NORTHERN TERRITORY
***of* AUSTRALIA**

Dr TANZIL RAHMAN MLA
Member for Fong Lim

HANSARD EXTRACT

LCAC VAD FINAL REPORT TABLING STATEMENT PART 2

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

Mr Young: They are being blocked.

Mr EDGINGTON: Can I answer the question?

Madam SPEAKER: Cease interjecting.

Mr EDGINGTON: Each local authority receives money from their council which is provided from the Northern Territory Government, and each authority can determine what the priorities are for their community. Each local authority makes recommendations to their council on where that money should be spent.

When it comes to decision-making about where local authority money should be spent, those recommendations are made to the council of the day, not to the department of Local Government. The local authorities determine the priorities and make recommendations to their council on where the money should be spent.

The Member for Daly is saying—or he is alleging, I should say, because nothing has been presented to my office suggesting that there is a problem. If the Member for Daly has a problem, he should come to me as the minister …

Mr Young: Respond to their emails.

Ms Uibo: He is asking the question now.

Mr EDGINGTON: … and talk about the issues, because coming to parliament and putting this on the table with no evidence to back it up other than a question to me—nothing has been presented to my office that I am aware of …

Mr Young: I have the evidence, mate.

Madam SPEAKER: Okay, stop the interjections.

Mr EDGINGTON: … but I would be happy to speak to the Member for Daly further about this. Each local authority makes recommendations to their council about where that money should be spent. If you have any further evidence to …

Mr YOUNG: A point of order, Madam Speaker! Standing Order 110; relevance. The question is: will you support the Wadeye Local Authority to ensure that their funding can be spent on the Wadeye swimming pool? They have come to me and said that your government told them that they cannot.

Madam SPEAKER: You have made your point, Member for Daly. Minister, you have the call. I think you were already answering it.

Mr EDGINGTON: I will make this clearer because the Member for Daly is struggling to understand what I am telling him. That is not unusual for the Member for Daly because he does not seem to get the basics. I will say once more that local authorities receive their funding from their council. They make recommendations to their council on what the priorities are and where that money should be spent. If the council has issues with those priorities, they should tell the local authority. If the member has any further queries he can see me about it. I will be happy to talk to him.

Mr EDGINGTON (Leader of Government Business): Madam Speaker, I move that any further questions be placed on the Written Question Paper.

PAPER TABLED

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

Continued from earlier this day.

Dr RAHMAN (Chair of Legal and Constitutional Affairs Committee): Madam Speaker, continuing from where I finished before lunch, recommendation 17 of the report sets the standard for a doctor who will make an assessment on voluntary assisted dying. The nomenclature becomes increasing important to recognise in this House as we move forward to explain to the public how VAD will work in practice.

It is a two-stage process. The first stage is to have what we regard in the Australian VAD model as the coordinating practitioner.

Recommendation 17 specifies that the coordinating practitioner must assess whether the person is eligible and meets all of the eligibility criteria.

Recommendation 18 is about the second doctor. This is the clear point about the fact that the VAD process in the Australian model is rigorous. It requires multiple checks and balances in order to make sure that VAD is not used in the wrong way or abused.

Recommendation 18 is about the consulting practitioner—again, a medical practitioner. The key thing with the consulting practitioner—it is confusing, I appreciate—is that they are not a 'consultant' practitioner. There is a difference in nomenclature. Two people who are accredited medical practitioners of equal standing—it does not require that the second one is a higher authority, a specialist or a consultant, as it were—must sign off on that process as well to determine whether somebody is eligible to be a candidate for VAD.

Recommendation 19 is about making sure that the assessment process involves the discussion of a plan for administrating the VAD substance further down the track.

Recommendation 20 is about the referrals process and the duties. It is the case that things happen and change, and doctors who sign into the process may be subbed out of the process. If and when they are it becomes necessary to make sure that we do not frustrate the intentions of people who are terminally ill and suffering and are unable to otherwise complete their VAD service. There is a mechanism within this for referrals, such that a coordinating or consulting practitioner can refer their role to another person if so required.

These are the kind of nooks and crannies of the law that are required that are not fully countenanced by the public when we are talking about, 'Do you support VAD, yea or nay?'

It is true that once upon a time the Rights of the Terminally Ill Act essentially set up a standard whereby two separate medical practitioners could make a determination about whether somebody would be a fit candidate for voluntary euthanasia. At that time in that Bill, the system was more cumbersome in the sense that there was a requirement in the Rights of the Terminally Ill Act for a psychiatrist to sign off on whether a terminally ill person should be a viable candidate for VAD. Even the proponents of the original Rights of the Terminally Ill Act would now argue that it was an unnecessary step that we did not need to take.

It is a clear example of where the world, the law and the Australian position has moved on, such that it is now necessary for us to work within the modern paradigm and make sure we have the checks and balances that are required within the system to provide equitable access to voluntary assisted dying should we so choose to legislate for it, but also safe and practical access.

Recommendation 21 is about eligible witnesses for the formal request process. Once two doctors have signed off on somebody as being an eligible candidate, there is still a process to seek formal request. That must be approved in an approved form and signed by the patient in the presence of two eligible witnesses. The person must certify that they are making that request voluntarily and understand the process they are agreeing to.

Recommendation 22 makes it clear that if someone cannot sign those documents, they can do so with someone else's assistance. That person cannot be the coordinating or consulting practitioner or one of the two witnesses. Again, these are the standardised checks and balances now embedded into the system. We have to provision for a mechanism that will allow people to access VAD but that we know cannot reasonably be expected to be abused. That is exactly the situation we would face if we were to adopt a more lenient strategy.

Recommendation 23 prescribes the eligibility requirements to act as a witness. This includes, again, that someone must be 18 years old, only one of the two witnesses can be a beneficiary under the person's will and that, likewise, the coordinating and consulting practitioners and whoever else should not be permitted to witness the formal request. These are clear checks and balances to provide for a safe system for people to part of or opt out of.

Recommendation 24 provides something novel that is not provided in the rest of Australia. Again, this is a key departure from the standard in the rest of Australia. We are now providing protocols to do things via video because we recognise that there are segments of our population with lower literacy and capacity to provide written consent. Not only that—we recognise that people who are terminally ill in places that are far flung and away from urban centres may require assistance to provide robust consent. Video protocols are now embedded for the first time, which is not provisioned for anywhere else in the country.

It may be the case that video consent is a more preferable option to written consent in a number of instances, when you think about the Northern Territory context. Notwithstanding, we have provided in the recommendations for the formalities that we believe should be satisfied, including that any video includes but is not limited to the coordinating practitioner being present to witness it; the person clearly identifying themselves, and who they are; and the person clearly making declarations to the effect that they are providing their consent.

Providing consent is difficult enough when you are sick, ill and remote, let alone if English is also not your first language. We know that in the Northern Territory a huge number of people do not speak English as a first language. Some of them are from culturally and linguistically diverse communities, and other people in Indigenous communities may speak English as a second, third, fourth or fifth language. Recommendation 25 is where we begin to discuss interpreters that are required to certify materials and that the interpreter must also be a qualified translator when required.

In recommendation 26 we have not adopted an arbitrary timeline, but we have adopted the standardised timeline between phases of requests. There is essentially nine days of what you could otherwise call a cooling-off period between making the first request and then making a formal request. Things cannot just happen like that on a whim or by accident. That is an important cooling-off period.

