty as to the extent to which the plan could be implemented at home but the plan, as fluid as it was, always contemplated the administration of sedatives at home with the possibility of admission to CHH if Ms Williams required stronger medication or otherwise required greater assistance than her family could provide.

126. As I have noted above, the crucial difference in Ms Williams' expectations was the length of time she was likely to be subject to the sedation therapy before she died. While Dr Pearce estimated that the likely length of time was a few days, the consistent advice of Dr Mather-Hillon, both before and after Dr Pearce's involvement, had been that the length of time was unpredictable and possibly up to two weeks. The advice she

had given to Ms Williams does not appear to have changed and it is apparent that Dr Raj agreed with that advice when he and Dr Mather-Hillon spoke to Ms Williams on 21 April 2023.

127. While it is apparent that Ms Williams relied on Dr Pearce's estimate in deciding to pursue PST as a pathway, she had also been given Dr Mather-Hillon's advice (and had rejected PST as an acceptable option when Dr Mather-Hillon had advised of the possible duration). Thus, the advice given to her on 21 April 2023 did not involve any change in the medical advice available to her in terms of the expected duration of the therapy before she died.

128. As I have discussed above, there was no palliative option that could be offered to Ms Williams to achieve her objective of ending her life, and nor had it been represented to Ms Williams by any of the medical professionals involved in her care that any palliative care option could be used to achieve that goal. She was advised that PST could not be used to hasten her death. Ultimately, the uncertainty that existed as to the length of time Ms Williams would be subject to PST before her death was unacceptable to her.

The appropriateness of the police welfare check

129. Ms Williams' family raised a number of queries in relation to the appropriateness of the police welfare check that was attempted at Ms Williams' house. Ms Williams' family noted that medical advice available to police (being Dr Raj's call to the AFP Coroners Team) was that a welfare check would likely exacerbate the complex psychosocial situation that Ms Williams faced. The family further submitted that it should have been clear to police that Ms Williams was under medical care and that her medical practitioners would be in a better position to understand the risks to her welfare than they could.

130. I do not consider that this issue relates to the manner and cause of Ms Williams' death, nor that it raises a matter of public safety.

131. As I wrote to Ms Williams' family previously, on receipt of genuine and credible information indicating that someone is at risk of harm, either by their own hand or from another, police will conduct a welfare check. Police welfare checks are often not welcome by those who are being checked upon, and it is acknowledged that interactions may cause distress to families. However, the greater risk is that police refrain from acting in protection of a citizen, particularly in circumstances where the information they have at hand may be minimal and often provided by a third party. No different considerations apply to someone who suffers from a terminal illness. The potential adverse outcomes involved in not responding to a report of risk of harm are significant.

132. However, I have written to ACT Policing to ask them to review their policy on welfare checks with a view to considering whether any change to the policy is desirable with respect to cases where medical professionals are involved, particularly in circumstances where a medical practitioner has advised against a welfare check being undertaken or has given advice that a welfare check is likely to increase a risk of harm.

The appropriateness of the police investigation

133. Ms Wiliams' family consider that the police response to Ms Williams' death, including their investigation of the circumstances of her death, seemed disproportionate and added to the distress experienced by her family. I do not consider that this issue relates to the manner and cause of Ms Williams' death, nor that it raises a matter of public safety, however I have addressed the matters that Ms Williams' family raised in relation to the police investigation below.

134. As I wrote to Ms Williams's family, in their handling of all deaths referable to the Coroner, police need to balance the impact of the death and investigation on the bereaved family, and the functions required by the Coroner and the Coroners Act. It is also to be kept in mind that assisted suicide, even if the deceased wished to die (as Ms Williams did) was and (outside the VAD scheme) is a crime, the possible commission of which police may need to investigate.

135. I was advised by the AFP that the Crime Team is dispatched to all suspected suicide matters in accordance with the ACT Policing Better Practice Guidelines, and that the number of AFP officers present at Ms Williams' home was the usual response to a coronial death investigation. I was advised that a five hour attendance by police, as occurred in Ms Williams' case, is on the shorter side of the standard response to a reported death. The reason why several hours are required by police is that each officer is involved in carrying out particular functions, and some functions necessarily follow others, which can unfortunately make attendance at the home lengthy.

