OPEN ACCESS

Self-administration of oral voluntary assisted dying medication in Victoria, Australia: the first 6 years

Michael Dooley ,[1,2] Tien Nguyen,[1] Phuc Phan,[1] David Seymour[1]

[1]Victorian Voluntary Assisted Dying Pharmacy Service, Alfred Health, Melbourne, Victoria, Australia
[2]Faculty of Pharmacy and Pharmaceutical Sciences, Monash University, Melbourne, Victoria, Australia

Correspondence to
Professor Michael Dooley; m.dooley@alfred.org.au

Received 13 January 2026
Accepted 21 April 2026

ABSTRACT

Objective(s) To describe the reported experience of patients who self-administered voluntary assisted dying medication in Victoria, Australia.

Methods A population-based retrospective study of voluntary anonymous feedback survey responses from carers of patients who had self-administered the voluntary assisted dying medication. The participants were carers of patients who self-administered the voluntary assisted dying medication in Victoria, Australia, between 19 June 2019 and 30 June 2025. The main outcome measures were time to swallow the mixture, volume swallowed, time to loss of consciousness and time to death.

Results Of 572 patients who self-administered the voluntary assisted dying medication, 563 (98.4%) reported that the patient swallowed the mixture in less than 4 min; and 95.1% swallowed the entire volume. Loss of consciousness was <10 min in 93.2% of patients and reported to be 30 s to under 2 min in four patients. All patients who swallowed the mixture died. The majority of patients (64.1%) were reported to have died in <30 min, with 86% within 1 hour. There were 37 responses (6.5%) where it took more than 2 hours for death to occur and 12 responses where the time taken exceeded 6 hours; the longest reported was 11 hours. 33 of the 37 patients that were reported to have taken longer than 2 hours to die were reported to have swallowed the entire volume of the mixture.

Conclusion Self-administration of voluntary assisted dying medication has been demonstrated to be safe and effective with the safeguards in place in Victoria, Australia.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Assisted dying has been available in a number of countries for over 30 years and has been implemented in, or considered for implementation, in a number of others.
⇒ This study was needed to demonstrate the outcomes associated with the medication used in the most contemporary implementation of assisted dying.

WHAT THIS STUDY ADDS

⇒ This analysis, over 6 years since implementation in 2019 in Victoria, Australia demonstrates that the method of self-administration is safe and effective.
⇒ This is the largest reported experience of oral self-administration and outcomes globally.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The method of oral self-administration and the medication used has now been shown to be safe and effective and should be used to inform those making decisions regarding potential access to assisted dying in various jurisdictions internationally.

INTRODUCTION

Voluntary assisted dying (VAD) has been legislated and implemented across a number of countries and is being considered in a range of others.[1] There have been, and continue to be, concerns raised regarding potential problems in patient self-administration of oral medication intended to cause death.[1–5] These concerns include that patients may be unable to successfully take the medication, that complications are frequent and that the medication may not result in death.

The most recent experience of implementing the use of oral medication for self-administration for assisted dying has been in Australia and this provides contemporary insight into approaches and safeguards that enable safe and effective adoption. A recent editorial by Hollins *et al*[5] expressing concerns did not include commentary on the implementation of assisted dying in Australia. The published literature to date does not include data on

Check for updates

To cite: Dooley M, Nguyen T, Phan P, *et al*. *BMJ Supportive & Palliative Care* Epub ahead of print: [please include Day Month Year]. doi:10.1136/spcare-2026-006106

the medication or method of administration used for VAD in Victoria.

VAD legislation was passed in Victoria, Australia in 2017 and became an option for patients in June 2019.[6] Key challenges comprised the implementation of procedures and safeguards, including the identification of medications to use and establishing processes to support safe administration across a diverse cohort of patients and practice settings.[7 8]

In Victoria, patients who satisfy the VAD eligibility criteria are able to request access to the VAD medication for self-administration. They may only request access for practitioner administration if they are physically incapable of self-administration or oral absorption of the VAD medication.[6 9] The design and delivery of a process where patients could safely self-administer the VAD medication was a critical step in the implementation of this practice. This included that patients would be able to administer the medication themselves and that the medication would result in their death.