Brought up regularly and consistently to the committee in community was, ‘Once I make a decision to start this process, can I back out?’—absolutely; at any stage up until administration you can back out. You can make a first request, have two doctors sign off on it, arrange for administration, have practitioners come to visit you and you can change your mind on the day. There is nothing to say that people should not have choice in this system; that has been the guiding principle for our committee on this whole process. We want to provide for access to VAD, but we want to make sure that anybody, whether they are an institution or an individual, has the option to withdraw from the process without fear or favour. That is an important unique principle that we are moving further on than the rest of the country, including with respect to the notion of cultural safety, which I shall come to later.

Recommendation 27 again provides accreditation requirements for interpreters, because it became exceedingly clear while we were out and about that, just like everything else, we have a shortage of interpreters. In many places it is extremely difficult to find interpreters who are conversant with local languages and who are not also family members or connected to people. It is difficult to find the right interpreters who are sufficiently and suitably accredited.

That is why, under recommendation 27(d), we have provided for the review board being authorised to overrule the requirements for meeting the minimum requirements when no other suitable interpreter is available. That is a practical reality. There will be instances when language, translation or interpreter services cannot be provided unless you use people who have some sort of interest in the sick party. Recognising the pragmatic reality of the paucity of interpreters in the Northern Territory is extremely important.

As a tangential matter, it has not made it into our report, but we note that standards on accreditation for interpreters and translators have changed in recent years. In an effort to raise the bar, we have limited the pool in some ways of people available to help out, particularly in the bush, on these issues.

Recommendation 28 is about transfers at the request of the patient. The coordinating practitioner’s role must also be provisioned to be able to be transferred.

Recommendation 29 relates to telehealth, which has become a casual thought without detailed consideration necessarily. If you take the time to go through many hours of witness testimony, you will find that everywhere we went, we asked ‘Tell us about how telehealth works in your particular place? Is it working? Is it not?’

The reality is that we found that there are significant deficits in the use of telehealth. In some places the connectivity is just not good enough. In some places the hardware infrastructure is not good enough. In some places there are no suitable translators or interpreters even if you have working infrastructure. But that is not everywhere. There are a number of places where we learned that telehealth works exceedingly well.

The medical profession has by and large, through the Health department and the AMA, made it clear to us that it would like for telehealth to be provisioned for and to be used in VAD. In other states and territories, increasingly, there are calls to allow telehealth to be used as part of the VAD process. However, at the moment, telehealth is not authorised under the Commonwealth *Criminal Code Act 1995* in relation to incitement by a carriage service.

In the same way you cannot use technology to incite someone to suicide through other means, you cannot use telehealth in this space. It is a grey zone. The reality is that some components of the VAD process are being subtly used in a grey zone in some jurisdictions. Our thinking at this stage is that we have provision for, if and when telehealth is more widely used, we could use it too. But in the first instance, VAD should be an in-person experience and process as a default position.

Recommendation 30 regarding administration makes clear that people must make unambiguous decisions regarding administration.

Recommendation 31 recognises that people struggle in relation to whether administration must be supervised or not. The fact is that is a difficult question that we spent a lot of time thinking about. In the Northern Territory context, we came to the consensus position that we want not to frustrate people who may be in remote areas, a cattle station or somewhere far flung or who may choose self-administration in an urban setting and do not necessarily want a doctor present for the process.

There are additional complexities when somebody is self-administering. You have to think about how they will access the substance, how they will take it and what will happen after the fact. That is why there are clear delineated rules for self-administration versus practitioner administration. We want to support people to make choices again.

A person who makes self-administration decisions may still request to have a healthcare worker present, and that healthcare worker is permitted to assist in the process but not administer in the process. That is a clear thing because we are trying to offer people the option to have support when they want it in their final stages. Not everybody has the benefit of being surrounded by friends, family and loved ones. Some people will elect to have a healthcare worker present based on testimony from other parts of the country.

Recommendation 32 is about the self-administration situation and notes that you require a contact person. It is fact that somebody has to accept legal obligations to provide information to the review board about the patient and what has happened. Somebody will have to, in the ordinary course of events, potentially collect a substance, return the residual of the substance and notify the relevant authorities. So we provided a standardised prompt two working days for the contact person to provide that information to try to keep the wheels moving.

Recommendation 33 makes clear that the contact person is legally permitted to receive, possess, handle, prepare and supply the VAD substance but that they also have explicit obligations to return unused substances, to report the person’s death and to provide information to the review board as requested. These are the realities and nooks and crannies of VAD that people need to understand.

Recommendation 34 is about the two business days, again, of notifying the review board.

In recommendation 35 we consider in detail what a prescription must consider because pharmacy has been a critical part of this which was almost overlooked in the early stages and became a curly question. Without wanting to derail all of what we are saying, there have been challenging situations in recent times when pharmacy protocols have not been followed perfectly, and it has led to people having to remediate.

For the most part we have a clear situation where VAD has been used safely and effectively across the country utilising the Australian standard, but there are exceptions. Those exceptions are worth knowing about so that we enter this process advisedly and do not make mistakes that other places have made. What does that mean for the Northern Territory? In practice, we have two great hospital pharmacy setups in Darwin and Alice Springs that have sufficient robust controls to house, safely store and dispose of pharmacological substances, and perhaps we do not want dangerous substances in locked boxes in other places that may not be as secure. We have tried as best as possible to think through these possibilities.

Recommendation 36 prescribes that we should consider definitions in the context of that space: who should be an authorised supplier; who should be an authorised disposer; and written information that should be provided to people to guide them on how to self-administer, to authenticate prescriptions and to return VAD substances, along with guidance in that space.

Recommendation 37 is about timely reporting to the review board, which is an extremely important part of this process for us.

Recommendation 38 is about practitioner administration decisions, and this is the critical decision. Some people will elect to self-administer; a good number also choose to allow a practitioner to do that. For that process to happen you require eligible witnesses to practitioner administration, people who need to witness and certify on the approved form that the person was acting voluntarily, without coercion, and that the administering practitioner administered the VAD substance in the presence of that witness. Certification needs to be provided to the review board within a couple of days for those processes.

Recommendation 39 again notes that, as with the two doctors making the assessment, the administrating practitioner can transfer their role to another practitioner. We do not want people to be frustrated in the process. We have a paucity of options available for people who may engage in the service, but we need to provision for the most practical application of VAD.

Recommendation 40 notes that the coordinating and administrating practitioner must notify the review board within two business days of the death of the person and that they died as a consequence of the VAD process.

Recommendation 41 is self-explanatory in relation to the cause of death certificate.

Recommendation 42 specifies, consistent with earlier recommendation on destigmatisation, that the underlying eligible terminal illness, disease or medical condition should be nominated as the cause of death.

Recommendation 43, so as not to unduly burden our Coroner, as was the case in some other jurisdictions because of ill-conceived legislation, that a VAD death is not necessarily a reportable death for the purposes of the *Coroners Act.* There is always the provision for things to be referred to the Coroner as and when required, but it is not an ex-officio default position.

Recommendation 44 is about the level of experience required by the people involved in this process. Nowhere in Australia have trainee medical graduates been involved in the VAD process, but there are other places that have varying degrees of expertise assigned to medical practitioners. We settled on the most common position that is also supported by the 2024 inquiry report, which is that medical practitioners must have at least five years of general registration or one year of specialist registration, in which case they essentially have the five years of general registration as well.

Essentially, we are saying that people who are standalone doctors and able to practise without training wheels are allowed to make decisions about VAD. That means we can tap into our public and private system by making sure that we have a decentralised model of VAD service delivery.

