NORTHERN TERRITORY
of AUSTRALIA

Dr TANZIL RAHMAN MLA

Member for Fong Lim

HANSARD EXTRACT

LCAC VAD FINAL REPORT TABLING STATEMENT PART 1

TUESDAY 14 OCTOBER 2025

This extract is taken from the Official Hansard of the Legislative Assembly of the Northern Territory

PARLIAMENT HOUSE, DARWIN NT 0800

PAPERS TABLED

Legislative Scrutiny Committee Report on Inquiry into the Environment Protection (Beverage Containers and Plastic Bags) Legislation Amendment (Expansion of CDS and Other Matters) Bill 2025

Mrs CARLSON (Chair of Legislative Scrutiny Committee): Madam Speaker, I table the report from the Legislative Scrutiny Committee's Inquiry into the Environment Protection (Beverage Containers and Plastic Bags) Legislation Amendment (Expansion of CDS and Other Matters) Bill 2025 and associated minutes of proceedings. Pursuant to Standing Order 200(4), the report was sent to the Speaker and made public on 8 October 2025.

Amending the *Environment Protection (Beverage Containers and Plastic Bags) Act 2011* and the Environment Protection (Beverage Containers and Plastic Bags) Regulations 2011, the Bill seeks to reduce complexity and increase recycling across the Northern Territory by strengthening the Container Deposit Scheme (CDS) and making a number of administrative reforms.

The committee received four submissions to its inquiry. While all the submissions supported the government's aim to increase the effectiveness of the CDS, concerns were raised regarding the inclusion of plain milk containers and the associated transition timeframe. However, following its examination of the Bill, the committee is of the view that the Assembly should pass the Bill with no amendments.

As set out in the report, the committee also considered several matters that were raised in submissions or during the public briefing that were beyond the scope of the current Bill, including whether the refund amount for permitted containers should be increased. Pursuant to section 50(2) of the *Environment Protection (Beverage Containers and Plastic Bags) Act 2011,* the committee has subsequently recommended that the next review of the operation of the CDS incorporates consideration of the impact of increasing the refund amount.

On behalf of the committee I thank all who have made submissions to the inquiry. The committee also thanks the representatives of the Department of Lands, Planning and Environment for briefing the committee on the Bill. I thank my fellow committee members for their bipartisan commitment to the legislative review process.

I commend the report to the Assembly.

Legal and Constitutional Affairs Committee Report on the Inquiry into Voluntary Assisted Dying in the Northern Territory

Dr RAHMAN (Chair of Legal and Constitutional Affairs Committee): Madam Speaker, this final report of the Legal and Constitutional Affairs Committee represents the best efforts of the committee to address the terms of reference provided on 14 May 2025 to inquire into voluntary assisted dying (VAD). The VAD inquiry was challenging on enumerate fronts. It was challenging in terms of subject matter, scope and timeframe for delivery. It is a great credit to all involved that the work presented in this report is of significant quality.

It is seldom the case that reports such as this can capture and represent all perspectives and materials gathered and submitted. For that reason, we encourage interested parties to engage with the source materials of our inquiry in conjunction with this report—being the many hundreds of submissions and hundreds of hours of witness testimony—in order to understand the breadth of the data collected and the positions presented.

Notwithstanding the aforementioned, I am pleased to present this final report on VAD in the Northern Territory to the Legislative Assembly and to the public at large as testament to our collective commitment to progress resolution of VAD for Territorians. In doing so, I express my gratitude, first and foremost, to my fellow committee members across the aisle and within the government and, likewise, to the committee secretariat for its diligence and respective efforts towards completing this extremely challenging inquiry. I again thank the many hundreds of Territorians who contributed to this process and whose contributions will undoubtedly enrich our understanding of what is involved in finishing-up well.

Voluntary assisted dying (VAD) is an extraordinarily complex topic that evokes emotion and tension. It challenges us all. In discussing voluntary assisted dying, we are literally interrogating questions of life and death.

Ultimately, conversations about voluntary assisted dying are not just about fairness; they are also about competing rights and tensions within our system and society. They are about the tension between the rights of individuals versus the rights of society, thinking about the common good and prioritising the needs of the one over the many. Sometimes lost in the debate is that these are also questions of a tension between equity and economy. Voluntary assisted dying is more than just an arbitrary concept; it is, in practice, something that requires support, structures, funding, rules, governance and compliance, all of which are essential parts of creating a framework to assist people with what we once referred to as euthanasia.

‘Euthanasia’ is a word derived from Greek terms; it speaks to the idea of a good death. Voluntary assisted dying—the modern nomenclature for euthanasia—is in some ways an imperfect expression of the idea, but it is the journey towards providing people with the option to have a good death and equitable access to voluntary assisted dying that has driven this inquiry.

It is important to recognise that this journey has been a long time in the making. It did not begin four months ago when this inquiry commenced but indeed, in the Northern Territory context, started some 30 years ago. One could argue reasonably that the pursuit of a good death is something that goes back even further than that.

In the modern context, as many Territorians who have been around for decades will know, the Northern Territory was the first jurisdiction in Australia and, indeed, internationally—depending on how it is defined—to legalise an assisted death on compassionate grounds for people who are terminally ill. The Rights of the Terminally Ill Act passed in 1995 when I was finishing high school. I can recall the fervour surrounding it at the time, and it is remarkable that the fervour has not dissipated. All these years later, there are still passionate advocates for the rights of the terminally ill in a legislative sense and in relation to the underlying subject matter.

The Rights of the Terminally Ill Act warrants mention as a precursor to discussing today’s report because it provides the foundation for the discussions we are having. Some 30 years ago the then Chief Minister, Marshall Perron, took it upon himself to introduce a Bill to legalise voluntary euthanasia. He did so at considerable political cost, demonstrating great courage at the time. That Bill ultimately passed, as we know, by the slimmest of majorities and not across party lines but on a conscience vote.

The final vote was from then MLA Wes Lanhupuy who, in his final assessment, determined that whilst voluntary assisted dying—or euthanasia, as it was at the time—was not something he envisaged his constituency, representatives or the broader Aboriginal public would want to avail themselves of, it was not something he felt he should stand in the way of for the remainder of Territorians who were expressing, with some clarity, a desire to have legislation for voluntary assisted dying.

That Bill was substantively about voluntary assisted dying, but it also represented a point of maturity and growth for this parliament. It represented that this parliament had the capability and capacity to work across party lines for the greater good of Territorians. The Bill signalled to the Commonwealth Government that this was a jurisdiction emancipating itself; it achieved self-government in 1978, stabilised its polity and representative democracy and had the maturity to prosecute complex arguments and come to a determination of what was right for Territorians.

As history students all know, that legislation did not endure. The Rights of the Terminally Ill Act was challenged the year after it was enacted. Only four Territorians availed themselves of the opportunity to have an assisted death. In 1996 the Kevin Andrews Bill, as it is colloquially known, by a backbench member of the then Howard conservative government interceded to stop Territorians and subjects of any territory from being able to legislate in a number of spaces, most notably in relation to euthanasia. Territorians, by and large, were then—and continue to be—aggrieved by that decision of the federal government in usurping the will of Territorians. That was a step backwards in our constitutional journey and our capacity to determine our fate for ourselves in relation to all of our affairs.