136. As occurred in this case, persons providing information to police in relation to an investigation usually do so individually. It is important for police to obtain a version of events from each person which is uninfluenced by others. This enables the person being interviewed to speak freely, and maintains the integrity of their version of events should the matter be the subject of further investigation or hearing. Nevertheless, in this case, [Redacted] and Mr Williams (senior) were able to remain proximate to each other in the backyard, and within visual contact of each other while speaking to police.

137. I note that all family at the home were allowed to see Ms Williams and say goodbye. While family were not permitted to touch Ms Williams or see her alone once police arrived, they had had the opportunity to do so before police were called. In circumstances where the Coroner was yet to direct the extent and nature of the post mortem examination, it was appropriate that the usual procedure be followed, as it was.

138. Ms Williams family also commented that the seizure of devices by police caused considerable distress to, and practical challenges for, her family over the following days and weeks. For example, without Ms Williams' phone, her family were unable to access her contacts to notify her friends of her death; without Mr Williams' laptop he struggled to find the names and contact details of Ms Williams' support workers and was unable to access a report that he was working on; and without Mr Williams' printer, the family needed to purchase a new one and set it up to attend to the various administrative burdens that they were labouring under.

139. Ms Williams' family noted it took 10 weeks for the printer to be returned. Ms Williams' family queried '*What important information for the Coroner was obtained from the printer, or could possibly have been obtained from that printer, that could justify the stress, disruption, inconvenience, and time cost to our family?*'. They also noted that, while they were able to negotiate for the relatively prompt return of Ms Williams' phone and Mr Williams' laptop, they understand that other bereaved families have not been able to do so.

140. As I have noted above, police need to balance the impact of the death and investigation on the bereaved family, and the functions required by the Coroner and the Coroners Act. While the deceased's family may understandably view the actions of police as causing stress, disruption and inconvenience for no apparent benefit, police are required to undertake an investigation and cannot know what information or evidence may be found on seized devices.

141. Unfortunately, forensic investigative steps, including in relation to technological devices, often takes time. I accept that, while necessary, that does mean that bereaved families do suffer stress, disruption and inconvenience.

142. I am not in a position to comment in relation to the experience of other families, however I am aware that the families of a deceased person are able to ask the assigned police case officer for access to any devices that are held by police. I understand that police will facilitate such requests wherever possible, as they did in this case, and that the return of devices being examined for a coronial proceeding generally involves police seeking the approval of the Coroner.

143. The two laptops that police obtained were returned to Ms Williams' family the day after Ms Williams' passing and [Redacted] was offered access to Ms Williams' phone and iPad in the days following, prior to Ms Williams' funeral, if she needed to obtain information from them. As Ms Williams' family noted, those devices were returned a short time later. The forensic procedures required to be undertaken to examine Mr Williams' printer meant that it took longer to return that item.

Conclusion

142. Ms Williams had been suffering from a debilitating disease for some time and only had 3 to 6 months to live. She chose to die by suicide before she became fully dependant on her family or others.

143. Ms Williams' family raised a number of issues for my consideration, however, for the reasons I have articulated, I do not consider that any matters of public safety arise in connection with this inquest. As I have found above, Ms Williams' identity, the location and time of her death and the manner and cause of her death are clear. I have nevertheless written to CHH to raise the issues that Ms Williams' family identified regarding particular aspects of her care there, and also to ACT Policing to ask them to review their policies on welfare checks.

144. Ultimately, there was no palliative care option that could be offered to Ms Williams to achieve her objective of ending her life, and nor had it been represented to Ms Williams by any of the medical professionals involved in her care that any palliative care option could be used to achieve that goal. She would have been an obvious candidate for the VAD scheme that has now commenced in the ACT. As I have noted above, its introduction represents a significant development in public policy in the ACT and Ms Williams' family should take pride in the role they played in the implementation of a VAD scheme in the ACT. As I have also noted above, as a result of Ms Williams' case, CHH is considering the development of a guideline for PST in the community.

145. MND is a cruel disease and the loss of autonomy, coupled with significant pain, that it brought to such a vibrant and capable woman must have been devastating for Ms Williams' family and many friends to witness. I acknowledge the contribution of Ms Williams' family to this inquest, and the significant loss they, along with Ms Williams' friends and the wider community, have suffered.

I certify that the preceding one hundred and forty-five [145] numbered paragraphs are a true copy of the Reasons for Findings of his Honour Coroner Temby.

Associate: Noelle-Alexis Bowles

Date: 10 March 2026