Recommendation 45 is about mandatory training. Even if you are a standalone doctor, you still must have completed the authorised prescribed training that the Department of Health CEO will have developed. There will be mandatory training for people to have completed to make sure that VAD is delivered uniformly, equitably and safely.

Recommendation 46 notes that the coordinating and consulting practitioners cannot be family members of the person requesting VAD or a beneficiary of the will of the person accessing VAD. Again, these are critical distinctions that need to be made on the front end.

Recommendation 47 is about providing flexibility in administration because once the difficult decisions have been made by doctors about whether somebody is an eligible person we recognise that it is not necessary for a doctor to be the person who administers a VAD substance; rather, an administrating practitioner could be a qualified medical practitioner, a nurse practitioner or a registered nurse who has practised in the nursing profession for more than five years. We say this because we know that it is nurses, particularly out bush and in communities, who have close contact with people in their end-of-life care and potentially in relation to a VAD service.

Recommendation 48 again makes clear that, like with doctors, administrating practitioners must have completed the standard mandatory training to be determined. We have advised, and we note in our testimony, that we could create economies of scale by working with other jurisdictions to find out their processes in relation to training. We do not need to reinvent the wheel on everything to do with VAD. If we want anyone to be able to practically access it any time within the foreseeable future, we will need to be agile in relation to working with other jurisdictions to benefit from their wisdom, experience and potentially training collateral.

Recommendation 49 notes that administrating practitioners again cannot be related to and cannot be beneficiaries under the will of the person.

Recommendation 50 notes that the relevant persons involved in providing or supporting the provision of healthcare services who conscientiously object can do so.

Recommendation 51 is a key NT-based consideration where you think about the people who can conscientiously object from the process. People who conscientiously object from the process are not just limited to a couple of doctors and nurses. In the Northern Territory we have a huge ecosystem of Indigenous healthcare and people who are essentially Aboriginal health workers and liaison officers by a range of different names, and under any standard legislation across the country those people are afforded no specific protections or indemnities.

We note that relevant persons involved in providing or supporting the provision of health or care services—which is a much broader category—should have the right to refuse to do any of the following: to provide information about VAD; to participate in the processes; to participate in administration; to prescribe or administer substances; and to be present at the time of the administration of a substance. If you are somebody who is uncomfortable, as a person who works in the Aboriginal health ecosystem, with participating in this, you can step away from it and will be entitled to do so under the provisions that we have championed within this document.

Recommendation 52 is about the duty to refer and/or inform for conscientious objectors. As we have made clear, you do not have to participate but you cannot actively block somebody who is otherwise terminally ill and requires access to information from getting to that information. At a minimum we say that the person must be given information about a healthcare practitioner or service that is likely to assist them, as well as the contact details of the official government state-sanctioned VAD navigator service.

Recommendation 54 is about health or care entities, noting that covers not just public and private hospitals and hospices but also residential aged-care facilities, nursing homes and other facilities. In the Northern Territory that is important because places outside of Darwin and Alice Springs have a limited number of providers of aged care, palliative care, disability care and even primary healthcare on occasions. Some of those organisations are auspiced by entities that do not necessarily want to be involved in VAD, so we have to specify who is who in this carefully.

Recommendation 55 is unique in Australia in that we have suggested that the Northern Territory should extend the opportunity for institutional objection and allow it to be permissible. The committee recommends that health or care entities that object to VAD may refuse to participate in VAD. For argument's sake, there is an aged-care facility that is auspiced by a church somewhere out bush. If that entity is uncomfortable with VAD being something it does within its premises, then it is allowed to make that choice. We are not compelling anyone to do anything they do not want to do.

However, we make it clear in that process under recommendation 56 that organisation or facility should make clear to the people residing in that facility that this is not a VAD facility. It is not a place that participates in VAD-related services. That is an acceptable compromise in the context of rights for the people on the Legal and Constitutional Affairs Committee. It must advertise its position publicly and notify persons in the health or care entity, including residents and patients who wish to access VAD, of its position, which we think is a reasonable compromise.

Recommendation 57 is about not blocking people at the door. You would not believe the stories that have come out in other jurisdictions of these things not being thought through. A sick person in the facility who does not want the VAD service then has proponents, practitioners or advocates knocking and trying to come through the front door and essentially being blocked. That causes a scene and upset for everyone. It is extremely important that we make it clear what everyone's rights and responsibilities are in this regard.

In essence, we said that the health or care entity must provide the person with contact details of the navigator service which then can help them. They must allow reasonable access to the person at the health or care entity by a member or employee of the official navigator service and, in general, not hinder the person's access to information. Information should be accessible to all Territorians.

Recommendation 58 is about not prohibiting or preventing an employee or healthcare worker onsite from initiating conversations. Again, we had testimony throughout our witness transcripts of people who made clear that previously patients wanted this information and simply could not receive it. However, under recommendation 59 it is clear that the relevant steps in the VAD process—the making of a first or formal request for VAD, the undergoing of a first or second assessment, the making of an administration decision and the administration of a substance—are things that an entity can object to participating in.

Recommendation 60 is the requirement to reasonably assist when somebody who is extremely sick or cannot move around is in a facility where they want access to VAD but the facility does not provide it. All we have asked for in that instance is for the health or care entity to take reasonable steps to facilitate the transfer of the person to—and, if required, from—a place where the relevant steps in the VAD process can be carried out. We want to prioritise choice and voluntariness.

Recommendation 61 is where we move to establishing the VAD review board in the Northern Territory. In recommendation 62 we make clear that the completed cases must be notified to the VAD board.

Recommendation 63 is where the powers of the VAD board are specified. They are broad and important powers, but they must be clearly specified powers at the outset to monitor the operation; review completed cases; refer instances of non-compliance to the Police Commissioner, the Coroner, Aboriginal health services and any number of parties that are relevant; collect, record, use and keep data so that we can learn from this process and maintain best practice; report to the minister or the CEO of the Department of Health in relation to the operation of the legislation, the board's functions or improvement of the processes; promote compliance; set standards; and maintain continuous improvement.

Recommendation 64 notes that there must be information provided at regular intervals to the Coroner, including the number of completed cases. We do not want to bury the Coroner in each bit of paperwork surrounding VAD processes, but Coroners must be informed of the number of complete cases.

Recommendation 65 is about requesting information and the board's power to request information for the purpose of exercising its function from the CEO of the department, treating practitioners and contract persons to maintain integrity in the process.

Recommendation 66 maintains that the board must act independently and in the public interest. It is, by default, not subject to direction from anyone, including the minister, about how it performs its functions.

There is a logical tautology—an inconsistency in that—a circular piece of logic in the sense that if you have this embedded within the Health department, of course there are lines of reporting that blend and become circular. If you refer to the testimony from 5 September, you will find that the Health department, when presented with the option, suggested it is possible. It would be unusual and has not been done elsewhere, but it is possible for us to use existing health structures and statutory powers under the Office of the Chief Health Officer to administrate a review board with integrity and separation from the minister and government.

Recommendation 67 is that the board is to be provided with the resources reasonably necessary to do its job. Set the board up to fail, and you can be sure that governance will fail on VAD as it has been tested in other places on occasion.

Recommendation 68 is about, on the recommendation of the Chief Health Officer, the membership of the board being assigned by the minister, which includes people with sufficient experience to do the job but also sufficient geographic and regional characteristics and spread to reflect the NT community and its diversity.

To that effect, in recommendation 69 we have specified a minimum composition for the board: the Chief Health Officer or another delegated person by the Chief Health Officer; one member who has clinical expertise, including medical or nursing; one member who has legal expertise; importantly, one member who is an Aboriginal person in a position to provide and seek advice from First Nations peoples in relation to cultural matters; and one member who is also employed or representative of an Aboriginal community-controlled health organisation (ACCHO).