Previously identified challenges associated with the oral route of administration include poor palatability, impaired absorption and variability in effectiveness.[1] Additional considerations for identifying the most suitable VAD medication included dosage, formulation, volume, availability and onset of action. Furthermore, due to the nature of the medication requiring self-administration, the preparation and practical administration steps had to be suitable for the eligible patient population.

In Victoria, it was decided that there would be a standard protocol for health professionals to prescribe, dispense and supply the VAD medication for self-administration.[9] This protocol has been in place since the commencement of VAD in June 2019. Since then, all States in Australia have implemented VAD, with the Northern Territory the only jurisdiction where this has not occurred.[10] Self-administration is available in all these jurisdictions. Practitioner administration is also available however self-administration is the default process in some jurisdictions with practitioner administration only available when the patient is incapable of self-administering. The medications and doses used for self-administration in Victoria have been adopted across Australia.

The VAD medication is pentobarbital (15 g) which is mixed with 30 mL of Ora-Plus and self-administered within 60 min of preparation. Patients and carers are advised that the medication must be taken in its entirety in less than 4 min, and preferably within 1 min. At the date of implementation, the protocol was unique to Victoria and involved the preparation of a mixture from a powder with 30 mL of the diluent added.

Since the implementation of the VAD legislation in Victoria, the Victorian Voluntary Assisted Dying Statewide Pharmacy Service has been solely responsible for providing pharmacy services to all Victorian patients. The medication is only provided to the patient once the pharmacist has assessed the patient as competent, able to absorb the medication, able to swallow the required volume of liquid within the required time, has someone who is able to prepare the medication for administration, and that the patient explicitly requests supply. There is no requirement for a healthcare professional to be present at the time of self-administration. The objectives of this study were to demonstrate the outcomes of those who self-administered the oral VAD medication, as reported by their carers. Since the commencement of VAD in Victoria, carers of patients who have self-administered the VAD medication have been able to complete a brief feedback form outlining their experience.

METHODS

We analysed all carer-reported feedback for the period of 19 June 2019 through to 30 June 2025, available from returned anonymous feedback forms received by the Victorian Statewide Voluntary Assisted Dying Pharmacy Service.

The feedback survey was developed by pharmacists within the Statewide Pharmacy Service at the time of VAD implementation in Victoria. The survey questions included:

- What was the powder mixed to make the mixture?
- Were there any difficulties making the mixture?
- How long did it take to swallow the mixture?
- Approximately how much of the mixture was swallowed?
- Were there any problems with swallowing the mixture?
- Was any other drink taken after swallowing the mixture?
- How long after taking the medication did loss of consciousness occur?
- How long after taking the medication did death occur?

Feedback forms were provided in paper format to the patient and/or carer at the time of provision of the VAD medication by the pharmacists of the Victorian Voluntary Assisted Dying Statewide Pharmacy Service. There was a section to record free-text information for the questions relating to difficulties in preparing or swallowing the mixture. In addition, there was a section at the end of the survey to add further comments. A pre-addressed envelope, addressed to the pharmacy service, was provided with the form. The survey form was voluntary and anonymous and did not include questions regarding the patient, demographics or location. The form could be completed by anyone who was present at the time the VAD medication was prepared and self-administered.

Data analysis

Returned feedback forms were collated and analysed using Excel 2020 (Microsoft). Blank responses were coded as ‘response not provided’. The data were summarised descriptively using frequencies and proportions.

Table 1 Preparation and self-administration of the mixture

Survey question	Answer options	N (%)
Were there any difficulties with making the mixture?	No	489 (85.5)
	Yes	67 (11.7)
	Response not provided	16 (2.8)
How long did it take to swallow the mixture?	<1 min	459 (80.2)
	1–4 min	104 (18.2)
	>4 min	3 (0.5)
	Response not provided	6 (1.0)
Approximately, how much of the mixture was swallowed?	All	544 (95.1)
	Most	15 (2.6)
	Half	2 (0.3)
	Less than half	3 (0.5)
	Response not provided	8 (1.4)
Were there any problems with swallowing the mixture?	No	506 (88.5)
	Yes	58 (10.1)
	Response not provided	8 (1.4)