Some 25 years or thereabouts passed before finally, in 2022, the Commonwealth Government amended that error and passed the Restoring Territory Rights Bill. That legislation was driven by members of the territories, including the ACT as well as our federal representatives from the Northern Territory. It provided the foundation for Territorians to once again determine their own futures in relation to voluntary assisted dying.

Many people assumed that there would be an immediate correction and that governments would seize the opportunity to act with haste to remedy what was an abrogation, in many people’s eyes, of the rights of Territorians. That is not how things played out, as we are aware.

In the background, from the start of 2017 states of the Commonwealth had all started to make the determination that voluntary assisted dying laws should be considered and enacted as a matter of equity and fair access to healthcare across all states. That process began in 2017 in Victoria where the first voluntary assisted dying legislation was passed. The passage of that Bill was a rollercoaster affair; it was achieved under herculean pressure. The efforts underpinning it were not to be underestimated, and the protagonists behind the Bill paved the way for every other part of Australia to gain access to voluntary assisted dying. It was Victoria first, followed by South Australia, Western Australia, Queensland and most recently New South Wales and the ACT whose legislation, whilst enacted, has still not come into full effect.

Each one of these expressions of voluntary assisted dying legislation has developed iteratively, and each one of these Bills has learned from the last to the point where now Australia has broadly coalesced around the Australian model for voluntary assisted dying. From the outset of this inquiry, old hats to the Territory would put it to members of parliament of all stripes that we should simply resuscitate the Rights of the Terminally Ill Act, scrub out ‘1995’, insert ‘2025’ and Bob’s your uncle. The truth of the matter is this is a much more complex matter now than at that time when there was a simpler regime for accessing an assisted death. For all intents and purposes the Rights of the Terminally Ill Act decriminalised the process of assisting with a death for a terminally ill person but lacked any of the checks and balances that are embedded in all subsequent legislation across Australia.

The process that Australia has settled on broadly for voluntary assisted dying is undoubtedly more burdensome and cumbersome than the Rights of the Terminally Ill Act was; however, it is also much more rigorous and contains checks and balances in process and procedure to ensure we have something which provides Australians equitable access to voluntary assisted dying without ending up on a slippery slope argument to abrogating rights and devaluing human life.

In 2023 and 2024 the Northern Territory Government chose to finally act on the *Restoring Territory Rights Act* and commissioned a report of independent experts to inquire into voluntary assisted dying and how to progress the matter for the Northern Territory. That inquiry is the basis for the one the Legal and Constitutional Affairs Committee has undertaken. The 2024 independent expert advisory report contained 22 recommendations for how to progress the agenda for Territorians.

Our remit as a committee was in the first instance to interrogate the parameters of that report and to consider whether it was fit for purpose, could be refined or we could add value to the equation to ensure a possible practical legislative implementation of voluntary assisted dying in the Northern Territory.

By and large, we set out on our journey not with a view to challenge or to codify the 2024 report but to simply add a body of knowledge to the 2024 report’s findings, particularly with respect to the views of Indigenous Territorians and Territorians who live in remote and regional areas. The challenge had been made that, in the past, consultations outside of major urban centres had been limited and that there was an opportunity for greater consultation to be done in areas outside of major cities.

The terms of reference for the inquiry were, therefore, fivefold: first, to provide a consultation paper to stoke the conversation again. With respect to the consultation paper, we provided a 50-page document for Territorians where we simplified the issues and broadly considered the main questions of access, eligibility and process. We did the best we could to distribute that information to Territorians across languages in multiple mediums and forms to provide people the opportunity to be grounded in the major issues surrounding voluntary assisted dying.

The second part of our terms of reference was perhaps the most important and value adding: the direction to consult extensively with people in remote areas of the Northern Territory to gauge views from people who may not have had the opportunity to fully provide views.

The third part was to evaluate existing VAD models across the country and, to some extent, the world to establish where we are up to and where we might go from here.

The fourth part of the terms of reference was to consider specific challenges for the Northern Territory, noting that we have unique geography, demography and economy to consider. As we are all aware, one size does not fit all, and the Northern Territory is measurably different than the rest of the states and territories of Australia.

Finally and uniquely, we were charged with the responsibility, if appropriate and if suitable support was found for voluntary assisted dying, to provide drafting instructions for model legislation. That final direction is extremely unusual by the measure of parliamentary inquiries. It is rare to be afforded the opportunity by the government of the day to prescribe what model legislation in a space might look like. The government is to be credited, in my opinion, for providing us the option not to simply make recommendations or provide testimony and evidence but to say, ‘This is what the VAD law should look like in the Northern Territory if we are seeking best practice and to make it work for Territorians’.

That final part of the process alone is many months of work. The totality of the terms of reference that we were provided was, in my opinion, a huge ask of any parliamentary inquiry, let alone within four months. I emphasise that point to reiterate that it is a great credit to all the people involved in this inquiry—the committee secretariat and government, opposition and crossbench committee members—that we could provide anything and submit a report of any quality, let alone of significant quality.

The protagonists involved in the inquiry had to work collectively and coherently, albeit in a highly pressurised, challenging space discussing extremely sensitive matters under impossible time constraints. Nevertheless, we produced a document which we believe will progress the VAD agenda for Territorians in a meaningful way beyond simply paying lip-service or, honestly, playing politics with the issue, which I reiterate—with no pun intended—is actually a matter of life and death.

My priority as the Chair of this committee has always been to oversee a process that has been rigorous and transparent but not necessarily to advocate for an outcome one way or the other. I am not interested in dying on a hill for the issue of VAD; I am interested in demonstrating that this parliament can take something challenging, as our predecessors did in 1995, and deal with it with maturity across party lines for the greater good of Territorians. By and large, we have done that.

What does rigour and transparency look like in the context of this inquiry? In the first instance rigour and transparency looks like keeping Territorians abreast of what we are doing. We were provided terms of reference mid parliamentary sitting on 14 May, and the committee wasted no time in meeting immediately to clear our calendars for four months and try to establish a timetable for how to deliver this process. That included doing things that are not often done in this parliament, which we did not to grandstand but to keep Territorians apprised of our work.

Interim reports were presented to allow Territorians to know that we were working on this continuously. The first interim report submitted in this parliament in July sittings outlined work that had been completed to date and the blueprint for the inquiry going forward to give people confidence in the process that we were seeking to follow.

Similarly, the second interim report tabled at the start of September, at the conclusion of all our hearings and consultations, outlined in detail exactly where we had been, who we had spoken to and the parameters of our consultation, including the details of specialist advisers whom we had procured to help guide our deliberations, noting that none of us are subject matter experts in this area.

Those interim reports were part of the process, as was regular engagement with media and providing media releases to allow Territorians to know where this journey started, where it is up to and where it goes next. That should be, in our opinion as a committee, the gold standard for how committee inquiries are conducted, particularly when they are substantive inquiries with heavyweight subject matter, as is the issue of voluntary assisted dying.