The service provision and model for care in the Northern Territory is shifting from entirely state-based provision, so ACCHOs are important to have representation in that space. That is not the total composition; that is the minimum composition. Those things may be prescribed and added to in the future by regulations and by the department.

Recommendation 70 is a clear expression of the fact that the Chief Health Officer should be the chairperson of the board. The reason we made that decision was specific; the Chief Health Officer position already has statutory powers and uses existing structures, and it is not a huge ask for us to build adjunct work under the auspices of the Chief Health Officer to manage VAD and the review board. We think that is a pragmatic, costeffective and reasonable way forward in terms of safeguards. Recommendation 71 provides for a deputy chairperson.

Recommendation 72 provides that cultural safety must be a consideration in these discussions. The committee had a diversity of opinion on a range of issues including this, but this is our consolidated position. This is our compromised position on everything. This is the first report in living memory that has not had a flood of dissenting reports surrounding it. That is because across the political spectrum the five committee members, ably assisted by the committee secretariat, did their best to find common denominator positions to progress the VAD agenda for Territorians.

Recommendation 73 is about the nuts and bolts of what happens on the board—the board administration. It is inane stuff, but if you do not specify from the outset the terms and appointment of the board, vacations of office, conditions of appointments and proceedings, they are not specified elsewhere. We recommend those things should be specified in the legislation.

Recommendation 74 is about annual reporting to the minister and the frequency of doing so.

Recommendation 75 is about how regularly the minister must table a copy of the annual report to the Legislative Assembly. That should happen in a timely and prompt manner so that this Assembly is always aware of what is happening in the VAD space.

Recommendation 76 makes definitions in relation to the reviewable decisions and eligible persons.

Recommendation 77 specifies that an eligible person can apply to NTCAT to seek review of a reviewable decision. That is an extremely important mechanism. We need bodies to have oversight of appeals processes on eligibility and, quite frankly, if and when things go wrong. NTCAT is the appropriate forum, notwithstanding that nothing in the NT legislation would affect the inherent jurisdiction of the Supreme Court to hear matters pertaining to VAD.

Recommendation 78 prescribes that the legislation should be reviewed three years after its day of commencement and every five years thereafter after the first review. That is consistent with the Australian position. Some people would like there to be a continuous process of review, but we did not think that was necessary. We think we have enough information to set this up sensibly on the front end, for it to be operational within a couple of years and then for there to be reviews thereafter.

The review must consider the principles set out in the legislation, the eligibility criteria and whether the legislation is operating as intended. We say that because we know that things are likely to change in the VAD space around the country. Other jurisdictions are starting to look at reviewing their legislation and adapting things. It may be the case that by the time we reach the review stage we are thinking more broadly about principles, eligibility and operation, and we may want to refine our processes. Embedding it on the front end is important to say, ‘These are the things you should be looking at’ when we first do a stocktake. A number of reviews are happening around the country in relation to VAD processes; we have learned a lot from them, and submissions have been made by some of the review boards to us.

Recommendation 79 is about the creation of new offences—again, not things that you turn your mind to when thinking, ‘Do you support VAD? Yay or nay?’ The fact is that when you create a VAD ecosystem you create opportunities for new offences to be committed. Some offences could be extremely serious; some could be more minor. Serious offences would include things like the unauthorised administration of a VAD substance, inducing a person to request VAD and inducing a person to self-administer; those are the horror scenarios that none of us want to happen, but we must create serious offences in the legislation to account for those things from the get-go. Likewise, to knowingly provide false or misleading information, statements or documents to the review board is an offence which must be created. We also need to create offences for non-compliance relating to procedural requirements by health practitioners or contact persons, for example, failing to return a substance within a timely period.

Recommendation 80 is about liability and exemptions for participation in VAD. We provide for the fact that a person will not be criminally, civilly or professionally, as relevant, liable for assisting somebody with the VAD process, being present or acting in accordance with the legislation.

Recommendation 81 is the same thing but for health practitioners’ indemnity, which is slightly different. Health practitioners will not be criminally, civilly or professionally, as relevant, liable for referring a patient who requests VAD services.

Recommendation 82 is about refraining from administering life-sustaining treatment. Under VAD circumstances, if people who are normally professionally obliged to provide life-sustaining treatment believe on reasonable grounds that a person was dying after receiving a VAD substance and that the person does not request lifesaving treatment, they would not be liable for not providing that. Think about paramedics in that context.

Recommendation 83 is about the fact that, notwithstanding all those indemnities for criminal, civil and professional liability, complaints are still possible. You can still make a complaint to the relevant oversight body, whether it is the review board, NTCAT or the Supreme Court.

There is a range of miscellaneous provisions under recommendation 84, recognising, for example, that technical errors on a form should not invalidate processes as they have frustrated them elsewhere on occasion and, likewise, that the CEO of the Department of Health should be empowered to establish an official VAD navigator service and work out who supplies and disposes of substances, what VAD substances will be in this jurisdiction, approved information, training and forms.

A huge body of work needs to be done to provide the structure and framework to be able to provision for VAD. Our position is that it would be prudent to work with other jurisdictions to try to license some of their collateral, if possible, but that will be determined over 18 months of implementation, which is the focus of recommendation 85.

It is standard across Australian parliaments that there be an 18-month implementation period after legislation has been enacted. That is why people ask us, for example, about the ACT and why its numbers are still zero. It is because the ACT has not started implementing VAD in practice for patients yet. That will start at the end of this calendar year at the conclusion of the 18-month implementation timeframe.

Recommendation 86 recommends that the government implements a culturally safe and accessible public information campaign during and after the implementation phase. One of the most consistent things in our witness data is people saying, ‘I do not know much about this; can you tell me more?’ A lot of our witness testimony is about having an iterative discussion to explain to people what we are talking about and them saying that they would like more information as this develops and changes. It will be an important job of the Department of Health to maintain communications if it is to oversee a VAD process after the introduction of legislation which the government has at this stage committed to.

The drafting instructions, Appendix 3 of the document, are the distillation of those 86 recommendations and a clear-cut blueprint. You can get a digested form of many of these things by simply reading this, but you will fail to see the context or the support for the position. Instead, for the most part, all of us are working with imperfect data regarding this agenda. ‘How many people support VAD? Do they support it in my community? What type of VAD are we talking about?’—we will fast approach the situation where it will be incumbent on everyone in this House to seek answers to those questions to make sure you can say with conviction that you made a decision on behalf of your constituents or that is representative of them or some combination thereof.

There are limits to how much you can test people’s opinions, so running referendums on the drafting instructions is not the suggestion; we suggest that when there is a Bill perhaps that should be the thing the people are tested on in relation to their yes or no answer, or before there is a Bill perhaps we may test some of the key propositions, like whether people are generally supportive of a requirement on prognosis being dispensed with, in line with the ACT.

One of the things that I wanted to see in the report, which is not included in any form, is mention of the limitations of the inquiry and the research design. The great irony is that the fundamental limitation of the research design and the inquiry was time. The absence of time is also why we did not talk about limitations and the things that could have been done better. It is good practice, in my opinion, in academic research and works like this to acknowledge that we did not do everything perfectly.

We simply could not do everything perfectly. The task put before us was significant. The commitment collectively by the group was to advance the task as best as possible within the time allocated. On 1 September the committee, across party lines, uniformly asked for extra time to present our final report a few months later, but the government asked us to provide it by the end of September as it initially intended, and we achieved that.