Table 2 Time to loss of consciousness and death

Survey question	Answer options	N (%)
How long after taking the medication did loss of consciousness occur?	<10 min	533 (93.2)
	10–20 min	29 (5.1)
	>20 min	0 (0)
	Response not provided	10 (1.7)
How long after taking the medication did death occur?	<30 min	367 (64.1)
	30 min to 1 hour	125 (21.9)
	>1 to 2 hours	32 (5.6)
	>2 hours	37 (6.5)
	Response not provided	11 (1.9)

RESULTS

A total of 572 complete feedback survey responses from carers of patients who had self-administered the VAD medication were returned to the Victorian Voluntary Assisted Dying Statewide Pharmacy Service. This equated to a response rate of 41.4% from the reported 1382 deaths from the self-administration of the VAD medication during 19 June 2019 through to 30 June 2025. The responses relating to the preparation of the VAD medication, how much was swallowed by the patient, and problems with swallowing are detailed in table 1. In over 85% of responses, there was no difficulty in preparing the mixture. In the 67 instances where difficulty was experienced, 63 related to how long it took for the powder to dissolve, four responses did not provide further detail.

Over 88% of responses reported that there were no problems with swallowing the mixture. In those where a problem was reported, the very bitter taste was the primary response. There were 563 (98.4%) reports that the patient swallowed the mixture within 4 min, with 3 reports of greater than 4 min. In these three cases, one reported that using a straw was problematic, one had difficulty swallowing and the other lost consciousness before finishing the entire mixture.

All of the mixture was swallowed in 95% of responses, with five patients reporting taking half or less than half of the mixture. Of the two reports of swallowing half, one was due to the taste and the other due to the inability to swallow and maintain consciousness. The responses relating to less than half the mixture being swallowed detailed that one patient coughed up the mixture, one was due to using a straw and one did not provide details. All responses reported that the patient died after taking the mixture, as detailed in table 2.

Loss of consciousness was reported to be in less than 10 min in almost 95% of patients and reported to be as rapid as 30 s to under 2 min in four patients. The majority of patients (64.1%) were reported to have died within less than 30 min of swallowing the mixture and 86.0% within 1 hour. Eight reports detailed that the patient had died within 5 min of swallowing the mixture. There were 37 responses reporting that death took greater than 2 hours, with 12 responses stating that death exceeded 6 hours, the longest reported was 11 hours. 33 of the 37 patients reported to take longer than 2 hours to die were described to have swallowed the complete volume of the mixture.

DISCUSSION

Self-administration of an oral dose of the VAD medication is the default method for VAD in Victoria, with practitioner administration via the intravenous route only available if a patient is unable to swallow or absorb the medication. Oral self-administration has been the route of VAD medication administration in 83.9% of reported VAD deaths in Victoria, with the majority of these in the home.[11] This analysis demonstrates that the method of self-administration used in Victoria is safe and effective.

It is the largest patient experience cohort of an oral self-administration of a VAD medication published globally to date. Internationally, self-administration of a VAD medication is uncommon, as most countries with legalised VAD have favoured clinician administration of an intravenous medication. For example, in Canada, 7595 cases of medically assisted dying reported seven (0.09%) cases of self-administration.[12] In the Netherlands, only 245 (3.9%) of 6361 cases of assisted dying reported in 2019, were following medication self-administration,[13] and in Belgium, only 1% of reported cases in 2013 used oral medications.[14]

There have been concerns raised regarding potential problems in patient self-administration of oral medication intended to cause death.[1–5] These papers do not include data on the medication or method of administration used for VAD in Victoria.

A recent editorial by Hollins *et al*[5] expressing concerns about VAD implementation did not provide commentary on the implementation of assisted dying in Australia. The authors presented data primarily from a narrative review by Zworth, which emphasised cases

experiencing complications.[3] Those cases involved the use of multiple medication cocktails and are not reflective of the single agent barbiturate used in Australia. The Zworth review was published in 2020 and did not include data from the Australian experience.[3]

There have been a range of medications used internationally, including barbiturates, benzodiazepines, cardiotoxic agents, sedatives and opioids, used in varying doses and combinations. Harty *et al* identified poor palatability, impaired absorption and widely varied effectiveness, with prolonged time to death or failure to cause death, as the major challenges of the oral route.[1] Their analysis recommended single-agent pentobarbital at a dose of 15 g for oral administration, based on the experience from the Netherlands, where this had been the practice since 2012.[15 16] This is the dose adopted for the Victorian VAD protocol. A study of oncologists, undertaken in the USA, reported concerns by clinicians in cases where patients attempted suicide but failed.[17] These reports were of patients administering medications already in their possession, rather than medications specifically prescribed to cause death.