We also prioritised at every stage the full and timely disclosure of submissions and evidence. We have iteratively released for public viewing all of the 400-plus written submissions that we received, whether they were manifestos and thesis length or simply two lines of somebody wanting to have their say. All that evidence is important.

As I pointed out, the reality is that all of that evidence can never be captured in its fullness in a report of 200 to 300 pages, but it is important to recognise that everyone who had a say counts. I say to everyone who provided a written submission to this committee: we heard, read and considered your submission. The fact is that we were asking the opinions of Territorians not for a tick-box exercise but because we are genuinely interested in what Territorians have to say on this matter.

Some of it is extremely intelligent; some of it is slightly bonkers, but all of it is important. That is why my fellow committee members and I took the time to wade through the materials—to say nothing of the committee secretariat which, similarly, has been drowning in VAD-related materials for months—and have surfaced with a report.

The other thing we did to give our process rigour was not exclude the prior voices that established the parameters for the VAD agenda. To that point, from the outset, the committee took a number of private briefings with key protagonists. The former Chairs of the 2024 independent expert advisory panel were at the top of our list. We are extremely grateful to the former Administrator, Her Honour the Honourable Vicki O’Halloran, and Duncan McConnel SC for taking the time to help guide our journey and cooperate with us at every turn to avail themselves and support our process without, at any stage, detracting from our efforts.

Other key people provided significant private briefings to us in the background, including key advocacy groups for voluntary assisted dying. We took those meetings deliberately because we wanted to hear from everyone we could reasonably hear from within a time-limited period. We heard from Go Gentle, the Voluntary Euthanasia Society and advocates. At subsequent junctures we also heard from key opponents of voluntary assisted dying to ensure that we did not silence the voices of Territorians.

To that point, the committee worked through all the submissions we received carefully to determine what should be available to the public, redacted or kept confidential. In the main, the committee has sought to provide transparency, provided that people’s interests would not be personally affected—of course, redacting people’s names and addresses, so on and so forth, in submissions. For the most part, we allowed people to have their say. Whether what they have to say is rational or reasonable is for everyone to judge for themselves. We wanted people to be heard and to ensure we provide transparency in this process so far as reasonably possible.

As I alluded to earlier, we also took the opportunity to appoint key subject matter experts as advisers. The first of those advisers was a medical and clinical subject matter expert. To Dr Geetanjali Lamba, on behalf of the committee, I express my gratitude for helping us as people without medical or clinical insight to work through challenging questions that only a subject matter expert could guide us with. It is a credit to her that she could do so dispassionately, notwithstanding that she herself was a member of the 2024 independent expert advisory panel and has a personal view of these matters. Her input was key in helping us to understand the finer details of what is involved in voluntary assisted dying in practice.

The other core group of advisers who we appointed and who have provided, in my opinion, immeasurable value to this process—and differentiate the work that we have done here from prior work—is the legal advisory team from Queensland University of Technology.

QUT’s team was headed up by Professor Ben White. Anybody who knows anything about voluntary assisted dying in a research or academic sense will know that Professor White is the Australian gold standard academic on these issues. Professor White was ably assisted by Dr Madeleine Archer, Katherine Waller, Dr Katrine Del Villar and Denisha Tyler. That group of people from the Australian Centre for Health Law Research provided us with the practical legal guidance we required to turn the committee’s policy positions and deliberations into quantifiable, executable legal drafting instructions.

The drafting instructions for model voluntary assisted dying legislation are appended to the final report in Appendix 3. To a large extent they have attracted a lot of the attention because they are, in essence, the distillation of a blueprint for how to go forward. It was important for the sake of legislators, parliamentary drafting counsel and our legal department within government that we could provide succinct and clear guidance on what we believe, as a cross-party committee, is the best way forward.

Having said that, they are not the totality of the story. Today, in the main, I will not focus on the drafting instructions but on many of the other materials supporting that, including the report itself, the recommendations and the underpinning data.

My focus today in sum is to provide clarity for Territorians and parliamentarians on why the Legal and Constitutional Affairs Committee (LCAC) has made the choices that it has; the ‘what’ of what we have done; and the underpinning logic of why. In isolation, simply reading the drafting instructions—detailed and as well produced as they are—does not necessarily provide the totality of the picture of how VAD could or should work in the Northern Territory.

Without being impolitic or impertinent about it, in the time since the report has been delivered, the sequence of questions that I and my fellow committee members have received from many people—the general public, our own colleagues, bureaucrats, advocates and lobbyists—all demonstrate to a large extent considerable misunderstanding of many of the issues surrounding voluntary assisted dying in practice.

We are looking to talk about things in a practical sense and explain the choices we have made for the benefit of everyone involved with a view to progressing the agenda, because here is the nub of the issue: in-principle support for VAD is one thing. Do you support VAD? Yes or no? That is a much less complex question to ask but a fairly imperfect one that does not progress the agenda for us meaningfully in isolation.

Without consideration for broader factors, practical and timely implementation and how we will achieve that, if we are not careful with what we do there is risk of endorsing, supporting or providing a legislative solution for voluntary assisted dying in the Northern Territory that prohibits Territorians from realistically accessing it anytime soon.

We have tried to make the tough choices on the curly questions. Today I will explain why we made the choices we have. That broader consideration required is, first and foremost, signposted and signalled within the table of contents, if you like, for the report. I go straight to the contents. There is a sense for what the priorities and issues are. It is not just about eligibility and whether somebody should be over or under 18; there is a broad landscape and ecosystem of intersecting issues.

For that reason, our report begins with background to the inquiry and an explanation of the conduct of the inquiry which, to some extent, I have highlighted today. Then it progresses immediately to considering the intersection of VAD with existing NT healthcare, because VAD does not operate in isolation; it is another component of healthcare that has interdependencies and interactions with, most notably, palliative care, aged care, primary healthcare, interpreters and telehealth. There is a range of interdependencies. To think about VAD simply in isolation does a disservice to the whole agenda.

We have tried, within a confined space, to consider challenges to healthcare delivery in the Northern Territory to situate the VAD conversation. We have considered remoteness and cross-cultural challenges, noting that 30% of the Northern Territory is Indigenous and we are the most culturally and linguistically diverse population in the country. We are ethically, religiously and racially more diverse per capita than anywhere else. We simply cannot ignore those factors when thinking about healthcare or burden of disease. Burden of disease plays into understanding of VAD.

As many have heard me speak about in this Chamber, in relation to other matters, we discussed at some length health workforce shortages. The fact is we have a shortage of healthcare workers, whether doctors, nurses, allied healthcare practitioners, patient care assistants, translators, liaison officers or Aboriginal healthcare workers. We have a strained system with a finite number of staff. We do not have standalone service delivery in a range of areas or a specialist standalone paediatric or cardiology setup.

It is important to recognise that this is a new component to the healthcare system and if we want to introduce it, it has to work alongside what we have and not come at the cost of it. Therefore, we consider the interface with existing health services: aged-care services; mental healthcare services; disability services; and Aboriginal medicine, belief and practices, noting our unique demography.

That is a lot of content to cover in 20 pages in one chapter, but it is indicative of the scale of what we were tasked with. Again, our report, in the main, is geared towards providing practical instruction for how to move a legislative agenda for VAD forward. To do so in isolation would be negligent and, in the committee's considered opinion, deleterious.