That is a positive development, and the right decision has potentially been made in that regard, but it has come at a cost. The cost was that we have had to compromise on every part of the process being perfectly executed. The only way that this VAD inquiry would ever be done and delivered was for us to multitask, so we had to wait until we had a consultation report before we could start thinking about where we would go. We went out and about as best we could, but at the same time we were collecting written submissions which we could not read before figuring out where to go. Hansard can only work so fast to process crazy numbers of transcripts from hearings out bush, so we were waiting on those transcripts to figure out what was happening before we could move forward again.

Time was the fundamental limitation of the inquiry and the research design. It meant that not all processes were conducted with the rigour that I would have liked. Nevertheless, the important point to make is that in spite of all the limitations, a short timeframe, the pressures of the subject matter and having to do things in a compressed and pressurised environment, we produced a substantive representative dataset from across the Northern Territory that adds huge value.

I do not seek to politicise the issue, but I acknowledge the Chief Minister's remarks from earlier that we have added knowledge to existing knowledge by recognising that there was never full, complete and comprehensive data collection and consultation in remote Indigenous communities.

Would we have liked to do more? Absolutely. Would we like to do more in the future? Potentially. All of this is true but, notwithstanding those limitations, we still got to many places, spoke to many people and received many written submissions.

I brought along all 400 submissions with a view to talking about some of them but, in the interests of being sporting, I will not. I note that the written submissions make for fine reading. The important thing to recognise in the written submissions is that some are hundreds of pages long and some are two lines long, but every one mattered to me and my colleagues on this committee. People should look at them because they explain reasonable and unreasonable objections and opinions. Some people simply want to say, point blank, 'I do not want it. That is all I have to say.' That is fine. There are other people saying, 'This is great. You should have already done it.' That may not be super helpful, but it adds to our body of knowledge.

All those people deserve to be heard, but we have not been able to—again, because of time limitations—provide, for example, qualitative and quantitative metrics pointing out how many of these things we somehow squished into the final report and how many people were fully heard.

The written submissions are worth reading and not as daunting as they look. There are complex, large and dense submissions. For example, submission 6 from Professor White, before we appointed him as an expert advisor, includes a long list of extremely potent academic literature regarding this. There are hundreds of pages of that submission.

Meanwhile, other things are one-liners—yes or no answers. It all matters, and I assure Territorians that if they do not see their name in a footnote in the report, it does not mean we ignored their submission or that we do not think it is valuable. We read all of it. Everybody worked extremely hard to process it all as fast as we could to produce the best work we could within a limited time.

To progress the issue, members of the Assembly will now essentially need survey data of their own. Everybody will have to go out and test in some defensible, empirically justifiable and quantifiable way what support for VAD is in their community. I assure you that if people come out saying that they are for or against this proposition on the basis of whose door they last knocked on and not much else, somebody else will skewer you and be unhappy.

This is an issue of life and death. It is worth everybody making an effort to do the best they can to survey their electorate. That may be through a newsletter, a phone canvass or a digital survey online. It could be any number of things, but I encourage you all to start that process now because existing sets of information that we have are extremely imperfect. None of them clearly spell out that 99% of people support VAD. All we have is a set of polarised opinions, but we do not have good, robust date to indicate the level of support for VAD across the Northern Territory.

One of the fundamental things I take objection to is the idea that all Indigenous people are the same, think the same and believe the same things. It is simply not true. Presented with the opportunity to express themselves, Indigenous people from across the Northern Territory—as best as we could cover it—expressed a vast diversity of opinions.

Many people are opposed to VAD and, culturally, do not want to participate in it. There are others—the majority, I would say, in our dataset—for whom there is a laissez-faire attitude of, 'It is not for me, but I do not mind if other people have it'. There is other testimony from Indigenous people from out bush in remote communities who are not only for it but have even had interactions with voluntary euthanasia in the past. That is extremely important testimony, findings and data that has not seen the light of day before and helps us understand that we are all fundamentally human and nobody wants to die a painful death; everyone wants to have a good finishing up—whatever that might look like.

We produced a substantive, representative dataset that adds considerable value to our understanding of euthanasia or voluntary assisted dying. Everyone should engage with, to some extent, the rich and nuanced data from witnesses to understand exactly what we found out bush.

I will not be forensic about it, but I will point out some broad, overarching highlights of what we learned in the places we have been to. This is the rich, qualitative data that is new and teaches us what might be suitable for the Northern Territory.

Broadly speaking, the committee endeavoured to be essentially on the road for a month. That is a significant commitment. All the other committee members have families and obligations; I just have a garden I am killing. I have the least obligations, but everybody else gave up precious time with their children, partners and families to be out and about and engage all over the Territory—occasionally at risk of life and limb; I will not tell the tale, but at least one our light aircraft had to make an emergency landing in Tindal.

We were able to cover some, but not all, of the Territory but enough for this to be a representative dataset. In essence, whilst we definitely got off the beaten track, we still focused our efforts on four primary locations. The first was Darwin; here we conducted testimony and hearings with public officials under perfect conditions, which is why we could get perfectly timed *Hansard*, ask more deep and meaningful questions and have everything in the public domain as quickly as possible.

To the many people who have reached out behind the scenes, wanting the information, that information was out first for practical reasons, not for any nefarious purpose to hide any other information.

Thereafter, consultations we did in Darwin involved Aboriginal communities coming to us. We started our process on day one by reaching out to the Chairs of the former independent expert inquiry, the heads of all the land councils and the head of AMSANT because we knew that going out bush and consulting with people in remote regional areas meant having the cooperation of people there. We extended the olive branch.

For the most part people did not immediately leap at the opportunity to cooperate with our inquiry, but with time as word got around that we were giving this a fair go across party lines to try to gather real information—with a Greens member, a member of the Labor Party and three members of the CLP—we had people coming to us. Representatives from Tarntipi Homelands Aboriginal Corporation, Wurrumiyanga and the Tiwi mob made time to talk to us en masse from the Tiwis. Maningrida sent an entire delegation of people to us in parliament. We could not make it to them, and they decided this was sufficiently important for them to make it to us.

I reject any suggestion that these consultations were not credible. These consultations were imperfect, and bush consultations involved trying to use technical equipment in odd circumstances and places, sometimes with things not going exactly as they would if we were collecting testimony in the parliamentary committee rooms upstairs in Parliament House. However, they were credible consultations, geographically dispersed across the Territory and representative of the views of Territorians generally, not just Indigenous Territorians.

Then there was a second sweep of consultations where we learned a tonne of things, which I consider the community hearing consultations, in Ngukurr, Borroloola, Barunga, Gunbalanya, Papunya and Numbulwar. Each of those places was a separate consultation involving day-long processes and multiple stakeholders. We are indebted to the people in and around the Roper Gulf region and for the cooperation we received from the Leader of the Opposition in helping us to facilitate that. We are grateful for the bipartisan work we have done in this in this space and for the fact that we could produce a report without any dissenting reports; there is a reason for that. It is because we tried hard under challenging circumstances to come up with a common denominator position—not a lowest common denominator position, but a common denominator position.

A third important sweep of consultations was based around Alice Springs. Alice Springs is not Darwin; the Centre is not the north, and all of what happens in the Centre cannot be collapsed into the same basket. We knew that from the outset, which is why we spent considerable time talking to people in Aboriginal engagement, at the hospital and in palliative care as well as to key protagonists like the Australian Christian Lobby. We did not shy away from having conversations. From the Old Timers centre and the Baptist Church we gained valuable data.