Groenewoud published data on clinical problems associated with the experience in the Netherlands in the 1990s.[4] Complications and problems were identified in 4% and 7% of the 116 cases of those reported to have received oral or rectal routes of administration, respectively. It was not reported which medication was used in these specific cases. There are very limited data on the experience in Canada, as oral self-administration is very uncommon.[18] In Belgium, oral administration of a medication is also not common and is very rarely self-administered.[19] Pentobarbital is not used for VAD oral self-administration in the USA as it has not been available since 2014.[20]

The Victorian experience has demonstrated that the oral medication protocol works as intended and is able to be self-administered. All patients who self-administered the medication died, including the small proportion that did not swallow 100% of the dose. In addition to this study data, over the 6 years since implementation, there have been no reports through the highly engaged healthcare VAD community or through the VAD annual report of any patient surviving self-administration of the medication.

The dose of pentobarbital used in Victoria replicates that used in the Netherlands and the outcomes are consistent with the limited data published from their experience. A report of anonymous feedback from 165 physicians and pharmacists on the use of 15 g pentobarbital, between 2013 and 2015, reported 94% of patients dying within 60 min of ingestion, compared with 86% in our 572 patients.[16] In 2% of cases, the time to death exceeded 2 hours, compared with 6.5% in Victoria. The specific time of death was not available in the overseas data. The higher frequency of time to death exceeding 2 hours reported in the Victorian feedback surveys may be reflective of a potential response bias, with carers providing feedback more frequently when cases were prolonged. Prokinetic agents are not used in Victoria as it was deemed that this would result in added complexity for patients. The only difference in practice in Victoria, compared with the Netherlands, is that a much smaller volume of liquid is taken by the patient (30 mL), rather than the 100 mL formulation used in the Netherlands. It has been suggested that a prolonged time to death may be due to the inclusion of patients with neurodegenerative disease, with potentially slower gastric emptying time. However, anecdotally, this has not been our experience. As these data presented is anonymous feedback, we were unable to analyse specific patient characteristics. In practice, we recommend that carers move patients onto their right side to aid absorption if they have not died within an hour.[21] Our clinical experience is that death occurs soon after this manoeuvre is performed.

The time between self-administration and death is variable, with the majority of patients dying in less than 30 min but with a small percentage taking longer than 2 hours. It is imperative that families and healthcare professionals are fully informed and prepared regarding this so that expectations are realistic and that a very quick death or a prolonged death is not unexpected. Clear communication and expectation-setting are paramount and this information regarding time to death is provided in VAD healthcare professional education, patient educational booklets and in the patient and carer interactions that occur before and during the pharmacist counselling. This is embedded in clinical practice across Australia and is crucial in providing support for carers supporting patients through self-administration.

There are a range of key safeguards in place in Victoria to support patient self-administration of the oral medication and these have been crucial in providing the outcomes reported here.[6 9 11] These include the use of a medication protocol that stipulates the medication to be prescribed, including the dose of the VAD medication and supportive medications, including anti-emetics to be taken an hour before and an anxiolytic 30 min before, if needed. The Victorian Voluntary Assisted Dying Statewide Pharmacy Service is responsible for the supply of all the medications. Patients also receive a visit from two pharmacists from the Service. During the visit, the pharmacists assess the patient's knowledge and decision-making capacity, as well as their ability to swallow the medication. This includes observing the patient swallow 30 mL of the suspending agent, or similar liquid, within less than 2 min. In addition, a detailed patient information booklet is provided and a step-by-step simulation of the medication preparation process is demonstrated. The patient is provided the VAD medication in a kit, including being in a locked box, if requested. Anyone

that the patient wishes to attend the pharmacist's visit is welcome, including health professionals. The pharmacy service works in partnership with the Victorian Care Navigator Service and nursing and medical staff caring for the patient to provide support for patients who decide to self-administer. As detailed earlier, this includes providing information and support regarding time to loss of consciousness and death. Other feedback from family members in Victoria has highlighted the positive impact of the Care Navigator and Pharmacy Services.[11 22]