We move on from thinking about intersection of VAD with the existing healthcare system to the phrase that we landed on that resonated most profoundly for Territorians across the width and breadth of the Territory, 'finishing-up well'. We found time and again that there was resistance and baggage associated with the word 'euthanasia', which is a dated word for some people—beloved by some, but hated by others.

We found all manner of resistance to words, the nomenclature, VAD or voluntary assisted dying. Some people simply did not like the terminology and felt that it detracted from the compassionate and decent side of what providing a good death was all about. When we talked to people, particularly in our remote consultations across the Northern Territory, about providing people with help and choice to finish up well, people nodded their heads in profound agreement.

The fact is we are, for all of our differences, human, and no-one anywhere wants to die a bad, painful, lonely or isolated death embedded in suffering. To that extent we considered what it means to finish up well and what medical treatment and pain relief provides in this space, including palliative care, palliation and palliative sedation. We considered a natural death and the testimony we have received from many places about people who stoically want to die unaided by assistance, even with great suffering. Pertinently for this inquiry we considered finishing-up on country, which was of profound importance to huge numbers of Indigenous people wanting to connect to place and have the opportunity, provision and support not to die in a hospital bed in an urban centre, miles from the place you are connected to culturally, spiritually and practically. Finishing-up on country, as a result, had to be mentioned with care and detail in our report.

End-of-life choices vary, and we had to explore, to some extent, palliative care and the idea of withdrawal from treatment because the brutal reality of it is that not every community in the Northern Territory is New York City. There are profound capacity deficits, service deficits and workforce shortages across the Northern Territory, and it is simply not possible to provide the full suite of services and opportunities in many places. I return to the fact that, by and large, people do not want to die a painful death; for the most part, they would prefer to be surrounded by loved ones in a place where they feel that they would wish to pass on.

It is an unreasonable expectation for most to be asked to withdraw from treatment and finish up on country, unaided with assistance and any of the tools of modern medicine to help you with pain relief and to pass on in a peaceful manner. We had to wrestle with these challenging questions and sensitive matters. The committee members represented all sides of the political spectrum, and we all have personal beliefs. We all carry, to some extent, political baggage and had to work together for the greater good. It has been challenging but a testament to the entire group that we found consensus positions in the main.

Nowhere is that truer than in relation to our fourth chapter: service delivery models. In some ways the signature piece of the 2024 independent expert advisory panel report was recommendation 2, which suggested that the Northern Territory should have a fully centralised VAD service delivery model. In practice, we are talking about, in the interests of providing clarity about where the lines of healthcare end and VAD starts—in the interests of prioritising cultural safety and not confusing people interacting with the healthcare system—a fully standalone separate VAD service.

When you dig into the nuts and bolts of what that involves, we are not talking about one doctor and one nurse on standby. There is an architecture surrounding the provision of VAD—the VAD navigator service, centralised pharmacy services, reviews board and governance and so forth, all of which I will come to in due course. A key deviation for this committee was to, on balance, decide that the best way forward for the Northern Territory in terms of providing equitable but also realistic and fast or at least timely access to VAD was to instead lean on what is broadly considered a community-based model—what is in fact utilised everywhere else in the country to a large extent.

I will provide just a small amount of definition to that before I speak about it at length later. The Northern Territory has some 1,400 doctors, give or take. We have, per capita, more doctors than anywhere else in the country, something like a metric of 5.2 versus 4-point-something for the rest of the states and territories. But we know because of our unique demography, geography and burden of disease that is still not enough doctors to manage our specific healthcare challenges.

The idea that introducing a couple more to stand separately from all that would manage this process for a finite number of people who might avail themselves of the service, at a considerable cost, is unrealistic and not a pragmatic outcome in our view. On the basis of that, we have advocated to deviate from the 2024 report in suggesting that we should be utilising the full network and tapestry of our service providers, including private healthcare practitioners who provide primary healthcare, some two-thirds of the time.

In essence, we want to basically make use of our existing structures and existing network of healthcare providers to allow people embedded within the healthcare system already, who choose to participate with voluntary assisted dying, the opportunity to do so.

We subsequently moved on in our report to purposes and principles which are often glossed over and not articulated clearly. What is the purpose of this report and the underlying legislation? What are the principles that underpin why we are doing this? I will come to that in detail shortly.

From that point onwards, the report becomes technical, substantive and gets into the guts of some of the things that we turn our minds to usually when we think about VAD straight off the bat—eligibility requirements broken down into voluntariness, medical conditions, residency, age and capacity; the request and assessment process that is followed for VAD—the flow diagram, if you like, of what happens, what happens next and what happens after that, then how many days you have to do this and where you get the drugs from—all of that business.

We will go through the assessment process in regard to formal requests and the use of interpreters and telehealth. The administration of the VAD substance is not an insignificant issue, which is the focus of our eighth chapter. Let me be clear: this is the kind of thing that will not be in the report, but that issue almost single-handedly derailed the Victorian effort to enact VAD legislation.

At the eleventh hour there were questions about safe storage and supply—where it will be, who will have the lock and key and how it will operate? These are the nuts-and-bolts questions when considering legislation for, implementation of and realistic and timely access for Territorians to VAD. There is then, of course, the question of what happens after a person dies. There are questions to be resolved, including the notification of death, interactions with the Coroner and so on and so forth.

We consider health practitioners' qualifications and training and, for the most part, land in the same place as the 2024 report and standards around the rest of Australia, noting however that we simply do not have a ton of doctors nor nurses and so relying on structures that are important and leaned upon heavily in other parts of the country—for example, like nurse practitioners—is less of a priority for us than it is for other places. Put simply, our position was to land on doctors making decisions and then to extend that to doctors and nurses having the opportunity to help with the administration of VAD if and when required, particularly on location.

There is also the issue of self-administration, which has a number of curly questions attached to it which we will go through shortly. A critical deviation for this committee regarding past work is in relation to non-participation by healthcare workers and entities. Our committee has broadly been of the view that choice is paramount in discussions about VAD—the choice to access VAD as a patient and the choice to conscientiously object if you do not want to be involved in the process as a healthcare worker. That is not to say that we want to frustrate the process, but in the contest of completing rights we should be prioritising choice at all times—the choice of an individual not to be involved with the process on whatever grounds they see fit and the choice for institutions to determine that VAD, if legislated for, is not something that people will be forced or compelled to deal with. We are trying to provide help and choice for people to finish up well and for people to participate in assisting people with voluntary assisted dying if they so choose, but also the protections in laws to withdraw from the process if they choose not to participate.

Accountability offences and protections are the kind of thing that you do not think about on the front end, but creating VAD legislation necessarily means that you have to think about all manner of other legal structures and intersections with the legal system. The review board is again a point of departure from many other states and Territories. We have landed on a consensus position where we have suggested that we should make use of our existing resources, tools, structures and mechanisms. Across the country the number of people who have availed themselves of voluntary assisted dying is not in the thousands; it is in the hundreds, and that is in states and territories with populations of millions. If you reasonably extrapolate to the best of your ability from that dataset, all our evidence suggests that we would expect reasonably no more than 10 to 20 people a year to avail themselves of VAD in the Northern Territory.