The final sweep of consultations was focused in the Barkly, which I am sure the Member for Barkly will be delighted to hear. Tennant Creek, Barkly, Pulkapulkka Kari, disability services, Tennant Creek Mob Aboriginal Corporation, the Northern Territory Cattlemen's Association and Tennant Creek Hospital. I sadly could not participate in the last day of consultations because I ended up in Tennant Creek Hospital at short notice after getting food poisoning, but I can vouch for the fact that it is a fine facility. We collected data in every conceivable way, including in person.

What did we learn there? I would love to quote aspects and forensically point things out. You could write an entire PhD thesis on the data we collected supplementary to the report that is being presented to explain the rich and nuanced findings of the bush in relation to voluntary assisted dying, but I will just provide some signposts for other people who may wish to explore further in the future.

On 5 August we held an initial public hearing with the AMA NT, AMSANT and NT Health, which set up the foundations for our inquiry. What were our health providers' plans for VAD? Did they have a plan? Could they implement this? What would it take? We quickly discovered not that they had no idea but that we were in a chicken-and-egg situation with them saying, 'You tell us what the law is, and we will tell you whether we can do it', and us saying, 'You tell us what you can, and we will try to make a law that works with that'. It has been an iterative process for us to establish the right set of recommendations and tools to potentially provide a framework for VAD in the Northern Territory. The testimony from that day is important, as are the written submissions from the same providers that follow it.

Equally important for us on that first day and deliberately chosen was public testimony from private citizens. One private citizen we spoke to was Judy Dent. As most people involved with voluntary assisted dying in the Northern Territory will know, Judy Dent's husband was the first person to avail himself of an assisted death as a terminally ill person under the Rights of the Terminally Ill Act in 1995. It was important, humbling and necessary for us to hear from Ms Dent to remind ourselves that this is not just a technocratic puzzle—much as I might be making it seem so through my remarks to some extent; this is about human beings, people, a good life, a good death, humanity, compassion, the greater good and understanding that people have different perspectives and are entitled to have those perspectives.

In terms of establishing our set-up, 5 August was an important day. In Darwin we had two other insightful sessions. One of which was with the Tarntipi Homelands Aboriginal Corporation, with a number of significant and senior people on a call from the Tiwis speaking to us in detail about dying on country. If you want to know what people have to say about dying on country, there is a tonne to be learned from that consultation.

The Maningrida delegation who flew in to meet with us gave some of the best testimony we had about the positives of telehealth. We heard in a number of places that telehealth, frankly, did not work well, could not be used effectively in criminal justice proceedings and should not be used in medical proceedings, but we learned that in Maningrida—albeit a large and well-resourced community—telehealth works well in many regards. That gave us hope for the fact that telehealth could be part of this equation and that we should not write it off completely. We learned about the positives of telehealth and service provision through the Maningrida process.

At the end on 5 September 2025 we wrapped up our consultations in Darwin by asking the AMA and the Department of Health to speak to us again on short notice about how to meaningfully deliver VAD. I cannot thank the witnesses enough for their generosity and honesty in being frank with us about the nuts and bolts of VAD and what it would take to make it work.

I do not want to quote extensively from this, but it is a question that comes up all the time. From page 20 of that testimony, I am quoting from my own words:

> ***Mr CHAIR:*** *I need to, for the sake of the record, just get this there.*
>
> *Notwithstanding that service models will evolve, as you indicate in your written submission as we have discussed today, what we are looking at if we have a core centralised service in terms of practical impost in terms of time and resources is something in the order of: an increase of palliative care that the AMA today suggested would be 30%, palliative care potential cost impost extra that we require; plus potentially extra help in aged care, which we have not discussed in great detail, noting that we have seen deficits in aged-care facilities elsewhere; plus the potential for buildings, physical location, to be able to provide VAD services standalone, albeit not building a new hospital; plus at least some FTE being a number between—conversations we have had now—four and let us call it 10 people, but less than 10. Is it fair to say that those are the costs and resource imposts we are looking at to introduce a VAD service in the Northern Territory in the future, notwithstanding that service models may vary?*

> ***Dr BURGESS:*** *I think that is not unreasonable. I think the missing component we have not really touched on in that list is the review board …*
>
> ***Mr CHAIR:*** *Yes, sorry; I forgot that one on that list too. It is on my list.*
>
> ***Dr BURGESS:*** *… and the pharmacy service which might be part of your FTE. The pharmacy service would be logically centralised within our hospital network.*

The point is that the Health department has been clear that it would like to help provide VAD but cannot do it without additional resources or by simply manipulating existing budgets. If we are to provide a VAD service, we cannot provide a Rolls-Royce for 20 people a year; it is not realistic or reasonable. We all know in this place that we have competing considerations when it comes to healthcare. We on the committee believe in equitable access to VAD and are proposing that there should be VAD legislation. That is why it is so important that this is done right, as the Chief Minister pointed out.

We are past the point when we can introduce any sort of VAD legislation and say, ‘We will just use this one and figure out the rest later’. It is the honest truth that will not work or end well for anyone. Now, with the benefit of a report that has multi-party support, I am hopeful that my colleagues will concur with me that we should work together but that we should work from the starting position of utilising this report, this set of drafting instructions and this set of recommendations so that we get the right results for Territorians as soon as meaningfully possible.

Moving on to the body of stuff we learned in those bush consultations—Ngukurr was the first place we went. The truth is it was a little scrappy. We were refining our technique and consultative process and trying to conduct a town hall meeting with a church full of people; microphones were going everywhere, and we were hearing personalised stories. We learned so much that day; it was an excellent place for us to start our process.

The Borroloola Local Authority, on 7 August 2025, is where we first started getting clear expressions of how angry a lot of older Territorians are about the fact that the Rights of the Terminally Ill Act was taken away. We heard loud and clear, ‘It should never have gone. Why can’t you bring it back? Do something about it.’

The Borroloola Local Authority was generous in squeezing us into its timetable and timeline for consultations and meetings within its council chambers that day.

In Barunga we heard multiple stories across multiple consultations—local stories from traditional owners and senior elders about clinics and service provision. The Barunga consultations were some of the best ones for us talking to everyday people, not through the filter of other voices or representatives of someone but talking to people on the ground who live in the community, have an opinion and wanted to express it when provided the opportunity.

Gunbalanya provided an important dataset that people should look at. We met on the school premises and discussed in detail with the principal and staff some of the curly questions about VAD. It is where we had some of the most clear-cut evidence of lived experience of Indigenous people with interaction with end-of-life care and euthanasia—not in a salacious or criminally prosecutable way, but in a way that acknowledged our shared humanity and the fact that nobody wants to die a painful death and everybody recognises that at the end of life we are all fragile creatures in need of help.

Our consultations in Papunya were the largest facilitated discussions we had. They were facilitated by none other than Alison Anderson, a former member of this Assembly, who was extremely gracious in running a mass community consultation which started off with, for want of a better word, outright hostility and ended with us learning a lot from one another. It was a great example of two-way learning and of us having a conversation, translating to people and learning about the importance of a VAD communication strategy going forward. People did not have a clear idea of what we are doing, and once they did they had a different perspective.

To be clear, there was overarching opposition to the idea of people in that Papunya community being involved with voluntary assisted dying in its ordinary form, but there was not blanket objection. There were important discussions about palliation, palliative sedation and people’s interaction with healthcare through somebody who is as fierce and knowledgeable an advocate as Alison Anderson. At Papunya we learned a tonne.