There are some limitations to this study. Participation was voluntary and self-reported by carers and response bias is possible. The response rate was over 40% of all reported deaths. It is possible that the experience of those completing the survey was not reflective of the overall population. It could be argued that those who had a poor experience may not have completed the survey and that the positive outcomes reported are consequently an overestimate. It is also possible that the individual completing the report did not report what actually occurred; however, this is considered highly unlikely. A more robust research approach would be for these data to be collected by a healthcare provider observing administration and death. In Victoria, the VAD practice model is for patient self-administration without supervision and an autonomous patient-centred approach was prioritised. The responses did not detail whether any healthcare professionals were present at the time of self-administration, as this is not mandatory in Victoria. There are no data regarding how often healthcare professionals may have been invited by the patient to be present at the time of self-administration. In our experience, the majority of patients have self-administered at home and have done so with only their family with them. The report did not identify individual patients and consequently, analysis of patient subgroups was not possible. The outcomes are relevant to the nature of the practice model and the safeguards in place and must be interpreted with that in mind. Further research should be undertaken with a specific focus on exploring variability in the time of death and approaches to improving the palatability of the liquid dose form.

In Australia, all jurisdictions that have implemented VAD legislation have replicated the medications and doses used for self-administration in Victoria.[10 23 24] This has included an extensive and independent review of the evidence available by each of these jurisdictions. In addition, the real-world experiences of this safe and effective medication protocol are evident in the degree of confidence now in Australia, with over 80% of people working in specialist palliative care comfortable in directing patients and carers to VAD information and supporting their decisions.[25] Assisted dying is being considered in the UK, with the additional safeguard for the self-administration to be supervised by a healthcare professional at the time of administration.[26 27]

The Victorian experience over 6 years demonstrates that oral self-administration is safe and effective with the safeguards that are in place and provides contemporary insight for those considering the design and implementation approaches for assisted dying.

Contributors All authors have made substantial contributions to the conception, analysis and interpretation of data included and drafting the manuscript, final approval of the submitted version and are in agreement to be accountable for all aspects of the work. MD is the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants. Ethics approval for this study was granted by Alfred Hospital Ethics Committee (Reference Project 521/23: Analysis of Carer Feedback Associated with Voluntary Assisted Dying Medication). Participation was from carers completing an anonymous brief feedback form outlining their experience of patients who have self-administered voluntary assisted dying medication. Consent was implied by the completion of the form.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available.

ORCID iD
Michael Dooley https://orcid.org/0009-0001-8697-4564

REFERENCES

1 Harty C, Chaput AJ, Trouton K, *et al*. Oral medical assistance in dying (MAiD): informing practice to enhance utilization in Canada. *Can J Anaesth* 2019;66:1106–12.
2 Worthington A, Finlay I, Regnard C. Efficacy and safety of drugs used for "assisted dying". *Br Med Bull* 2022;142:15–22.
3 Zworth M, Saleh C, Ball I, *et al*. Provision of medical assistance in dying: a scoping review. *BMJ Open* 2020;10:e036054.
4 Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, *et al*. Clinical problems with the performance of euthanasia and physician-assisted suicide in The Netherlands. *N Engl J Med* 2000;342:551–6.
5 Hollins S, Lishman S, Starling G, *et al*. Untested, unlicensed, unregulated: prescribing and oversight issues in physician-assisted dying/suicide. *BMJ Support Palliat Care* 2025;15:447–50.
6 Parliament of Victoria. Voluntary assisted dying act 2017 [act no. 61/2017]. Available: https://www.legislation.vic.gov.au/in-force/acts/voluntary-assisted-dying-act-2017/004 [Accessed Mar 2024].
7 Department of Health and Human Services (Victoria). Ministerial advisory panel on voluntary assisted dying: final report. 2017. Available: https://www2.health.vic.gov.au/about/

publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report [Accessed Oct 2023].
8 White BP, Willmott L, Close E. Victoria's voluntary assisted dying law: clinical implementation as the next challenge. *Med J Aust* 2019;210:207–9.
9 Department of Health and Human Services (Victoria). Voluntary assisted dying: guidance for health professionals. 2019. Available: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/voluntary-assisted-dying-guidance-for-health-practitioners [Accessed Dec 2025].
10 Go Gentle Australia. 2026 state of vad report: a snapshot of voluntary assisted dying in australia. 2026. Available: https://www.gogentleaustralia.org.au/2026_sovad_report [Accessed Mar 2026].
11 Voluntary Assisted Dying Review Board Report. Annual report july 2024 to june 2025. Melbourne Safer Care Victoria; 2025. Available: https://www.health.vic.gov.au/voluntary-assisted-dying/voluntary-assisted-dying-review-board
12 Health Canada, Second Annual Report on Medical Assistance in Dying in Canada 2020, 2021. Available: https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annualreport-2020/annual-report-2020-eng.pdf [Accessed 23 Jul 2023].
13 Regional euthanasia review committee, regional euthanasia review committees rte annual report 2019, 10. Available: https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports [Accessed 23 Jul 2023].
14 Dierickx S, Deliens L, Cohen J, *et al*. Euthanasia in Belgium: trends in reported cases between 2003 and 2013. *CMAJ* 2016;188:E407–14.
15 KNMG/KNMP guidelines for the practice of euthanasia and physician-assisted suicide. 2021. Available: https://www.knmp.nl/richtlijnen/uitvoering-euthanasie-en-hulp-bij-zelfdoding [Accessed Aug 2024].
16 Horikx A. Facts and figures on euthanasia and PAS. 2016. Available: https://www.nvve.nl/files/3914/6530/4417/Annemieke-Horikx-G104-12-05-2016.pdf
17 Emanuel EJ, Daniels ER, Fairclough DL, *et al*. The practice of euthanasia and physician-assisted suicide in the United States: adherence to proposed safeguards and effects on physicians. *JAMA* 1998;280:507–13.
18 Stukalin I, Olaiya OR, Naik V, *et al*. Medications and dosages used in medical assistance in dying: a cross-sectional study. *CMAJ Open* 2022;10:E19–26.
19 Dierickx S, Cohen J, Vander Stichele R, *et al*. Drugs Used for Euthanasia: A Repeated Population-Based Mortality Follow-Back Study in Flanders, Belgium, 1998–2013. *J Pain Symptom Manage* 2018;56:551–9.
20 Hoffman DN, Strand GR. Clinical practice and pharmacology decisions of medical aid-in-dying providers in the United States. *BMJ Support Palliat Care* 2025;spcare–2025.
21 Lee JH, Kuhar S, Seo J-H, *et al*. Computational modeling of drug dissolution in the human stomach: Effects of posture and gastroparesis on drug bioavailability. *Phys Fluids (1994)* 2022;34:081904.
22 White BP, Jeanneret R, Close E, *et al*. Access to voluntary assisted dying in Victoria: a qualitative study of family caregivers' perceptions of barriers and facilitators. *Medical Journal of Australia* 2023;219:211–7.
23 Braun K. Self-administration or practitioner administration? The scope of future German assisted dying legislation. *Med Law Rev* 2022;31:141–57.
24 White BP, Willmott L. What next for voluntary assisted dying in Australia? *Aust Health Rev* 2023;47:3–4.
25 Palliative Care Australia. Australia's palliative care workforce: challenges and opportunities. september 2025 national palliative care workforce survey report. Available: https://palliativecare.org.au/statement/australias-palliative-care-workforce-challenges-and-opportunities/ [Accessed Aug 2024].
26 Assisted dying for terminally ill adults (scotland) bill. n.d. Available: www.parliament.scot/bills-and-laws/bills/s6/assisted-dying-for-terminally-ill-adults-scotland-bill
27 Terminally ill adults (end of life) bill. n.d. Available: https://bills.parliament.uk/bills/3774/publications