Ten to 20 people does not in our minds—in the first instance as a matter of expediency, time and equity—justify setting up huge and expensive separate structures, and that is part of the reason why we have suggested that our review board, unlike any other review board, should be chaired ex officio by default by the Chief Health Officer of the Northern Territory, embedded within the Northern Territory Department of Health, not a totally standalone separate statutory entity that will require time and significant resources to be set up and be supported in perpetuity. We recognise that means there is complete and perfect separation from the health system or from direction from the government of the day or the minister, but on the balance of all available possibilities we think that it is a constructive way forward.

I note also—to foreshadow that I will come back to it—that these are matters we interrogated extensively with the Department of Health in our discussions with them in public hearings on 5 August and 5 September. I thank witnesses from the Department of Health who spoke to us at length and were extremely honest and clear cut with us about the practical, pragmatic reality of VAD, what it would take in relation to implementation, what the true cost would be and what would be required to not set up the health system to fail on poor delivery of voluntary assisted dying.

I can remember them off the top of my head. I am grateful for Chris Hosking, the CEO of the department; Dr Paul Burgess, the Chief Health Officer; Dr Kane Vellar, a clinical subject matter expert in palliative care; Dr Jeremy Chin, the Chief Medical Officer; as well as Dr John Zorbas, the head of the Australian Medical Association. Those five individuals took considerable time to report to us in person and in writing to help us understand what was possible in practice. As a matter of equity, they all felt that people should have access to voluntary assisted dying in some form. That is essentially the position that this committee has landed on as well. However, as a matter of practice, we had to dig into what it would cost, how we would do it, what the best way forward is and how we can make best use of what we have.

Returning to chapter 12—Accountability, offences and protections—we had to consider the composition of the review board carefully. I will go through that shortly.

There must be appeal in law—rights, procedures and options for people to take VAD outside of the medical process and the healthcare system. The natural fit for that in our jurisdiction is NTCAT, the NT Civil and

Administrative Tribunal. We know how overstretched the NTCAT is. We understand adding a workload to it on complex matters that may not be entirely within its subject matter expertise adds an extra layer of challenge. However, we deem it to be the appropriate forum to make the subjective determinations when there are appeals processes. What if somebody does not quite meet eligibility or residency requirements? What if there are problems in the formal assessment process or reviewing documents, testimony or witnesses? None of which preclude the fact that all rights under law should still exist in terms of appeals with the Supreme Court.

Creating this kind of legislation also necessarily requires us to create new offences and contravention provisions because if the processes of VAD are misused or abused, it is necessary for there to be measures in law for remediation and justice, as it were.

Finally, there are a number of miscellaneous provisions which we had to address, including one that would not necessarily turn to mind, which is the public education component of all of this. Little is known or understood about voluntary assisted dying in practice by a great number of protagonists. It is important that, whatever happens with his matter moving forward, the government of the day continues to maintain clarity of communication with all Territorians. Many of our witness transcripts will validate that we had iterative discussions with Territorians about VAD, much more so than just saying, ‘What do you think about X?’ To some extent the question would then come, ‘I do not know anything about X; I have not heard much about it. Tell me about it.’ It will be extremely important for us to take into consideration public education, implementation and the package of materials that will be required to progress VAD meaningfully.

I turn my attention to the fundamental goal of this report, which has always been to progress the issue for Territorians, not to be determinative in any specifically prescribed way in one direction or another. The focus has always been largely on the drafting instructions—the blueprint and the recipe for how to bake the cake. Drafting instructions are a distillation of the inquiry; they do not represent the totality of the inquiry or the report. On the contrary, the report has a significant number of separate and specific recommendations detailed.

I turn my mind to the report recommendations with a view to elucidate the broader issues. Embedded within the report are 80-odd recommendations. My remarks will not focus on those that are self-explanatory. A number of recommendations are self-explanatory and do not require contextualisation; however, a great number of them require more clarity. It is not my intention to read out the report, submissions and data—as much as I would like to do so—but rather to provide context and establish the underlying logic and highlight the interdependencies between a number of these recommendations which are the next level up from the drafting instructions in terms of explaining the ‘what’ but not necessarily the ‘why’ of how we proceeded,

With respect, I say to the Assembly that Territorians have been waiting many decades to talk about this issue, for progress and to be heard. Without belabouring points, I will take my time to explain to Territorians how we think we should move VAD forward.

The report has many recommendations, some of which marry up closely with the drafting instructions but some that are separate to the drafting instructions, are a level above the drafting instructions and are important to making sure that VAD in practice will work in the Northern Territory.

Recommendation 1 seems harmless enough: we recommend that the government drafts legislation as per our drafting instructions to progress the agenda on VAD. We are saying to all of you that we have comprehensively looked at these issues as a committee of five, across parties. We have delivered a report for the first time in living memory for some that has no dissenting report. We have a unified position on what we think will work, challenging as it was to figure it out.

The report is comprehensive, as are the drafting instructions. More importantly they are context specific; they are not cookie cutter, taking a Bill from another jurisdiction, mucking around with it a bit and seeing if it will work. We are talking about creating bespoke legislation that is consistent with VAD legislation across the rest of the country and the Australian VAD model but that is unique to the Territory, recognising our unique burden of disease, demography, geography, limitations, capacity deficits, workforce shortages, fiscal position—all of the above.

Our starting gambit is to say that this committee determined that there should be draft legislation to move this agenda forward. Why do we make that determination in the first instance? Because we believe that there is more than 51% and less than 100% support for VAD. We cannot measure that, nor were we tasked with doing that. It was not the job of this committee to run a referendum on VAD to say ‘X% of people are for; X% of people are against.’ That will now become the job of all parties involved with VAD going forward to determine within individual communities and constituencies the extent to which there is support for voluntary assisted dying of a specific type and model, pertaining to a specific Bill.

I encourage—I believe I speak on behalf of the committee—all parliamentarians to be canvassing opinion on voluntary assisted dying, not just in principle but with some reference to practice. In the absence of a better framework to articulate that practice, an excellent starting proposition would be Appendix 3, the drafting instructions for model voluntary assisted dying legislation in the Northern Territory. Seek opinion not just on whether people are a 'yay' or a 'nay' but if they are on board with what is embedded here.

The second recommendation of the report at face value might look glib or like a bit of a nonsense throwaway but it is not; it is a carefully considered thing that we have said, which is that we recommend that the government names any forthcoming legislation the 'rights of the terminally ill'. We have said that not just to pay homage to Marshall Perron or people who have come before us on this issue but because we think that the history and legacy of this issue should be recognised and embedded in our thinking for voluntary assisted dying moving forward.

The fact is that in other places the nomenclature 'voluntary assisted dying' rather than 'euthanasia' or 'terminally ill' has taken over to provide for the possible expansion or development of voluntary assisted deaths. But in Australia, there is real clarity regarding the fact that voluntary assisted dying should be available not to people with dementia, who lack decision-making capacity or who are exclusively suffering from mental illness, but to people who are—for want of a better word—terminally ill.