Numbulwar is one of the few places that I am not in a position to provide personal testimony because I was absent that day. I am extremely grateful to the Member for Casuarina, Khoda Patel, who, on 13 minutes' notice, availed himself to get on a light aircraft to ensure the committee had a quorum to take testimony.

That was another situation where we had to be agile and had an imperfect set of circumstances, but under the auspices and careful management of the Deputy Chair and the Member for Wanguri, we collected valuable testimony in yet another setting that day.

Alice Springs, as I mentioned previously, was one of the most important places where we collected data on a number of fronts. We met with the Aboriginal Engagement and Strategy Unit of the Alice Springs Hospital and learned about the necessity to provision for conscientious objection, not just for doctors and nurses but for what you might call healthcare adjunct workers. We heard testimony from people who were interpreters, liaison officers and people who engage with Indigenous healthcare through the hospital who made it clear to us, 'I do not want to translate information on VAD as part of my job. I do not want to have these conversations and present this information. If this becomes a necessary job requirement for me, that will put me in an impossible position.' We understood that first, best and most clearly in the Alice Springs Hospital when talking to the Aboriginal Engagement and Strategy Unit.

We then spoke to the palliative care team. The Alice Springs Hospital, with involvement of Dr Christine Sanderson, who is a specialist doctor in palliative care there, had already provided us a detailed submission which was important to look at. We discussed that further in person, which gave it more light.

One of the key things we took away was the importance of where VAD happens. The Alice Springs Hospital palliative care team made clear how hard they worked to make sure that there is trust in that hospital and that people in the wider Alice Springs catchment area treat it as a place of healing, not a place to die. We want to make sure that is maintained.

For purveyors of healthcare in Alice Springs, including the palliative care team, it was important for them that if and when there are VAD services they do not have to take place only within a hospital setting. We wrestled with the idea of whether to suggest that they should never take place within a hospital setting. The wisdom of the Health department, through the testimony provided in public hearings, was, 'Do not stop us from being able to do that, but it is important that we have other spaces'.

In a perfect world, people could have VAD services in the comfort of their home or perhaps back in their communities surrounded by their family and loved ones, back on country. There will be instances when people are too sick to leave hospital, and it will need to be done in a hospital. There will be instances when we need safe third-party places. We cannot build entire new VAD facilities, but we must provide for neutral spaces for people to access that level of service.

It is a shame and deficiency of our inquiry that we were unable to get to Nhulunbuy and Gove, where we know there is a good set-up of palliative care existing next to a hospital with access for family and community to be proximate. The Health department and government may want to look at that in terms of a best-practice model for providing palliative and aged care in remote and Indigenous settings.

Returning to the Alice Springs Hospital care team, we learned not only about the 'where' but also about the importance of cultural safety and about group decision-making and practice from the perspective of the practitioners, not just the perspective of people in community. We learned about palliative care in practice, what people can and cannot do and what the limitations are.

Another critical thing we learned in relation to workforce is that patient care assistants are much maligned in our system. A lot of the time people think they are not quite proper nurses and that they just get tea and biscuits, but they are a lot more than that. In relation to end-of-life care, palliative care and healthcare, they are super important. We explored the fact that more patient care assistants would be extremely valuable for our healthcare system. Why is that important? It is because they are easier to get, cheaper and not entirely ubiquitous, but they are not a precious commodity in the same way as a nurse practitioner is. Patient care assistants can be a part of helping us work on problems within our healthcare system; that is an important finding.

We also learned that it is one thing to have people out bush saying, 'No, I do not want any of that treatment' and another thing to have palliative care teams talk to you properly about people's pain tolerances and thresholds. Do you know what? A lot of people out bush are seriously hard as nails. They say, 'No, I do not want anything. I will die a natural death. I believe I should die.' Whether it is because of cultural reasons or religious reasons, suffering is a part of the human condition. That is important to hear from a palliative care team.

We then went to the Alice Springs Baptist Church, and I encourage all members to look at that testimony because it was such a good example of legitimate, reasonable and measured objections to VAD on religious grounds. We had the benefit of hearing from the pastor who made it clear that life is sacrosanct, and he would not ordinarily endorse VAD. However, when we pushed him on the point and asked for him to provide specificity—I quote from page 6 of that testimony on Thursday 21 August at the Alice Springs Baptist Church—Mr Brown said:

> *As a pastor, my responsibility is to meet people where they are at, so if somebody chose that path I would not necessarily endorse it, but at the same time I would be there with them 100% of the way and help them to discover that God is present within it. I do not think the church would simply remove—or I hope not themselves from that space just because it makes them uncomfortable. The church has a responsibility to meet people where they are at, from my perspective.*

There are balanced, nuanced and reasonable objections to VAD from people on a range of grounds, and you will find them if you look at the testimony and go through the witness transcripts.

In that same vein, in Alice Springs we met with a representative of the Australian Christian Lobby. The Australian Christian Lobby is in many regards often maligned, perhaps unfairly so on occasion. I think this testimony is worth looking at in that regard because it offers not only clear-cut opposition to VAD—no doubt about that—but also a considered, reasonable set of conscientious objections on faith-based grounds. In the competing rights and priorities of the healthcare system the witness on that occasion made clear that his priority would be for us to do much more in palliative care rather than to put our efforts into VAD.

We as a committee believe that more should be done in palliative care but also that people should have equitable access to VAD. It is important to understand that we have not just put together a rubberstamp glossy report without hearing what Territorians have to say on this issue. That does not mean that we agreed with everything they had to say, but we tried to weigh all the data and make careful, considered decisions about a reasonable, practicable way forward.

Old Timers Aged Care Service in Alice Springs was a good example of two-way learning. We were asked a basic question by someone in the audience about what percentage of people support VAD, to which we were slightly flummoxed because we were like, ‘We do not know the answer to that question’. We are not here to run a referendum, and it is important that we collectively start figuring out the answer to that question.

The other interesting thing was to have somebody say, ‘Why do we have to call it VAD? What is VAD? I do not even know what VAD is. VAD sounds so insensitive. Why can’t you properly call it voluntary assisted dying, given the seriousness of it?’ That is one of those things that fed into us trying to understand why ‘rights of the terminally ill’ might be the right nomenclature to use in this regard.

I do not want to take away from the importance, significance, weight and gravity of this discussion, but I point out that VAD (voluntary assisted dying) is still so confusing that we genuinely have on record testimony from an elderly gentleman who turned up thinking that the consultation was about dying wool, not about dying people. He turned up and told us, ‘I did not realise. I thought this session was about wool dying. I just want to live as long as possible. Thanks; see you later.’

Nomenclature—words—matter. I am being pithy with the observation but, in all seriousness, words matter. How we describe things and definitions matter. We learned two other important things from that session. That session was attended by ex-Victorian nurses who straightaway asked us all the hard questions, saying ‘I was there when this happened in Victoria. I remember being gagged and all the angst surrounding whether or not I was allowed to speak or if could refer anything to anyone, or family members saying, “You are not allowed to have that conversation with my elderly father or mother”.’ Those questions need to be resolved from the front end.

In our report we have strongly leaned in favour of initiating the conversations. Our report is not a libertarian report, but we have fundamentally tried to prioritise transparency and openness and to allow much of the information that we have collected to see the light of day. To that point, we want for healthcare practitioners, medical practitioners and people adjunct to the healthcare process not to be inhibited from having conversations, even if that conversation says, ‘This is not for me. I do not want to be involved.’ The minimum expectation is, ‘Here is the number of the VAD navigator service. Here is a connection to somebody you can talk to.’

Return to country programs were also discussed in that space. They are important to understand. They are already under the auspices of community health organisations—programs in place to help people who are elderly, infirm and often terminally ill or in the last stages return to country in some form, not necessarily to provision them to pass on country but to at least connect to country. There are existing mechanisms for us to work in parallel with so that we do not reinvent the wheel.

We simply do not have the money to quadruple what we do in patient travel assistance, CareFlight or whatever it might be. We have to be agile about thinking how we can provide equitable access, something like a return to country scheme already exists for us to be part of.

The final of the four major sweeps of areas we covered was the Barkly and Tennant Creek region. In those places we learned extensively about the aged care sector, the significance of moving to ACCHOs, things like self-care dialysis and the viability of it and about pharmacy control of VAD substances. It was a clear example when somebody involved in pharmacy services said, ‘We do not think it is a good idea to have these substances in our community for any longer than necessary’. It is important for people to understand that even a decentralised VAD service would require centralised pharmacy services to ensure the safe supply, storage, use and disposal of pharmacological substances.

Beyond the Barkly Regional Council and meeting with the folks there, we looked at yet another aged-care facility, Pulkapulkka. That was a great opportunity to talk with a gaggle of nurses and hear their stories and concerns about indemnity from liability if they were to be involved in VAD. They discussed protection for carers, palliative care services as they are provided and visits to country. They provided us with stories of agility in helping people.

In Tennant Creek, in community consultation drop-in sessions we arranged, we learned about disability, dementia and terminal illness from people in disability advocacy. It was important to understand that because we were unable to cover every aspect, nook and cranny of respondent whom we would like to have covered, we have a good representative dataset, and it is not to be underestimated.

It is a lot to suggest that with 300 pages of reporting, an appendix and drafting instructions, one should still refer to the source materials. The fact is that the real meat and potatoes is in the source materials—the witness transcripts from out bush and the 400-plus written submissions provided by Territorians from all over.

We had further consultations in Tennant Creek with the Cattlemen’s Association and individual Tennant Creek people. Some of those transcripts are still not publicly available. That is unfortunate and imperfect, but it is the result of us having done this on a compressed timeline.

I commend the people who helped us to output this work, not just the committee secretariat but parliamentary Hansard staff who worked around the clock to churn out these transcripts for us over and again. This was for us to read, process and publish safely and as expeditiously as possible to ensure that today people can discuss not just the report and finished product but the raw ingredients that inform that finished product and to learn, cite and quote from that.

Nothing is being hidden at any stage. Everything has been as transparent as we could reasonably make it, and our priority has been to progress the VAD agenda. This would not have been possible without the committee secretariat, and I thank them all for their enormous efforts in meeting our timeline.

I thank the five committee members individually—all of whom put in a significant amount of work to make this happen. I am grateful to the Deputy Leader of the Opposition for helping to provision access for us in many Indigenous spaces, for being a willing participant in the conversations and for the robust discussions we could keep within the confines of meeting spaces. In a similar vein I am grateful to the Member for Nightcliff whose world view and mine do not align in many regards, but who was diligent in trying to prosecute her case, have a contest of ideas and hold her ground but also cooperate with us as a multi-party committee to produce a unanimous report.

Above all I owe a debt of gratitude to my two government colleagues on the committee, the Members for Wanguri and Blain. I single them out not least because they were there for all of it—the hundreds of hours. Even I as the Chair of the committee must confess that I missed two of the sessions due to illness. They were there for all of it—every meeting, consultation and every hour of every minute of all the hearings. They took the time, as with the others, to get across all the materials as best they could and demonstrated, as is evident through our minutes, inquiry testimony and witness transcripts, they were prosecuting the agendas, asking the hard questions and trying to dig deep and get answers. I am enormously grateful to them for their time in that regard and separately to the Member for Blain as the Deputy Chair of the committee for deputising for me on the occasions when I was unavailable. It is not easy to get thrown in the deep end on something like this when you are suddenly the one tasked with trying to build a bridge in a foreign place on a complicated topic that nobody actually wants to talk about. I thank the Member for Blain for his sincere effort in that regard.

I reserve my final thanks to those who have generously shared their time and stories with us from across the Territory. It is not an easy thing to talk about the death of a loved one at any time, even when it is an historical issue. It is not an easy matter to discuss the harsh realities of palliative care and end of life. People did not have to speak with us. There was a better-than-even chance that we would arrive at a lot of destinations with limited notice and suddenly find ourselves eating sandwiches, sitting on the red dirt with no-one to talk to, and that never happened. Everywhere we went people came to talk to us. The secretariat was extremely diligent in setting up people for us to get started with and then—by a culmination of luck, design, cooperation, collegiality and commitment to the cause—word got out that we were available to have a yarn with people if they were interested in having a yarn with us, and we managed to capture huge amounts of testimony in the time we had available to us.

No research process, consultation or inquiry is ever perfect, and I freely admit on behalf of the committee for the sake of the committee taking ownership of the issue that this inquiry was replete with imperfections, but for all its imperfections we have produced a report of high quality. We have a large catalogue of evidence which people can, at their time and discretion, interrogate to understand the totality of what we have learned on VAD. I believe we have satisfied the core goal that was always at the forefront of my mind, which was not to decide on VAD but to provide progress on the issue of voluntary assisted dying for Territorians.

I have, as everyone is aware, erred on the side of completeness to cover the field. I have done so advisedly, but I am grateful for the indulgence of my government colleagues and, likewise, to the opposition and members of the crossbench who have been willing to afford me as the Chair of this committee the opportunity to make a substantive tabling statement. I have done so because I believe that this is an important issue that Territorians have been waiting 30 years for real progress on. Finally, together collectively, we have the opportunity to present that we as a parliament can move forward on this issue for the benefit of all Territorians.

As Chair, I thank all the people who participated in the inquiry in any form. I am extraordinarily grateful to my committee members and, likewise, to the secretariat, Hansard and parliamentary staff, all of whom have been instrumental in making it possible for us to achieve a result.

My final plea in my capacity as the Chair of the Legal and Constitutional Affairs Committee and my duty, as I see it, is to ask the Assembly in earnest and to implore the government of the day and, for that matter, the opposition, to work collectively to ensure that the Bill we hope will come to this House in due course will reflect this final report and these drafting instructions with consideration for the report recommendations.

On that note, I move that the report be noted.

K McNAMARA (Nightcliff): Mr Deputy Speaker, I took part in the inquiry into voluntary assisted dying as a member of the Legal and Constitutional Affairs Committee.

I start by thanking every person and organisation that contributed to this inquiry through submissions and attending hearings. The submissions we received and the verbal testimony we heard, regardless of their stance on voluntary assisted dying, were heartfelt, passionate and considered.

The contributions were informed by people's personal experiences, expertise, spirituality, culture and personal philosophies. It is vital for the varied experiences and opinions of the public on weighty topics such as this to be heard by those who make policy. I hope all those who contributed feel proud to have participated in this democratic process and know that their voices have shaped the recommendations before us.

I am grateful to have heard so many of these contributions firsthand and feel humbled by the trust and generosity that so many people demonstrated in sharing their stories with us. Some shared experiences of unbearable suffering; others shared their fears about what voluntary assisted dying might mean for their communities; and others shared their deeply held spiritual and cultural beliefs about death and dying. Every contribution mattered.

I also thank all of my constituents who have spoken and written to me about this issue. To the best of my knowledge all of those I have heard from have said that they are supportive of VAD legislation.

I heard many times before this inquiry commenced and many more times during it that the NT has waited far too long to regain the rights we originally had for people to have choice about a dignified death. It has been