There is specific nomenclature for that, which is in the legal term 'having an advanced and progressive condition'. We will come to that shortly. We think it is significant and important to take back to the public that we are looking not to resuscitate the 1995 Act but to pay respect to it and recognise that, in the Northern Territory, Territorians should have access to finishing-up well through their implied and expressed right as a terminally-ill person to avail themselves of a good death. I encourage whoever goes forward with this process to consider the importance of maintaining the focus on terminally ill persons and their implied to right to a good death.

Our third recommendation is an extremely significant and substantive one which is not mirrored in the drafting instructions at all because it does not, in truth, necessarily have a place in any forthcoming legislation. It is a recommendation that government reviews current palliative care services and develops a palliative care strategy that is broader than what it has now, recognising the mountain of evidence we have that shows that there is an increased need for palliative care services following the introduction of VAD.

If you look carefully at the testimony from 5 August and 5 September with the Health department, you will see the clearest expression of that from our healthcare practitioners saying, 'We know we already have significant limitations in palliative care'. We are stretched on all those fronts, and there are many places that cannot avail themselves of palliative care properly. To introduce this, we know, will place additional strain, so you will find robust questioning from me of those parties to work out just how much more we need, how much more it will cost and what the real workforce impost is of introducing voluntary assisted dying.

Again, I thank the witnesses for their clear and honest testimony. The fact is, estimates range between 10% and 30% of additional impost. That level of extra effort in the healthcare system in palliative care is not something that will happen readily or easily at a time when we are constrained fiscally, but it is a necessary thing to turn your mind to. To give it some context, we know full well that in other states that have implemented VAD legislation, one of the common refrains of mistakes we made and the things we should have thought of beforehand when we were going through the VAD process was the extent to which they should have had both discussions concurrently about VAD and palliative care.

Victoria probably has the best evidence of just how slammed they have been in palliative care since the introduction of voluntary assisted dying legislation. The same could be said of every jurisdiction across the country, so it is extremely important that as we develop this we also turn our minds to equitable access to palliative care and appropriate resourcing of those services in a place that has significant capacity deficits and healthcare challenges.

Recommendation 4 is the recommendation we have made explicitly and clearly that VAD in the Northern Territory should be provided via a decentralised service delivery model, consistent with the VAD Australian model. This is about not letting the perfect be the enemy of the good. If we were flush with cash, population and a healthcare workforce, I would be the first one to say in the interests of maintaining complete confidence in the healthcare system for everybody and separation from aged care, palliative care and primary healthcare that we should have completely standalone division of VAD, build a building for it, put the standalone workforce in it and make that the place where all these discussions can be had, but that is just not realistic.

To be clear, that is not specifically, entirely or necessarily what the 2024 report has suggested; they simply made a clear statement that a centralised model would be ideal—and their preference—without necessarily specifying what components should be centralised and decentralised. Our thinking, as expressed in the report to some extent but more obvious through the hours of testimony, witness hearings and lines of questioning we pursued, is that certain core components of VAD must be centralised, like the pharmacy service and the VAD navigator service. Certain parts must be funded to succeed and maintain suitable separation even with Chinese walls—as the expression goes within a law firm—in regard to the review board.

There are other components of the voluntary assisted dying process that should be decentralised. We should be making use of our network of primary healthcare providers not just in the public system but in the private system. That means, for practical purposes, the many private GPs we have across the Northern Territory can opt in and become accredited providers of VAD services if they so choose.

We are not suggesting that there should not be, in the interest of equity, a state-based service provision of VAD. Where that is, how that happens and exactly how that is most equitably achieved it is too much straight out of the gate to put that entire burden on the Health department. It is important that you can at some point access VAD services through the state-based health system, but we believe it is equally important and does not compromise unduly the integrity of the VAD system to utilise our existing mechanisms and focus on a decentralised service delivery model.

Essentially, we made decisions not as bean counters, not because we do not care about equity and not because we think that people who are Indigenous, out bush or on a cattle station should not be able to access VAD; we absolutely do. We know statistically speaking that the majority of our, let us call them 200-odd cases a year, can probably avail themselves of systems and services in urban centres, initially, and as we have seen elsewhere these things develop iteratively over time. There has been some change in VAD legislation, although I add to that point that individual states have found it hard once they do something to them re-open the can of worms and then prosecute a better VAD system. What has tended to happen is that one state has gotten this in place and then the next state has had a better think about it, learned a few lessons, improved upon a few things and tweaked things and so on and so forth, but it is all still within a tolerance of sameness of the Australian model for VAD at this point. Decentralised service delivery is a part of that.

Recommendation 5 is about the purposes of VAD, and they are quite often not articulated expressly. It is important that they are, because the purpose of VAD legislation is in the first instance to provide a lawful, authorised and safeguarded process for voluntary euthanasia and for good deaths. Our recommendation is about making sure people have a legally authorised option to hasten their death, that we establish a lawful process, that we provide legal protections for healthcare practitioners who are in the system, that we ensure that there are safeguards and that we ensure there is a review board to oversee the process.

I seek leave to table a paper titled, ‘A right to die? Euthanasia and the law in Australia’ by Bartels and Otlowski.

Leave granted.

Dr RAHMAN: I, as many of you know, am partial to quoting the data, science, literature and evidence. There is a mountain of things that I would like to bring to the table but that I will not introduce to the debate at this stage. This one piece of literature, I think, is extremely useful for everyone in the House to flick through, and it is because it is not recent; it is from 2010, and as far back as 2010 it provides a clear expression of the fact that people have been trying to get voluntary assisted dying legislation up and failing. This pre-dates any of the Australian setups providing voluntary assisted dying legislation. It also documents the Territory’s journey and the Commonwealth’s intervention to nix that journey to provide voluntary euthanasia.

One of the key points that it makes, which often people who are outside of healthcare practice are shocked by, is the following, which I will read directly from the article, under the heading, ‘Ineffectiveness of the criminal law prohibition and risk that the law is brought into disrepute’. This is under the section in this paper regarding the euthanasia debate and arguments for providing a legislative framework for VAD. I will read two sentences:

> *Another key argument in support of legislation is that the criminal prohibition is ineffective in practice in preventing the occurrence of euthanasia. Over the years there has been incontrovertible survey evidence that active voluntary euthanasia is being performed in Australia, with approximately one-third of the respondent doctors reporting that they had at some stage provided such assistance.*

Then there is a footnote with reference to another 10 pieces of literature, just in the Australian context, including ‘Doctors’ practices and attitudes regarding voluntary euthanasia’ from 1998; ‘Voluntary euthanasia and the logical slippery slope argument’ from 2002; ‘Euthanasia: attitudes and practices of medical practitioners’ from 1994; ‘A third of surgeons in New South Wales admit to euthanasia’ from 2001; ‘End-of-life decisions in medical practice: a survey of doctors in Victoria’ from 2007; as well as the book from Magnusson, *Angels of Death*, exploring the euthanasia underground by Melbourne University Press in 2002.

I table this document for the benefit of everyone in the House so that we can apprise ourselves of the fact that our legislation, if it is to exist, must exist for a purpose. That primary purpose is to provide a legally authorised framework for euthanasia or voluntary assisted dying—a lawful process with legal protections and safeguards, without which these practices occur and are known to have occurred. There is empirical evidence to suggest so across all cultures, peoples and countries of the world.

Recommendation 6 of the report is about the principles that underpin voluntary assisted dying. The purpose is one thing; the principles are another. The principles that are embedded will not be to everyone’s liking and reflect the nomenclature of human rights Acts, to a large extent. As all of you in this House will know, the Northern Territory does not have a human rights Act. However, the principles as reflected here are done so because they are the same principles mirrored in other Australian VAD legislation.

I argued that I believe harmonisation and consistency with legislative frameworks around the country is always our best possible position to maintain, wherever possible. This recommendation takes that idea and puts it in practice by saying that every human life is of fundamental importance; people’s autonomy is extremely important; end-of-life choices should be respected; people should be provided high-quality care and treatment; registered health practitioners should be able to conscientiously object and be shown respect for their culture, beliefs, values and personal characteristics; and within the Northern Territory context especially, people have the right to cultural safety in relation to VAD. It is a recommendation that I believe belongs in our legislation in some form—recognition thereof—irrespective of whether we have other protocols governing human rights.

Recommendation 7 is about destigmatisation for some people, which essentially says that when people die via a VAD process, taking that substance does not mean they died by suicide but by the disease, illness or medical condition that allowed them to be eligible for VAD in the first instance. That is important not just because of destigmatisation but because of practical considerations and effects that interact with things like insurance, liability and death certificates. It is important that we provide the protections required for people who interact with the system. This is another one of those.

Recommendation 8 is about voluntariness and acting without coercion. Voluntariness in this whole process is paramount to our committee. There are two parts to the recommendation, which in some way seems contradictory but is not because we understand where the balance of where our rights and responsibilities are. We essentially say that people must be acting voluntarily and without coercion but, likewise, in our context, a person may voluntarily request family members or other culturally important decision-makers to be involved in making VAD decisions in accordance with culturally accepted practices of decision-making.

Those two things are not in conflict; they are in tension, and that tension is resolved in our drafting instructions at 3.13 where we make it clear that in the formal request processes for voluntary assisted dying that it is the decision of the individual person who is accessing voluntary assisted dying. That is paramount. It is that person who must make a choice voluntarily and without coercion, albeit we recognise that they may do so within an ecosystem of friends, family, community, church and culture. All manner of other agents may influence the decision, but the decision remains with the individual in law as prescribed in this report.

Recommendation 9 will have attracted attention because it is the determination that we have made on the vexed issue of prognosis. In Victoria when this first got up it was a real challenge and a close-fought thing to get voluntary assisted dying legislation passed at all. In many ways, whilst Victoria was first, it is the hardest and most cumbersome jurisdiction to access voluntary assisted dying in. You can google ‘VAD reform’, ‘suicides’, ‘not working’, ‘reform required’ or any combination of those words and will find a lot of press, as recently as a couple of weeks ago, suggesting that the Victorian system requires reform to catch up to other jurisdictions so that people can access VAD without being frustrated from the processes.

There are a couple of critical things that hold things back. The first one is the issue of prognosis and timeline to death. Every Australian state has some combination of saying, in simple terms, that you must be dying in 12 months or less. In some places it is six months for certain classes of conditions, but there is a timeline at prognosis to death. The ACT, which is the most recent jurisdiction to pass voluntary assisted dying legislation, dispensed with that requirement. After much deliberation, our committee agreed that we should concur with the ACT position. We did so for a number of reasons. The first, most important, is that we spent four months looking at this in an extremely congested, manic, high-pressure inquiry. The ACT had a much longer time horizon and did an exhaustive amount of work on the issue of prognosis, and their conclusion was ultimately that 12 and six months were arbitrary and difficult to determine metrics to use in eligibility.

We have not done anything vanguard. We are not ahead of the rest of the country; we are simply keeping pace with the iterative development of voluntary assisted dying legislation across the country. We decided, as a group, that people must have an advanced and progressive condition which is expected to cause death but that there is no requirement to specify whether that death will take place within six or 12 months irrespective of the condition. It is not a single standalone provision, though; the medical condition must be causing intolerable and enduring suffering that cannot be relieved in a manner that the person feels is acceptable.

We have allowed for the inclusion of anticipatory suffering, which is one of the curly question issues of development in VAD legislation. We have recommended that suffering can also be caused by anticipation or expectation based on medical advice of future treatment or the progression of the medical condition.

I will not speak about slippery slope arguments and the range of other weak arguments that oppose VAD; there are some good arguments in opposition to VAD. I simply do not believe, and I do not think anyone on our committees believes, the slippery slope arguments of, ‘This is the thin end of the wedge. If we do this everything will fall apart; the healthcare system integrity will fall apart and people will be knocking each other off left, right and centre.’ There are rigorous controls in the Australian model for VAD. Is it more cumbersome than the Rights of the Terminally Ill Act was? Absolutely. But there are better checks and balances to ensure that only people who are eligible can access the mechanisms.

The thin-end-of-the-wedge arguments do not carry water with us, and that is why we think anticipatory suffering is a fair thing to include within advanced and progressive condition and intolerable and enduring suffering. The issue in lay terms for us was, ‘What is the price of entry into the club versus what is the price of drinks once you are inside?’ We have set this up so that Territorians should not be prohibited, if they are suffering and terminally ill, from accessing the beginnings of the VAD process.

From that process onwards, we maintain a high watermark for ensuring that the people who make determinations on eligibility, legal rigour, witnesses and document—those standards are maintained at a high level, and we have made no compromises in respect of any of that. In simple terms, there is no cover charge to come in, but drinks are expensive, as opposed to other systems where there is a small cover charge but drinks are cheaper. This is distinct from some versions of this overseas where basically you get in for free, and drinks are on the house. We think we have the right balance to make this pragmatic and equitable.

Recommendation 10 is the first of the recommendations in regard to eligibility on residency. Again, I am here to allay concerns about any histrionics regarding VAD tourism. Nobody will come here first. It will take a while to get this set up. There are other places where this is already working and where people can avail themselves of these things sooner. That is why we have maintained the standard of two years’ residency in Australia and, ordinarily, 12 months residency in the Northern Territory.

What does that mean for somebody who is ill now and wants to use VAD services in the foreseeable future? I will not be dishonest about it; the probability is you could not access a VAD service in practice for at a minimum 18 months and closer to, at best—I would say, as a non-betting man—a couple of years. Why is that? It is because even once we have a Bill and it passes, which may take months, there is a standardised 18-month implementation window that has been adopted across Australia so that health departments, service providers and the public can wrap their heads around what needs to be done and how to do it properly.

I have nothing but sympathy for people who are suffering in the Territory and are in an advanced stage with a progressive condition that will cause them death. The reality is that it has taken time to get to this point, and it is worth us getting it right to make sure that if and when VAD legislation comes to the House, it is the right legislation, it is suitable for Territorians and people can meaningfully, practically and consistently access these services without compromise to the greater community and polity.

It is important to note that recommendation 10 has a built-in exception, which we recognised as extremely important, to make sure people who have a strong family connection, cultural connection or support linkages through the Territory—such as people who might have been here once upon a time and left—might be able to avail VAD services in this place. Without wanting to be cheeky about it, the straw man that we use for this argument on all occasions was Marshall Perron. What if Marshall Perron, who was the Chief Minister and the architect of the initial legislation and who has a long and deep-seated connection to the Northern Territory but has resided interstate for some years now, wanted to come back to use voluntary assisted dying services in the Northern Territory? Would we account for or allow for that?

We are allowing for the process for people to apply to the review board at least for exceptions and exemptions. We think that allows sufficient flexibility to make sure people do not forum shop in our forum, but also so that somebody who is connected to a cattle station, lived here once upon a time or wants to be back at their ancestral place or place of significance can be here for a voluntary assisted death.

Recommendation 11 is completely uncontroversial. I say that because it in unbelievable how many questions I have had from people such as, ‘What will the age limit be on VAD?’ In our exhaustive 30 meetings and deliberations traipsing across the Territory we spent no more than 30 seconds on because it is a no-brainer for us that only people aged 18 or over can access this. That is not to diminish the argument that there are young people under 18 who suffer and fall into the category of people who may have an advanced or progressive condition, may be intolerably suffering and may have the reasonable expectation of anticipatory suffering. The Australian standard at the moment, which we have sought to keep pace with without getting ahead of, does not provision for minors to access voluntary assisted dying in any form. We maintain consistency with that position.

Recommendation 12 is about decision-making capacity. It goes to the complex question that arises time and again about people who have dementia. Our same line in the sand exists with the issue of people who suffer from dementia as it does with minors. At the moment, no Australian jurisdiction provisions for people who do not have full decision-making capacity to avail themselves of VAD services.

We recognise that a person’s capacity may fluctuate from time to time, but that is a person with capacity to make decisions in the first instance who, perhaps because of illness, is now fading in and out of full capacity as they progress through the stages of the VAD process. We have made clear that all persons must have full decision-making capacity in relation to VAD at all stages of the VAD process. We will discuss the stages of the VAD process shortly.

Australia is simply not yet there with allowing people who have dementia alone to be decided for by other people. That may change in time. I have no personal position about it beyond the fact that, as a lover of the law, I believe in the harmonisation and consistency of our legislative frameworks. This is consistency with the legislative position across the remainder of the country.

Recommendation 13 again makes clear the situation with regard to mental illness. Mental illness is commonplace, ubiquitous and almost inevitably interacts with people who are dying. However, it is not, in and of itself, enough to be the sole basis by which to access VAD. A person can have a mental illness and an incurable condition and be eligible for VAD but cannot, on the basis of mental illness and malaise alone, access voluntary assisted dying.

This is one of those differentiating lines between the Australian VAD model and notably some situations in parts of Europe where people who are suffering have been deemed to be eligible for voluntary assisted dying services even when they do not have a terminal illness. We maintain the position that people must have an advanced and progressive condition, and mental illness and disability cannot be the sole basis for a decision regarding voluntary assisted dying.

Recommendation 14 is where we begin to consider the initiation of conversations by medical practitioners. This is an extremely important topic where other jurisdictions have essentially tangled themselves in knots by being overly restrictive in not allowing people to have conversations. As far as our committee is concerned, we believe people should be able to access information unrestricted but that choice should always be protected. In practice we are talking about allowing medical practitioners to initiate conversations about VAD, provided that they also canvass all other treatment options and the nature, scope and availability of palliative care services. Likewise, with the next class of people down, the healthcare workers may initiate the conversations where they have in fact been prohibited expressly from doing so in a number of other states.

We found evidence of the same in our own inquiries, with ex-Victorian nurses who were now embedded within our healthcare system who asked the question, ‘Will I be able to talk to people in my facility or under my care about this? I was around when they introduced this in Victoria, and it was a nightmare when we were expressly prohibited from having the conversations, referring someone or having the conversation on a specific premises.’ We have tried to work through those issues to ensure that there should be no restriction on healthcare workers being able to provide information on a topic. To that point, we have also clearly defined who constitutes a healthcare worker as well as people who provide health services or personal care services, meaning registered health practitioners as well as another person who provides health or personal care services.

The next segment of recommendations pertains to the process of VAD. The process of VAD will be seen by many who are not familiar with the Australian model to be cumbersome, much too complicated and frustrating, but it is the Australian standard. It is essentially a four-stage process of a first request, a second request, written formal request for the process and then administration. It is broken down into much more fine grain detail and steps than that, and I encourage everyone to become familiar with the flow diagrams that are embedded within the drafting instructions to understand it better—I am struggling to find the page now, but in any case, people can find the diagrams for themselves in relation to the process followed.

Recommendation 15 is the first place where we consider that the individual is still paramount, that a first request must be an explicit request for assistance to die and that requests can be made only to a medical practitioner. They can make that by themselves and not by somebody on their behalf, and it must be clear and unambiguous.

Recommendation 16 is about the medical practitioner being able to choose to accept or refuse that request. Again, this is where we have embedded that people can conscientiously object because they either conscientiously object to be involved or they are otherwise unwilling, but even when they do we have made sure that those medical practitioners are still compelled to provide patients with referral information and access to the approved information, package and materials that would say, ‘I cannot help you with this, but here are the materials, the number for the VAD navigator service and the people who can help you’. You cannot restrict people from accessing these services even if you as a medical practitioner choose not to participate in the process.

We also make first mention of our standard timely timeframes for keeping the process moving. Recommendation 16(b) mentions two business days, which is to say that the medical practitioner has to notify the person whether they accept or refuse that first request for VAD within two business days. That is the kind of standard we have tried to maintain throughout the entirety of the suite of recommendations.

Recommendation 17 is about the first doctor involved in the assessment process …

Madam SPEAKER: Member for Fong Lim, it has just hit midday. Would you like to conclude your comments, or would you like to continue?

Dr RAHMAN: No, I would like to continue my comments.

Madam SPEAKER: Member for Fong Lim, I have been in this Chamber for 15 years, and I do not remember anyone speaking for as long as you have spoken this morning: one hour and 45 minutes. It is extraordinary. I am not gagging your debate, but I think it is extraordinary for me and probably people sitting in this place that you even intend to continue further.

The skill of a parliamentarian is usually to be succinct, concise and able to deliver a speech within a restricted timeframe. A tabling statement is unlimited, but I do not think you should be taking that literally. It is an important topic. A lot of people in this Chamber intend to talk on this topic, and I ask you to be mindful of trying to be a little more concise about the remaining content of your speech. Although your timeframe is unlimited, it is not to be abused. I do not want to gag debate. You can continue talking for hours if you like, but I do not think that is in the best interest of the intent of this Assembly, the standing orders and what people expect. On that note …

Dr RAHMAN: Madam Speaker, may I …

Madam SPEAKER: No, you cannot. I suspend the Assembly for lunch.

Debate suspended.

The Assembly suspended.

NOTICES

J DAVIS (Johnston): Mr Deputy Speaker, I give notice that on the next General Business day I shall present an amended General Business notice number 1 standing in my name: